Health Psychology Update

is produced by the Division of Health Psychology (DHP) of the British Psychological Society and is designed to serve as a forum for discussion of issues related to the scientific analysis of psychological processes of health, illness and health care and the development of professional skills in research, practice, consultancy and teaching/training.

Health Psychology Update aims to:
◆ disseminate information to the membership on behalf of the DHP relating to the training and continuing professional development of health psychologists at all levels of competence;
◆ stimulate debate among the membership and to provide a forum for the discussion of issues relating to teaching, research, consultancy and the practice of health psychology;
◆ disseminate information which may impact on members as with respect to changes in national and regional practice and policy.

Submission to Health Psychology Update
Health Psychology Update contains regular features, such as training update, postgraduate update, forthcoming events and book reviews. Other features will also appear over each volume, such as themed issues, ‘Research in Brief’, current debates and conference updates. Suggestions for themed issues and debates are particularly welcome. Papers should be submitted in accordance with the 'Notes for contributors' on the inside back cover to the appropriate editor.

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Co-ordinating Editor: Kerri McPherson.
Co-Editors: Diane Dixon, Alice Forster, Nigel Hunt, Carrie Llewellyn, Nicola Payne, Phil Watson.
Welcome to this autumnal issue of Health Psychology Update. In the first half of this issue you will find the regular mix of interesting and informative review and research articles. These are followed by three articles designed to give you more insight into the workings of the various subcommittees of the DHP, the role of the Support Officer, and the British Psychological Society’s Ethics Committee. Finally, following our regular book reviews, and on the request of readers, we have introduced a new ‘Readers’ Opinions’ section.

We begin this issue with a research article, by Nicola Davies (Cranfield University), Gail Kinman (University of Bedfordshire), Robert Thomas (The Primrose Oncology Unit, Bedford Hospital) and Tracey Bailey (Cranfield University), exploring the relationship between health baseline comparisons and quality of life in patients treated for breast and prostate cancer. Following this one of the same authors, Gail Kinman (University of Bedfordshire), writes about Multiple Sclerosis. She provides readers with a brief review of the literature demonstrating a link between stress and disease symptomology before describing the ‘Stress Masterclass’ she has developed for MS health professionals. The third article in this issue, by Stephanie Kilinc and Carol Campbell (University of Teesside), considers the experience of transition from undergraduate study to postgraduate health psychology study. In particular, the authors explore the need for more specialist undergraduate degree programmes as a means of facilitating progression to postgraduate study.

In the second half of this issue Martin Hagger (Chair, Division of Health Psychology) introduces an article that outlines the purpose and recent undertakings of the various DHP Committee Subcommittees. As you will read, the members of the DHP Committee work tirelessly to ensure that the needs of health psychology are represented within the Society and the broader community. In addition, the Committee plays a significant role in determining policies relating to continuing professional development and health psychology training and, of course, as Bath seems ever closer, work to promote the value of health psychology as a discipline. To compliment this article DHP Support Officer, Althea Valentine, presents a report that will give readers some idea of her work over the past 18 months. Sadly, Thea will be stepping down as Support Officer in September and I am sure all of our readers will join with the Editorial Team in thanking Thea for her hard work and wishing her well for the future.

We are delighted to include an article from our colleague Tony Wainwright, a member of the Division of Clinical Psychology, and thank Clinical Psychology Forum for allowing us to reproduce this here. Ethics committees are often viewed with suspicion and it is hoped that this article will give readers an insight to the workings of the Society’s Ethics Committee but also encourage submissions to Health Psychology Update that have an ethical dimension or spark debate. It is our intention to canvass similar articles about from other Society committees for future issues.
There follows a report of ‘Health Psychology In Focus’, a two-day event in July, 2008, organised jointly by the DHP Postgraduate Subcommittee and BREATHE. Then our regular book review section.

Finally, we publish the first ‘Readers’ Opinions’ with Paul Millar encouraging us to think about ‘Health Sexism by Default’. We are sure readers will have their own thoughts and opinions about the issues raised by Paul and would encourage you to write in response or spark debate in other areas.

As ever we would like to thank all of our contributors and urge you to make your own submissions to Health Psychology Update to ensure its continued success. In particular, we would be grateful to receive, and publish, your thoughts on the articles in this issue or any other matters relating to health psychology.

The Editorial Team
Cancer – Quality of Life

‘...there seems to be a sort of general assumption that for all (cancer patients) the objective will be to live as long as possible ... (but for some) it will be the quality of life and the quality of life means being, or at least feeling, healthy - that's the more important thing.’ (Interview 03, Dipex, 2004).

IN THE UK, breast and prostate cancer are the most common cancers among women and men, respectively. Recently published figures give the UK annual prevalence rate for breast cancer as 172,000 and 31,000 for prostate cancer (Cancer Research UK, 2006). Cancer has become a chronic disease for a high proportion of patients which, in part, can be explained by earlier detection resulting from screening procedures. Increased survival rates mean that health-related quality of life (HRQoL) has become a much more important consideration in the cancer pathway (Cancer Research UK, 2007). Indeed, it is now recognised that HRQoL outcomes are just as important as ‘hard’ outcomes such as mortality (Rosenbaum, Fobair & Speigel, 2006).

HRQoL has been defined as ‘the level of well-being and satisfaction associated with an individual’s life and how this is affected by disease, accidents and treatments from the patient’s point of view’ (Lovatt, 1992, p.??). In research that has examined the role played by psychosocial variables in the cancer experience, HRQoL has traditionally been measured as an end-point in clinical trials rather than a factor to be monitored throughout the diagnosis, treatment and terminal or remission process (Waalan, 1990; Gotay et al., 1992). Furthermore, in clinical settings measures of HRQoL typically require patients to make a global judgement rather than more focused, multi-dimensional assessments. The available research implicitly assumes that an individual is able to evaluate their health status, and accordingly estimate their HRQoL, in a ‘realistic’ manner. It is argued that an individual’s assessments of HRQoL will be influenced by the extent to which they have incorporated into these evaluations any change in health status. Thus, whether these evaluations are more or less ‘realistic’ may be significant predictors of self-reported HRQoL. This paper aims to explore this issue. It describes the recently developed health baseline comparison theory (HBCs; Davies & Kinman, 2006) and utilises this theory to examine multi-dimensional HRQoL in a sample of breast and prostate cancer patients.

Health Baseline Comparisons

HBCs are defined as the baselines adopted as points of comparison at the early stages of evaluating one’s health status (Davies & Kinman, 2006). Since health naturally fluctuates with the inevitable experiences of aging and illness, it is argued that the baselines adopted to evaluate health status will need to be adapted to accommodate these experiences. The potential implications to well-being of not adapting HBCs to accommodate current circumstances may be diverse considering that cancer patients often undergo a long process of adjustment to multiple health threats and experiences.
It is argued that where HBCs are more realistic and, for example, based on rapid adjustment to current personal health circumstances, the psychological strain and negative impact on QoL that often accompanies cancer (Portenoy et al., 1994; Kornblith et al., 2001) might, to a certain degree, be reduced.

The nature and impact of HBCs have been explored with rheumatoid arthritis (RA) patients, where a less realistic HBC was found to predict self-reported depression and poorer adjustment to illness (Davies & Kinman, 2006). Research into the structure and outcomes of HBC is ongoing as part of the first author’s PhD research programme. Preliminary PhD research suggests that HBCs comprise a number of categories, such as social comparison baselines (i.e. comparing one’s health with other people’s health), biological baselines (i.e. taking into consideration lifestyle factors), illness-specific baselines (i.e. acknowledging treatment side-effects), turning to others (i.e. forming one’s health baseline based on information gathered from others), and situations where no baseline comparisons are utilised.

Aims and objectives
The present study proposes a new theory for the understanding of quality of life in patients treated for cancer and tests this theory as a predictor of multi-dimensional HRQoL in people with breast and prostate cancer. These two types of cancer were selected based on them being the most common cancers in women and men, respectively, along with the high and increasing five-year survival rates amongst these patient groups. The following research questions are addressed: 1. Are HBCs significantly related with HRQoL?; 2. Do HBCs have a greater impact on some aspects of HRQoL than others (in terms of physical, social, emotional, and functional well-being)? It is anticipated that the findings of this study, and subsequent research into the construct of HBC theory, will help inform the development of interventions that could be implemented at an early stage of the cancer experience to improve HRQoL outcomes.

Method

Ethical approval
Ethical approval was granted by Cranfield University, and Bedford Hospital provided Trust approval. As this study was classified as an audit and full patient anonymity was preserved, full ethical scrutiny by the Local Research Ethics Committee was not required.

Participants
There were 102 breast cancer participants and 112 prostate cancer participants (N=214). Patient demographics and information regarding diagnosis and treatment can be seen in Table 1.

Table 1: Mean Demographics for 214 participants.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate Cancer</td>
<td>52%</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>48%</td>
</tr>
<tr>
<td>61+ Years</td>
<td>48%</td>
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<tr>
<td>White Ethnicity</td>
<td>96%</td>
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<tr>
<td>Hormone Therapy</td>
<td>22%</td>
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<tr>
<td>Radiotherapy</td>
<td>14%</td>
</tr>
<tr>
<td>Surgery</td>
<td>13%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>11%</td>
</tr>
</tbody>
</table>
**Procedure**

Patients attending The Primrose Oncology Unit of Bedford Hospital were initially approached by their Consultant Oncologist, who introduced the study and directed them to the Principal Investigator if they were interested in taking part. Participants were provided with the Health Baseline Comparison Questionnaire (HBCQ) and the Functional Assessment of Cancer Therapy (FACT-G) QoL questionnaire.

**Measures**

**Demographics**

Participants were asked to provide information pertaining to their age, ethnicity, educational status, cancer type, cancer treatment, and any co-morbidities.

**HBCQ**

The 22-item HBCQ (Davies & Kinman, 2006), developed from earlier PhD research, was subjected to principal components factor analysis. This produced a five-factor solution explaining 62 per cent of the variance. Scree plots were examined and factors with eigenvalues greater than one were accepted (Kaiser, 1960). Factor loadings of above 0.40 were used (Kline, 1994). Subscales were named: social comparison baselines (SCB, eight items, $\alpha = .89$); biological baselines (BB, five items, $\alpha = .75$); illness-specific baselines (ISB, three items, $\alpha = .74$); turning to others (TTO, two items, $\alpha = .50$), and no comparisons made (NC, one item). Items began with the prefix ‘When thinking about how healthy I am, I take into consideration …:’ and examples of items from each subscale are: the health of people I know (SCB); my physical fitness (BB); the symptoms I expect from this type of cancer (ISB); my doctor’s view (TTO); ‘When thinking about how healthy I am, I do not take into consideration other people’s health’ (NC). Responses were scored on a five-point Likert scale of ‘strongly agree,’ ‘agree,’ ‘unsure,’ ‘disagree,’ ‘strongly disagree,’ with higher scores representing more frequent use of each HBC. A single-item open-ended question of ‘What other factors, if any, do you take into consideration when thinking about how healthy or unhealthy you are?’ was included in order that participants could highlight any HBCs not referred to in the questionnaire.

**FACT-G**

The 27-item FACT-G (Cella et al., 1993) measures global QoL and/or four different dimensions thereof (i.e. physical well-being (PWB, e.g. I have lack of energy, $\alpha = .83$), social well-being (SWB, e.g. I feel close to my friends, $\alpha = .83$), emotional well-being (EWB, e.g. I am satisfied with how I am coping with my illness, $\alpha = .65$), and functional well-being (FWB, e.g. I am able to work, $\alpha = .87$). The internal consistency of the whole scale is .71.

The overall score and four subscale scores were used in order to identify relationships between HBCs and multi-dimensional QoL. The measure was assessed on a five-point Likert scale ranging from ‘not at all’ to ‘very much,’ with higher scores in each subscale representing higher QoL.

**Analysis**

A correlation matrix was computed on the HBC factors and QoL dimensions. This was followed by a hierarchical multiple regression analyses to identify the HBC subscales that were the strongest predictors of global QoL and its four well-being dimensions.

**Results**

The correlation matrix can be seen in Table 2. A significant correlation was found between social comparison baselines and emotional well-being ($p < .01$), whereby those who were more likely to use social comparisons as a health baseline tended to have lower emotional well-being. Significant negative correlations were found between illness-specific baselines and physical well-being, emotional well-being, and overall QoL (all $p < .001$). Those who were more likely to use illness-specific baselines tended to have higher physical and emotional well-being as well as higher overall QoL.
Table 2: Correlation Matrix (N=214).

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<th>1</th>
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<td>2. Biological Baselines</td>
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<td>.33**</td>
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<td>4. Turning to Others</td>
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<td>.14**</td>
<td>-.19**</td>
<td>.00</td>
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<td>.15*</td>
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<td>6. Physical Well-Being</td>
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<td>-.07</td>
<td>-.22**</td>
<td>-.02</td>
<td>-.02</td>
<td>.00</td>
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<td>7. Social Well-Being</td>
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<td>-.03</td>
<td>-.11</td>
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<td>.15*</td>
<td>.00</td>
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<td>8. Emotional Well-Being</td>
<td>.17*</td>
<td>.04</td>
<td>-.23**</td>
<td>.05</td>
<td>.11</td>
<td>.44**</td>
<td>.24**</td>
<td>.00</td>
<td></td>
<td></td>
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<td>9. Functional Well-Being</td>
<td>.10</td>
<td>.12</td>
<td>-.08</td>
<td>.07</td>
<td>-.02</td>
<td>.48**</td>
<td>.42**</td>
<td>.45**</td>
<td>.00</td>
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<td>10. Overall QoL</td>
<td>.13</td>
<td>-.05</td>
<td>-.26**</td>
<td>.04</td>
<td>-.00</td>
<td>.72**</td>
<td>.54**</td>
<td>.64**</td>
<td>.77**</td>
<td>.00</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01
In Step 1 of each regression analysis, age and educational status were entered in order to control for possible effects, as research has found that such demographic factors might be important predictors of QoL (Wenzel et al., 1999). In Step 2, cancer type was entered, and in Step 3 treatment type was entered, both of which will have varying implications for QoL and, therefore, need to be controlled for. In Step 4, co-morbidities were entered in order to control for any potentially confounding effects of previous illness experience. The five HBCs were entered in Step 5. Details of the regressions are shown in Table 3.

**Predictors of Global QoL**
Age and educational status entered in Step 1 were significant, accounting for eight per cent of variance in estimates of global QoL. Cancer type, entered in Step 2, significantly explained three per cent of the variance whilst treatment type, entered in Step 3, failed to account for variance. Co-morbidities, entered in Step 4, were also a significant predictor, explaining a further four per cent of incremental variance. The HBC factors entered in Step 5 together explained four per cent of the variance. Examination of the betas indicated that only one HBC factor was a significant predictor of this outcome: illness-specific baselines. The final model explained 19 per cent of the variance in overall QoL.

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**Predictors of Physical Well-Being**
Age and educational status entered in Step 1 were significant, accounting for five per cent of variance in estimates of PWB. Cancer type, entered in Step 2, failed to account for any variance as did treatment type, entered in Step 3. Co-morbidities, entered in Step 4, were a significant predictor, explaining a further three per cent of incremental variance. The HBC factors entered in Step 5 together explained three per cent of the variance. Examination of the betas indicated that only one HBC factor was a significant predictor of this outcome: illness-specific baselines. The final model explained 11 per cent of the variance in PWB.

**Predictors of Emotional Well-Being**
Age and educational status entered in Step 1, accounted for four per cent of variance in estimates of EWB. Cancer type, entered in Step 2, failed to account for any variance, as did treatment type entered in Step 3 and co-morbidities entered in Step 4. The HBC factors entered in the Step 5 together explained six per cent of the variance. Examination of the beta values indicated that only one HBC factor was a significant predictor of this outcome: illness-specific baselines. The final model explained 10 per cent of the variance in EWB.

**Predictors of Functional Well-Being**
Age and educational status entered in Step 1 were significant, accounting for two per cent of variance in estimates of FWB. Cancer type entered in Step 2 and treatment type entered in Step 3 both failed to account for variance. Co-morbidities, entered in Step 4, were another significant predictor, explaining a further three per cent of incremental variance. The HBC factors entered in Step 5 together explained one per cent of the variance. Examination of the beta values indicated that only one HBC factor was a significant predictor of this outcome: biological baselines. The final model explained six per cent of the variance in FWB.

**Discussion**
This study found significant relationships between HBCs and multi-dimensional QoL. Multiple regression analysis highlighted the factors within the HBC construct that were the strongest predictors of QoL. Illness-specific baselines appear to be the most influential HBC factor in QoL among individuals with breast and prostate cancer, explaining four per cent of the variance in global QoL, three per cent in physical wellbeing, and six per cent in emotional well-being. Although only accounting for six per
Table 3: Hierarchical regression analysis of predictors of QoL outcomes (N=214).

<table>
<thead>
<tr>
<th>Predictor</th>
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<th>Step 3</th>
<th>Step 4</th>
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<td>-.24**</td>
<td>-.06</td>
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<tr>
<td>Biological baselines</td>
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<td>.01</td>
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</tr>
<tr>
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<td>No Comparisons</td>
<td>0.00</td>
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*p < .05, **p < .01, ***p < .001
Table 3: Hierarchical regression analysis of predictors of QoL outcomes (N= 214) (continued).

<table>
<thead>
<tr>
<th>Predictor</th>
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<th>FWB</th>
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<td>Beta</td>
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<td>Age</td>
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<td>5.12**</td>
<td>(.05)</td>
<td>.14</td>
<td>3.49*</td>
<td>(.03)</td>
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<td>(.01)</td>
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*p<.05, **p<.01, ***p<.001
of the variance, HBCs accounted for the largest proportion of variance in emotional well-being out of all variables entered into the regression analysis. Biological baselines were shown to have a small but significant impact on QoL, more specifically on functional well-being. The remaining three HBC factors (i.e., social comparison baselines, turning to others, no comparisons) did not significantly predict QoL or the four dimensions thereof (PWB, SWB, EWB, FWB) in this patient group. Nevertheless, a significant relationship was found between social comparison baselines and EWB, supporting previous HBC research (Davies & Kinman, 2006) whereby it was found that a tendency to make social comparisons is maladaptive in terms of adjustment to illness. Furthermore, as discussed earlier in this paper, emotional factors are of paramount importance in oncology (Portenoy et al., 1994; Kornblith et al., 2001) and, therefore, these findings may offer scope for further insight into this aspect of cancer QoL. It may be that interventions need to be developed which encourage cancer patients to utilise health baselines that incorporate personal health circumstances as opposed to information obtained from social comparisons.

Of interest is the finding that illness-specific baselines appear to influence QoL negatively, as demonstrated by the direction of the relationship with PWB, EWB, and overall QoL. It was believed that acknowledgement of the illness and treatment experience might facilitate adjustment to cancer and thus increase QoL. However, it is plausible that the use of illness-specific baselines results in the development of a strong illness identity, which has been found to be associated with higher levels of psychological distress in individuals with allergies (Knibb & Horton, 2006). This has implications for health interventions aimed at reducing the salience of illness identity and increasing a sense of control over the illness through the use of more adaptive coping strategies.

Since illness-specific baselines were the strongest predictor of QoL, it was interesting to find that treatment type did not predict QoL or any of the dimensions thereof. One possibility is that cancer patients evaluate their health according to biological markers as opposed to procedural markers (i.e., cancer pathway factors). It appears that the cancer itself is more likely to inform health baseline judgements than are procedural issues such as treatment type or treatment outcomes. Since treatment can play an important role in the assessment of health status and health needs, for example recognising a symptom as being a treatment side-effect as opposed to a sign that the cancer is getting worse, this is an area worth exploring. Further insight into this may facilitate patient understanding of their changing health status throughout the treatment process, thus potentially maintaining QoL via better adjustment.

The amount of variance in overall HRQoL and its dimensions that was explained by HBCs is low in comparison to some of the other demographic variables entered into the regression. However, an analysis of qualitative data obtained from the open-ended question of the HBCQ suggests that cancer patients draw on a range of other baselines not included in the present version of the HBCQ. These will inform questionnaire development for the next stage, so that a more thorough investigation of the influence of HBCs on QoL can be examined.

A limitation of this study is the lack of data pertaining to disease severity or staging. Such data, especially in terms of metastases and recurrence, might influence HBCs as well as perceived QoL. A further limitation was in participant selection, breast and prostate cancer being the most common in women and men, respectively, but incomparable in terms of HRQoL. It proved difficult to identify gender- and cancer-specific differences between the two cohorts. Accordingly, breast cancer will be the cohort of interest in the next phase of this research programme since HBCs appeared to play a more significant role in this cohort.
A limitation in the questionnaire used to measures HBCs is that it was not possible to identify the direction of HBCs (i.e. whether people’s baselines were positively or negatively focused, e.g. consideration of negative treatment side-effects or positive treatment outcomes, etc.). The HBCQ has been modified to provide such data and is currently being pilot tested.

Once the measure has been further refined, the flexibility/stability of HBCs throughout the cancer pathway will be explored with breast cancer patients undergoing a course of chemotherapy. The inclusion of interviews in the design of this next stage may also provide some valuable first-person insight into how people with cancer make judgements about their health from the early stage of forming a health baseline to the cognitive and behavioural outcomes of these health evaluations.

Acknowledgements
Gratitude is extended to Alex Buckley, who has played a fundamental role in the development of HBC theory and subsequent research strategies. Gratitude is also given to the patients and staff of The Primrose Oncology Unit who helped in my research.

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References


Managing stress in multiple sclerosis

Gail Kinman

What is MS?

There are currently around 85,000 people with multiple sclerosis (MS) in the UK (MS Trust, 2008). MS is a chronic progressive disease whereby the immune system attacks the myelin sheath of axons within the central nervous system. For around 85–90 per cent of people, MS is an episodic condition characterised by periods of exacerbations and remissions which can frequently result in residual impairment. Symptoms vary but include fatigue, muscular spasticity, loss of balance, incontinence, difficulty with fine hand movements and cognitive impairments. Living with the restrictions and uncertainty imposed by MS can be stressful and family, social and working life is frequently disrupted (Hakim, Bakheit, Bryant et al., 2000; Janssens, van Doorn, de Boer et al., 2003; De Judicibus & McCabe, 2005). A significant risk of depression and emotional distress amongst people with MS has been highlighted (Gulick, 2001; Siegert & Abernethy 2005). There is also recent evidence that MS patients frequently experience PTSD-type reactions following diagnosis (Chalfant, Bryant & Fulcher, 2004).

A link between MS and stress

A link between psychological stress and the exacerbation of MS symptoms was first highlighted by Charcot in 1877. Over the last 20 years or so, evidence has accumulated from longitudinal studies that stressful life events are indeed implicated in disease activity (e.g. Franklin et al., 1988; Mohr et al., 2004). A recent prospective cohort study of 73 people with MS by Buliljevac et al. (2003) found that stressful events were associated with double the risk of subsequent relapse. Although the mechanisms underlying the relationship between stress and relapse are not yet fully understood, it is known that stress can modulate immunological mechanisms via the hypothalamic-pituitary-adrenal axis and sympathetic nervous system activity (Sternberg, 2001).

Managing stress in MS

Although research findings indicate that many people with MS believe that stress contributes to relapse, little information is available to them on stress and how best to manage it (Hepworth, Harrison & James, 2002). Due to the proven links between stress and MS relapse discussed above, learning to manage stress effectively is important for people suffering from the disease. For the last couple of years, I have been working with two MS charities to raise awareness of the role played by stress in symptom exacerbation and communicate ways by which stress might be effectively managed by people with the disease. In collaboration with the MS Trust, I have developed a ‘Stress Masterclass’ for MS health professionals. Little is yet known about the stress management interventions that are particularly effective for people with MS, but Cognitive Behavioural Therapy (CBT) techniques and deep muscle relaxation have been found to be beneficial in reducing distress and fatigue (Scroggie, 2005; Foley, 1987; van Kessel, 2008).

The first training event held in London in the summer of 2007 was successful with more than 50 MS specialists attending. The programme was fairly broad. Ways in which the physiological stress response might interact with MS symptoms were initially examined. How personal awareness of the idiosyncratic physical, emotional and behavioural early warning signs of stress could be enhanced in people with MS was discussed. The benefits of keeping a diary in establishing links between stressful experiences,
behaviours and subsequent symptoms were emphasised – this was generally believed to have the potential to enhance perceived control as well help with fatigue and symptom management.

Lifestyle factors, such as diet, exercise and rest were included and the benefits to MS patients of exercising within personal limits were emphasised. Research findings indicate that particular coping styles, such as problem solving and acceptance coping, challenging appraisals, personal health control and emotional release, are important predictors of well-being in people with MS (Pakenham, 2005; Chalk, 2007). Ways in which coping styles could be enhanced were, therefore, examined. As peer support has been found to be beneficial for the donor as well as the recipient in people with MS, (Schwartz, 1999), the importance of enhancing social support via social networks and peer support was emphasised. Sally Jones, Mental Health Nurse Specialist in MS from the Institute of Psychiatry, explored ways of enhancing problem solving abilities via CBT techniques. This practical session proved to be one of the most popular features of the training day, with delegates gaining an insight into how they could personally use these techniques as well as recommend them to their patients or clients. A range of relaxation techniques were introduced by Vicki Matthews, Nurse Advisor of the MS Trust, who provided a practical demonstration of mindfulness. A growing number of clinicians are incorporating mindfulness techniques into their practice and there is growing evidence for its effectiveness as a stress management tool (Carmody et al., 2008). A pilot study has recently been conducted into the role played by mindfulness of movement in the symptom management of people with MS (Mills & Allen, 2000). Findings highlight benefits for patients over a broad range of symptoms.

Early this year, I was approached by the MS Society to record an awareness raising film for people with MS. This is one of a series of six talks by MS specialists that are made available on the internet to patients and their families. The video introduced different stress management methods but focused specifically on enhancing self-knowledge, developing effective coping strategies and utilising CBT techniques. The need for such information was highlighted by the fact that the video had over 700 viewings the six weeks since it was made available in February, 2008. Following the recording of my talk, I hosted an online question and answer session on the role played by stress in MS exacerbation. A wide range of topics were covered, including coping with work stress and the stress of caring for a loved one with MS. I am currently developing information sheets for the MS Society giving practical advice on various forms of stress management. Future research plans involve examining the type of information provided to patients on the importance of managing stress by GPs and MS specialist clinicians.

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References


MORE STUDENTS are now obtaining an undergraduate degree, leading to increased competition in finding employment. As such, the number of students choosing to study at postgraduate level is increasing, particularly in the discipline of psychology (Candy, 2000). It has long been established that undergraduate degrees develop a broad understanding of a subject, introducing core topics and issues, with postgraduate courses developing specialist knowledge of a given sub-discipline (Aitkenhead, 2002). However, the progression from learning at undergraduate level to postgraduate level is an under researched and under-developed area of the teaching and learning literature.

It is widely agreed that undergraduate courses should promote a deep approach to learning, with students assigning meaning to the material which is learnt (Fry, Ketteridge & Marshall, 2003). It is argued that deep learning is encouraged through subject-specific learning outcomes and working through problems which are based on professional practice (Gentle, 2004; Ramsden, 1992; Stein, Isaacs & Andrews, 2004) particularly in the discipline of psychology (Schwartz, 2004). By applying textbook-based knowledge to solving practical-based problems, students are argued to transform their knowledge into ‘expert knowledge’ (Tynjala, 1999, p.357). This notion is allied to the constructivist school of thought and Kolb’s (1984) theory of Experiential Learning, arguing learning is an active process involving a qualitative transformation of existing knowledge (Fry, Ketteridge & Marshall, 2003). Additionally, Leinhardt, Young and Merriman (1995) assert that the university environment is more conducive to such forms of learning than the workplace, by allowing learners time to reflect on their responses to the problems and ultimately their learning. Indeed, practical experience in a psychology post is difficult to secure due to ethical constraints.

Taking Kolb’s (1984) view that learning is a continual process of reforming knowledge through reflecting on experience, it is argued here that single honours psychology students who progress to a postgraduate health psychology degree may not have the relevant practical health psychology experience to reflect upon. In turn, they may experience more difficulty in transforming their knowledge to understand the new health psychology material, as opposed to a student who has previous health psychology experience to reflect upon in the learning process.

The experience of progression from undergraduate study to postgraduate study is an under-researched area in the teaching and learning literature. Phenomenological interviews were conducted with five current health psychology postgraduates. Students who welcomed the development of more specific undergraduate degrees saw them as a means of developing critical thinking, discussing a shift in the notion of what constitutes a specific rather than a broad undergraduate degree. The concept of experiential learning (Kolb, 1984) and reflection was prominent in participants’ responses, highlighting the need for practical based tasks in both undergraduate and postgraduate courses. Coupled with the increasing importance of relevant practical experience, a need for more subject-specific undergraduate degrees is advocated.
Consequently, the issue of relevant and meaningful practical/professional experience at undergraduate level may suggest the requirement for reflection on undergraduate degrees (particularly in psychology) as introductory and non-specific, and a possible shift towards specialist, in order to promote a deeper approach to learning and facilitate in the progression to postgraduate study.

This small-scale study aims to explore the experience of moving from undergraduate to postgraduate study, with particular reference to the requirement of promoting more specialist undergraduate degree programmes, as a means of facilitating progression to postgraduate study.

Method
Design
Phenomenological interviews were conducted with current postgraduate health psychology students at the University of Teesside (academic year 2004–2005). The focus on the meaning of the learning experience at postgraduate level lends itself to the philosophy of the phenomenological approach (Creswell, 1998) and is becoming widely used to explore learning (e.g. Gentle, 2001; Haggis, 2002).

Participants
The five participants were all current, full time health psychology postgraduates. Although they all had an accredited undergraduate degree in psychology, none had taken a specialist undergraduate health psychology degree. However, three participants had practical experience in the health care system.

Procedure
Interviews lasted approximately one hour, and took place in an interview room at the university. Participants were told prior to the interview that they should be honest in their answers, but it must be recognised that some bias may have occurred as they were students of the researcher. The interview questions were non-directive and allowed respondents to discuss issues of importance to them, but they centred around the themes of the experience of their undergraduate and postgraduate degrees, and their opinions of practical experience in both courses.

Analysis
Following a phenomenological analysis advocated by Moustakas (1994) four themes were identified which described the experience of progressing to a postgraduate degree in health psychology.

Theme 1: The specialism continuum
Participants discussed the undergraduate degree as providing a broad overview of psychology, and described the ways in which following their degree they decided to develop more specialist health psychology knowledge, as though it was the next logical step.

‘...So I finished the undergraduate course, which gave me a broad overview of all the concepts in psychology...So I thought I will go onto the Masters now and this is where I can focus onto the specific health psychology of it.’ (M5, page 2, lines 4–8)

Although participants saw the psychology undergraduate degree as a broad introduction, leading to the opportunity to specialise in health psychology at postgraduate level, the following participant recognised the specialist areas within health psychology and the need to be allowed to explore these interests in more depth at postgraduate level.

‘...a good overview of health psychology (at undergraduate level) to know what it is all about and to know everything, you know everything what is covered. So that you can make up your mind what direction you want to take, is it health promotion, or is it smoking cessation, or cancer care...’ (M2, page 9, lines 4–7)

Theme 2: ‘Starting from scratch’
Despite some participants stating that given the opportunity they would not have chosen an undergraduate degree in health psychology
psychology, they did discuss how this meant they felt they had more work to do at postgraduate level, learning new theories, etc.

‘...I felt that I had no knowledge base to or...framework to stick the information to and so I felt very, very lost with that.’ (M1, page 2, lines 24–25)

It was described how a specific health psychology undergraduate degree would facilitate postgraduate students to explore issues in more depth.

‘...I think that is the bulk of the work really, cause you are getting into a new topic area... if you did a BSc in health psychology you wouldn’t need to acquire all this knowledge, you would have it somewhere already, you would just go more in depth with it.’ (M2, page 7, lines 24–27)

Theme 3: Career path
Generally there were conflicting ideas regarding whether a specific or broad undergraduate degree is more useful. Some felt the broad degree meant they could make a more informed choice of what psychology career path to take, whereas others reported feeling some aspects of the course were irrelevant. The discrepancy appears to be linked to those who knew they wanted to pursue a career in health psychology prior to, or whilst on their undergraduate course.

‘I think that the BSc helped me to explore all areas of psychology, so then you could make your choice...’ (M2, page 8, lines 1–2)

‘...there were certain parts of it that I thought this isn’t going to help me in my life, profession, they were things that I didn’t seem were relevant.’ (M5, page 4, lines 10–11)

Theme 4: Practical experience
All participants reported benefits to incorporating practical experience into the postgraduate course. They particularly felt it would help in the development of critical thinking and to question theories.

‘I think it would help you to criticise them [theories] more and be more aware of them.’ (M2, page 10, line 15)

Interestingly, participants discussed the role of practical experience in terms of aiding reflection.

‘...most people like to place it with real life and most people struggled. I think what we would have liked is to have a project to do...’ (M4, page 2, lines 16–18)

However, the use of role plays and techniques which don’t require going into the field, were described as being unhelpful as they don’t allow students to learn how to respond to the pressure of real practice situations.

‘And I think they are only skills that you can get vocationally if you like, and to apply it and I don’t think role-play gives you that. And you don’t learn the key skills and key phrases cause you’re not under the same pressure.’ (M1, page 10, lines 27–30)

Discussion
The analysis highlights a number of issues which correspond to generic issues and concepts in teaching and learning. Firstly, students described their postgraduate study as their opportunity to develop specialist health psychology knowledge, continuing from the broad perspective of their undergraduate degree. This viewpoint mirrors the dominant view of the roles of postgraduate and undergraduate study which has been long established in British Higher Education (Aitkenhead, 2002). However, some participants in this study developed the notion of a specialist postgraduate degree further, seeing it as a means of exploring particular interests in a sub-discipline of health psychology, following from a broad introduction to the discipline of health psychology at undergraduate level. This idea portrays a shift in the notion of the form of degrees which can be classified as broad and specific.

Alternatively, not all participants felt they would have welcomed the opportunity to study on a specific health psychology undergraduate degree, opting instead for a generic psychology degree which would allow them to explore a diverse set of psychological topics and issues. This discovery may
be associated with an unclear idea of which career they want to choose.

Furthermore, participants recognised the benefits of subject-specific knowledge at undergraduate level. Some described how previous knowledge of health psychology theories and concepts would have helped them to develop critical thinking at postgraduate level, as opposed to ‘starting from scratch’ (M4, page 5, line 10).

In keeping with Kolb’s (1984) theory of experiential learning, participants described their uncertainty about how to apply the knowledge they had acquired at undergraduate level. Consequently, the incorporation of practical elements in the postgraduate course was deemed to facilitate learning, as a means of reflecting upon theories and concepts and the success of their learning.

However, one participant noted that only experience which mirrored the experience of working in the health psychology field would be beneficial, allowing them to adapt to the pressures of the work. This is in contrast to research which argues the benefits of practical based work in a university setting is beneficial in allowing students time to work through and reflect on the problems (Leinhardt, Young & Merriman, 1995). Indeed, Kolb (1984) asserts that experiential learning is only advantageous if it is seen as meaningful and relevant to the student. As such, it may be important that more research based experience, such as case studies, be used to provide practical experience. These forms of learning are more applicable to the field and advocated as a useful means of integrating practical experience into both undergraduate and postgraduate degree courses (Fry, Ketteridge & Marshall, 2003).

**Conclusion**

It is advocated that the inclusion of practical experience be encouraged at undergraduate level, as not all students will secure placements in the health care system following undergraduate study. Furthermore, for those students with clear career goals to become health psychologists, the development of a specific health psychology undergraduate course, with health-related practical elements (e.g. case studies, etc.) may enable students to reflect on practical experience which is relevant and meaningful to them. Additionally, the inclusion of practical experience at postgraduate level was deemed to encourage reflection on the theoretical constructs which are inherent in Stage 1 training. In future research it would be interesting to explore the progression from Stage 1 to Stage 2 in health psychology training, in order to further develop our understanding of the role of practical experience in the route to chartered health psychology status. Although the sample was small and unrepresentative of other disciplines (and indeed other higher education institutions) further research may also explore the application of experiential learning and the role of reflection in the progression from undergraduate to postgraduate study.

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References


Chair’s introduction

As Chair of the Division of Health Psychology I thought it would be timely and appropriate for the Committee to collectively demonstrate our roles and responsibilities to the membership. The Committee members work tirelessly and voluntarily on behalf of the membership, but often these unsung heroes of health psychology in the UK go unheralded. The rewards of serving on the Committee are personal and intrinsic and I know, to a person, that the members of the Committee are truly interested in the development of the discipline of health psychology in the UK and are deeply committed to their roles. I think many members will also be surprised as to the scale and scope of the Committee’s work to promote and represent the interests of health psychology in the UK. The Committee is the highly organised heart of the Division. It is structured into an Executive Committee which is made up of the Chair, Deputy Chair (Dr Daryl O’Conner), Chair Elect (Prof Stanton Newman), Honorary Secretary (Dr Katherine Brown), and the Honorary Treasurer (Dr Vicky Senior). The Executive oversees the work of the numerous Subcommittees whose remit is to co-ordinate specific work and tasks within key areas identified by the Executive. The Subcommittees are chaired by ordinary Committee members and each Subcommittee will have members of the Committee (including the Executive) as well as other co-opted members. People can be co-opted to Subcommittees to contribute specific expertise to the work of that Subcommittee. The Chairs of the Subcommittees have done an excellent job in bringing their role to you in this article and one that will follow in the next issue so, without further ado, I present their personal portfolios to you. I hope this section will provide you with new insight into the Committee’s activities, and I hope it will inspire you to get involved yourself, health psychology needs you!

Martin Hagger
Division of Health Psychology Chair.
Postgraduate Subcommittee
The Postgraduate Subcommittee promotes and supports the interests of all health psychology postgraduates and Stage 2 trainees. The Subcommittee aims to provide peer support and guidance, address information and training needs, and provide effective communication between the DHP and health psychology postgraduates. The Chair of the Subcommittee represents the interests of postgraduates on the main DHP Committee. The Committee also comprises a Publicity and Liaison Officer, a representative of PSYPAG and the BREATHE President.

To achieve our remit, the Subcommittee has developed ongoing activities which are undertaken each year. These are:

- Identifying training and information needs via jiscmail lists (HEALTHPSYCHOLOGY POSTGRADUATENET@JISCMAIL.AC.UK) and (HEALTHPSYCHTRAINING@JISCMAIL.AC.UK).
- Organising and running an annual postgraduate event aiming to develop skills and address the information needs of postgraduates and Stage 2 trainees.
- Identifying and encouraging postgraduate submissions to HPU and a Stage 2 Q&A section.
- Maintaining communication and raising awareness by using our lists to communicate relevant news, opportunities and bursaries with the postgraduate community; contacting and updating course directors of Health Psychology; and manning a postgraduate stand at the annual DHP conference, advertising relevant courses and events.
- Remaining up-to-date on national PSYPAG and BREATHE activities.

Jilly Martin
Postgraduate Subcommittee Chair.

Publicity and Liaison Subcommittee
The Publicity and Liaison Subcommittee of the DHP includes those members of the Committee responsible for publicity, consultation and specialist knowledge, Health Psychology Update and the DHP website. The Subcommittee aims to promote awareness of health psychology, the DHP and its members; increase DHP representation on policy consultations and topical news items; and act as a means of communication between the DHP and its members.

The Committee’s publicity work includes promoting awareness of health psychology to a variety of audiences including potential employers and employees (including those within the NHS) and the general public. This work has recently involved the production and distribution of a range of promotional leaflets and a DHP members’ information pack (copies available through the DHP website). We also work with the media, particularly in the run-up to the annual DHP conference when, in collaboration with the British Psychological Society’s Press Office and presenting authors, we issue press releases on the presentations that we feel might attract media attention. Whilst it is very difficult to predict the amount of media interest that will be generated during the conference, we work hard to promote DHP members’ work in this way and to respond quickly to any media enquiries at the conference and throughout the year. We also respond to media enquiries on topical health issues and are becoming increasingly pro-active, for example, by contacting the media in advance of events such as condition-specific health awareness weeks, etc.
Publicity and promotion of health psychology is very important. For example, it is one way of raising the profile of the discipline in order to increase job opportunities. We are, therefore, always looking for new ways of promoting the DHP and are very keen to hear DHP members’ suggestions.

Diana Harcourt (Publicity & Liaison Subcommittee Chair).

Consultation and Specialist Knowledge List

Consultation and Specialist Knowledge falls into the remit of the Publicity and Liaison Subcommittee of the Division of Health Psychology. The Division is frequently asked to comment on initiatives related to health policy, promotion, education and research. These calls are usually issued by Governmental services such as the NHS or Department of Health, independent organisations responsible for standards in health, such as NICE, independent reports compiled on behalf of the Government (e.g. the Cooksey Review of UK Health Research), and international organisations such as the World Health Organisation.

When calls for consultation come in from these organisations, they are first sent to members of the Policy Support Unit of the British Psychological Society or people representing their organisation in the Society. These individuals will then forward calls relevant to the discipline of health psychology to the Consultation and Specialist Knowledge Co-ordinator on the DHP Committee. On receiving the call, the Consultation and Specialist Knowledge Co-ordinator is charged with identifying a suitable specialist or specialists in the area of the call and approaching them to ask whether they are prepared to make a comment or form a response and, if so, to forward their comments by a specified deadline. Once received, the Co-ordinator will then send the response(s) back to the Society who then make a society response to the organisation.

These responses are very important to the DHP whose remit is to represent the interests of health psychology in the UK. Members on the Specialist Knowledge List report that they gain useful first-hand information of recent health issues relevant to health psychologists and they provide an important service to health psychology in the UK. Members’ contributions are acknowledged in the responses made to the Society and the organisation making the call for consultation and on the DHP website.

The Consultation and Specialist Knowledge Co-ordinator holds two key documents which are continuously updated. The first is the Consultation Reviewer Log, which includes details of the area and date for all calls for consultation, and the names of those who have contributed to a response on behalf of the DHP. An up-to-date version of this document is submitted for the Consultation and Specialist Knowledge Co-ordinator’s annual report. Quarterly versions are also included in the agenda for each DHP Committee meeting to monitor DHP output in this area. The second document is the Specialist Knowledge List, which holds the details of all members of the DHP who have agreed to represent the areas that they can provide their expertise. Usually it is only members on this list who are asked to contribute to calls for consultation. However, on occasions, calls are made in areas where there is no representative on the DHP Specialist Knowledge List. In these cases, a request call is sent around the DHP e-mail list. This often works well in gaining the expertise required, one recent example being a call for specialists in the area of Placebos for the BBC’s The One Show which led to four expressions of interest. Members who are on the list are also sent details of any recent relevant documents or policies in their areas by the Consultation and Specialist
Knowledge Co-ordinator and those who have been involved in providing a response for a call will receive the final policy document and society response, which is also often published on the main Society’s website (www.bps.org.uk).

The Specialist Knowledge List has increased by 45 members over the last year, almost doubling the number of expert members on the list to 101. We also continue to engage members in responding to consultations and have responded to 24 calls for consultation to the Specialist Knowledge List in the last year. Areas that the Division has been able to respond to include; the NICE review on Computerised Cognitive Behaviour Therapy, Rehabilitation Measures for Cancer Service, Health of the Working Age Population, Preventing the Uptake of Smoking by Children, Workplace Activity, Stroke, Strategies for Alcohol and Substance Misuse, Critical Illness Rehabilitation, Cardiovascular Service Framework, Services for Chronic Pain and many more. Recent feedback from within the Society about DHP involvement in this process has been very positive.

The work of the Consultation and Specialist Knowledge Co-ordinator could not continue without the ongoing support, time and effort of the DHP members who are kind enough to share their expertise, and we would like to take this opportunity to express our thanks. We are always keen to hear from DHP members who have yet to join the Specialist Knowledge List. If you would like to be involved in the most up-to-date consultations in your specialist interest areas within health psychology please send a brief resume of your background in health psychology and key words to represent an overview of your area(s) of interest to:

Dr Angel Chater,
Consultation and Specialist Knowledge Co-ordinator.
E-mail: angel.chater@beds.ac.uk

We would also welcome any feedback on ways to develop and increase this service further for the benefit of all involved.

Angel Chater
Consultation and Specialist Knowledge Co-ordinator.

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**CPD Subcommittee**

The remit of the CPD Subcommittee is to keep members informed about CPD requirements, support members’ CPD needs and (until the handover to HPC) assess CPD logs.

As such the Activities of the Subcommittee involve:

- Maintaining a CPD page on the DHP website.
- canvassing members to ascertain CPD needs/requests.
- Organising CPD workshops in response to member needs.
- Assessing and providing feedback on randomly selected CPD logs (five per cent of members each year).
- Organising CPD activities at DHP conferences (e.g. stand and workshops last year).

- Attending the Society’s Standing Committee for CPD meetings to represent DHP members.
- Attending the Society’s Assessor’s Committee meetings to represent DHP members.
- Responding to member queries re. CPD requirements.

Workshops that have been run so far:

- Health Psychology in Action; Julian Bath, Sarah Dryden & Andy Champion; Friday 18 May, 2007; Stoke-on-Trent.
- Cognitive Behavioural Therapy for Physical Health Problems; Dr Andy Keen; Tuesday 11 September, 2007; Nottingham.
- Reflective Practice and Reflexivity in Research; Dr Rachel Shaw and Dr Sheila Bonas; Friday 7 March, 2008; Stoke-on-Trent.
● Behaviour Change Intervention: Design and Evaluation; Professor Charles Abraham; Friday 9 May, 2008; London.

Future events include:
● Motivational Interviewing; Sasha Cain; Friday 14 November, 2008; London.
● Consultancy; Dr Mark Forshaw, March, 2009, Stoke-on-Trent.
● Systematic Reviewing and Meta-analysis; Dr Richard Cooke and Dr Chris Bridle. Summer, 2009; date and venue TBC.
● Behaviour Change Intervention: Design and Evaluation; Professor Charles Abraham; date and venue TBC (re-run due to popular demand).

● Mindfulness. Facilitator, date and venue TBC.

If you have a CPD Workshop request, or would be willing to facilitate a future workshop then please contact Emily Buckley, Chair of CPD Subcommittee, on e.j.buckley@staffs.ac.uk

Emily Buckley
CPD Subcommittee Chair.

Workforce Planning Subcommittee
This Subcommittee’s main role is to provide representation on key Society, Department of Health and Union committee’s to ensure that the important issues for the DHP members are put forward. This Subcommittee keeps the DHP Committee informed on matters of Workforce Development. The main committees mentioned above relate to applied psychology, therefore, this is a main focus of the work. Over the past couple of years this has included significant input into the Department of Health strategy (New Ways of Working (NWW) for Applied Psychologists) for the future development of applied psychology as a profession within the NHS. This included developing proposals of how applied psychologists will work within leadership roles, multi-disciplinary working and the resulting requirements that there will be for training programmes for the future. This work is relevant to all psychologists in ensuring a senior role within the NHS of the future.

This Subcommittee has also contributed to the work that has been going on relating to improving access to psychological therapies (IAPT). Involvement in this work has been important to ensuring that the DHP is able to make appropriate decisions to ensure that health psychologists will not be left out of work in this area.

Each year this Subcommittee supports the Department of Health’s Workforce Review Team (WRT) to report on the activities of health psychologists within the NHS and to advocate for paid training places for our profession. We have been successful in the past two years in providing the evidence for the significant role of health psychologists in the NHS. Due to the poor financial situation of the NHS in the past, this has not yet resulted in the roll out of paid training, but we remain hopeful for the future.

Finally, this Subcommittee provides support for health psychologists working within the NHS through links with the British Network of NHS Health Psychologists, which provides a forum for those who work in the NHS, and also through availability to provide advice and support such as the special meeting organised for health psychologists in the NHS in 2007 which was well attended and received.

Proposed future work for the committee will be the continued attendance of Society, DH and other relevant meetings. Organising a second meeting for NHS Health Psychologists (Spring/Summer, 2009), the development of a placement scheme for Stage 2 trainee’s to gain experience of working with an NHS Health Psychologist and finally, in
light of the commissioning changes within the NHS, to develop proposals in key areas of public health for how services can reduce/improve health outcomes based on the health psychology evidence base. This would skill up Provider Services to be able to bid for this work, including identified posts for health psychologists.

Sasha Cain
Workforce Planning Subcommittee Chair.

Stage 2 Review Working Group
The Stage 2 Review Working Group was established in January, 2006. The remit of the group was to review the requirements for Stage 2 training in the light of various drivers and developments which had occurred since the original publication of the Stage 2 regulations in 2001.

The drivers which have shaped the deliberations of the working group have included:

- The current shortage of Stage 2 trainees and programmes.
- Feedback from current trainees about the burden and costs of training.
- Feedback from supervisors and programme teams about the burden of assessment.
- The perceived need to provide a clear and straightforward route to Chartership in Health Psychology for those choosing the PhD route.
- Government initiatives increasing the emphasis on public health; the opening of the Public Health Register to health psychologists with appropriate competences.
- Feedback from a number of sources, including trainees, supervisors, and SHAs about the desirability of including intervention skills as a core competence for health psychologists.
- Government initiatives to increase the number of ‘therapists’ in the workforce (IAPT).
- The possibility of the adoption of a three-year model of training for Applied Psychologists (New Ways of Working; MPTB).

- The Society’s Generic Professional Competences.
- The Society’s Clinical Health Psychology Competences.
- The Society’s Standards of Proficiency for the Health Professions Council (HPC).
- Recent NICE guidance on behaviour change.

In the latest draft, the group has proposed reducing the number of core units from 19 to five, and the number of specific competences from 73 to 50. The core areas of Professional Skills, Research, Teaching and Consultancy remain, and Intervention competences have been added.

Where are we now in this process?
The latest draft of the revisions has been sent to members of the DHP Committee, the DHP Training Committee (DHPTC) (who in turn have circulated Stage 1 and 2 programme leaders), the DHP Board of Examiners (DHPBoE) and to the originators of the Stage 2 Training Route for comment. The mechanism for consulting the membership of the DHP as part of this process will be announced at the AGM in September. All feedback will go to the DHPTC and DHPBoE who will shape the final proposal. This will then be submitted to MPTB for approval. It is hoped that this process will be completed by the Spring of 2009, in order for Stage 2 programmes to incorporate the revisions into the 2009/10 academic cycle.

Nicky Rumsey
Stage 2 Review Working Group Chair.
Report from the Division of Health Psychology Support Officer
(April, 2007 – September, 2008)

Althea Valentine

My background
I GRADUATED IN 2002 with a First Class Honours degree in Psychology from the University of Derby and then completed an MSc in Health Psychology, at the same institution, which I passed with distinction. I’m currently finishing a PhD alongside the Stage 2 Qualification in Health Psychology at the University of Nottingham, under the supervision of Dr Heather Buchanan. My PhD is looking at children’s understanding and experience of stress.

During the initial stages of my postgraduate study I was involved in committee work for the Psychology Postgraduate Affairs Group (PsyPAG), where I was the PsyPAG Vice-Chair (2006–2007), Division of Health Psychology (DHP) Representative (2004–2006), The British Psychological Society Membership and Professional Training Board Representative (2003–2004), and PsyPAG Quarterly Editor (2003–2005). These positions enabled me to develop knowledge of the workings of the Society and DHP, as well as gaining organisation skills which provided me with an excellent foundation to gain employment as the first DHP Support Officer in April, 2007. During my employment, I have worked with members of the DHP Committee to promote health psychology, as well providing administrative support to the Committee. This report outlines my progress and some of the activities that I have been involved in.

The role of Support Officer
To ensure that the position made a lasting contribution to the development of the Division and its strategic aims, the past Chair (Dr Daryl O’Connor) and members of the DHP Committee developed several key work-packages for me. Importantly, it was clear that in order to provide adequate support, the Support Officer role necessitated being up-to-date with recent developments within health psychology (e.g. New Ways of Working, Improving Access to Psychological Therapies and Statutory Regulation), as well as being familiar with recent events from within the Division. Thus, time was spent increasing familiarity with the Society, Department of Health, and the Division websites and related documents, including reading several years of enthralling DHP minutes! Once my knowledge was up-to-date I began working on the work-packages, mainly for the Committee, as well as supporting the conference and publicity and liaison teams.

General Committee support
Initially, I worked closely with the past DHP Secretary, Karen Rodham, to develop an understanding of what was needed during meetings and discussed how duties would be split between the Secretary and Support Officer, as I was to take over some secretarial duties. The support from Karen was invaluable during this time and I am really grateful to her for this. Sadly, Karen stood down prior to my first meeting as Support Officer; this meant that I took on some additional secretarial duties for the first six months of my tenure.

Throughout the year, I attended all DHP meetings and Away Days, during which I took minutes. After meetings, I produced a digest (summary of the minutes) to be made...
available online for members of the Division to see what the Committee is doing on their behalf and find out the most recent developments. I also produced backdated summaries for the previous year. All summaries are now available online.

The Society’s harmonisation process over recent years has led to some changes within the Society as a whole, as well as within our Division, for example new standardised rules were recently approved, which will streamline and clarify the election process of committee members in-line with other Society subsections. Working with the Chair executive, I have been involved with updating the Committee structure, producing spreadsheets and diagrams and ensuring that the Committee aligns with the new DHP rules.

I have also worked on finishing an induction pack for Committee members that Karen Rodham began. This will enable new members of the Committee to find out about the DHP, will ensure greater transparency for recruitment to the Committee and hopefully help elected members settle into the Committee easier and faster.

**Annual Conference**

Early on in my position, I began to support the local conference organiser with some basic administrative duties associated with the DHP 2007 conference. In both 2007 and 2008, support was also provided to help the National Conference Organiser (Dr Jo Hart), tasks included: checking the database from the conference scientific committee, proof reading the conference programme and abstracts, and organising Chairs for each individual session during the conference.

I also prepared a short report for the conference organisers considering issues of disability accessibility at the conference; I will prepare a more detailed report for the Division as part of my Stage 2 consultancy.

During the 2007 conference I was available to assist the Press Office and generally lend a hand where needed, as well as take minutes at the AGM. After the conference I summarised the feedback and wrote a report with Jo Hart for publication in *Health Psychology Update* (2008).

**Publicity and Liaison**

During my involvement with the DHP Committee, I noted how much the Division achieves each year and the benefits of Divisional membership, although sharing this information with members has previously been difficult. Consequently, I have worked with the Publicity and Liaison Chair (Dr Diana Harcourt) to develop an information pack for members of the Division, which aims to provide details of the DHP, the benefits of membership and ways to get involved. I have also looked at ways of promoting the Division and informing members of the Division activities, for example, providing an information stand at the DHP Annual Conference.

I have been involved with liaising with the Society and the DHP Committee to produce two leaflets, with the assistance of Emma Eaton, who acted as a consultant for the development of the leaflets for people working with Health Psychologists within the NHS and for NHS employers. I have been involved in beginning to disseminate these leaflets, created a database to record distribution of leaflets to MSc Course Directors and university career’s services and developed a plan for future development to PCT Service Managers and relevant NSF leads.

With Diana Harcourt, I have also written and produced a leaflet explaining Health Psychology to the general public.

Also promoting health psychology, I have written a report for the European Health Psychology Society (EHPS) newsletter promoting the Division and health psychology in the UK; began to create a leaflet promoting the Division to MSc students; updated a PowerPoint presentation to promote health psychology; and summarised examples of good practice obtained throughout the year.
The future of the DHP Support Officer

Although I am rather biased(!), I believe that the Support Officer position has helped the Division. The creation of this role has alleviated some pressure from Committee members who volunteer their time to promote and develop health psychology and the employment of a Support Officer has allowed some projects to come to fruition quicker. I have recently been collating the work-packages developed throughout the past 18 months, which now form the basis of a job description for Sophie Cleanthous, who will take over as Support Officer from September, 2008. Sophie is completing a PhD at University College London, and has previously gained administration experience working on large projects.

I would like to thank the DHP Committee for giving me the opportunity to work with them and for being so welcoming and look forward to working with Sophie for a short period when she begins her tenure.

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Note from the Chair

I am sorry to announce that Thea will step down as the DHP Support Officer from September to focus on her PhD studies and Stage 2 training. Thea was the outstanding candidate when we appointed the first DHP Support Officer in 2006 and she has set the bar extremely high as the inaugural DHP Support Officer. Her knowledge of Society procedures and the intricacies of the DHP are second to none, which is extremely useful for someone like me who tends to forget who’s who and who did what and when! Thea has been at the forefront of making the ambitions and strategic plans of the DHP Subcommittees work over the past two years. She has been instrumental in developing initiatives like the DHP leaflets, the survey of members, rule changes, conference plans and scientific committee duties to name but a few as well as managing day-to-day DHP business. Overall, Thea has made the role her own and she has exceeded expectations by far. I would like to thank her personally and on behalf of the DHP Committee for her tireless dedication and hard work over the past two years. She has been truly excellent. I am pleased that Thea has volunteered to act as a mentor to the new Support Officer, I couldn’t think of a better person for the job, and I wish to her the best of luck in her future endeavours.
On the Ethics Committee

Tony Wainwright

We are living through times of great change both for psychology as a profession, but also for humanity world-wide. These changes have significant ethical dimensions. The British Psychological Society’s Ethics Committee was established 10 years ago and provides a place for the debate and formulation of policy advice to the Society, which has ranged from the Code of Ethics and Conduct to the Society’s response to climate change. This paper is an account of the work of the Committee and a request for readers to become involved in this work.

I HAVE WRITTEN this article for two reasons. Firstly, I believe there are urgent ethical issues involved with living with the consequences of human activity to the natural environment (dangerous climate change, ocean acidification, biodiversity loss, peak oil – see, for example, the position statement from the Australian Psychological Society; Reser, J.P. [n.d.]). Partly as a consequence of these impacts there are increasingly serious global conflicts with implications for psychology (Society for an ethical APA, 2008). In a more local way, but nevertheless not without its own ethical challenges, the substantial changes in our professional world (Statutory Regulation, Agenda for Change, IAPT) are connected with comprehensive changes in the way professions are organized and socially sanctioned (see Bowlby, 2008). These issues pose critical dilemmas for all of us; both as citizens of planet Earth but also more specifically as psychologists.

My second reason, however, is that ethical issues are stimulating and challenging and I would like to see much more active discussion about them. So, readers, discussion articles with an ethical dimension for future issues of Health Psychology Update would be very welcome. I will start with an account of the past and current work of the British Psychological Society’s Ethics Committee. This meets quarterly and details of its future work will be available on the Society’s website (www.bps.org.uk). The second part of the article will be developing ideas on how we might integrate ethics into the Health Psychology Update in the future.

The work of the Ethics Committee:
The Ethics Committee (a Standing Committee of Council) had its first meeting on 30 June, 1998, and so it has just reached its 10th anniversary. Its membership is drawn from the various Boards and Divisions of the Society as well as lay members, and I am the current representative from the Division of Clinical Psychology (Kerri McPherson is the representative from the Division of Health Psychology and a full list of members is available below). Its original purpose was to review the publications on ethical guidance which the Society had then produced and to produce revised guidelines. This took longer than anyone anticipated, but the new guidance finally emerged in 2006 (British Psychological Society Ethics Committee, 2006), nearly eight years later. I participated in many of the discussions on the emerging Code and while the final version looks simple, to get to this point took a great deal of hard work; my own view is that it is a useful document. However, it is worth considering, for instance, whether Codes of Ethics have an ethical dimension themselves – are they simply marketing tools for closed shops, or do they perform important protective functions (or both)? (Bouville, 2008).

The Committee also had to consider its membership, and under its terms of reference had to include ‘Not less than three non-psychologists drawn from a constituency
which may include past, lay-members of the Disciplinary Board, distinguished moral philosophers, representatives of the users of psychological services and those working to support the victims of abuse by professional people.’ The Committee has since always had a representative from Prevention of Professional Abuse Network (POPAN), now Witness, who have been key to the publication of the influential guidance on professional boundaries. The Chief Executive of Witness, Jonathan Coe, is the current representative and his focus on how we prevent unethical behaviour and deal with its consequences is both informative and salutary. Another new member is Professor Julie Stone, one of the key authors of the Clear Boundaries documents which she worked on while Deputy Director of the Council for Healthcare Regulatory Excellence – the regulator of the regulators.

An early ‘lay’ appointee was Professor Peter Rickman, who was Emeritus Professor of Philosophy and Chair of the Philosophy Unit at City University, London, and has over 50 years of university teaching in philosophy under his belt. Over the years, his contributions have been enormously helpful in keeping the Committee clear about its thinking. As a group we can often find ourselves trapped in parochial discourses (Statutory Regulation, Agenda for Change, etc.) and lose the bigger picture. It is often when we are in the middle of a discussion like this that Peter will intervene with a few words reflecting on what Hegel, for example, might have contributed to the debate. These interventions have influenced the Code so that it has the emphasis it has on ethical thinking and reasoning. He always emphasizes the importance of giving each of us the responsibility for thinking through ethical dilemmas and not relying on the Code as a sort of recipe book. You can’t look it up and see what the right thing to do is, that is not the way life is.

The present Chair of the Committee is Richard Kwiatkowski who is an occupational psychologist and senior lecturer at Cranfield University and he has been an active advocate of the importance of ethics in professional practice. As an example the Division of Occupational Psychologists’ in-house journal POW (People and Organisations @ Work) has a Spring, 2008, issue (Kwiatkowski, 2008) devoted to Ethics and Psychology. Richard wrote the cover article (Kwiatkowski, 2008) on the conflicts of interest which may arise when someone works for a large organisation, between the interests of individuals and the requirements of the organization. He takes as a working example the problems which arise when a company needs to ‘shed’ some staff. He shows how the psychologist involved in these processes will have to think through carefully the ethics involved as there are many pitfalls and potential conflicts of interest. There are a number of other articles, and all cover ground with which the Clinical Division will be very familiar and shows how much in common applied psychologists have in the field of ethical practice.

The Committee is currently working on the development of guidelines for postgraduate training courses in ethics with the Membership and Qualifications Board. From what I can gather, ethical thinking as a topic is not strongly covered on courses and ethics may be understood to be embedded in the teaching of other subjects. I recently ran a half-day session for second year clinical psychology trainees which covered ethical thinking, and the feedback was very positive – on the whole being in favour of a whole day on the subject, and it being available in each year. The reason for the interest, I think, is that we all face difficult choices when working as applied psychologists in complex organisational systems, and rarely have the chance to work through in detail the logic which lies at the root of ethical reasoning.

Another area for which the Committee has responsibility is ‘to monitor and develop the mechanisms which the Society has in place to give ethical advice to individual members in all forms of professional practice and to ensure the effectiveness of these mechanisms.’ As part of this role we
receive quarterly accounts of all the enquiries which come into the office. For the last quarter, for example, there were 37 which were reported to the committee, ranging from relatively simple questions which had relatively simple answers, to very complex and difficult situations. It was reading through these each meeting that prompted me to write a short piece for *The Psychologist* (Wainwright, 2008) about how you might go about giving ethical advice. We now also have an arrangement with the office team so that if someone rings in with a query from the DCP, they will be asked if they mind being put in contact with me, so that either anonymously, or attributed, their problem and solution can be described in *Clinical Psychology Forum*. We are also hoping to have a searchable database on the Society's website of the themes from the enquiries so that we can help people get information quickly and easily.

The Committee has been involved, as is the rest of the Society, with the opportunities and concerns about the probable transfer of regulation from the Society alone, to the Health Professions Council. This is a major change with the loss of disciplinary responsibility and policing but inevitably the Society will still need to set standards.

As well as these more practice-based topics, the committee has had one-off seminars on areas with much wider scope. As examples, we had a very powerful session on Human Rights and Security to which we invited Dr Namish Patel, Head of Clinical Psychology at the Medical Foundation of the care of victims of torture, and Dr Gail Walker Smith, Consultant Clinical Psychologist with the Ministry of Defence. I found this a very disturbing discussion in many ways, and it has stayed with me as it raised questions about the role of psychology in contemporary conflicts (see also Kagan, 2007) and more broadly in terms of how psychologists might work with the machinery of the state.

Another significant session was on ethics, sustainability and climate change. The invited speaker was Professor David Uzzell, Professor of Environmental Psychology, University of Surrey, who has been both academically and practically involved over many years in this area (Uzzell et al., 2006; Uzzell & Räthzel, 2008). The Society has since decide to hold a major conference probably in February, 2009, on the contribution psychologists can make to understanding better how we can change human behaviour to both alleviate the human contribution to climate change, but also to adapt to the consequences we now inevitably face. Health psychology has much to contribute to these debates.

Finally a recurring theme for the Committee was on ethics and TV programmes involving human participants – reality TV. Those invited were Dr Tanya Byron (Sutton, 2005) and Dr Cynthia McVey (McVey, 2002). Also invited were three officers from OfCom who provided very helpful background to the quite demanding ethical framework in which the public broadcasters have to operate. Again very stimulating and raised important issues, highlighting the very important educational role such programmes can play and the potential risks.

**Ethics in Health Psychology Update**

The Editorial Team will be exploring how to cover ethical issues in future issues of *Health Psychology Update* perhaps including:

- News features where novel ethical dilemmas have emerged which pose important concerns for clinical psychologists.
- Themes from the enquiries to the Society’s office, either anonymous or attributed.
- Agony aunt/uncle section. Members could send in their queries and a selection could be printed in one issue with an open invite for people to e-mail.

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1 There is a similar system in place for members of the Division of Health Psychology who can be put in contact with Kerri McPherson.
in their suggested solutions or reflections. A selection of these could be published and those which couldn’t fit in the print journal could be published on the Society’s website.

Of course we would also welcome more traditional articles with the caveat that they should be useful. It would be tempting to have rather abstract theorizing about ethics without it being of practical help. However, it is possible to combine both. Alan de Botton’s best seller *The Consolations of Philosophy* (De Botton, 2000) manages to combine a touchingly personal account of the lives of some great philosophers with how we can use the thoughts they had in our lives – a very psychological piece of work.

**To conclude**

As mentioned at the start of this article there have been very fierce debates in the US about the ethical stance of the APA on psychologists involvement with interrogation techniques which have led to some very senior resignations (Shinn, 2007) and a highly politicized campaign for the next President (Reisner, 2008). As with the American housing market collapse, what happens in the US can turn up in the UK with a bit of a time lag. It is clear that the pressures of dealing with terrorism can lead to threats to human rights and psychology is not immune from these threats.

Finally with the impending move to statutory regulation by the Health Professions Council (HPC), the regulatory framework will be shifting. The Society has been consulting about the implications of the new arrangements, but however they turn out some things are clear. The current HPC practice where professionals who have allegations made against them are publicised before the hearings will be a big change for psychologists. Furthermore, whatever happens with the HPC there are likely to be more websites and blogs being published with detailed accounts of psychologists who have been subject to disciplinary hearings. The growing number of psychologists in private practice may also be a driver for some of these developments. This again is a major change. Interesting times!

**Ethics Committee Members**

Chair and Professional Practice Board Representative, Richard Kwiatkowski.
Division of Teachers and Researchers, Elizabeth Attree.
Division of Educational and Child Psychology, Phil Stringer.
Division of Clinical Psychology, Tony Wainwright.
Division of Counselling Psychology, David Draysey.
Division of Forensic Psychology, Wendy Morgan.
Division of Sport and Exercise Psychology, Remco Polman.
Division of Health Psychology and Publications and Communications Board Representative, Kerri McPherson.
Special Group in Coaching Psychology, Julie Allan.
Special Group for Psychologists in Social Services, John Newland.
Register of Psychologists Specialising in Psychotherapy and Membership and Professional Training Board, Sheelagh Strawbridge.
Research Board, John Oates.
Past President and Chair of EFPA Standing Committee on Ethics, Geoff Lindsay.
Standing Committee on the Welfare of Animals in Psychology (SACWAP), Nigel Foreman.
Standing Committee for the Promotion of Equal Opportunities, Tony Walsh.
Psychology Postgraduate Affairs Group (PsyPAG), Helen Watts.
External Member, Chartered Institute of Personnel and Development, Angela Baron.
External Member, WITNESS, Jonathan Coe.
External Member, Philosopher, Peter Rickman.
External Member, Healthcare Regulation, Julie Stone.
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References

Available at: http://news.bbc.co.uk/1/hi/programmes/analysis/7360349.stm


Web-based resources


Health Professions Council Complaints. www.hpc-uk.org/complaints/hearings/

Witness (was Prevention of Professional Abuse Network).
Main site: www.popan.org.uk/
Training site: www.professionalboundaries.org.uk/Home.aspx
‘Health Psychology In Focus’: A review of the 2008 postgraduate workshop

Natalie Taylor, Laura Ashley, Alice Forster, Clare Llewellyn, Gareth Lloyd, Jilly Martin, Eleni Vangeli & Laura Webber

Held by the DHP Postgraduate Subcommittee and BREATHE, July 2008, University College London.

Background

THE DIVISION OF Health Psychology Postgraduate Subcommittee (DHP PGSC) and the British REsearch and Training in HEalth Psychology initiative (BREATHE), both allied to the British Psychological Society, aim to enhance training and collaboration for early career researchers and postgraduate students in health psychology. A key objective of both organisations is to run annual workshops providing knowledge, skills, and an informal environment for participants to get to know one another. This year, for the first time, the two organisations collaborated in a joint two-day workshop at University College London. The two main topics for discussion were ‘Health Psychology: In Action’ and ‘Health Psychology: Stage 2’. Well respected experts working in the field of health psychology were invited to share and discuss their knowledge and experience with the workshop delegates.

Summary

The workshop was organised and run by members of the DHP PGSC and BREATHE. Committee members chaired each session, all of which facilitated interesting questions and discussions between the presenters and workshop delegates. Applied psychology practice was encouraged through a number of small group exercises, which resulted in a variety of interesting debates and opportunities for personal reflection.

Day 1. Health Psychology: In Action

Session 1: Applied Health Psychology jobs

The first morning began with presentations from Chartered Health Psychologist, Dr Jane Speight, and Trainee Health Psychologists, Vicky Lawson and Antonia Rich, who work in a range of applied psychology settings, including independent research consultancy, the charity sector, and the NHS. The interesting and informative presentations from the speakers revealed diverse experiences and alternative applications of health psychology. Demonstrations of these under-represented avenues for health psychologists rekindled hope with regard to future career opportunities in health psychology.

Session 2: Coaching skills for Health Psychologists

This session was led by Dr Tim Anstiss, an expert in behavioural medicine. Tim’s interactive workshop focussed on Motivational Interviewing (MI), a technique to enhance intrinsic motivation by exploring and resolving ambivalence. Tim performed an entertaining and informative role-play demonstrating motivational interviewing techniques, with one of the delegates. This provided an excellent illustration of the ‘do’s and don’ts’ when delivering MI, including possible futures, agreeing goals, and rolling with resistance. Small group role-play activities followed giving delegates the opportunity to practice MI. Tim regularly runs short courses in MI for those who wish to obtain training in this technique.
Day 2. Health Psychology: Stage 2

**Session 1: Statutory regulation update**

Dr Martin Hagger, Chair of the Division of Health Psychology, opened Day 2 proceedings with an update on statutory regulation. Delegates were informed of Government plans to introduce statutory regulation whereby applied psychologists will be regulated by the Health Professions Council (HPC). Although discussions between the British Psychological Society and the Government are currently ongoing, it is likely that the HPC will be responsible for disciplinary issues, accreditation of courses and maintaining a register of applied psychologists. Importantly, the title of ‘Health Psychologist’ (and other specified psychologists) is likely to be protected such that individuals not registered with the HPC will not be permitted, by law, to use this title. In addition, a requirement for retention of the title ‘psychologist’ will include a practising certificate that is annually updated through demonstrations of continuing professional development.

As workshop delegates were at different phases of health psychology training, there were a number of questions posed to the presenters regarding the consequences for all concerned. Neil and Mark are in the process of putting together a Q&A summary document in response to the session, which will be posted on the DHP website in due course.

**Session 2: Stage 2 update**

The second session of Day 2 was held by Dr Mark Forshaw, Chief Supervisor and Registrar of the Board of Examiners in Health Psychology, and Dr Neil Coulson, Chair of the Society’s DHP Training Committee. Mark and Neil presented the changes to Stage 2 training that are due to commence in 2009, and potential changes that are being planned for a later stage. In 2009 changes to the curriculum will include: (1) a reduction in the overall workload/assessment; (2) removal of optional competencies; and (3) introduction of a compulsory intervention competency. An idea for the future is to combine Stages 1 and 2 into one three-year programme, although nothing concrete has been decided yet. The changes to the current curriculum have ramifications for those choosing to commence Stage 2 training, but will not affect those already registered on the route.

Delegates’ feedback about the workshop

Forty-eight delegates attended the workshop, of whom 27 completed evaluation forms, in which they rated nine different aspects of the workshop, using a five-point Likert scale ranging from 1=strongly agree to 5=strongly disagree, with a higher score representing a more positive evaluation. Feedback was extremely positive – the summary findings are presented in Figure 1 below. Delegates’ current programme of training or employment was varied – 33 per cent were MSc/MA students, 26 per cent were PhD or DPsych students, 19 per cent were in academic research posts, and the remaining 22 per cent had ‘other’ occupations. Interestingly, only 60 per cent were DHP members.

Session 3: Stage 2 student panel

The final session of the workshop consisted of presentations by Jackie Bailey, Esther Murray and Eleni Vangeli, and Sunita Sturup-Toft who completed Stage 2 via an accredited PhD, an accredited taught doctorate, and independently with the Society (respectively). Each presenter provided an insight into their journeys through Stage 2 so far, the pros and cons of gaining the qualification through their respective route, and most importantly their belief in the benefits gained from their chosen route. The pros and cons for each route are displayed in Table 1 below.
Table 1: Pros and Cons of each of the three possible Stage 2 training routes.

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**PROs**
- 2 qualifications in 1
- Time management independence
- Internationally recognized qualification
- Development of applied skills as well as research skills
- Network of support
- Very small thesis
- Manageable workload
- Inexpensive
- Trained in intervention skills but no recognised qualification
- Can be isolating
- Student grant not salary
- Juggling full-time work commitments alongside study
- Very expensive fees
- No ‘Dr’ title
- Adequate supervision difficult to find
- Not enough relevant work roles to fulfil competencies
- Hard work

**Mean evaluation scores (range = 1–5)**

<table>
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<th>Knowledge gained</th>
<th>Handouts</th>
<th>Venue</th>
<th>Social programme</th>
<th>Overall organisation</th>
<th>Participate again</th>
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A personal reflection
As a PhD student in the area of Health and Social Psychology, I found the ‘Health Psychology: In Focus’ workshop interesting and informative. The useful presentations on statutory regulation and changes to Stage 2 training helped me to further understand the intricacies and challenges involved in becoming a Chartered Health Psychologist, and that the decision to undertake this training should not be taken lightly. I particularly enjoyed the presentations in the ‘Health Psychology in Action’ workshop as they enabled me to realise the scope of potential occupational opportunities within health psychology. These insights both reassured my thoughts about the future after my PhD and sparked an element of excitement with regards to previously unidentified and alternative avenues that my career path could take.

Acknowledgements
BREATHE and the PGSC would like to thank the Division of Health Psychology who provided 10 bursaries to cover travel and accommodation costs for delegates living outside the London area.

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www.researchdigest.org.uk/blog
People involved in teaching research methods to undergraduate or post-graduate students and active researchers alike will be aware there is a growing interest at all levels in using qualitative methods and a consequent need to understand the range of methods available and the assumptions underpinning the different approaches. People who have grown up with quantitative methods and their often unexamined philosophical underpinnings can find themselves baffled when confronted with the diversity of qualitative methods and their very different epistemological assumptions. This volume, which is edited by two of the leaders of the qualitative trend in research in the UK backed up by an impressive Editorial Advisory Board, is a most welcome addition to the texts already available. Carla Willig has already produced what is virtually the standard text on qualitative research in the UK and there are other excellent texts, such as Smith’s and Marks and Yardley’s, but this is much more comprehensive than those. It is divided into three sections; one dealing with the methods themselves, one examining particular issues and specific techniques and the third looking at applications. The first section covers just about all of the major qualitative approaches in 13 chapters, including Grounded Theory, Interpretative Phenomenological Analysis, Discursive Psychology, Foucauldian Discourse Analysis, Narrative Psychology and Conversation Analysis. All are written by leading figures associated with each of the approaches and each chapter provides background to the approach and a description of how the method is employed in practice, frequently employing examples from the authors’ own research. I was slightly disappointed not to find chapters on content and thematic analysis, although TA is mentioned briefly in Brown and Locke’s chapter on Social Psychology. Braun and Clarke have produced an excellent guide to TA, but it is a pity that it is not covered here. There are also chapters in this section on what are, perhaps, slightly less familiar qualitative methods, such as Psychoanalytic approaches and Memory Work. There is also a very entertaining and informative chapter by Stenner, Watts and Worrell on Q-Methodology that makes interesting points about the intersections between qualitative and quantitative methods (or its qualiquantological heritage as they have it). The second section has six chapters on important issues such as ethical issues in qualitative research, feminist psychology, the use of the internet and the use of computer packages for analysing qualitative data. There is also an interesting chapter here by Reavey and Johnson on the use and interpretation of images, which demonstrates nicely that qualitative approaches are not restricted to verbal and textual material. The final section contains 12 chapters on the applications of qualitative methods in a range of psychological sub-disciplines. These include all the areas that you might expect, including social psychology, health psychology (the authors of which, Chamberlain and Murray, are likely to be familiar to readers of Health Psychology Update), clinical psychology, educational and forensic psychology. The hand-
book is topped and tailed by introductory and review chapters by the editors. The former does a nice job of briefly providing a historical background to qualitative approaches and locating them in relation to more established quantitative methods while the latter looks forward to the future of qualitative methods. It seems somewhat churlish to be too critical of such a comprehensive and useful volume, but there are two things that I would have liked to have seen dealt with as topics in their own right. One is the issue of selecting a qualitative method. This is something that students in particular often struggle with and, although a careful reading of the Introduction and of the various chapters in the first section will provide guidance, a detailed consideration of the topic would have been very helpful. The other is discussion of the issue of quality in qualitative research (roughly the equivalent of reliability and validity in quantitative research). This is still a topic that gives rise to debate among qualitative researchers and has been the focus of some critical comment, particularly in relation to depth of analysis. Those of us who have been involved in submitting proposals for qualitative research to ethics committees are unfortunately familiar with the fact that not all such committees are familiar with these issues, despite a growing awareness of them (thankfully, it is rare nowadays to be asked to provide power calculations for a qualitative study).

The price of this book (at least in its current hardback incarnation) is likely to put it out of the reach of all but the most committed and enthusiastic students and might even be off-putting to cash-strapped academics, but it is certainly worth putting on reading lists and on library shelves.

Dr Ken Gannon
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University of East London.
Books for Review

The following books have been sent to *Health Psychology Update* for review. If you would like to review one of these books, please contact Diane Dixon. Also, we particularly welcome reviews of books or multimedia that are not listed here but which would be of interest to health psychologists.

**Contact:** Diane Dixon, Department of Psychology, University of Stirling, Stirling FK9 4LA. E-mail: diane.dixon@stir.ac.uk

*Informed consent and clinician accountability: The ethics of report cards on surgeon performance*
Cambridge University Press.

Deonna, T. & Roulet-Perez, E. (2005)
*Cognitive and behavioural disorders of epileptic origin in children*
MacKeith Press.

*More hypnotic inductions*
Wiley.

*Inside anorexia: The experiences of girls and their families*
Jessica Kingsley Publishers.

*Eating disorders in children and adolescents*
Cambridge University Press.

*Filling a need while making some noise: A music therapist’s guide to paediatrics.*
Jessica Kingsley Publishers.

*Patient management problems in psychiatry*
Elsevier, Churchill Livingston.

*The Cambridge textbook of bioethics*
Cambridge University Press.

*Drug abuse: Concepts, prevention and cessation*
Cambridge University Press.
Health sexism by default?

Paul Millar

Accidental sexism is a concept to beware of in health psychology, especially as we know that health sex differences are embedded in our culture, environment and in our bodies. Most of us are comfortable with the knowledge that males and females are distinctly different in some areas of health use and that in catering for such differences, we do not discriminate. Discriminating accidentally, however, is always a possibility and we should ensure we are careful in our practice to avoid this.

Outside health psychology, for example, accidental sexism can be seen dramatically in toilet queues in motorway service stations. Men can freely enter their mass pissoirs while women join long queues, embarrassingly in open view, and wait with increasing anxiety for the distant safety of cubiced relief. This plea is for health psychologists to be aware of such accidental sexism in our own assumptions and work practices.

It is well known that some diseases and conditions affect males and females differently and, of course, some conditions are specific to one sex or the other. Unfortunately, some health conditions become engendered in a stereotypical manner. This creates problems when they occur in the ‘wrong’ sex. An example is male breast cancer. Breast cancer is problematic enough for women with its life-challenging dangers, difficulties in diagnosis, intervention issues and post-treatment issues of self-identity. There is, nevertheless, a huge resource machine dedicated to education, prevention and support for women with breast cancer. Male sufferers of this condition, in contrast, struggle to be heard once diagnosed, or even believed to have the disease in the first instance, let alone find support groups or information for their small numbers. While this discrimination is not deliberate, it exists (see Breast Cancer Care, 2005).

In a less dramatic instance, osteoporosis is also engendered as one-in-two women in their later years will fracture a bone, mostly through this condition, compared to only one-in-five men (National Osteoporosis Society, 2008). In my own brush with the condition I was given a hospital-produced leaflet to help me understand that my osteoporosis may be caused by my oestrogen levels falling due to my under-performing ovaries after menopause. As a man, I found this explanation unconvincing. Following successful treatment, the results of my bone scan came back with another locally-produced leaflet that explained that my bone density was now very good and a graph indicated that I had the spine and hips of a 25-year-old woman. I suppose I should be pleased, but I hope she never comes looking for them!

My latest encounter with unintended sexism has been with my own profession. The new design of The Psychologist is awash with pretty colours; however I, as a colourblind man, find this new style makes the publication quite unreadable in parts. Squinting in good light can bring out hidden words eventually but, sadly, my pleasure in reading my own profession’s publication is gone. Colour-blindness, as you may know, is male-biased with few women affected (Neitz & Jacobs, 1986). About 10 per cent of men have the commonest form, as I do, of weak red and green colour perception and I have passed my concerns about the new style of The Psychologist to the Society. (You can test yourself, friends and partners for colour-blindness free at: www.toledo-bend.com/colorblind/ishihara.html)

So my plea is that, as health psychologists, we should take care when designing leaflets for our clients/patients, information for our
research participants and teaching material for our students, that these truly represent the engendered needs of the audience. Ensuring that fancy colours don’t hide critical texts for colour-blind men and ensure, of course, that health information and teaching material is in plain readable language.

Web pages too, should be carefully assessed for colour choices, avoiding substantial amounts of red or green backgrounds or coloured texts on coloured backgrounds, unless they have a strong contrast. If you are aiming at male participants in particular, remember that reds and greens can appear dull and lifeless to the 10 per cent of the male audience with red-green colour-blindness. It is always very useful to find someone with colour-blindness to check out your publications. And for those of you who need more convincing that colour-blindness can cause more than annoyance to a reader I suggest *Colour-blindness: How to alienate a grant reviewer* (Ross, 2007). It can lose you a research grant.

As health psychologists, we should be more aware than most people of accidental sex discrimination through assumptions of engendered conditions; for example, colour perception insensitivity. Unless, of course, one wishes to be discriminatory for a purpose, to hide text from a colour-blind colleague! I note that this year’s Division of Health Psychology and European Health Psychology Society’s Annual Conference website was designed using a range of pastel reds and greens in logos, highlights and titles (www.bath2008.org.uk) and parts of the text are in blue. These highly coloured websites might be appealing to some but to others, including the 10 per cent of men, who, like me, can barely read parts of it, they are inaccessible. Oh, dear, do we never learn? Red faces all round, or in my case … is that green?

References

Available online at: www.breastcancercare.org.uk/docs/men_with_breast_cancer_08_web_0.pdf


Notes for contributors to Health Psychology Update

Health Psychology Update editors invite contributions from all areas of health psychology including experimental and clinical research, the aetiology and management of acute and chronic illness, research into health behaviours and health promotion and psychological aspects of clinical interventions and the health care system.

Articles (including extended articles) may provide a broad overview of a particular area or issue, review the literature, include original research, discuss and debate theory, practical or professional problems in health psychology. The editors would also like to encourage the submission of book reviews, short research reports, letters, news of members, work in progress and news of forthcoming events.

Guidelines for submission to Health Psychology Update

Empirical articles, extended articles and short research reports should be clearly written as for an educated audience but non-specialist, with non-technical language and aim to engage the interest of the membership at large. Sexist, racist and other discriminatory or devaluing language should be avoided. Empirical articles should be between 800–2000 words (excluding references). Extended articles should be between 2000–4000 words (excluding references) and a maximum of 800 words for ‘brief research reports’.

All manuscripts should be typed on A4 paper, double-spaced, with complete references (kept to a reasonable minimum). Full bibliographic references should be contained in the list of references at the end of each article (between 10–15), listed alphabetically by author, be complete and accurate and in the format used in the British Journal of Health Psychology. Authors are asked to supply a PC-compatible 3.5” disk of the article at the time of submission. Submission of material by e-mail is strongly encouraged.

Review Procedures

Health Psychology Update operates a policy of blind peer review by two independent referees for all original articles. Book reviews, material for ‘Research in Brief’, letters, conference reports and forthcoming events are not refereed but evaluated by the editors.

Submissions should be sent to:

- **Original research, extended articles, letters, news of members:** Dr Kerri McPherson (Co-ordinating Editor), Division of Psychology, Glasgow Caledonian University, 70 Cowcaddens Road, Glasgow G4 0BA. E-mail: Kerri.McPherson@gcal.ac.uk
- **Brief research reports and work in progress:** Dr Phil Watson, University of Edinburgh, 20 West Richmond Street, Edinburgh EH8 9DX. E-mail: Philip.Watson@ed.ac.uk
- **Articles relating to consultancy in health psychology:** Dr Carrie Llewellyn, Dept. of Primary Care & Public Health, Brighton & Sussex Medical School, Mayfield House, Falmer, Brighton BN1 9PH. E-mail: C.D.Llewellyn@bsms.ac.uk
- **Articles relating to the teaching and training of health psychologists:** Dr Nicola Payne, Psychology Academic Group, Middlesex University, Queensway, Enfield, Middlesex EN3 4SA. E-mail: N.Payne@mdx.ac.uk
- **Articles relating to professional issues:** Dr Nigel Hunt, Institute of Work, Health & Organisations, University of Nottingham, William Lee Buildings 8, Nottingham Science & Technology Park, University Boulevard, Nottingham NG7 2RQ. E-mail: nigel.hunt@nottingham.ac.uk
- **Book Reviews:** Diane Dixon, Dept. of Psychology, University of Stirling, Stirling FK9 4LA. E-mail: diane.dixon@stir.ac.uk
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