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editorial

The internationalisation of the editorial process: a response to Keith Petrie**Robert M. Kaplan^{1*} and Alan J. Christensen²**¹ Editor-in-Chief, *Health Psychology*² Editor-in-Chief, *Annals of Behavioral Medicine*

Petrie (2007) challenged the editorial review process in our journals. He argued that the journals are American-centric, that our journals are biased against publishing non-US contributions, and have little or no non-US representation on our editorial boards. We share Petrie's view that health psychology is truly an international discipline and that substantial and broad international representation is crucial to scientific progress and to the journals we edit. However, we disagree with Petrie's claims of bias and find some of his claims and data about our journals to be in error or misleading.

Petrie states that "the status afforded non-Americans can be seen in the make up of the editorial boards" of our journals. It is true that most of the members of our editorial boards are from the United States. However, there is greater diversity than Petrie indicates. For example, Petrie claims that the *Annals of Behavioral Medicine* has "no non-Americans on its editorial board". In fact the *Annals* has five board members from non-US institutions as of this writing and has had for some time (Kerry Courneya, Jerry Devins, Blaine Ditto, Wolfgang Linden, Neville Owen). Importantly, in terms of manuscript reviewers the *Annals* called on and received external reviews from 49 non-US reviewers, for papers considered for the last volume (i.e., 3 issues) alone. Petrie states that *Health Psychology* also does not include editorial board members from outside the US. Since affiliations are not listed for *Health Psychology* editorial board members, it may be been easy to overlook the inclusion of Josh Bosch (University of Birmingham) and Andrew Steptoe (University College, London). Like *Annals*, *Health Psychology* makes regular use of reviews from a variety of countries.

Disagreement about numbers aside, the concern about editorial board member diversity and representation deserves some careful thought. *Health Psychology* is the official journal of the Division of Health Psychology of the American Psychological Association. *Annals of Behavioral Medicine* (published by a predominantly European publisher, Springer) is the official journal of the Society of Behavioral Medicine. Each of these organizations has membership



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that is primarily American. Membership on the editorial board is typically regarded as service to these societies by their members.

We checked a few other international journals. The *Australian Journal of Psychology*, for example, has an editorial board made up exclusively of Australians. A review of recent contributions to the journal suggests that virtually all of the authors reside in Australia. Editorial boards from other society journals located in specific countries tend to include members who reside in those same countries. The Canadian journals, for example, include editorial board members and authors who are primarily

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editorial

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Canadian. The problem is even more acute for non-English journals. German journals for example, focus on German authors and German editorial board members.

We are in agreement that we want to publish the best research from all over the world. Clearly we do not want to limit contributions to American or North American authors. High quality science is not restricted by international borders. We simply do not believe that there is discrimination against authors from other countries. In the case of *Health Psychology*, personal and institutional identity of authors is completely blinded in the review process. The editor does not know the identity of the author until the time a decision letter is created. Even in the preparation of the editorial decision, the editor and associate editors remain blinded to the affiliation of the author. Sometimes the method sections of articles reveal the country in which the research was conducted. However, we see no clear evidence of discrimination against international papers. In fact, reviewers are often attracted to studies that use subject populations that are different from our norm. Petrie reported his count of the proportion of papers published in our journals that were first authored by someone outside the U.S. However, without knowing the proportion of papers submitted by international authors, it is impossible to answer the central question Petrie's article raises. Is it indeed true that the rejection rate for international papers is higher than it is for US contributions? We believe the answer is, slightly. However, the reasons for rejection are typically based on methodologic concerns or judgment that the topic area is not appropriate for our journals. To more clearly quantify the possible differences in rejection rates, we examined the editorial disposition of the last 200 consecutive initial submissions for which decisions have been reached (as of 9/30/07) for the *Annals of Behavioral Medicine*, one of the journals Petrie suggests may be biased toward non-American submissions. Of the last 200 non-solicited submissions to the journal, 135 (67.5%) of these papers were submitted by authors at American institutions while 65 (32.5%) were submitted by non-US authors. In terms of disposition, 78 of these same U.S. submissions (58%) were rejected outright (without opportunity for revision and resubmission) as compared to a slightly higher 41 (63%) of the non-U.S. submissions (note that these slight differences are for a journal in which blind review is not used).

In addition to the review of *Annals of Behavioral Medicine*, we could not find much evidence to suggest that *Health Psychology* discriminates against non-US

authors. Robert Kaplan became editor of the journal in 2005, but papers he accepted did not begin appearing until March of 2006. Since that time 149 papers have been published and 44 of the published papers (or about 30%) have been contributed by non-US authors (30%). These authors have been from the United Kingdom, Canada, Australia, Italy, Israel, the Netherlands, Greece, China, Sweden, Finland, and several other countries. The real issue is that, because of space limitations, *Health Psychology* must reject nearly 90% of what is submitted. Understandably, many authors feel angered and discriminated against when their work is not accepted. However, foreign authors do about as well as US authors in their probability of having papers accepted.

Where do we go from here? We are proud to be the editors of the most widely circulated journals in our field. We would like nothing better than to have our journals grow even further as the international platform, not just the American platform, for high quality research. Further, we believe that the mission of our journals is to publish the best science, independent of where the scientific studies were conducted. We are not sure how best to achieve the goals of further internationalizing our efforts. Petrie's suggestion that our meetings be held in other countries may not be the best solution. There are international behavioral medicine meetings and we and other American journal editors and scholars do attend them. The organizations that sponsor our journals are American societies that depend primarily on meeting registration for revenue. The APA Division of Health Psychology, for example, meets as part of the American Psychological Association Convention. Placing that meeting in another country is an unlikely solution.

Making our journals the publication outlets for the best science in the world is indeed a worthy goal. While we believe each of our journals is making substantial progress, we also agree that there is more work to be done. We are pleased that hundreds of international authors have submitted and published their work in our journals and are confident that these numbers will continue to grow as we work to achieve a greater international presence for *Health Psychology* and the *Annals of Behavioral Medicine*.

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editorial

Advancing the international perspective in behavioural medicine and health psychology: a response to Dr. Keith Petrie**Christopher R. France**^{1*}¹ Editor-in-Chief, *Journal of Behavioral Medicine*

As a Canadian who has lived and worked in the US for almost 20 years, I am certainly well-aware of the phenomenon that Dr. [Petrie \(2007\)](#) described in his recent article titled “The invisibility of international health psychology research.” And, I agree with his basic premise that, historically, a number of high profile behavioral medicine and health psychology journals seem to be underrepresented in terms of papers that originate outside of the US. In fact, increasing the proportion of such papers was a goal that I set for myself when I took over the role of Editor-in-Chief of the *Journal of Behavioral Medicine* in 2005. However, I must admit that it was not my first priority; my most important goals were to introduce an online electronic submission system, to reduce the journal’s lag-times for editorial decisions and publication of accepted manuscripts, and to develop a board of Associate Editors where none had previously existed. Although I might have done a better job of anticipating Dr. Petrie’s concerns by recruiting Associate Editors from around the world, it is perhaps not surprising that I chose instead to recruit people that I knew best to ensure that the aforementioned goals could be achieved.

It is important to note that the *Journal of Behavioral Medicine* has always been an international journal open to submissions from scientists all over the world. In the three years that I have been Editor-in-Chief, 39% of our submissions have been from outside of the US, 26% of our reviews have been conducted by non-US reviewers, and 26% of the articles that we have published have included non-US authors. Further, 40% of the articles that will appear in 2007 were contributed by authors from outside of the US, reflecting a growing proportion of international papers. As an aside, it is worth noting that papers that originate from the US do not necessarily include only American authors. Because people such as Dr. Petrie and I come from all over the world to live and work in the US as students, post-docs, and faculty, it is often the case that publications have been informed and benefited from an



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international perspective even though the paper may identify an American institution as the author’s affiliation.

Given the above statistics I hope that Dr. Petrie would agree that we are moving in the right direction. Nonetheless, I do believe that the time is right to prioritise the goal of increasing the international face of the *Journal of Behavioral Medicine*. We currently have two Associate Editors from outside of the US (Linda Cameron, University of Auckland and Tavis Campbell, University of Calgary), but I would like to see this proportion grow. To that end, I extend an open invitation to colleagues who would like to serve as a reviewer for the journal and who may be interested in earning a position as an Associate Editor. Interested parties are encouraged to contact me by email (france@ohio.edu) and to provide a copy of their curriculum vitae along with a brief description of their primary areas of expertise.

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editorial - response

One step up

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I was delighted to see Christopher France's reply (this issue) as the editor of *Journal of Behavioral Medicine* to [my editorial](#) on the invisibility of international health psychology research. He has clearly also seen the potential benefits for increasing the engagement of international health psychologists with his journal.

The defensive response of Christensen and Kaplan (this issue) was harder to fathom. Firstly, it is important to say that nowhere in my editorial did I claim that their journals were biased or in any way discriminated against publishing non-US contributions. The fact that they don't publish as many international papers as *Psychosomatic Medicine* is a matter of record, but there may be many reasons for this. My editorial was trying to comment on why this may be the case.

I did however point out that the make up of their editorial boards is largely North American. If anything their response underlines this. No more so than their statement pointing out that there are actually five *Annals of Behavioral Medicine* editorial board members "from non-US institutions" – in fact four of these are from Canada and one is from Australia. This means only one of the journal's 40 or so editorial board members is from outside North America. This to me looks as international as the major league baseball World Series.

Their comparison with general journals from Australia, Germany and Canada also is spurious. It would be more reasonable to compare their journals to other health psychology publications such as the *British Journal of Health Psychology* or *Psychology and Health*. A glance at the compositions of these journals' editorial boards (Google "editorial board" and the journal name) does show up the weakness of their argument.

While the policy of *Annals* and *Health Psychology* is clearly unlikely to change in the near future, I believe changes towards adopting a more international



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perspective are inevitable. Greater use of electronic databases and internet access to the journals means these changes will come eventually and the field as a whole will benefit from an increased visibility of European and other international health psychologists.

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If any of the pieces in this or past issues of the **European Health Psychologist** have inspired you to want to write a reply, please contact the editorial team!

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original article

Crying as a multifaceted health psychology conceptualisation: crying as coping, risk factor, and symptom

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Abstract

We summarize popular and pre-scientific conceptions of the relationship between crying, well-being, and health, and we review the scientific literature on this topic. It appears that crying can be conceived in three distinct ways: (1) crying as coping; (2) (non)crying as a risk factor for the development of disease; and (3) crying as a sign of distress and a symptom of disease. First, the focus is on whether crying brings relief and facilitates emotional recovery after stressor exposure. Next, we discuss the evidence addressing whether crying or its chronic inhibition is associated with increased risk of developing health problems. Finally, we address crying as a sign or symptom of distress, pain or disease. It is concluded that the question regarding whether crying serves a coping function and brings relief has yielded seemingly contrasting findings, dependent on the design of the study. Concerning the second and third issues, there is a lack of sound studies. We present evidence for a relationship between neurological disorders and crying. The relationship between crying and psychiatric disorders such as depression is less clear. There is also mainly anecdotal evidence of increased crying in a wide variety of health problems, which may reflect symptoms of disease, co-morbid depression, adjustment problems, or side effects of treatment. Furthermore, some recent studies suggest a positive effect of crying on health status in certain patient groups. More systematic and well-designed studies are needed to clarify the relationship between crying and health.

Introduction

Crying is a universal and uniquely human way of expressing emotions. It permeates our lives from the very beginning (e.g., “the primal scream”) until the end, when we die. Important emotional events are typically associated with the shedding of tears, but since such major events are rare, most crying actually occurs by rather common everyday experiences. This suggests that not only the specific causal event is relevant, but other contextual factors and person characteristics also play a significant role in crying behaviour.



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The capacity to shed emotional tears has surprisingly received little serious attention from the scientific community, and the little research that has been done has employed very different theoretical viewpoints with a lack of connection between the studies. This may explain why we know rather little about this intriguing phenomenon, and many obvious questions concerning antecedents, moderators and consequences of crying cannot yet be answered adequately. In this contribution, the focus will be on the relationship between crying and health. For health psychologists, crying can be conceived of in at least

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three distinct ways. First, crying may be considered a coping behaviour. In addition, as a logical consequence, crying or the chronic inhibition of tears may be perceived as a risk factor for the development of specific disorders. Finally, crying may be regarded as a sign of distress or pain or a symptom of disease.

It is important to distinguish between the immediate effects of crying (versus suppression of a single crying episode) and the long-term effects of regular crying (versus chronic inhibition of tears). First, there is the claim that crying has immediate positive effects upon our mental and physical well-being, and therefore brings relief. This idea dates back to as far as 2000 years ago, when the Roman poet Ovid voiced this conviction when stating that "It is a relief to weep; grief is satisfied and carried off by tears." More recently, Breuer and Freud (1968, p. 8) referred to tears as "involuntary reflexes that discharge affect so that a large part of the affect disappears." According to Menninger, Mayman and Pruyser (1964), crying may be considered as perhaps the most human and most universal of all relief measures. Such quotes seem to reflect the conviction that crying may be a rather effective way of coping with stressful situations.

However, crying is not only expected to bring immediate relief, but long term benefits as well. In common lore, the chronic inhibition of tears has been claimed to endanger our physical health. As shown by Cornelius (1986), in a review of 130 years of popular media, the conviction prevails that crying should be regarded as beneficial for one's health, whereas withholding one's tears may have damaging health effects. There is an even longer history of the presumed association between crying and health in writings on medicine and the arts. For example, as early as 1694, the Dutch physician and philosopher Franciscus Mercurius Van Helmont wrote about the necessity of crying after bereavement in order to prevent the development of distemper or sickness. Similarly, the famous British psychiatrist Sir Henry Maudsley (1835-1918) stated that "Sorrows which find no vent in tears may soon make other organs weep" (Lutz, 1999, p. 119).

It is clear that popular belief regards crying as beneficial to one's health; however, what is the scientific evidence? In what follows, we will focus on the relationship between crying and health from three different perspectives: (1) crying as coping: the immediate effects of crying on mental and physical

well-being; (2) the long-term health effects of the expression and inhibition of crying; (3) the relationship between distress or pain and crying, as well as crying as a sign or symptom of disease.

Crying as coping: Does it bring relief and promote physical recovery?

Concerning the immediate effects of crying on one's mental well-being, mixed results have been reported, varying by the design of the study. Specifically, laboratory studies have demonstrated negative effects as a result of the shedding of emotional tears. People who cried while watching a sad film, without exception, felt sadder and more depressed afterwards than people who did not cry (see Cornelius, 1997; Stougie, Vingerhoets & Cornelius, 2004 for a review). In contrast, naturalistic studies in which participants are asked to report on their last crying episode using survey or experiential sampling techniques yield a very different picture. For example, as reported in Bylsma, Vingerhoets, and Rottenberg (under review), when participants were asked about their most recent crying episode, just over 50% reported feeling better mentally after crying compared to how they felt before crying, whereas approximately one-third reported feeling better physically after crying.

How can we explain these seemingly contrasting findings? Are the retrospective self-reports biased? Do they rather reflect what the people think that should have happened rather than their actual feelings? Alternatively, do the positive effects of crying occur gradually over an extended period of time, making the timing of the measurements in the quasi-experimental studies not optimal, since they generally measure effects a very short period of time after the crying is elicited? Could it be that the "no pain, no gain" hypothesis is valid, stating that the crying individual first has to experience the deepest and most negative feelings, before the recovery sets in? May people feel embarrassed when crying in the laboratory? Cornelius (1997) further emphasizes that crying in response to a film does not bring any resolution to the situation that precipitated the crying episode, whereas in real life crying may have an impact on individuals who are present, stimulating them to change the conditions that caused the individual to cry. Alternatively, the relief might also result from the comforting words and behaviours of

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the other individuals in the social environment, providing an indirect benefit of crying. Indeed, in an international study spanning 37 countries and including over 5500 respondents, Becht and Vingerhoets (2001) established that self-reported mood improvement was negatively associated with the shame induced by crying. Also using data from this same set of respondents, Bylsma et al. (under review) found that self-reported mood improvement after crying was related to receipt of positive social support, resolution of the situation that caused the crying to occur, or experiencing a new perception of the situation. Furthermore, suppression of crying and the experience of shame during crying were negatively related to mood improvement after crying. Additionally, Cornelius (1997) showed that there was an association between the self-reported effects of crying on one's mood and the effects of crying on the situation or the relationship with the other present people. However, the self-reported mood effects of crying alone compared with crying with others present revealed that, contrary to expectations, there was no difference in the effects of shedding tears on one's well-being between these two situations. In conclusion, the issue of the immediate effects of crying on one's mood is not yet definitively settled, and it is not yet clear to what extent the reactions of the social environment play a role.

There are also a few studies in which cardiovascular activity has been measured before, during, and after crying, although it is not easy to determine the precise onset and offset of crying

behaviour (see Hendriks, Rottenberg, & Vingerhoets, 2007). These studies unequivocally show that crying is associated with physical arousal. However, there is also some evidence that in a later phase crying is associated with increased activity of the parasympathetic nervous system, which is linked specifically with recovery processes and relaxation. However, Hendriks et al. (2007) could not establish whether the increased parasympathetic activity followed or preceded the crying; therefore, a causal relationship cannot yet be established. Finally, there are two studies (Labott, Ahleman, Wolever, & Martin, 1990; Martin, Guthrie, & Pitts, 1993) investigating the effects of crying on secretory immunoglobulin A (S-IgA), an immunologic variable that serves as a first-line defense against invasion by potential pathogens. When people cried in this study, they exhibited significant decreases of S-IgA levels, representing decreased protection against pathogens, but these decrements were not found when subjects only felt sad but did not cry.

In conclusion, we have not found strong evidence that crying has a relaxing effect, although there is also no evidence unambiguously against this view. It is nevertheless important to consider the value of crying as a coping mechanism, which helps an individual deal with stress. As summarized in Figure 1, crying may theoretically be considered a unique coping behaviour, because it may unite in itself the induction of social support, as well as both emotion-focused and problem-focused coping strategies.

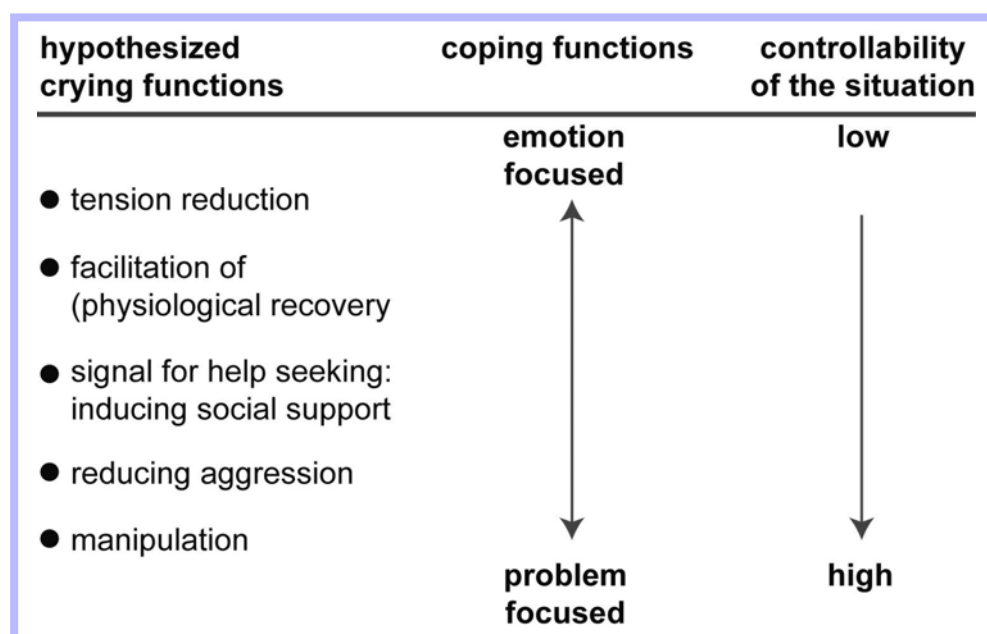


Figure 1

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*(Continued from page 70)***Crying as a risk factor: Does the inhibition of crying promote disease development?**

Regarding the second question, whether the chronic inhibition of crying may put individuals at risk for the development of health problems, two kinds of studies are important to consider. First, one may wonder whether people who never or rarely cry have a greater risk of developing health problems. Alternatively, similar to the so-called “buffer-hypothesis” of social support (Cohen & Wills, 1985), one could speculate that the hypothesized beneficial effects of crying are only present when exposed to emotionally stressful events, whereas crying has no relation with health if one is spared the confrontation with emotionally demanding situations. Unfortunately, the few relevant studies all suffer from serious methodological limitations, preventing definitive conclusions from being drawn. We have conducted a few studies to establish the relationship between crying proneness or frequency and self-reported health status, but these studies typically found zero or very weak negative correlations, suggesting, if anything, that people who cry more often feel less, rather than more, healthy (see Vingerhoets & Scheirs, 2001, for review). There is one study (Labott & Martin, 1987) particularly designed to examine the buffer hypothesis of crying. They demonstrated that individuals with a high number of stressors who cried frequently did not feel better – actually even worse – than comparable persons who failed to cry in similar conditions.

Interestingly, some remarkable findings have been reported in clinical populations, demonstrating a beneficial effect of shedding emotional tears on physical health. For example, Saul and Bernstein (1941) and French (1939) found intriguing relationships between crying and course of urticaria (i.e., hives) and asthma, respectively, suggesting that crying reduces the symptoms of these conditions. Kepecs, Robin and Brunner (1951) reported a relationship between crying and exudation into cantharides blisters in the skin, showing that the inhibition of crying was followed by an initial drop in the exudation rate, later followed by an increase if the inhibition continued. More recently, a study among patients with rheumatoid arthritis revealed that shedding tears reduces the negative influence of stress on the neuroendocrine and immune responses in peripheral blood (Ishii, Nagashima, Tanno, Nakajima, & Yoshino, 2003), and Kimata (2006) showed that

crying reduced allergic reactions. Furthermore, an experimental rat study (Ilinskii et al., 1985) even suggests that stimulation of the lacrimal gland may have a positive effect on wound healing. However, these intriguing findings need replication.

In addition to the question regarding in which conditions crying may be beneficial (see Rottenberg, Bylsma, & Vingerhoets, submitted) it is important to have insight into the putative underlying mechanisms that might be responsible for the supposed positive effects of crying. The following four potential relevant hypotheses have been formulated. The first idea, mentioned earlier, is that crying stimulates the activity of the parasympathetic nervous system, which is connected to relaxation and recovery, but also to helplessness and giving-up (Vingerhoets, 1985). Along these lines, Rottenberg, Wilhelm, Gross, and Gotlib (2003) and Hendriks et al. (2007) have demonstrated that crying is indeed associated with a parasympathetic rebound mechanism. Another possible mechanism that has received much attention in the popular media is Frey's (1985) idea that tears function in the removal of toxic waste products (e.g., stress hormones), which are released in the blood when we are in distress, which is presumed to result in a better mood and perhaps even better health. However, the amount of toxic waste products removed by tears is very small at best and tears are mainly reabsorbed again in our nose. A third idea is that sobbing increases the amount of inspired cold air, which may result in the cooling of the hypothalamus, or that the accompanying changes in the facial muscles and vasculature by facilitating or inhibiting neurochemical processes in the brain influence one's mood (McIntosh, Zajonc, Vig, & Emerick, 1997). Finally, based on preliminary animal work by Panksepp (1998), one could speculate that crying promotes the release of substances like endorphins that could produce positive mood effects; however, we are not aware of any direct test of this hypothesis.

In conclusion, review of the literature reveals a serious lack of well-designed studies directly relevant to the questions of interest. There is currently no evidence suggesting that the inhibition of crying is causally related to the development of health complaints; however, given the poor quality of the studies conducted until now, there is neither any strong evidence for or against this idea.

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original article

Vingerhoets, A., & Bylsma, L. (cont'd)*(Continued from page 71)***Crying as a sign of distress or pain or symptom of disease states**

There is little doubt that the crying of babies serves the purpose of communicating to their caregivers that they are in pain or distress and need assistance. However, the crying of babies is likely more than simply an alarm signal (Furlow, 1997). Most notable is that babies with a compromised health status, such as neurological disorders, disturbed metabolism, and infectious diseases cry not only more often and more intensely but also at a higher pitch than healthy babies. The crying signal thus provides the parents with information about the health status, or in evolutionary terms, the fitness of the baby. Although there is little human research addressing this issue, it has been demonstrated in twin studies that mothers react faster to the crying of the healthy baby than to the distress vocalizations of those with a compromised health status (Mann, 1992).

In adults, the research on crying in pathological groups is mainly focused on neurological disorders, particularly stroke and multiple sclerosis. A significant minority of these patients suffer from what has been labeled, among other things, pathological crying or involuntary emotional expression disorder (Cummings et al., 2006). In addition, there is a limited research on crying in psychiatric disorders and other adverse health conditions, which we will briefly discuss. It is generally not clear to what extent in such cases the increased emotionality of patients reflects distress or a real symptom of disorder or disease.

Crying and neurological disorders

Since the end of the 19th century, clinicians have been aware that neurological disorders may be accompanied by increased emotionality and crying. The terminology for this condition is rather confusing in that many labels are used in the literature to describe this phenomenon, including pseudobulbar affect, emotionalism, emotional incontinence, pathological crying, and Involuntary Emotional Expression Disorder (IEED; Cummings et al., 2006). There is some disagreement regarding whether or not the displayed emotions accurately reflect the individual's emotional experience or just reflect a pathological motor behaviour. The behaviour is considered to be pathological because it is not appropriate to the context of situation and it may continue unabated. Others emphasize that the main characteristics of this

condition imply that the person has difficulty in keeping his/her emotions and/or behaviour under control.

A few studies have carefully analyzed the crying episodes of stroke patients, including the antecedents and the setting of crying (Allman, Hope, & Fairburn, 1992; Grinblat, Grinblat, & Grinblat, 2004). Grinblat et al. (2002) concluded that the antecedents of the crying of these patients differed considerably from that of healthy individuals; however, we feel that these findings strongly suggest that there is a quantitative but not a qualitative difference between the crying of stroke patients and healthy controls. Since it has been established that crying decreases significantly in the first year after a stroke, and these patients likely have a lot to cry about due to the major losses associated with this disorder, Mark, Van Hoek, and Vingerhoets (in press) have recommended reluctance to apply terms suggesting a disorder or pathological condition, which may unnecessarily stigmatize these patients. Despite the problems with the definition and specific diagnostic criteria of this excessive crying, it is important that health professionals recognize this condition and offer treatment, because it is clear that it may significantly interfere with rehabilitation and social integration.

Crying and other disease conditions

A review of the literature suggests that there are quite a few illustrations, though primarily case studies, which suggest increased crying in other patient groups as well. Several psychiatric disorders have been associated with excessive crying, including mood disorders, anxiety disorders, and schizophrenia. In addition, there are several examples of case studies suggesting a relationship between disease states or treatment and increased crying (see Vingerhoets & Bylsma, in press, for review).

Of the psychiatric disorders, depression is the most frequently associated with changes in crying behaviour. Similarly to the presumed health promoting effects of crying, it is quite easy to find quotes in the popular and (semi-) scientific literature suggesting that depression and crying are very closely linked. However, despite the popular belief in the association between depression and crying, crying has not consistently been used in diagnostic

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interviews and measures of depression (see Vingerhoets, Rottenberg, Cevaál, & Nelson, 2007) and the research examining this relationship has been limited with mixed findings. Some studies have found that depression is associated with increases in crying or feeling like crying in both clinical and non-clinical samples (e.g., Hastrup, Baker, Kraemer & Bornsetin, 1986; Frey, Hoffman-Ahern, Johnson, Lykken, & Tuason, 1983; Rottenberg, Cevaál, & Vingerhoets, in press). However, other studies have found no relationship between depression levels and crying (e.g., Kraemer & Hastrup, 1988; Labott & Martin, 1987; Rottenberg, Gross, Wilhelm, Najmi, & Gotlib, 2002). Others have suggested that very severe levels of depression are associated with less crying or an inability to cry, suggesting a non-linear relationship between depression and crying (e.g., Vingerhoets et al. 2007). In conclusion, the relationship between mood disorders and crying remains unclear; findings may vary by severity of the depressed sample and the design of the study (naturalistic versus laboratory).

In sum, crying may be seen in patients suffering from a wide variety of diseases. However, the specific status of it may differ considerably – it may be a symptom, a side effect of a treatment, the symptom of co-morbid depression, or a reflection of problems with adjustment, among other possibilities. In some cases, there seems to be a close association with mood, while in other examples, the tearfulness may come quite suddenly and the association with mood is rather loose. It is apparent that this complex picture prevents the formulation of simple advice regarding how to deal with the crying of medical patients. A careful evaluation and systematic examination of all possible causes is a first requirement.

Conclusion

In the present contribution, we have considered crying from different perspectives, and we have summarized and contrasted the popular lore and research evidence that has examined the relationship between crying and health. The focus was both on the immediate psychological and physiological effects of crying (“crying as coping”), suppression of crying as a risk factor for the development of health problems, and crying as a sign or symptom of a compromised health status. We have demonstrated that there is a wide gap between what the general public and clinicians believe and what actually has been scientifically demonstrated. More specifically, there is little empirical evidence

supporting the popular idea that crying brings relief or that the inhibition of crying may be damaging for one's health. In the same vein, the notion that there is a strong relationship between crying and depression is also not supported by the current available data. On the other hand, excessive crying is a relatively common problem in patients with neurological disorders, but it is uncertain to what extent this reflects adjustment problems or is the consequence of neurological damage.

Investigators have not considered crying as an important research topic, perhaps because they considered it merely a symptom of sadness or depression. However, upon closer examination, it appears that crying is much more than simply a symptom of a negative mood state; it is a complex behaviour with unique evolutionary and developmental features, as well as remarkable intra- and inter-individual differences. For an adequate understanding and appreciation of this complex phenomenon, the collaboration of scientists with different backgrounds and perspectives is greatly needed.

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original article

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EHPS report

Psychology and the EHPS present at the United Nations**by Irina Todorova**

On October 10th, 2007, the United Nations organized the *First Annual Psychology Day*, which took place at the UN Headquarters in New York. With its title, the event promised to be the first of a regular yearly series of meetings, devoted to acknowledging the contributions of the discipline of psychology and its representatives at the UN to fostering the agenda and values of the international organization and its many programs worldwide. The event was initiated by several psychology associations, which have official NGO status with the United Nations and several of its committees. It began with an introduction of the agenda and goals of the meeting, followed by several panels during October 10th and October 11th 2007. The first panel focused on the role of psychology and psychologists at the United Nations, and included a presentation of the participating psychology associations, which included the *American Psychological Association*, the *Association for Women in Psychology*, the *International Association of Applied Psychology*, *International Council of Psychologists*, *International Union of Psychological Science*, *International Psychoanalytic Association*, *International Society for Traumatic Stress Studies*, *Society for the Psychological Study of Social Issues* and the *World Federation for Mental Health*.

The topics of the following two panels were: *Peace and Conflict Resolution* and *Human Rights and the World of Work*. October 11th was devoted to the Celebration of World Mental Health Day with the theme of *Mental Health in a Changing World: the Impact of Culture and Diversity*. It included a briefing from the UN Department of Public Information on the topic of *Psychological Response to Disasters*. Speakers during these two days included Rachel Mayanja, Assistant Secretary General of the UN and Special advisor on gender issues and the advancement of women; Helene Gosselin, UNESCO representative to the United Nations; Norman Anderson, CEO of the American Psychological Association; Florence Denmark, Chair of the Planning Committee for Psychology Day, and many other psychologists and United Nations representatives.

An overarching theme which cut through many of the presentations was that of reciprocal transaction between the UN and the accredited psychological associations – psychology contributes its perspective, theoretical considerations and practical recommendations to UN events and resolutions; and at

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the same time the philosophy of the United Nations comes to be represented in the activities of the psychological societies. As Norman Anderson pointed out, such a partnership leads to a contribution of psychological knowledge to furthering the mission of the UN. Psychologists participate in many of the NGO committees, such as the NGO Committee on Ageing, on Children's Rights, on HIV/AIDS and on Mental Health. Examples of several recent forums, at which psychologists were central speakers are: the panel discussion on Creating Preventive Measures to Eradicate Violence against Women and Girls at the Individual, Community, and State Level; AIDS: Eliminating Stigma and Discrimination; The Psychological Impact of Natural Disasters.

Acquiring NGO status with the United Nations happens through a lengthy application process through the NGO section of the Department of Public Information at the UN. Detailed information about the UN NGO section is available at www.un.org/dpi/ngosection/index.asp. Through this process, the European Health Psychology Society could join the group of psychological associations affiliated with the United Nations. As an initiative undertaken by Susan Michie, past president of EHPS, the Executive Committee is currently exploring this possibility and asking all EHPS members to share their views, as well as their experiences working with UN programs and projects, such as with the World Health Organization. With official NGO status at the United Nations, the EHPS would be able to have a say in shaping international policy on health through appointing EHPS representatives, participating in the

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deliberations of different NGO committees at the United Nations, and informing and implementing UN decisions.

Members of the EHPS have had collaborations with several United Nations institutions though the years. For example, several EHPS members and member countries (Bulgaria, Romania, Hungary, Switzerland and others) are involved in the longitudinal WHO collaborative research, health promotion and policy project *Health and Behavior in School-Aged Children*, which has been collecting data and providing policy recommendations on school health since 1986. Our research team at the Health Psychology Research Center in Bulgaria has collaborated with the UNFPA office in Bulgaria on programs for prevention of cervical cancer. Adriana Baban, past secretary of the EC and other EHPS members from Romania have consulted with UNICEF on topics of prevention of domestic violence, child trafficking and alcohol use among adolescents in Albania. Suzanne Skevington, an EHPS member, is currently Director of the WHO Centre for the Study of Quality of Life. She and other

EHPS members from the United Kingdom have worked on projects for: *Improving cross-cultural assessment of quality of life in health and health care* (WHOQOL Group 1992- date) Division of Mental Health WHO, Geneva; *Active ageing and quality of life in older adults* (WHOQOL-Old Group); WHO European Regional Office, Copenhagen (2001-2004); *Assessing quality of life in HIV/AIDS* (WHO Geneva and UNAIDS 1998-2003); *AIDs-competent communities* (UNAIDS, Geneva, 2000-2004); *Biodiversity, health and quality of life* (UNESCO Paris, 2005); *Child-friendly schools* (WHO Geneva, Department of Mental Health and Substance Abuse 1999).

With its broad international network of psychologists, its commitment to improving health and well-being in a global context and its devotion to developing health policy, the EHPS can actively contribute to the work of the NGO committees at the United Nations. We hope to be able to develop further partnerships with the United Nations and the NGO's affiliated with the UN.

Dear EHPS members, we look forward to your opinions, suggestions and recommendations regarding EHPS affiliation with the UN. For the application process, it would be very helpful if you could send us examples of past and current projects and activities that you have undertaken in collaboration with the United Nations and its programs, such as WHO, UNESCO, UNICEF, UNFPA and others. Please send such information to Irina Todorova, and let us know if we can include it in the EHPS application to the UN.

Irina Todorova
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EHPS 2007 Conference Poster Awards

Poster Award Winners

Cristina Neculai Simmelweis University, Hungary	Living in institutional care predicts cardiovascular risk factor sin adulthood
Gyöngyver Salavecz Simmelweis University, Hungary	The effects of work and marital stress on depressive symptoms
Lukasz Kaczmarek Adam Mickiewicz University, Poland	Induced positive affect, resiliency and cardiovascular reactivity and recovery

Runners-up

Amelie Wiedemann Freie Universitaet Berlin, Germany	Intentions, planning and health behavior change: evidence for moderated mediation
Martin Dempster Queen's University Belfast, Northern Ireland	Response shift in quality of life assessment during cardiac rehabilitation
Iman Elfeddali Maastricht University, The Netherlands	Smoking cessation and abstinence within a quit an win contest
Andries Oeberst Jacobs University, Germany	Stereotypes as warrants of apprehension in HIV-risk perception

conference reflections

Reflections from the 2007 European Health Psychology Society conference

Dr. Eleanor Mann*King's College London, England*

This year's conference in Maastricht was my first EHPS conference. The scientific programme had a lot to choose from, and so as a relatively new researcher, I attended the conference wanting to learn.

A key interest of mine concerns interventions that change cognitive antecedents of behaviour and their impact on subsequent behaviour. The symposium, 'Behaviour Change Interventions: design, content and effectiveness'¹, chaired by Charles Abraham and Nanne de Vries, gave a good overview of the approach. Meta-analyses presented by Delores Albarracin^{4,5} and Paschal Sheeran⁹ suggested that successful manipulation of attitudes, normative beliefs and self efficacy have resulted in changes in intention and behaviour. However, Charles Abraham suggested that while these findings were interesting, they may be difficult due to inadequate reporting of trial protocols². He presented a taxonomy of behaviour change techniques which could be applied to systematic reviews of interventions in order to identify the most successful methods of intervention³. I found it prompted me to think carefully about the mechanisms by which I expect behaviour change to occur in my own research. The take home message for me was that there is some experimental support for social cognition models such as the theory of planned behaviour, but that quality studies of theory based interventions face many challenges in their implementation.

The latter conclusion was borne out in other presentations. Herman Schaalma presented a keynote address on intervention mapping⁸, which showed the researcher how a quality intervention could be designed and implemented, but it was very clear that there are no easy answers. My impression was that often studies reported at EHPS this year showed no effects of the intervention – clearly behaviour change is not easy. However, the insights provided by these studies were very interesting; for example, the theory used to design the intervention still predicted behaviour change, suggesting that a key problem might be successful manipulation of these mediators.

For me, perhaps some of the most memorable studies were the ones that explored ways of manipulating proposed antecedents of behaviour change. I was fascinated by Jill Whittingham's use of eye tracking to measure attention for different aspects of health

promotion posters¹¹. Her work suggested that, although creating successful health promotion materials can be hit and miss, we may be able to create better posters by systematically drawing upon attention and memory research. John McAteer reported the development of a hand washing intervention for nurses based on the self regulation model⁶. He identified several behaviour change techniques through piloting, but encountered some difficulties in implementing 'feedback' in the form of peer presentations. He highlighted the importance of implementing behaviour change techniques in ways that were acceptable to participants.

A lot of the interventions reported were designed to persuade individuals to undertake a particular course of action. However, I was also interested in social cognitive approaches to promoting informed choice. Informed choice interventions promote a particular decision making process rather than a particular decision outcome. Susan Pick suggested that facilitating informed choice (informing and empowering) was critical to the success of the sexual health interventions she reported in her inspiring keynote address⁷. However, in a session of papers on screening, studies reported that providing information and promoting value consistent decisions might not promote screening uptake, when individuals do not consider screening to be in their best interests. Shoshana Shiloh, for example, found that individuals' preferences for risk of false positive and false negative results influenced screening choices¹⁰. I think a social cognitive approach to understanding informed choice has a lot to offer in terms of informing health policy and testing models of social cognition, and I look forward to learning about further research on this topic at next year's conference.

So overall, I got a lot out of this year's EHPS conference. I met a lot of people and had many interesting discussions. I came away with a lot of ideas, and what's more, I had fun too.

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conference reflections (cont'd)

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8. Schaalma, H. (2007). *Reflection on evidence-based health promotion*. Keynote Lecture to the 21st European Health Psychology Conference, Maastricht, The Netherlands.
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Emily Arden-Close

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I was particularly impressed by the first keynote speaker, Dr Susan Pick. Before, I had not seen academic health psychology research as rarely having a significant impact on the world. However, her talk was truly inspirational – by listening to the people whose lives she aimed to improve, and battling on even in the face of opposition, she had developed a programme of aid that had spread throughout Mexico, and to other continents. This consisted of 4 main steps: detecting needs, carrying out a pilot study, dissemination and replication, and scaling up. This inspiration was reinforced by Lynn Myers' talk on illness perceptions in a Chinese population, where she reported that pharmacists who developed an intervention based on understanding of illness perceptions in Bangladeshis with diabetes, had managed to reduce their HbA1c levels from well over 20 to within normal levels. These talks highlight something crucial: change is possible, provided that sufficient background research has been carried out prior to undertaking interventions. While on this theme, Herman Schaalma's talk on intervention mapping (see Bartholomew et al., 2006) was highly pertinent – it explained a step-by-step programme for developing theory and evidence-based interventions, which

highlights the fact that sufficient planning is necessary before developing an intervention – too many interventions have been hastily assembled, without sufficient evidence for their effectiveness. This step-by-step process can be used in a variety of projects, and should be seen as a useful tool to stimulate the systematic replication of science.

However, even if this process is not carried out, authors can lay shortcomings bare by reporting the limitations of their research. Reflecting on what has been neglected in planning interventions goes a long way towards explaining why many are unsuccessful. However, even if interventions are planned with due care and attention, they may be ineffective. In this case, as scientists we have a responsibility to science to publish and report accurate information, without withholding facts. Given the 'publication bias' null effects of intervention studies are often masked, which is far more damaging to patients/ health promotion in the long run. James Coyne's talk on psychotherapy and survival in cancer patients highlighted that results are often misinterpreted as positive, in an effort to support 'myths' that may be embedded in lay beliefs. These errors are very rarely noted, and minor positive effects tend to be accentuated over time, and shortcomings forgotten, rather like 'Chinese Whispers.' All manuscripts should be viewed with a critical eye (Coyne et al., 2007). The recent set of CONSORT guidelines, endorsed by a number of leading journals, are a major step in the right direction, but we still have a long way to go.

Another highlight of this conference was a symposium on men's health, which consisted of qualitative studies exploring men's attitudes towards current issues in health psychology (i.e. dieting, self-help group membership). This symposium highlighted that many men view use of health services as weakness. This research can be used as a springboard for enhancing men's use of health care services, which may to a large extent depend on breaking down stereotypes.

Finally, Jan van den Bulck's talk on media influences was also thought-provoking – even the younger generation of health psychologists cannot hope to understand the impact of the media on children and adolescents, since the internet has revolutionized access to information. He called for the media to be evidence-based, stating that 'reach' is not the same as 'effect' – we need hard evidence that media campaigns are effective. We would not assess the effectiveness of an intervention solely by

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conference reflections (cont'd)

assessing participation rate, yet the effectiveness of media campaigns is often assessed solely by asking people about their awareness of a particular campaign. This reflects a common theme running through the EHPS conference: in order to make scientific progress, health psychology needs to be evidence-based at all stages of the research process.

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Elaine Dutton

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This was the 1st time I was attending the EHPS conference and I was impressed by the variety of the scientific programme. Symposia were even dedicated to specific areas of research e.g. Effects of contextual cues on stair climbing – which shows that the conference is flexible to new research areas whilst at the same time still dedicating space for pillars of health psychology research such as ‘illness perceptions’ and ‘treatment beliefs’. This also shows that health psychology itself is not stagnant but that it is continuously evolving and branching out into new fields.

A paper I found particularly interesting was the one by Pijl et al (2007) on ‘family history of diabetes type 2’. Coming from a country where diabetes type 2 (DM2) rates are considerably high, it was interesting to hear what participants thought of the role of genetics in this condition and the fact that participants were generally unaware of ways to prevent DM2. This made me think even more about health education campaigns that take place and which are sometimes vague in their message. For example, whilst people may be aware that a balanced diet is ‘good for your health’ they may not make the link between healthy diet, healthy weight and disease prevention.

I agree with the President’s words that we need to understand social-cultural influences not only as ‘mediated moderators’ (Renner, 2007) but that we need to understand how these are influencing the health-related beliefs and cognitions of individuals. I also believe that Health psychology has a big role to play in helping people not only address intra-personal constructs to change health behaviour but also in coping and overcoming environmental barriers that may be specific

to a particular society. The applicability of health psychology in every day public health interventions in health centres and during health promotion campaigns for example needs to be further recognised. I also concur that we need to infiltrate our scientific knowledge into societal decision processes in order to have a greater impact at the population level (Renner, 2007). Combining it with a statement that Susan Pick mentioned in her address (Pick, 2007) we are much more ready than we think we are! Research is good, but I do feel sometimes that it is seen as just an end in itself. I personally see research as more of a means to a larger ‘end’ – that ‘end’ being population health on a larger scale. Health psychology so far has mainly grown in terms of research and largely within academia. I see health psychology as having a huge role to play outside that realm as I am sure many others agree.

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Evie Kirana

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Reporting on the EHPS meeting is a great honour but also a challenge. Following are a selection of some of the high quality presentations, areas for future research, and comments on the format of the meeting.

The symposium on multiple behaviour interventions included many presentations that were coherent, of high quality, and highlighted important implications. Although there is evidence that multiple-behaviour interventions have the potential for much greater impact on public health than single-behaviour interventions, little is known about what is the most effective way to intervene on multiple behaviours. The meta-analysis presented by Susan Michie (Michie, Abraham, Whittington & McAteer, 2007), as well as a series of studies by de Vries, Kremers, Smeets, Van t Riet, & Brug (2007) clearly illustrated the difficulty in designing effective multiple risk factor interventions, since different techniques may be differentially effective for

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different behaviours. Although the concept of multiple-behaviour research is appealing, it presents several emerging challenges. For example, what are the key behavioural constructs and processes common to these problem behaviours? How could measurement issues be resolved in order to be able to provide evaluation criteria to apply to multiple health behaviours? It was of great importance to include this symposium at the conference, since it is a field with important implications which needs to be studied further through high quality studies such as those presented.

A different but also relatively new and emerging field that brought out important research implications concerned internet delivered health interventions. A systematic review by Oenema & de Nooijer (2007) provided an overview of the effectiveness of internet delivered health interventions. 4000 titles were screened to identify those that were eligible for inclusion in the review. Eligible studies were randomised controlled trials or used quasi-experimental designs and compared the internet intervention with that of another channel. Surprisingly, only *nine* studies met the eligibility criteria. This study provides the only overview of the efficacy of internet based interventions and reveals the lack of well-designed studies.

Several studies presented involved self regulation processes, but two of them made a special contribution because of their a) high quality research design, and b) their clear practical implications. Concerning physical activity, Reuter, Ziegelmann, Wiedemann, Lippke, Schuz, & Schwarzer (2007) concluded that intentions influence behaviour at least partly through strategic planning. Concerning diseases, a meta analysis by Maes, De Gucht, Shoval, & Boyle (2007), concluded that when self regulation theory is an important part of therapy in medical interventions for rheumatoid arthritis, they are more effective. It would be of great benefit for the field of intervention planning for health behaviours and for diseases to implement such high quality longitudinal studies and/ or meta-analysis.

The presentation by Alison Hipwell (Hipwell, Turner, & Barlow, 2007) highlighted the complexity of implementing both culturally-integrated and ethnically-specific public health interventions. The challenges in the field of cross cultural health research and interventions were also evident during the SYNERGY 2007 workshop. However, health psychology needs to respond to the health needs of intercultural environments.

Men's health and aging is also a field that could be further explored in future conferences. The increasing aging population and the respective increase of urological conditions have been well documented yet despite the high prevalence of the diseases, many patients remain untreated and drop out rates are high. Bio-medical research has been able to explain very little, and there is a lack of contribution from health psychology.

Overall, the EHPS 2007 conference was very well organised and comprised of multiple high quality presentations. In addition, the 'meet the expert' was incredibly useful! It would be interesting if future conferences could include a) *debates*, as well as b) clinical *guidelines* based on meta-analysis.

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Synergy 2007 reflections

Culture, Health and Illness Representations: reflective perspective on the 2007 SYNERGY workshop

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The 2007 SYNERGY workshop took place in August at the University of Hasselt in Belgium. This workshop was facilitated by Michael Diefenbach, Jeanne Edman and Alison Karasz and attracted 14 participants from seven different nations. Katja Rüdell organized the workshop with guiding input from Lynn Myers.

Prior to the workshop participants were invited to share their goals and aspirations for what they wanted to achieve at the 2007 SYNERGY workshop. The goals were:

- 1) To meet other researchers in this area, be able to talk freely and openly about research problems with cross-cultural groups, to learn from their experiences and exchange ideas.
- 2) To develop a collaborative research project or identify people that could be drawn on for future collaborations.
- 3) To advance the dialogue in Europe about the influence of culture on illness perceptions and other health-related psychological constructs.

It is helpful to use these goals as a framework to reflect on what was achieved at the 2007 SYNERGY workshop. Feedback from participants suggests the first goal was achieved successfully. Participants were able to present their own work in a collegial and professionally supportive atmosphere, generating much open discussion of the rewards, challenges, and possible future directions for research in the area of culture, health, and illness representations. The international diversity present among workshop participants was a strong positive feature as it enriched discussions, and enable vigorous debate of the different approaches to research focusing on culture and illness representations at both a theoretical and practical level.

The tone of the workshop was characterized by motivated interest in this area, engagement, openness to new ideas, and respect for the useful contributions of all

participants in this workshop. A wide range of prior experience was evident. This contributed greatly to the quality of the workshop, as experts in different areas took turns to lead discussion. Topics included; definitions of culture, psychometric issues for cross-cultural validity, anthropological research methods, culture and self-construal, models and theory to inform research development, and practical and conceptual issues to consider in the conduct of cross-cultural research. The breadth of presentations spanned many regions of the globe. By taking part in this workshop, we feel we learnt a great deal from other participants, and very importantly we also know now who to approach for more advanced expertise in specialized areas.



In terms of the second goal, it emerged during the workshop that approaches to research questions and methodologies were very different between different members. Although we spent some time discussing various options for cross-cultural health related research we could not spend as much time on developing collaborative research projects as perhaps initially envisaged. However the premises for such work were explored and the group worked on a consensus agreement detailing common guidelines for good cross-cultural health related research. Furthermore the workshop enabled researchers to identify other individuals that shared interest for a common research question. We therefore felt that this objective was partially achieved. In our view the enthusiastic sharing of ideas at this workshop helped to identify areas of common interest, creating a fertile environment for future collaborations.

In relation to the last objective, the workshop fully addressed its potential. Whereas European health psychologists have actively contributed to our growing understanding of health inequalities and the contribution of socio-economic status to variance in health; we have not yet developed expertise that clearly informs researchers how best to define

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Synergy 2007 reflections (cont'd)

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culture and how to measure it in health-related psychological research. This is identified as an important unanswered question. It seems that despite the high level of migration between European states, and the fluid ability to work and live in different states, there has been limited examination of how culture and health care differences influence our models. Sharing views and expertise created the beginning of a scientific dialogue on how to deal with these issues in research and health practice.

In order to advance dialogue about the influence of culture on illness perceptions and other health-related psychological constructs, we need to provide conceptual clarity regarding the definition and measurement of culture in health psychology research. This was discussed at length in the workshop. One promising approach to the assessment of culture in health psychology could be to use self-construal of the individual within a cultural environment, with assessment via proxy indicators such as nationality, language, religion, and ethnic background. The implication is that conceptually culture might sit *within* theoretical frameworks that represent the self-system, rather than an upstream antecedent of social cognitive variables (as this places culture external to models of, for example, the self-regulatory system).

Practical issues were also considered, with workshop participants working collectively to identify examples

and principles of 'good research practice'. This generated excellent critical discussion, for example, regarding the merits/pitfalls of forward and back translation. We also considered how variation in different cultures and health settings might affect the reliability and validity of our research.

In summary the 3-day SYNERGY workshop was highly successful in advancing dialogue about the influence of culture on illness perceptions and other health-related psychological constructs. We believe dialogue at the workshop has created platform for future collaborative opportunities to emerge. We would like to extend our gratitude to Professors' Michael Diefenbach, Alison Karasz, and Jeanne Edman for doing such an excellent job of facilitating the workshop, and thank Jeroen Meganck for his superb organisational skills and warmth in welcoming SYNERGY participants to Hasselt. Finally we wish to thank our fellow participants for creating a positive atmosphere of openness and collegiality at this workshop, and for contributing three days of very stimulating discussion. SYNERGY 2007 sowed the seeds for an international agenda for cross-cultural research within health psychology - we look forward to continuing growth in this important area of health psychology.

CREATE 2007 reflections

On the use of theory in *Intervention Mapping*

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Set in the charming city of Hasselt, Belgium and a short distance from the site of the 2007 EHPS conference in Maastricht, the Netherlands, the 2007 CREATE workshop provided participants with an intensive introduction to Intervention Mapping (IM; Bartholomew, Parcel, Kok, & Gottlieb, 2006). Facilitated by Prof. Gerjo Kok, Prof. Herman Schaalma and Dr. Rob Ruiter, the timeliness of a course on intervention design was both notable on a personal level as I begin my PhD, but I suspect also useful to the wider community of new European health psychologists in training. Indeed, the focus of health psychology has clearly shifted away from simple cross-sectional designs

re-testing well-known theories and moved towards efforts at engendering actual health behaviour change. The complexity involved therein is suggestive of the need for frameworks to guide researchers interested in designing behaviour change interventions.

Emerging from the health promotion literature, Intervention Mapping provides researchers with a systematic series of steps aimed at designing and evaluating interventions. The steps delineated in IM guide the development of interventions iteratively to ensure maximal consideration of potentially relevant factors that contextualise the behaviour targeted for change. In particular, IM highlights the need to conduct a needs assessment (Step 1), to specify the determinants of the targeted behaviour and the change

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that the intervention is meant to produce (Step 2), to use theory-based methods to change the identified determinants, and strategies to deliver these methods (Step 3), to develop the actual intervention (Step 4), to consider and plan how the intervention will be implemented in practice (Step 5), and finally to evaluate the effectiveness and process of the intervention (Step 6; Bartholomew et al, 2006). The involvement of the targets of change, those who might deliver the intervention on a wider scale, and the impact of the environment are all essential components of IM.



The 2007 CREATE workshop was of exceptional quality in terms of both presentation and personal utility. The format of the workshop was constituted of structured lectures, the content of which was then applied in case study-based group work to allow workshop participants to work through each of the steps of the framework. This was further aided by the workshop facilitators who each immersed themselves into the work of a respective group. Their expertise and patience were most appreciated and aided considerably in advancing our understanding of the IM process. The group work also set the stage for the social programme which allowed workshop attendees from across Europe (including Finland, the Netherlands, Norway, Germany, Poland, England, Scotland, Wales, Ireland, and even Canada) to meet, to discuss common research, and to enjoy the nightlife that Hasselt has to offer. A further notable highlight was the 1st CREATE football match, an event sure to repeat itself next year.

Reflecting upon the content of the workshop, the way in which theory is used in Intervention Mapping provides a notable topic for further discussion. Firstly, the scope of the use of theory in IM extends beyond the consideration of the individual behaviour level to also consider environmental theories and models at the interpersonal, organisational, community and societal level (Bartholomew et al, 2006). As such, its aim towards consideration of all the potentially relevant contextual factors impacting on the behaviour necessarily invokes the need for a multidisciplinary team-based approach to intervention design, thereby bringing to light the role that the health psychologist can play within these teams. While these broader levels of analysis certainly deserve attention in their own right,

the current reflection will focus exclusively upon the use of individual-level behaviour theory in intervention design.

The IM position on the use of theory in developing an intervention is clear: it is a problem-based approach, *not* a theory-testing one (Bartholomew et al., 2006). IM aims to solve health problems by employing insight from a variety of theories to design interventions, and its pragmatic application of theory has shown considerable success. Specifically, the authors advocate a multi-theory approach by identifying all individual-level theories potentially relevant to a particular context, followed by selecting the particular (changeable) constructs from those theories that are deemed to be determinant of the problematic behaviour. Upon identification of the determinant constructs, methods and strategies are then identified to change them (e.g. Francis, Michie, Johnston, Hardeman, & Eccles, 2005). From a pragmatic perspective of wanting to effect change by utilising insights from the constructs included in various theories, IM seems to be a very useful tool for guiding the intervention development process. However, by eschewing the overarching theories in favour of selecting salient constructs from multiple theories IM-based interventions are inherently exclusive to their respective contexts. Is this problematic? One might argue that extracting constructs from their original theoretical models and reassembling them ad-hoc no longer allows the intervention to be categorised as theory-based (at least not as far as the behaviour-level theories are concerned) and might be more accurately construed as construct- and method-based. While the distinction between a theory-based and a construct-based approach has theoretical implications, if it is effective in achieving the aims of IM does it really matter if the constructs are separated from their original theoretical models? Do the mediators and moderators specified in the source theories matter or can we favour the assembly of various constructs from various theories for each context intervened (and can we still call this theory-based)?

Given IM's position on theory testing, it might be argued that these questions are of no importance. Nevertheless, the non-traditional utilisation of the term 'theory-based' by the IM approach suggests a need for clarification. The connotation of a 'theory-based' intervention might suggest that it is based on a particular theory in its entirety (including the theorised and tested causal pathways to behaviour) which is not

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CREATE 2007 reflections (cont'd)

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necessarily what is meant by 'theory-based' in IM. The potential strength of interventions based on a particular theory lies in the wealth of accumulated knowledge underpinning it. An intervention based on a particular established theory can use a causal pathway based on theorised and tested explanatory and/or predictive links and mediators between constructs. The IM approach to the use of theory potentially loses this strength by assembling various constructs which may be relevant and changeable in a particular context but are as such not based on any cumulated knowledge of the application of a particular theory in its entirety. Inherently then, an IM-based intervention will be testing a new causal model of behaviour even though that is not the explicit purpose of the approach.

However, does this matter if what we are aiming for is behaviour change? The answer likely depends upon whether it is reasonable to assume that each context necessarily involves its own distinct set of constructs. If the answer is yes, then the IM approach to the use of theory should be applied widely. However, if the answer is no, then the generalisability, replicability and thus knowledge accumulation offered by employing an established theory seems rather compelling when contrasted against the ad-hoc assembly of constructs which does not offer such possibilities. In an age of high prevalence of behaviour-linked health problems (e.g. obesity, diabetes, cancer) and constrained resources to address them, it seems critical that it be determined whether our resources should be spent operationalising particular theories or whether the IM approach is the way forward.

If approaches to the use of theory such as IM have emerged, it is perhaps because the individual theories may not be sufficient for the applied uses they are subjected to. Could this serve as a rallying call to further develop theory, as others have suggested (e.g. Michie, Rothman, & Sheeran, 2007)? For pragmatic eyes of wanting and often *needing* to intervene, calls for more theory might be met with revolt. However, do these two approaches need necessarily be mutually exclusive? Could the strength of the IM framework be used as the vehicle to develop theory while it is applied to address the challenges of problematic health behaviours? Could we test the context as a moderator within established theoretical models rather than assume that each context warrants a separate causal model? Applied research seems to provide an ideal means to answer these questions (Francis et al, 2007), thereby allowing us to move out of theoretical stagnation while maintaining the fundamental aims of IM. As behaviour change takes a front seat in the field and as tools continue to be

developed to allow us to better accumulate a knowledge base (e.g. Abraham & Michie, in press), the way in which theory is utilised seems to be at a crossroads. Do we maintain the conceptual integrity of an existing theory and aim to develop it further or is the ad-hoc assembly of constructs from a variety of theories more effective—and if the latter be true, is this truly still 'theory-based'?

In summary, the CREATE 2007 workshop was a brilliant success and I am in debt to both the organisers and the facilitators for allowing me the opportunity to gain this important skill. It has allowed me to recognise the complexities of intervention design, and provided a framework to guide me through the process. IM highlights the need to consider the wider environmental context's impact upon behaviour, for the systematic development of not only the intervention but also the means with which it is implemented and subsequently evaluated. The role of the health psychologist while seemingly central to the discussion (we are changing individual behaviour after all!) is clearly embedded within a multidisciplinary team. These realisations, along with the thought-provoking perspective on the use of theory advocated by IM have brought me back to the fundamental assumptions of our science and if only for that reason, this workshop has been a great success for me.

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conference announcements

conference title	date	location
5th Annual Conference of the PSI Division of Health Psychology	19 March 2008	Derry, Northern Ireland
5th World Congress on Prevention of Diabetes and its Complications (WCPD 2008)	1–4 June 2008	Helsinki, Finland
Society for Behavioural Medicine 29th Annual Meeting & Scientific Sessions	26–29 March 2008	San Diego, USA
XXIXth International Congress of Psychology	20–25 July 2008	Berlin, Germany
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