Health Psychology Update

is produced by the Division of Health Psychology (DHP) of the British Psychological Society four times a year 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.

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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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EDITORIAL
Sara Cox & Kerri McPherson

Welcome to the third edition of the 15th volume of Health Psychology Update. We would like to begin by thanking everyone who was involved in this year’s Annual Conference, hosted by the University of Essex, and look forward to publishing reviews of this and other conferences in the next edition.

This year is one that has been dominated by the complex issue of statutory regulation. We hope that you have had the opportunity to contribute to the debate this has generated and provide feedback to the Society on the proposal for the establishment of a Psychological Professions Council.

While these new proposals may have implications for us as health psychologists they do, of course, come alongside significant developments within the Division in the training of health psychologists. There are now 89 approved Stage 2 supervisors and we hope that the themed ‘teaching and training’ articles in this and the previous issue help support supervisors and trainees alike.

In the first of these themed articles, staff and students from London’s City University share their experience of Stage 2 health psychology training. Next, Dr Mark Forshaw, Chief Supervisor and Registrar for the Board of Examiners in Health Psychology, compliments the advice he gave to Stage 2 supervisors in the last edition by addressing questions commonly asked by Stage 2 trainees. Finally, we hear from Alice Theadom from Brighton and Sussex Medical School and Emily Bucky from Staffordshire University. Alice was, of course, the first successful trainee taking the BPS route and Emily the first successful trainee taking the University route; they describe the benefits and potential pitfalls of the two routes.

In addition to the themed articles we are delighted to have six individual articles. These begin with Carrie Llewellyn (Brighton and Sussex Medical School) and Markus Themessl-Huber’s (University of Dundee) demonstration of the potential benefits that health psychologists can bring to Departments of Primary Care.

The two articles that follow make clear the important role that health psychology has in ensuring health messages reach their target audience. The first, describes research being carried out by Zoe Chouliara, Alison Goulbourne, Helen Smart (all from Queen Margaret University College) and Athanasios Karatzias (Napier University) investigating young Scottish women’s perceptions of Chlamydia and condom use. The second, by Sue McHale from Sheffield Hallam University, explores the role of the health psychologist in informing young people about the potential harms associated with cannabis use.

Next, Nicola Davies and Gail Kinman from the University of Bedfordshire discuss the role of health baseline comparisons in individual’s evaluations of their current health status. In this particular piece of research the focus is on people with rheumatoid arthritis but the wider implications are discussed.

For many people the term ‘war veteran’ conjures images relating to the Second World War; however, more recent conflicts have their own veterans. In the fifth article, colleagues Karen Burnell, Nigel Hunt, and Peter Coleman discuss the potential benefits of narrative analysis to developing our theoretical understanding of reconciliation in veterans from past and present wars.

Our final individual article by Karen Goodall, Chris McVittie and Elinor Snowdon, all from Queen Margaret University College, details the experience of young people who have made the transition from residential care to independent living.
We hope that you enjoy reading this edition and, as always, look forward to hearing from those of you who would like to share their own work in the field of health psychology.

Sara Cox & Kerri McPherson

DHP ANNOUNCEMENTS LIST

Did you know that members of the DHP can receive details of relevant meetings, conferences, jobs and news from the DHP committee direct to their inbox?

Joining the DHP Announcements e-mail list can help you to keep up-to-date with what's happening in Health Psychology.

Members of the list can also advertise relevant meetings, jobs, conferences, etc., for free, to more than 1000 members of the DHP.

Have you signed up yet?

To join the list, just send a blank e-mail to: subscribe-dhp-announce@lists.bps.org.uk
Health psychology informs chronic disease management, palliative care, acute care, health promotion, health assessment and health management. This dynamic discipline has developed in response to the needs of the real world and at Aston University’s School of Life & Health Sciences, you will enjoy a vibrant research environment that is committed to high quality health research and practice.

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Our Health Psychology course is accredited by the British Psychological Society (BPS) as Stage 1 training, providing the first step for you to become a Chartered Health Psychologist.

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Following the framework developed by the BPS for professional training in health psychology, modules of Health Psychology cover a thorough grounding in theories, methods, practice and application. Teaching includes lectures, seminars and workshops and all students are supported by personal tutors.

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HEALTH PSYCHOLOGY TRAINING has been up and running for several years. Currently there are two training routes, through a university doctoral programme or independently through the Society. The development and expansion of the training programmes means there has been an increase in interest in following a career in health psychology. However, the training is still very much in its infancy. This can cause anxieties for Course Directors setting up training programmes and for students making career decisions. We believe that it is important to share experiences and collaborate with other health psychologists in order to continuously develop the profession of health psychology. Here we describe the training programme at City University and reflect on the programme team’s and trainees’ experience.

The Doctorate in Health Psychology is part of the research degree programme at City University. The Doctorate of Psychology (DPsych) award has been offered at City University since the mid-1990s. City University’s Stage 2 Health Psychology Training programme provides the trainee with all of the competencies required by the health psychologist as well as a tailored development of individual skills and experience. The programme was accredited by the Society in May, 2005. We currently have four members of staff on the programme team and other experts teaching on the workshops.

The ultimate aim of the programme is for the trainees to be able to both competently and confidently practice in health psychology and produce an original piece of research that contributes to the knowledge of health psychology.

We recognise that each trainee has different needs at different times of the programme. Supervision is needs-led and can be arranged both in and out of office hours. The training programme focuses on skills development and is committed to continuous improvement. It aims to provide training incorporating the latest knowledge in health psychology practice. The training programme includes both core workshops and optional workshops. The workshops take place the first Monday and/or Tuesday of every month of the academic year. We offer a range of workshops linked to the competences such as Cognitive Behavioural Therapy Skills for Health Psychologists, Counselling Skills for Health Psychologists, Systematic Reviews, Consultancy Skills, Designing and Implementing Training Workshops, Ethics in Health Psychology, Psychometrics in Health Psychology, etc.

The training provides support and guidance to trainees working in the field of health psychology who wish to obtain chartered status. It develops the Trainee’s practical skills and ability to integrate theory into practice. The training aims to develop trainees as independent and self-critical learners.

We currently have 22 trainees registered on the training programme. Over half of the trainees received help with the funding of their training (continuous professional development funds, bursaries, grants and sponsored placements). Two trainees have already been awarded chartered status and are extending their research for the DPsych
award. The most common enquiry is related to job opportunities for the Stage 2 placements and for chartered health psychologists. Our trainees work in a range of settings. Table 1 gives an indication of the fields that our trainees are working in. We have set up a webpage aimed at MSc students looking for work experience and job adverts suitable for chartered health psychologists (http://www.city.ac.uk/psychology/research/degrees/dpysch/Suitable_Jobs.html).

It is the trainee’s responsibility to find a suitable placement. However, students on the MSc Health Psychology programme at City University receive guidance on finding suitable placements. The team has also linked up with Health Psychologist Sasha Caine from Camden PCT to provide three sponsored placements, and with South East London Cardiac Network to provide a student bursary.

Setting up the training programme has been hard work and has required dedication and determination. However, observing the development of trainees is very rewarding. Feedback from the workplace contacts has been very encouraging. They all note the benefits of having a trainee health psychologist in their organisation. One trainee has been nominated for a ‘Reducing Inequalities’ award for her work in promoting the health of people with mental health issues.

At times we have questioned the amount of work trainees are required to do, in particular the practice log. However, there seems to be an agreement amongst the trainees that all the pieces of work are essential. Although time-consuming for the trainee to complete and the supervisor to read, the practice log is the only document that allows an understanding of the trainee’s daily practice. Given that the supervisor is often not on-site, the practice log is an essential record of practice. We also emphasise that the practice log is a learning tool as well as a record of evidence of practice. It becomes a burden to complete if it is seen purely as a record. Regular reflection on practice is strongly encouraged. The amount of work and commitment required by the trainee should not be underestimated by the trainee thinking of embarking on the training or by the supervisor supporting the trainee. The demands of the workplace and the training

Table 1: Trainees’ field of work and setting.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Number of Trainees</th>
<th>Field</th>
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<tbody>
<tr>
<td>NHS</td>
<td>14</td>
<td>Exercise and obesity</td>
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<td></td>
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<td>Smoking cessation</td>
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<td>Cardiac rehabilitation</td>
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<td>Oncology</td>
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<td></td>
<td>Sexual health</td>
</tr>
<tr>
<td>Charities</td>
<td>2</td>
<td>Brain injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health promotion</td>
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<tr>
<td>Pharmaceutical company</td>
<td>1</td>
<td>Alzheimer's disease</td>
</tr>
<tr>
<td>Private hospital</td>
<td>1</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Community</td>
<td>1</td>
<td>Young people's health</td>
</tr>
<tr>
<td>University</td>
<td>2</td>
<td>Depression and people who have had strokes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smoking cessation</td>
</tr>
</tbody>
</table>
combined can be very challenging. Due to these pressure points, supervision needs to be flexible to cope with the challenges that the trainee has to face.

Despite this, it is clear that at the end of the training the trainee becomes an independent and competent health psychologist. The trainee learns to become capable of supporting the learning of others, lead and work effectively in groups, use a wide range of learning resources, undertake innovative research tasks, communicate complex or contentious information clearly and effectively to specialists and non-specialists and, last but not least, act as an effective consultant. Stage 2 training in Health Psychology is an exciting career choice for both the trainees and the trainers. The four examples given below give a further insight into four trainees’ experience within the City University programme.

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**Clare Eldred**

**Completed Stage 2 Health Psychology Training in two years**

While completing the Stage 2 training I have been working for Rehab UK, a charity that provides vocational rehabilitation services for adults with acquired brain injury (ABI). This role involves assessing clients’ rehabilitation needs, providing interventions on a group or one-to-one basis, overseeing clients’ progress toward their rehabilitation goals and providing support to staff.

During the Stage 2 training I developed skills in the core competencies by:

- Providing consultancy for a pilot project, established by a Social Services team, to provide and evaluate an arts-based intervention for adults with ABI.
- Designing, and implementing, an individual stress management intervention.
- Developing and directing the implementation of a pain management intervention designed for adults with ABI who experience chronic pain.
- Training vocational rehabilitation staff on managing issues of awareness in adults with ABI.
- Teaching adults with ABI about the nature of stress and training them in the use of stress management strategies.
- Conducting a systematic review of research relating to psychosocial interventions for caregivers of survivors of stroke.
- Carrying out research into the psychological impact of going through the stages of increased awareness, acceptance and adjustment following ABI and the changes in mood experienced by significant others of adults with ABI going through these stages.

The skills and confidence I gained through the Stage 2 training has allowed me to develop my role at the workplace. After completing my training, I was promoted to Lead Psychologist within the rehabilitation centre. I am currently completing my research for the DPsych in Health Psychology.
Claire Howard
Entered the programme with six months prior accredited learning.
Submitted her portfolio of competence for the Stage 2 Health Psychology Training qualification within two years.
I started the Stage 2 training at City University in October, 2004, and worked in the NHS in a clinical health psychology department. In between finishing the MSc Health Psychology and starting the Stage 2 programme, I worked as a health psychologist in the area of respiratory disease, so I backdated six months of this experience, which gave me a head start. The experience I have gained in the NHS has been varied, stimulating and challenging. I have worked in three different services within the last three years: respiratory medicine, smoking cessation and cardiac rehabilitation within multidisciplinary teams, which has enabled me to develop as a health psychologist and fulfil the Stage 2 competencies.

I currently provide health psychology input to a breathlessness clinic in a group setting for patients with chronic lung disease addressing psychological issues such as panic and anxiety, coping, adjustment, relaxation, building confidence in daily activities and goal-setting. Evaluating this clinic formed the research component for the Stage 2 qualification. I also run a community cardiac rehabilitation programme alongside a cardiology nurse facilitating recovery and adjustment from a heart attack and/or heart surgery, which involves seeing clients in their homes. I enjoy working in the NHS in an applied psychology role, although it can be stressful at times due to funding issues. The most challenging aspect of the Stage 2 has been balancing a full-time job with the requirements for the course and finding the time to complete work. The monthly workshops at City University have addressed the competencies and complement what is learnt ‘on the job’. The workshops are an opportunity to meet and gain support from other colleagues. I feel that I have developed as an applied health psychologist through working directly with clients implementing interventions in groups and individually and through undertaking research in an NHS setting.
Eleni Vangeli
Third year part-time trainee aiming to complete the Stage 2 training and DPsych by September, 2007.

I have been working as a Research Psychologist in smoking cessation at University College London for the past two years. My post involves conducting research and implementing interventions (i.e. NHS stop-smoking group and one-to-one treatments). It provides a solid base for achieving the Stage 2 qualification. I chose to follow the professional doctorate in Health Psychology route to become chartered (instead of via PhD) because it focuses on developing applied skills (i.e. designing and implementing interventions, teaching/training, and consultancy) and research skills equally.

The doctoral programme at City University provides training workshops for each of the Stage 2 Competences and facilitates skill development in each of the areas. In most of the workshops we have the opportunity to practice the key skills involved in the different competencies in a safe environment. This has been particularly helpful in terms of learning how to communicate with patients/clients and health care professionals. It is hoped that focussing on these applied skills as well as research skills will assist me to find a career in an applied setting (e.g. in the NHS facilitating patients to adjust to living with a chronic illness).

Being on the Stage 2 programme with other health psychologist trainees working in different fields has been valuable and also somewhat reassuring as the majority of them also work with clients in some way. Finding a post as a Chartered Health Psychologist in an applied setting, however, presents a greater challenge as the role of Health Psychologists is not yet well established. It is likely to require a great deal of determination and confidence in one’s own skills and ability to achieve such a position. Ironically the disadvantage (or toughest challenge) presented by the professional doctorate route may also work out to be an advantage. Balancing the demands of a full-time job whilst seeking out and taking on all the additional projects necessary to demonstrate the competencies can be exhausting but also trains you to be pro-active, and to develop and reflect on the skills you possess in order to create other opportunities. This assisted me to obtain a grant from Cancer Research UK to conduct a research project in the NHS, investigating the causes and processes of relapse back to smoking.
Pamela Gbesemete-Akyeampong

Third year full-time trainee planning to submit her portfolio of competence in six months and expand her research for the DPsych.

Although my job title does not say ‘Health Psychologist’, the aim of my role is to co-ordinate and manage a young people’s health education and promotion project located in an area of high deprivation (ranks within five percent of most deprived communities in England and Wales). This involves translating psychological theories, models and knowledge into ‘practical’ and approachable activities that promotes the health and well-being of young people living in such a significantly deprived communities.

My main responsibilities are to develop and implement activities to address health and social needs of young people living in the project target area, taking into consideration the personal and socio-environmental circumstances and barriers that may prevent the young people from engaging in a healthy lifestyle.

In addition to developing creative and interactive opportunities for young people to acquire health knowledge and skills, I am also responsible for recruiting and training young people as Community Health Mentors (peer health educators). These young people once trained are contracted as sessional workers working with other young people to increase their knowledge and skills in health and health behaviours.

My management role involves managing sessional staff of young people, and other health, social care, and youth providers. I am also responsible for income in excess of £100,000, as well as undertaking activities that generate income (i.e. grants/funding applications) in order to sustain the many health and personal development opportunities that the organisation offers.

Being in this setting has afforded me with the opportunity, among youth, health and social care providers and the community, to highlight the benefits of applying health psychology principles in tackling health needs of the community.

The biggest learning outcome since embarking on the Stage 2/DPsych Health Psychology training in such a vibrant and non-clinical setting, is seeing the impact that involving the community can have on the success of health promotion activities in terms of raising awareness and promoting change.
The BPS Stage 2 Qualification in Health Psychology: Being a Health Psychologist in Training

Mark Forshaw, Chief Supervisor and Registrar, Board of Examiners in Health Psychology

The BPS Stage 2 Qualification in Health Psychology is still rather new to all of us, despite being some years old, because it takes some time for the first trainees to work their way through the system, and become fully qualified, Chartered Health Psychologists as the ultimate result. The qualification evolves daily, as we learn more about the practicalities involved, and we develop increasing examples and ‘case law’, as it were. A crucial factor in the success of the qualification, and the success of its candidates, is the accurate dissemination of information. This article attempts to add to the growing body of advice and knowledge on Stage 2, and is most useful if read in conjunction with the previous article in the last edition of Health Psychology Update, addressing concerns and queries that supervisors might have.

What a trainee needs to know
The qualification is competence-based, which means that over time you amass a body of written and other evidence, under supervision, to demonstrate that you are capable of practising independently without supervision. Some people argue over whether this is training, or an apprenticeship, or something different altogether, but for convenience and consistently across the Society’s Divisions we refer to it as training.

Exactly how you come to the qualification depends on a number of factors, and no two candidates are the same. However, what you definitely need before you can get started is appropriate health-related employment (it can be voluntary) and someone willing to supervise you. You must be supervised by an Approved Supervisor, and a list of these is available on the Society’s BoEHP website at http://www.bps.org.uk/careers/society_qual/health.cfm. Bookmark and check this page regularly for a range of items and updates. Note that not all listed supervisors are able or willing to take on trainees at any specific point in time.

Be aware that many supervisors charge for their time and expertise. This can be off-putting to some, especially after accounting for Society fees and so on, but, in my experience, even the most ‘expensive’ supervisors are considerably cheaper than they might be if they were using a full economic costing model. Therefore, supervision is generally excellent value for money.

You will negotiate yourself with the supervisor about all kinds of details, and this is actually a useful skill to practise anyway. If you win them over, and they agree to supervise you, you must then formally request approval from the Chief Supervisor, and pay the Initial Fee. After that, you work on the plan (you’ll find example plans on the website detailed above), and when you submit the plan you pay an Enrolment fee. If the plan is approved, then away you go (although you have probably started the work before you even submit the plan, and we allow for backdating requests in certain cases to accommodate this). Then, each year, you pay a fee to the Society to maintain your enrolment, and finally you pay a fee to be examined at the end (which consists of a
viva voce examination and a thorough investigation of your written and video evidence). If you are a PhD student, or otherwise meet the Society’s requirements for a fee reduction, you are entitled to pay only half of the total fees to the Society.

**Timescales**
The process of approval of supervisors who are already trained is a technicality than can usually be achieved within a few weeks, if not days. Approval of plans can take longer because it involves at least three people in different places, although we always aim to act swiftly. One of the reasons why there is the possibility of backdating is to account for any delays in our processes.

**Contracts**
You and your supervisor are advised to set out a contract in advance, just as you would for a piece of consultancy work, some rhinoplasty or building a conservatory. A sample contract is available on the Society’s Board of Examiners in Health Psychology webpage. This was written by the Chief Supervisor and was deemed acceptable for use under English law by a solicitor.

**Stop-gaps**
If the person you want as a supervisor is not approved, and will not be able to undertake the process of approval for some time, there is a solution in the shorter term. This involves identifying a ‘stop-gap supervisor’ who will provide supervision until such a time as a change over is feasible. To all intents and purposes, this person is the supervisor until the change is requested, and must be responsible for the training. This arrangement is never permissible or condonable where a stop-gap supervisor is merely acting as supervisor in name only and masking the real nature of the supervision, however.

**Credit for prior learning**
If you have already gained a qualification, or have considerable demonstrable experience in a particular area, then you might be able to claim Accreditation for Prior Learning (or Accreditation for Prior Experiential Learning depending on the fine detail) against one or more competences. Candidates will be expected to provide evidence for any APEL/APL claimed for, and should be able to demonstrate that they are claiming exemptions only for skills and knowledge which have not lapsed. They can also be examined on APL/APL at the end of the process. If you have studied for a competence as part of a modular and accredited professional doctorate in health psychology (for example as an associate student), then you are entitled to automatic APL, provided that you have passed. You still can be examined on it, however.

The reason that we can and do examine APL work is that we must be satisfied that, at the end of your period of supervision, all of your competences and skills are up-to-date and none have lapsed. For that reason, it might be worthwhile keeping a summary log of your post-APL experiences, so that you can easily demonstrate that you have continued to keep things up-to-date. The Regulations on assessment do not require this, but you might save yourself some time and trouble if you take the additional step.

‘Best laid plans’
Even perfect plans can change. If you find that your work changes, or you decide to take up some consultancy opportunity on a completely different topic, for example, you need to notify us of this, and in some cases you will need further approval. You can do this using a Section Two form. If in doubt, contact the Chief Supervisor who will advise on the specific nature of your case.

**The future of Stage 2**
The development of the qualification depends, in part, on the nature of the actual experiences of Stage 2 as lived by the trainees and supervisors. Please tell the Chief Supervisor about any unusual or interesting challenges that you have faced, and always
seek advice if in doubt. It is this very type of communication which has already fed into the current review of our Qualifications in Health Psychology (both Stage 1 and 2), detail of which will be made available over the coming year.

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WHEN I STARTED THE STAGE 2 qualification through the BPS route a few years ago, I did feel a little daunted that there were so many units and sub units of competence, I began to wonder how it would ever be possible to demonstrate them all! On reflection, however, I needn’t have worried; I was applying or developing the knowledge and skills as part of my job every day and I just needed to think about how my work fitted in with the competencies more clearly.

I completed the Stage 2 qualification over two years, whilst working in the NHS. I spent six months working as a Research Assistant and 18 months working in a stop smoking service. My supervisor (to whom I owe my eternal gratitude!) was external to these two posts and based within a university.

After my MSc, I contacted the Society for the course materials and went about finding a post that would be relevant to the qualification. I then arranged to meet with my supervisor to discuss the supervision plan. It was difficult at first to think how I would be able to demonstrate all the competencies, particularly when I was so new in post. I did find that I needed to update my supervision plan over the course of my training for a few competencies. For example, I found that opportunities for consultancy arose after I’d developed a network of contacts over time in my job. However, completing the initial supervision plan was useful and enabled me to break the whole qualification down into more achievable steps and to think about what was required for each competency. This preparation helped me to identify suitable opportunities when they arose.

It did take time to prepare my supervision plan and be accepted on the course, although I backdated some of my work (up to six months) so that none of the work I’d completed was lost. I filled in my log book at the end of each week which was great for keeping everything updated and enabled me to reflect on my practice and to think about how I was applying health psychology to my everyday work. I also sent my supervisor reports of my progress each month and met with him at least every two months.

I used work from my job and work completed in my own time to demonstrate the competencies, as I was keen to develop my skills in a wide range of areas to improve my employment prospects afterwards. As an illustration: I used my experience as a Research Assistant to demonstrate the generic professional competencies such as establishing and maintaining systems for the security and control of information; I used my work in the stop smoking service to demonstrate several competencies such as the consultancy competency, implementing interventions, training health professionals, directing the implementation of interventions and the systematic review; I completed my research into the effect of sleep and coping on quality of life in Fibromyalgia Syndrome; and I used my experience of lecturing to postgraduate students at a local university for the teaching competency. I found that having a table with a list of all the competencies and summarising how I demonstrated this and where the evidence was located helped me to clearly state how I’d met all the competencies, and as a way of organising the ever growing piles of paper that began to stack up!
The real benefit of the Society route is its flexibility, as this enabled me to organise and reorganise my workload to fit around work and life commitments. For example, I was able to submit the evidence for each competency to my supervisor on completion, rather than for a pre-set deadline, although I found I had to be highly self driven to keep on track and to complete the competencies steadily over time. It can be hard to resist the pressure of putting the Stage 2 work on the back burner when things get hectic at work.

There is also a lot of flexibility in how you present the evidence for Stage 2. This has the advantage of enabling you to use work completed as part of your role such as service evaluation reports and needs assessments, rather than having to rewrite the work in a certain way to meet the course criteria. Some evidence is required in formats that most trainees will not have encountered before starting the Stage 2 such as case studies and I did find it useful to draw on information from other areas of psychology and other professions, for example, using guidance on writing a case study from clinical psychology and information on managing organisational change for my consultancy work.

The Society sends out details of all the submission deadlines to all trainees registered on the Stage 2 qualification each year and you need to let them know three months before the submission date that you are planning to submit your portfolio. This is great as it gives you the opportunity to ensure all the evidence has been signed off by your supervisor and work contacts and to make photocopies (you need to submit three copies of your portfolio and don’t forget to keep a copy for yourself!). You may then need to think creatively about how to present and bind your portfolio and how to get the portfolios to the office in Leicester for the submission date! If the two external assessors feel that the competencies have been met in your portfolio you will then be invited for a viva voce. This was not quite as scary as I thought and it was actually really nice to have someone interested in (or forced to listen to as the case may be!) all the work I’d put into my portfolio and my experiences and how I felt I’d developed over the course of my training, which helped to tie the whole experience together for me.

Overall, the Stage 2 qualification provided me with a great opportunity and framework to identify areas for personal development, increase my confidence to apply psychology to the real world and to develop a reflexive approach. An additional benefit of the Stage 2 qualification was that it helped me to explain to employers the skills a health psychologist could bring to an organisation and gave me clear examples to illustrate my skills and experiences. Since completing Stage 2, I have been working as a Research Health Psychologist in the NHS and I would highly recommend this flexible, innovative and inspiring route into life as a qualified Health Psychologist!

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FROM SEPTEMBER, 2002, UNTIL December, 2005, I was registered on the Professional Doctorate in Health Psychology programme at Staffordshire University. Throughout the duration of the programme, students are supervised by a Chartered Health Psychologist, supported by the health psychology team, who guides them through the key elements of the programme and the production of a portfolio of work. The students also receive a supportive programme of workshops and lectures covering the required competencies. Students must have secured a suitable placement before applying for the course, and must perform successfully at interview in order to be accepted on the course. A suitable supervisor from the teaching team must also be available to supervise them. Trainees are required to spend one day per week on Doctorate work (once every two weeks for part-timers), and attend workshops every fortnight during the first year (then only as needed in the remaining year).

My placement during my time on the programme consisted of three years of contract research/consultancy in health promotion, alongside teaching in the Psychology Department at Staffordshire University. Initially I found it quite difficult to envisage how I was going to complete all of the competencies, but after discussions with my supervisor I came to realise that most of the work could be completed through work I already had planned as part of my employment. My empirical research consisted of two studies; one evaluating the impact of a sexual health promotion intervention, and a health needs assessment for a local Strategic Health Authority. The systematic literature review was an article evaluating school-based drug, alcohol and tobacco education. Due to the opportunities that arose, I was contracted to conduct a systematic review in a different area than my research, but for most people it will be easier to do the review in the same area as the research. The teaching module includes a case study and evaluation reporting the delivery of a level three undergraduate psychology module ‘the Psychology of Drugs’. My teaching plan, video and reflection document a full-day workshop I delivered to 12 nurses and allied health professionals on the psychology of adjustment to illness, and my teaching diary reflects upon my teaching development over the three years. My consultancy module consists of a case study reflecting upon the preparation of an executive summary for the systematic review described in the systematic literature review, and the contract is a needs assessment conducted for a drug treatment agency. The professional skills competence contains a logbook reflecting on my professional development over the three years whilst on the professional doctorate programme. Finally, my two optional competencies focus upon the measles, mumps and rubella (MMR) triple vaccination; firstly a chapter on the MMR vaccine for the second edition of the Cambridge Handbook of Psychology, Health and Medicine, due to be published in Spring, 2007, and secondly the dissemination of the results of my MSc dissertation to the participants of the research, and in a short article published in the PsyPAG Quarterly newsletter. It is probably also worth mentioning that whilst I had been dreading the viva voce examination since I enrolled on the programme, as with Alice, I actually enjoyed the experience and it was nice to be able to share my work with an interested audience.

The main benefit for me of doing Stage 2 was that you can work at your own pace through the competencies, depending upon the opportunities that are available to you. I also enjoyed the variety of completing six different competencies (four core plus two options), and the Staffordshire University route allowed me to submit pieces of work
individually (e.g. consultancy case study) once I had completed them, rather than having to submit everything at the end of the programme. The main advantages that I perceived from doing the Staffordshire University route were getting a Doctorate at the end of the programme and the level of support that is provided; you have a principal supervisor, a workplace contact and access to a team of six more Chartered Health Psychologists for advice. You also receive formative feedback on your work in advance of the viva voce examination; all work is double-marked internally and then approved by an external examiner before you can submit the portfolio. The fact that pieces of work can be submitted individually also allows you to take on board any comments before submitting further pieces of work.

I would advise anyone doing Stage 2 to take advantage of any opportunities that arise; many of the pieces of work in my portfolio were unanticipated opportunities that arose throughout the three years, whilst a number of things I had planned didn’t come to fruition. This is possible as you don’t need to know exactly what you plan to do for every competency before you can register for Stage 2, you just need to have enough decided that you can be getting on with it, and your plans can change over the duration of the qualification. I would also advise people to try to minimise the workload by using one project for a number of competencies; although the actual outputs should be different, the work conducted can be used more than once (e.g. two outputs from my systematic review). The main piece of advice that I would give is to choose your supervisor carefully, as you will have to work with them for two (or more) years and so they need to be someone that you feel you can approach. My supervisor was fantastic and I definitely could not have completed the qualification without his help. Whilst completing Stage 2 is currently expensive and entails a great deal of hard work, I feel that it is a very worthwhile qualification to have; once you’ve completed your portfolio you can say to potential employers and clients that you have demonstrated that you are competent to do research, teaching, consultancy, and the two options that you chose. Even if the job you want doesn’t require all competencies, they are very useful to have, and situations may arise that require them. Plus, of course, Stage 2 is the only way to become Chartered as a Health Psychologist if you began your post Stage 1 training after September, 2001. Ultimately for me Stage 2 has been very useful, I gained a lot of experiences that I probably would have declined if not doing Stage 2, and since finishing the programme I have been appointed as a lecturer in psychology at Staffordshire University, which means that I get to use my demonstrated competencies regularly.

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Promoting Mental Health and Well-being in Communities: Psychological perspectives

A one-day event open to all members of the Society

2 February 2007

The BPS London Office, Tabernacle Street, London EC2A

9.30 Registration and Coffee
10.00 Welcome and overview of the day
10.10 Community Psychology in theory and practice
   Presenters: Elaine Swift, Reachout with Arts in Mind, Alloa, Scotland; Cathy McCormack, Easterhouse, Glasgow, Scotland, and David Fryer, University of Stirling, Scotland
11.10 Audience comments and contributions
11.30 Coffee Break
11.50 Promoting community across the lifespan: A developmental and social justice perspective
   Presenter: Serdar Degirmencioglu, Department of Psychology, Istanbul Bilgi University
12.45 Audience comments and contributions
1.00 Lunch
1.45 Moving out of conflict: Empowering peaceful communities
   Presenter: Ed Cairns, Department of Psychology, University of Ulster
2.35 Audience comments and contributions
2.55 Discussion groups
3.30 Plenary session
4.00 Final reflections from today’s speakers
4.30 End of workshop

For a registration form, please go to www.bps.org.uk/collegeoffellows or contact Marie Petcher at marie.petcher@bps.org.uk or (0116) 2529555

A Big Issue Psychology event organised by the College of Fellows
The need for health psychology researchers in primary care

Primary care is playing a pivotal role in UK health services, dealing with over 90 per cent of all patient contacts within the NHS (Hannaford et al., 2001). Many contacts concern the management of illness, primary, secondary or tertiary prevention, or rehabilitation, all health psychologists’ areas of expertise. Moreover, each contact is governed by applying the existing evidence-base in a manner bespoke to each patient. Over the past decade, there has been a concerted increase in interdisciplinary research activity in primary care while at the same time trying to maintain a coherent national and international approach. These activities were supported and partly driven by an increasing policy focus on primary care. For example, the Mant Report provided a compelling overview of arguments for supporting Primary Care Research (NHS Executive, 1997).

Among these arguments were clear indications of the importance of evidence-based primary care research to patients, the NHS and the people working in health care. The report also recognised that the capacity of primary care to undertake the Research and Development (R&D) necessary to provide a firm evidence base is at present limited and that evidence-based health care must cross professional and organisational boundaries. It was also emphasised that the appropriate involvement of all primary care staff in R&D would likely increase the quality of clinical care in the NHS. Following the Mant report, it has been reiterated by many sources that there is a need for an increase in high quality interdisciplinary research to support the development and implementation of primary care services (Committee NAPCRG, 2002; Thompsen et al., 2006). As a result, there are now a wide variety of opportunities for general practitioners, nurses and allied health professionals to develop research skills. Yet, it is also acknowledged that few GPs are able to devote a substantial amount of their time to acquiring and maintaining these skills. It is also debatable whether the research skills obtained in such a limited period of time would be rigorous enough to conduct high quality research comparable to specifically trained researchers. A report from the Heads of Departments of General Practice and Primary Care in the Medical Schools of the United Kingdom (2002) suggested that increasing the number of non-clinical academics, including health psychologists may be a way of meeting the challenges to primary care research. In order to increase quality research output it has recently been recognised that there is an urgent need to recruit and retain primary care researchers with the training to deliver quality research (Society for Academic Primary Care, 2002; Wilson et al., 2005).

A ‘service-academic partnership’ model of primary care

Given the competing demands on time and resources within clinical settings, the link between primary care and academic research institutions plays a crucial role in effecting positive changes for patients. Providing and applying evidence-based findings and ensuring the effectiveness of the organisation and delivery of health services within primary care are significant demands. These mandates are embedded within an ambiguous, complex, and ever changing context. Many lives, the quality of life of many patients, and the
The expertise of research health psychologists

Departments of psychology, specialist health psychology units, as well as individual health psychologists in primary care departments, have the potential to be decisive factors in overcoming many of the issues raised above. Health psychologists not only contribute skills of critical and analytical thinking and a considerable understanding of methods, but also a long tradition of identifying decisive factors to make individual and/or social changes assessable. Psychological theory underpins much of the non-clinical aspects of nursing and medical care as well as organisational processes. Indeed, reports of psychologists working within the NHS R&D have shown that their skills and knowledge are invaluable (Swann 2001).

Health psychologists, by virtue of their training, experience, and professional focus, also provide an attractive package to contribute to further understanding of the interplay between physical and psychological factors in the complex context of primary care. Figure 1 (overleaf) provides an overview of areas where academically and clinically oriented health psychologists have contributed to primary care research and practice. It shows that health psychologists, along with medics and nurses, have every right to place themselves in the centre of primary care research and provision.

Browsing through health psychology journals further illustrates the importance of psychological theory in converting biomedical and epidemiological insights into beneficial treatments for patients. Medical journals frequently publish articles highlighting the limitations of medical research in terms of its utilisation to advance patients’ everyday life. In addition to this encouraging situation a further opportunity for health psychologists exists to boost their presence and prestige in primary care research: The Brisbane Initiative.
Figure 1. Health psychology's contribution to primary care.

HEALTH PSYCHOLOGY’S CONTRIBUTION TO PRIMARY CARE RESEARCH

- Identification of psychological factors affecting physical illness
- Prevention and management of illness and disease
- Promotion and maintenance of health
- Patient attendance, compliance, concordance
- Decision-making of professionals and patients
- Risk perception of professionals and patients

Health promotion and prevention of ill health

Complementing other disciplines and sectors

- Basic and clinical research on the interplay between behaviour and physical health and illness
- Amalgamation of biomedical and psychological insights
- Formulation of health policy
- Improvement of the health care system
- Health behaviour and change
- Reduction of disability
- Quality of life
- Coping with acute or chronic illness
- Treatment satisfaction

Examples of patient outcomes
The Brisbane Initiative – International Primary Care Research Leadership Programme

The Brisbane Initiative (BI) was founded in order to facilitate the development of international support for and coordination of education for future research leaders in Primary Care. It was created in Brisbane, Australia, in 2002, by leaders in primary care research from eight different countries. The initiative’s aim is to address the international shortage of scientific leadership in primary care discussed above by offering training and facilitating academic exchange and co-operation across health-related professions nationally and internationally. The Brisbane Initiative is based on the co-operation between existing primary care research units and between these units and other disciplines, including psychology. Under the umbrella of the BI a critical mass of current and future leaders in primary care research are brought together to learn and at the same time address the gaps in Primary Care research. Following an application process, the authors were offered two-year training fellowships for the Brisbane Initiative’s International Primary Care Research Leadership Programme, along with 12 other international colleagues including eight GPs, one nurse, and three other health care researchers with backgrounds in social science. The fact that two psychologists had been selected along with GPs and nurses is an encouraging testament to the important role this profession could and needs to play in primary care research.

Conclusions

It needs to be highlighted that there is a clear role for health psychologists with rigorous training in research methods (and not necessarily clinical training) to deliver high quality research in clinical as well as non-clinical settings. The continued funding focus on molecular research may actually turn out to be beneficial to psychology and other disciplines if health psychologists are able to demonstrate their value in amalgamating biomedical progress and psychological insights to enhance patient care and well-being. For this and other reasons, health psychologists are currently in a prime position to gain career positions within academic Departments of Primary Care, utilise their specialist knowledge and skills and work in a stimulating multidisciplinary environment. Conversely, primary care research will benefit in the long term from the knowledge base and rigorous research skills brought by those trained in the discipline of health psychology.

Acknowledgements

We would like to thank the Brisbane Initiative, our colleagues in the first cohort of the Brisbane Initiative – International Primary Care Research Leadership Programme, our academic departments and the Scottish School of Primary Care for supporting our applications and fellowships.

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References


Society for Academic Primary Care (2002). *New century, New challenges. A report from the Heads of Departments of General Practice and Primary Care in the Medical Schools of the United Kingdom*. Available at http://www.sapc.ac.uk

Thomsen, J.L., Jarbol, D. & Sondergaard, J. (2006). Excessive workload, uncertain career opportunities and lack of funding are important barriers to recruiting and retaining primary care medical researchers: A qualitative interview study. *Family Practice* (online advance access).


Perceptions and experiences about Chlamydia in young women in Scotland: Knowledge, condom use and access to health services – a pilot qualitative study (Brief Research Report)

Zoë Chouliara, Athanasios Kratzias, Alison Goulbourne & Helen Smart

Chlamydia trachomatis is a sexually transmitted infection that, despite being largely asymptomatic, can have serious effects on women’s health, including inflammatory pelvic disease and even infertility. Despite recent increase in the rate of Chlamydia infection especially in young women, research in this area in the UK and Scotland in particular is rather limited. As a result our understanding of the views of this high-risk group regarding Chlamydia and measures to protect from infection (e.g. condom use) is very limited.

This on-going pilot study will focus on the views and experiences of young women in Scotland regarding Chlamydia. Twelve semi-structured individual interviews will be conducted with female university students, addressing knowledge about Chlamydia, views about use condoms as protection against a Chlamydia infection and about access to sexual health services. It is envisaged that the findings will provide important information on this important health issue in a high – risk population group. It is anticipated that such issues will be examined in depth in the main study and that findings of the present research will inform future research and policy in this area.

**Keywords:** Chlamydia, young women, university students, experiences, knowledge, condom use, health services.

**Background to the Study**

Sexually transmitted infections (STIs) are a significant cause of long-term and serious disability in the UK (DOH, 2005). New diagnoses in the UK have risen continually since 1995 (DOH, 2005). Indeed, the number of Chlamydia diagnoses in Scotland increased by 110 per cent between 2000 and 2004. Two-thirds of diagnoses were in those below 25 years of age (ISD Scotland, 2005). Such an increase could be attributed to the fact that more young people have more sexual partners than ever before (Graham, 2004). Chlamydia trachomatis has more serious effects on women’s rather than on men’s health, as it is a leading cause of reproductive morbidity in women, including pelvic inflammatory disease and infertility.

However, detection is difficult as it is largely asymptomatic (Gates & Wasserheit, 1991). It is estimated that, as a result, a number of individuals remain undiagnosed and untreated, increasing the risk of infection in the community.

Therefore, primary prevention of Chlamydia, including use of condoms, as well as secondary prevention, including access to services for early diagnosis and treatment, is of great importance especially in high-risk groups (i.e. young women). However, our knowledge about the factors that affect the decision to use condoms to protect against STIs and access sexual health services is rather limited (Sheeran et al., 1990; Johnson et al., 1996; Adler, 1996). Only a limited number of studies have focused on sexual health in young people in the UK and
Scotland in particular. Such studies suggest that knowledge about sexual health, Chlamydia, condom use as a means to prevent infection and special services for STIs is rather poor and superficial (Macintyre & West, 1993; Garside et al., 2001). Although there is little research on university students regarding the above issues, existing studies reported inaccurate factual knowledge even in medical students, which reflects a lack of sexual awareness of young people in general (Fayers et al., 2004).

Furthermore, despite the increased risks involved for young women, there is a distinctive lack of research addressing perceptions of Chlamydia in healthy young women in the UK and Scotland. Existing studies have stressed the importance of psychosocial factors. For example, women’s willingness to access services is mediated by psychosocial factors such as embarrassment, whereas choice of services are influenced by lay referral system, knowledge of health services, referral by health professionals and the need to have alternatives to general practice care (Dixon-Woods et al., 2001).

In summary, previous existing research presents with a number of limitations: there is a distinctive lack of studies on young women. More specifically, young women’s perceptions and experiences about sexual health and safer sex have rarely been examined in relation to Chlamydia infection. Finally, despite increased incidence rates, the above issues have not been examined in Scotland in this particular high risk group. Considering the limitations of previous research, we have planned a small qualitative research project to explore the views and experiences of young women in Scotland regarding these issues (Queen Margaret University, Small Project Fund, Contract No: PRHP001A). It is our intention that the present pilot study will inform a large-scale project that will investigate the above issues in depth. The present report aims to discuss the aims, methodology and potential implications of the pilot study.

Aims
The aims of the project are:
- To identify the perceptions and factual knowledge of young women in Scotland about Chlamydia.
- To elicit their views and experiences about condom use in relation to Chlamydia
- To elicit their views and experiences regarding access to and use of sexual health services in relation to Chlamydia and/or other related concerns.

Methodology
Design
This will be a 12-month pilot study. Because of the complex emotional investments and social taboos surrounding sexual relationships (Ainslie, 1999), qualitative methods will be employed, as these are appropriate for such sensitive and complex issues (Black, 1994; Buston et al., 1998).

Participants and procedure
A purposive sample of 10 female university students, aged 18 to 25, will be employed. Prospective participants will be recruited from the student cohorts (Nursing/Social Sciences) from one university in Lothian. All students from the above cohorts who fulfil the inclusion criteria will be invited to participate via e-mail and will be sent an information letter. Responses will be anonymised. Semi-structured individual interviews will be carried out on campus by the same researcher, in order to ensure continuity of approach. Signed consent will be obtained prior to interview. Interviews will last approximately 40 minutes and will be tape recorded and transcribed verbatim. The interview schedule will be carefully piloted and updated concurrently with data collection (see Figure 1).

The content of the interview is based on relevant literature and the primary investigators’ experience in sexual health, health promotion, and sensitive interviewing (Chouliara et al., 2004).
Data analysis
Data will be analysed by using Interpretative Phenomenological Analysis (IPA), which is a method seeking to capture the experiences and views of participants and identify key themes (Smith, 1996). Analysis will be aided by computer software suitable for the management and analysis of qualitative data (i.e. NVivo). Individual interviews will be read repeatedly and then coded to identify emergent themes. Recurrent themes will then be identified across transcripts. Such themes will reflect a shared understanding by participants of the issues under investigation. Data will be constantly compared and analysed until we are satisfied that the themes, categories and codes adequately describe the text and that final themes closely reflected the data (i.e. until saturation is reached; O’Callaghan, 2001). To ensure rigour a cohort of the transcripts will be read by other member of the research team and recurrent themes will be discussed. Emergent themes will also be modelled to provide a meaningful working framework of strategies for practice, informed by the views and experiences of the participants. Ethical approval has been granted by the higher institution, where recruitment will take place.

Contribution of the study
It is envisaged that the study will provide information on an important sexual health matter in an under-researched high risk group, such as young women in Scotland.

Figure 1: Interview schedule.

1. Knowledge and views about Chlamydia
   - Have you ever heard of Chlamydia before? Would you like to describe what you think Chlamydia is?
   - What do you think the symptoms of Chlamydia are?
   - What problems do you think Chlamydia could cause?
   - How common do you think Chlamydia is?
   - How could you know if someone is infected by Chlamydia?
   - Are you concerned about being infected with Chlamydia or any other sexually transmitted infection? Why/Why not?
   - How would you feel if you found out that you had an infection like Chlamydia?

2. Condom use in relation to Chlamydia
   - How do you feel about using condoms to protect yourself from contracting an STI, e.g. Chlamydia?
   - Are the reasons that could put you off using condoms to protect yourself against a Chlamydia infection?

3. Views and experiences of access to sexual health services
   - Do you know what health services are available for you to go to for advice, if you were concerned about Chlamydia? What do you think these are?
   - If you had a choice, which of these services would you choose? Why?
   - Are there any reasons that would prevent you from accessing available services for a Chlamydia-related concern? What are these reasons?
   - Have you ever needed advice in the past regarding sexual or women’s health issues? If yes, which health service did you access? How was the experience for you?
   - Do you think that your experience of using such services could be improved? In what ways? How?
   - Are there any positive aspects in your experience of using such services? What are these?
Such an investigation is both timely and justified for the following reasons. Firstly, given the increase in sexual infection rates, health authorities in the UK and Scotland acknowledge the importance of focusing on promotion of better sexual health strategies to address the increase in STIs. Proposed strategies in both governments stress the importance of: improving access to health services, destigmatising diagnosis, challenging unhelpful attitudes towards sex and relationships, focusing on younger people and vulnerable groups and addressing attitudes towards condom use (DOH, 2003; Proposal to Scottish Executive, 2005). A number of these priorities will be addressed in this study in relation to Chlamydia. Secondly, a focus on the perspectives of health service users and those of the general public is in line with current priorities in the NHS for patient involvement and patient-focused provision of care (DOH, 2003). Findings are expected to inform the main study which will further address these issues in a larger scale, in order to inform policy and effective interventions.

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References


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LIFESTYLE HAS AN ENORMOUS impact on health, and there are clear links between what people ingest and the development of chronic disorders. Eating too much food or food of the wrong sort can lead to obesity and diabetes. Smoking from a young age or over a long period can lead to heart disease and lung cancer. Drinking alcohol above the recommended guidelines or taking cocaine, ecstasy or heroin may lead to addiction and will almost certainly impact on long-term health outcomes. There have been numerous and varied health campaigns to change behaviour relating to food, drink and drug intake in the hope of improving health and limiting certain conditions known to be associated with these behaviours. Few health psychologists would question the veracity of these statements, or the need to engage people in attempting to change potentially damaging behaviour.

The status of cannabis regarding its use and its impact on health has changed over the years, particularly with its recent reclassification to a category C drug and changing attitudes to the acceptability of cannabis use. It is time that we started asking questions about the impact of cannabis on health and illness, over and above cannabis’ putative role as a gateway to other more ‘dangerous’ substances of abuse.

Recent figures suggest that in the UK, 28 per cent of 15- and 16-year-olds have used cannabis (Department of Health, 2001) and 7.6 per cent of 15- and 16-year-olds report being heavy users (Miller & Plant, 2002). Reclassification and lighter sentencing for possession mean these figures are likely to increase. The psychoactive constituent of cannabis, *δ*-9-THC, binds to cannabinoid receptors in the brain which are found in high densities in the frontal lobes and the medial temporal lobes of the cerebral cortex. (Herkenham et al., 1990). These areas are critically involved in working memory (WM) and executive functioning (EF).

WM is a system that enables temporary storage of intermediate products of cognition and supports transformations of those products in the face of distracting influences (Baddeley & Hitch, 1974; Goldman Rakic, 1987). The acute effects of cannabis interfere with both visuo-spatial working memory (VSWM) and tasks loading heavily on central executive (CE) resources. Lundquist, in a recent review of the cognitive effects of cannabis use (2005), concluded that the acute neuropsychological effects of cannabis (within 12 to 24 hours) included deficits in attention, executive function and short-term memory. Pope and Yurgelen-Todd (1996) suggest that heavy cannabis use is associated with reduced attention, decreased mental flexibility, increased perseveration and reduced learning.

Prospective memory (PM) is an important aspect of everyday memory that may rely on CE functions (Kopp & Thorne, 2000). There have been self-reported deficits in PM (Rodgers et al., 2001), and empirical studies I am currently conducting – not self-report but an experimental task – suggest that there are PM deficits in moderate to heavy cannabis users.

There is also evidence to support the effects of cannabis on perception. A number of empirical studies show that time slows during intoxication. There is also support, from a variety of sources, including empirical work, suggesting that perception of space is altered (Chait & Perri, 1992). These
effects may be confounded by a complex interaction between the perceptual disturbances in space and time. The deficits in WM and executive function appear much greater when the cognitive demands of the task are high. Over-learned tasks, placing little executive loading on WM and CE resources, may be performed with few signs of impairment. In contrast, tasks requiring short bursts of sustained attention or rapid switching in an otherwise over-learned behaviour may result in sudden impairment or decrements in performance. These effects have implications for everyday functioning in the 24 hour post ingestion phase, especially for those involved in demanding or dangerous occupations. For example, driving may be seriously impaired whilst under the influence of cannabis (Walsh et al., 2004) and there is evidence to support cannabis-positive drivers being involved in more accidents than drug-free drivers (Blows et al., 2005).

Studies of long-term moderate to heavy users of cannabis are difficult to undertake and fraught with confounds and have thrown up a variety of conflicting findings. A series of studies using more rigorous methodology (see review by Solowij, 1998) have allowed the following conclusions to be drawn about the long-term cognitive effects of cannabis use. Long-term users are less efficient at performing complex cognitive tasks, or tasks that require cognitive flexibility. Long-term users also appear to be less efficient at learning or recalling information over the short term, especially if the task is complex or unfamiliar, and these effects appear to be retained long after stopping cannabis use. There have been few studies on the impact of lifetime cannabis use and the aging process, particularly in relation to memory deficits. As the neurological disorders resulting in dementias are more prevalent in a society that lives longer and are particularly characterised by loss of memory and executive function, heavy lifetime use of cannabis may exacerbate and lower the age of onset of the dementias. Further research is urgently required to examine the impact of chronic cannabis use on neurological disorders associated with aging. Conversely, little is known about the developmental implications for children who start using cannabis before the brain has developed in full.

These research findings, taken together, demonstrate that both the acute and long-term effects of cannabis may provide subtle yet serious risks to health and wellbeing, and ultimately safety. Health psychologists have a significant role to play in both highlighting the psychological impact of moderate to heavy cannabis use and in raising awareness in young people of the risks that moderate to high use of cannabis places on everyday functioning, learning and the implications this may have for the aging process.

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References


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The Midlands Health Psychology Network was founded by health psychologists for health psychologists to share professional experiences of research and practice.

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**Health Baseline Comparison Theory: Adjustment to rheumatoid arthritis**

Nicola Davies & Gail Kinman

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**What are Health Baseline Comparisons?**

The term ‘HEALTH BASELINE COMPARISON’ (HBC) refers to the baseline used for comparisons by people evaluating their current health status. To determine whether health is ‘good,’ ‘bad’ or ‘indifferent,’ a comparison with a baseline is necessary. This baseline is influenced by past health, social representations of health obtained from the media, comparisons with other people, or alternatively, consideration of current personal circumstances. All of these factors at any one time may play a role in the health baseline invoked. HBCs can be ‘accurate’ or ‘inaccurate’ (AHBC and IHBC, respectively). Comparisons between present and past health or with social idealisations of health can be less accurate, whereas consideration of current circumstances is more likely to produce perceptions of health status that might be more realistic. For example, changes in functional ability could be due to illness or ageing; therefore, health baselines should naturally change throughout the lifespan and in accordance with any contracted illness or disability. Adapting HBCs in accordance with such inevitable changes could facilitate acceptance of uncontrollable health deteriorations; it could subsequently encourage individuals to behave according to actual health status, rather than to a possibly less realistic health status. To clarify, an accurate health baseline is taking into consideration changes to health and adapting to these changes so as to enhance acceptance, adjustment and well-being.

**Supporting research**

Core research that has informed the development of HBC theory can be found in the Self-Regulatory Model (SRM) developed by Leventhal et al. (1980). Self-regulation is defined as ‘those processes, internal and/or transactional, that enable an individual to guide his/her goal-directed activities over time and across changing circumstances’ (Karoly, 1993, pp.23–52). The SRM suggests that illness is dealt with in the same way as other problems. HBC theory extends this notion by acknowledging that health and illness perceptions may be inaccurate and inappropriate coping strategies may be sought or, alternatively, no effort might be made to cope with a health problem. Leventhal’s model assumes that given a health crisis or general change in health status quo, the individual will be motivated to solve this problem in order to re-establish a state of normality. Similarly, HBC theory predicts that given a problem or change in health, the individual will be motivated to cope and adjust to this situation in order to re-establish baseline health status.

HBC theory also shares some features of social comparison theory (Festinger, 1954), which suggests that individuals make sense of their world by comparing themselves to certain others. Festinger theorised that social comparisons are one of the most important influences on self-judgements. Such comparisons can either be downward, whereby a comparison is made with those who are perceived to be worse off, or upward, whereby a comparison is made with those who are considered better off. In the context of HBCs, upward or downward comparisons would be based on judgements of health. For example, an individual with a respiratory disease who judges their current health according to someone of similar age but without this disease will be prone to a downward comparison due to the contrasting health status.
Health baseline comparisons in rheumatoid arthritis

An initial study was conducted to examine the predictive ability of HBC theory. In this study accurate and inaccurate HBCs were explored in relation to rheumatoid arthritis (RA), a chronic, inflammatory autoimmune disorder that causes the immune system to attack the joints. Research conducted by Groarke et al. (2004) revealed that perceptions of disease are more influential in adaptation to RA than actual disease status. Perceptions of disease explained 27 per cent of the variance in depression, 23 per cent in physical functioning, and 22 per cent in pain. Groarke et al. report that illness perceptions explained 23 per cent of variance in physical function over and above the 15 per cent explained by disease status; the pattern of predictors being the same for pain. These findings indicate that researchers should focus on subjective perceptions of illness as well as objective health status; there is also a need to investigate how subjective perceptions of illness are formed. It could be argued that HBCs might play an important role in this process; more specifically, an IHBC could worsen these negative experiences whereas an AHBC could reduce them. It is necessary to differentiate between those who do and do not adjust successfully to RA and other conditions, so as to increase effective interventions to improve quality of life in acute and chronic illness.

Method

Participants:
Participants (N=68) from the National Rheumatoid Arthritis Society (NRAS) were aged between 20 to 60+ years. Participants were predominately female (N=52) with disease duration spanning three months to 52 years. Fifty per cent had moderate RA, 35.3 per cent severe, and 14.7 per cent mild.

Procedure:
The NRAS distributed a series of questionnaires to participants via e-mail, along with a covering letter of participant information providing details of the study; completed questionnaires were returned to the researcher via the same method. The series of questionnaires included a HBC scale to measure levels of HBC accuracy, a COPE scale to measure the use of particular coping styles, and the Arthritis Impact Measurement Scale (AIMS) to measure objective health status and psychosocial adjustment to RA.

Scales:

HBC Questionnaire (HBCQ)
The 13-item HBCQ was developed by the researcher based on the theory of HBC and related literature discussed above. The questionnaire measured HBC accuracy and perceived health. Perceived health items were intended for comparison with AIMS scores to determine the accuracy of these perceptions and the degree of consistency between perceived and actual health. The health baseline comparison items were intended to produce scores to be categorised as either ‘accurate’ or ‘inaccurate’ according to the extent to which participants agreed or disagreed with statements regarding how their current health status was judged. Items included: ‘I am as healthy as anyone I know’; ‘I am not as healthy as I used to be’; ‘I judge my health according to media representations’; and so on. Items were rated on a four-point Likert scale of ‘strongly agree’/’strongly disagree,’ with higher scores reflecting a less accurate HBC and a lower perceived health status. The option of ‘undecided’ was intentionally omitted so as to encourage decision making among participants. A pilot study of 16 individuals from an RA internet support group revealed the HBCQ to be effective in its required aims. However, the reliability of this new scale was reasonably low, with a Cronbach’s alpha of 0.36 for the HBC subscale and a much more acceptable 0.50 for the perceived health subscale. This has been resolved in current HBC research whereby the scale has so far achieved a Cronbach’s alpha of 0.73 on a small pilot study.
COPE
An adapted version of the COPE Questionnaire (Carver et al., 1989) was utilised. Two adaptive coping styles were selected (i.e. acceptance, positive reinterpretation and growth), two maladaptive coping styles (i.e. denial, behavioural disengagement), and one ‘filler’ coping style of humour. The scale was scored on a five-point Likert scale of ‘I don’t do this at all’/’I do this a lot’, with higher scores reflecting more frequent use of a particular coping style. The internal consistency of these subscales is acceptably high and above 0.6 on Cronbach’s alpha (Carver et al., 1989).

AIMS
The 63-item AIMS (Meenan et al., 1980), an assessment of physical, emotional and social well-being, was divided into the subscales of physical functioning, social activity, and pain. These subscales were used to evaluate objective health status and to compare this with perceived health in order to determine levels of consistency and thus establish participants as having a more or less realistic perceived health. The depression and anxiety subscales were used to identify relationships between AHBC or IHBC and psychological adjustment to RA. The scale was scored on a five-point Likert scale of ‘all days’/‘no days’, according to how frequently symptoms associated with RA were experienced; higher scores reflected poorer health. The reliability of AIMS has been demonstrated across rheumatic diseases, with a Cronbach’s alpha of between 0.72 to 0.91 for each subscale (Meenan et al., 1980).

Results
Before the analysis of results commences, attention is to be raised to the demographic details of participants. Participants were predominately female (N=52) and had a mean age of 51 to 60 years old. The mean duration of RA among participants was nine years (SD=11.19) and the mean severity of RA was moderate (50 per cent). There was a wide diversity of disease duration, the minimum being three months and the maximum being 52 years.

Descriptive statistics

<table>
<thead>
<tr>
<th>Descriptive</th>
<th>No. of Participants</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>68</td>
<td>51–60 years (N=23)</td>
</tr>
<tr>
<td>Gender</td>
<td>68</td>
<td>Female (N=52)</td>
</tr>
<tr>
<td>Severity</td>
<td>68</td>
<td>Moderate (N=34)</td>
</tr>
<tr>
<td>Duration</td>
<td>68</td>
<td>9.306</td>
</tr>
</tbody>
</table>

Data from participants was analysed in a sequence that enabled outcomes of HBCs and then the importance of HBCs to be either supported or disputed. This sequence commenced with a Pearson Chi-Square to identify the affect of HBCs on perceived health, followed by a two-factor mixed design ANOVA analysing the interaction between HBCs and the adoption of adaptive and maladaptive coping styles. To conclude, a Pearson’s (r) Product Moment Correlation was carried out to identify whether levels of HBC accuracy co-vary with levels of depression and anxiety.

Hypothesis 1: Individuals with an AHBC will have a more realistic perceived health than those with an IHBC.

Seventy-five per cent of participants with an AHBC had more realistic perceived health. This compares to those with an IHBC, where only 20 per cent had a more realistic perceived health but as many as 80 per cent had a less realistic perceived health. Pearson Chi-Square showed the relationship between HBC accuracy and the reality of perceived health to be highly significant ($\chi^2=17.631, df=1, p<0.001$).
**Hypothesis 2:** Maladaptive coping styles will be more frequent in individuals with an IHBC than an AHBC.

A two-factor mixed design ANOVA showed adaptive coping to be similar among those with an AHBC (mean=24.40; SD=4.63) and an IHBC (mean=24.15; SD=5.62). The mean score for maladaptive coping was higher in those with an IHBC (mean=12.50; SD=3.40) than an AHBC (mean=10.96; SD=3.70), but findings failed to reach acceptable significance.

**Hypothesis 3:** There will be a positive correlation between IHBC and anxiety/depression. Pearson’s (r) Product Moment Correlation demonstrated that as HBC inaccuracy increased, levels of depression also increased. This correlation was statistically significant (r=0.261, p<0.05). No significant relationship was apparent between HBC inaccuracy and anxiety (r=0.095, p>0.05).

**Discussion**

The significant correlation between HBC accuracy and depression levels suggests a role for HBC in adjustment to RA. This role does not appear to be related to coping styles as individuals with an inaccurate HBC did not engage in more maladaptive coping styles than those with an accurate HBC. The role of HBC in adjustment to RA appears to be more related to the significant inconsistency between perceived and actual health associated with an IHBC.

Of great interest was the lack of significant relationship between HBC accuracy and anxiety levels. It could be concluded that a certain level of anxiety is natural with a progressive condition such as RA. In fact, there is evidence that anxiety is likely to contribute towards successful adjustment to illness and the promotion of well-being, at least in the early stages; by promoting action to reduce anxiety levels. Examples of such action might include the seeking of social support (Catania, 1992) or medical consultation (Hu et al., 2002; Cheng, 2000). Therefore, anxiety is not necessarily a detriment in illness adjustment but may be an important part of the adjustment process. In the context of the present study, this notion can be supported by the fact that a majority of participants presented with a significant level of anxiety, scoring reasonably high on the AIMS anxiety scale, yet this did not necessarily relate to their overall well-being. Future HBC research may gain from a greater focus on those affective factors that are purely detrimental to illness adjustment.

**Future research**

The scope for further research into the implications of HBC for health status is considerable. The applicability of HBCs to unrealistic optimism (Weinstein, 1983) is one of many possible developments. Weinstein (1983) suggests that individuals continue to practise unhealthy behaviours due to inaccurate perceptions of risk and susceptibility, which he termed ‘unrealistic optimism’. Evidence has accumulated to support this relationship (Weinstein, 1987; Weinstein, 1999). HBC theory expands on the possibility of individuals genuinely believing they are not susceptible to certain illnesses because they are, as far as they have evaluated, in good health; as such HBCs could be used to supplement the cognitive components that contribute to unrealistic optimism. Much research is based on understanding how to manage and reduce unrealistic optimism, yet HBC theory could, perhaps, facilitate understanding into what constitutes realistic optimism; a potentially important factor in quality of life and adjustment to illness.

Since HBC theory has similarities to social comparison research, it could be beneficial to assess the conditions under which HBCs are upward or downward, the subsequent health outcomes of such judgements, and the most effective periods for interventions. This would have been a valuable addition to the present study since IHBCs in the form of downward comparisons have been found to be particularly prevalent in arthritis (DeVellis et al., 1991).
Findings suggest that HBCs may play a significant role in mental health. Depressed individuals tend to use upward comparisons (Ahrens & Alloy, 1997); therefore, it would be worth investigating whether they also use upward HBCs. The very nature of depression could have extremely detrimental effects on the way illness is cope with and adjusted to as well as on the success or failure of any treatment outcomes. Possible future research could apply the theory specifically to mental health and recovery, and examine whether depressed individuals have a less realistic outlook on their health status.

The next stage
The next stage for HBC theory is in the further development of a questionnaire to measure the accuracy of HBCs. This measure will then be used in the field of oncology to assess the implications of accurate and inaccurate HBCs in cancer patients and the implications of these judgements for prognosis and subsequent adjustment. It is envisaged that, ultimately, AHBCs could provide some insight in the initial seeking of a diagnosis, treatment choices made following diagnosis, participation in health promotion interventions, and the enhancement of patient choice and quality of life.

Acknowledgements
Gratitude is extended to Alex Buckley, who made a huge contribution to the development of the theory and notions outlined in this paper. His ideas and support have been fundamental to the creation of HBC theory. Gratitude is also given to the NRAS to whom this research would not have run as smoothly without.

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References

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Statement of Interest forms and further information are available from Molly Ross at the Society’s Leicester office either by telephone on **0116 252 9509**, or by e-mail at **molly.ross@bps.org.uk**.
THE CONCEPT OF NARRATIVE IS embedded in our every communication. We talk to each other in story form, exploring self-identity and sharing experiences (Bruner, 1990). In terms of health psychology, one of the most important ideas that narrative introduces is making meaning of our experiences so that we are able to grow from them (Pennebaker & Seagal, 1999). This will apply to any medical or psychological problem. In the case of traumatic war experiences, this is informative because theories from narrative research have suggested that it is the creation of a coherent story that allows survivors of trauma to come to terms with their experiences (Zoellner et al., 2002).

Social support is a vital element in the reconciliation of traumatic memories (Dirkzwager et al., 2003; Fontana & Rosenheck, 1994). From the narrative perspective, reconciliation is the integration of traumatic events into the overall life story thereby increasing coherence, and reducing the threatening nature of traumatic memories (Burnell et al., 2006). We are in a continual state creating the life story (McAdams, 2001), so an appropriate approach to understanding how traumatic memories are reconciled is to study how veterans have integrated their experiences into their life story. We need to study the meaning-making process.

If social support is an important aspect of reconciliation, how can social support resources aid or hinder this reconciliation? We believe that can be addressed by applying the concepts of narrative form and content to qualitative semi-structured interviews with war veterans. By finding out how veterans of all stages through the lifespan process memories, we may be able to encourage earlier reconciliation, before important cognitive, social, and physical resources required for reconciliation are lost in later life.

Two levels of analysis are employed to gain understanding of the relationship between the content (social support experiences) and the form (coherence) of the narrative. Whilst this relationship is not causal, the qualitative relationship between levels of coherence and experiences of social support provide important indicators of factors that need to be investigated in future research. Analysis is, therefore, two-fold. Interviews are transcribed and inductive thematic analysis is conducted. This differs from classic thematic analysis in that the themes of social support are perceived as the narrative content of the personal narratives. Descriptions, uses, and perceptions of social support are analysed as case studies, thus preserving context.

After this stage, the narrative form of the transcripts is analysed. Coding criteria were developed to perform this analysis, because despite the theoretical importance of coherence within the life story, coherence is not clearly defined (McAdams, 2006). The work of Baerger and McAdams (1999), Habermas and Bluck (2000), and Androutsopoulou et al. (2004) have been integrated to establish coding criteria of narrative form that is applied to meaning units in the interview transcripts (see Table 1, overleaf).

After this analysis, the findings from the content and the form of the narrative are discussed within case studies of individual veterans in order to establish the types of
Table 1: Coding criteria for coherence (narrative form).

<table>
<thead>
<tr>
<th>Type of Coherence</th>
<th>Coding Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Storytelling Principles</strong></td>
<td><strong>Orientation and Structure</strong></td>
</tr>
<tr>
<td></td>
<td>● O1 Introduction of main characters (scene setting).</td>
</tr>
<tr>
<td></td>
<td>● O2 Temporal, social, historical and personal context.</td>
</tr>
<tr>
<td></td>
<td>● S3a Structural elements of an episodic system presented with causal and temporal coherence (does not include contradictions). Structural elements include an initiating event, an internal response, an attempt, and a consequence.</td>
</tr>
<tr>
<td></td>
<td>● S3b Explicit recognition of temporal coherence, i.e. 'I've jumped the gun/where was I?' Explicit recognition of storytelling.</td>
</tr>
<tr>
<td><strong>Affect</strong></td>
<td>● A4 Past or present emotional evaluation of what described events mean to the narrator communicated through explicit statements of emotion.</td>
</tr>
<tr>
<td></td>
<td>● A5 Consistency of verbal and non-verbal within a meaning unit. (Unless otherwise stated affect is consistent.)</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>● I6 Meaning of events/ experiences is expressed within the context of the larger story. This includes a coherent theme linking all the events (theme may be explicit and/or implicit).</td>
</tr>
<tr>
<td></td>
<td>● I7 Contradictions between events or the narrator's personality traits or values, emotional evaluation, or changes in attitudes are acknowledged and explained in a causally coherent manner.</td>
</tr>
<tr>
<td></td>
<td>● I8 Presence of fragmentation of the narrative defined as long pauses and broken speech, and unfinished sentences. Also, defined as incongruent information within the context of the larger narrative. (Unless otherwise stated the narrative is fluid.)</td>
</tr>
</tbody>
</table>
social support that are associated with the 
coherence of the narrative. When the inter-
views of veterans from World War II to the 
current Iraq war are analysed, these indi-
vidual case studies can be amalgamated into 
a theoretical model which can then be used 
to further investigate the process of reconcil-
iation experienced by war veterans, and help 
promote more effective and potentially 
more cost effective ways to facilitate reconcil-
iation that can be carried out within the 
natural process of making meaning.

References


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Successful outcomes or psychological losses? Young people's experiences of leaving residential care

Karen Goodall, Chris McVittie & Elinor Snowdon

Outcome-based evaluations of the transition from residential care settings to independent living tend to point to successful transitions, however, little research exists that investigates ex-residents’ perceptions of the process. Based on semi-structured interviews, the present study examined eight participants’ perceptions of the transition and their experience of independent living. Using interpretative phenomenological analysis, four themes emerged: unplanned leaving, losing support, alternative support, and psychological ill-health. Although participants’ concerns were consistent with those identified in outcome-based studies, their perceptions of independent living point to ongoing problems such as the need to find support and maintain psychological well-being.

**Keywords:** young people; residential care; transition; independent living; psychological ill-health.

The majority of young people in residential care will leave home at a much earlier age and experience a more abrupt transition to independent living than will their peers in the general population (Biehal et al., 1992; Garnet, 1992; Jones, 1995). Moving from a very structured environment to an independent setting also impacts negatively on young people’s ability to manage (Biehal et al., 1995) and the loss of attachments and lack of support provided after leaving care seems to contribute to subsequent loneliness and fear experienced by some young people (Utting, 1997). It seems hardly surprising then that children who have been in care are over-represented in the homeless population (Strathdee & Johnson, 1994). In view of these potential problems, the Children (Leaving Care) Act was introduced in 2001 to provide a new framework for leaving care services. Its purpose was to delay transitions up to the age of 21, improve preparation and planning for leaving and improve the consistency of support and strengthen financial assistance post-leaving (Department of Health, 2001).

The success with which local authority care settings manage the transition has been examined in various ways, most commonly through interviews (Biehal et al., 1995) or questionnaires (Dixon & Stein, 2003). The majority of this research, however, has been outcome-driven, emphasising the measurement of psychosocial social outcomes (Scholte & Van Der Ploeg, 2000) or predetermined individual outcomes such as accommodation, life skills, and education (Biehal et al., 1995; Dixon & Stein, 2003; Stein, 1997). These studies tend to identify and rate outcomes on these dimensions in a global fashion such as poor, fair, or good.

The findings from the majority of outcome-based studies suggest that local authority homes are relatively successful in preparing young people for independence. However, we must cast a critical eye over the validity of the outcome measures approach. Stein (1997) has argued that the minimum requirements for broadly good outcomes (a person who is in good accommodation, has a regular means of support and has some degree of self-esteem and control over their life) set lower expectations for young people leaving care than for young people in the general population.
It is also questionable what outcome measures tell us about how the transition to independent living is perceived by young people themselves. The issues raised by the application of broad measures to understand individual experiences have been documented in relation to other areas of health psychology, for example quality of life (Hendry & McVittie, 2004). Commonly, such measures fail to reflect individuals’ subjective experiences of the topic under consideration. In the present instance therefore, it is unlikely that the focus on measurement of outcomes will meaningfully reflect individual experiences of leaving care. The aim of the present study was to explore young people’s understandings of the transition to independent living, following the implementation of the 2001 legislation.

Method
Semi-structured interviews were conducted with eight former residents of a children’s home in Scotland, UK. Participants comprised five females and three males, ages ranging from 16 years to 26 years, who had lived in the home for periods of between two years and eight years. They comprised a purposive sample of former residents who had left the home in the preceding 10 years and who responded to invitations made via the home to participate in this study. The occupational status of participants was as follows: two f/t education, five employed, one unemployed.

Each interview lasted approximately 30 minutes and was conducted in the Family Resource Centre within the home. Participants were asked questions on topics that included their experiences of leaving the home and subsequent lives. Interviews were tape-recorded with participants’ consent and later transcribed. All data were anonymised to preserve confidentiality. The study received institutional ethical approval.

Interview transcripts were analysed using interpretative phenomenological analysis (IPA) (Smith, 1996; Smith & Osborn, 2003). Analysis focused on identifying the participants’ own understandings of the topics of study. We initially explored the transcripts on a case-by-case basis to identify indicators of participants’ understandings. Indicators were checked against subsequent transcripts and then grouped into emerging themes. Themes were examined for relevance to all transcripts in the data set and revised as necessary during analysis. From this analysis, four themes emerged that usefully accounted for the participants’ understandings. Analysis was conducted and agreed by the first and second authors.

Analysis
The four themes that emerged were unplanned leaving, losing support, alternative support, and psychological ill-health. These we discuss below.

Unplanned leaving
A first theme for the participants was that their exit from the home had been rushed, with little or no choice on their part as to the timing, for example:
I: Did you feel prepared for life outside [home]?
P3: No. I just thought it went too quickly. They told me I was getting a house then 10 minutes later, I’d got one and I was out.

Although the home provided an ‘independent living unit’ (ILU), designed to provide preparation for independent living prior to leaving, not all of the children necessarily gained this experience, as seen below
I: Did you feel prepared for life outside [home]?
P5: Not really, ‘cause I never went to [ILU]. I moved straight from [home] to my flat.
I: Did you choose to leave [home] when you did?
P1: I got chucked out. Well basically I chose, well I never exactly chose ‘cause I never wanted to go to [ILU] at the time and then I just left.

In consequence, on leaving the home in a rushed manner and commonly without sufficient preparation, the participants experi-
enced their exits as leaving them largely unprepared for independent life.

**Losing support**

In addition to the abrupt change in physical environment, the participants experienced sudden changes in their psychological environments. In particular, they viewed their departures as bringing withdrawal and loss of social support that they had enjoyed previously.

P3: At [home] I felt they helped me through quite a lot but politely I think the aftercare is really shite. Since I've got in my house I haven’t seen any of them, none of them have bothered to come down and see me.

In so far as the home was perceived to play any continuing part in the participants’ lives, it did so only in dealing with major problems.

P6: I've never asked [home] for anything unless its dire straits, as they see it I fall off the end of the earth for years on end then I show up at a dire straits time, I've only used it four times in 10 years, it's only been really big problems I've used it for.

The home, therefore, came to be regarded as having little continuing role in the participants’ lives, providing at best a last resort for them should all else go wrong.

**Alternative support**

In view of the perceived lack of ongoing support from the home, many participants looked elsewhere for support. For some, such support comprised mainly provision from statutory agencies. For example:

P4: I’ve got workers. I’ve got helpers people that come in my house and help me out, but staff in here didn’t get that my social worker organised that but I’ve got like people that come in.

Some participants, however, successfully developed social networks of friends that they found to provide support as and when required.

P8: Now, I’ve got my own house, I’ve got my own girlfriend and that. I’m doing alright, I’m trying to look for work.

P6: At the crucial points, I had a car accident and ... the ones that I’ll do anything for you, the ones that will give you the last £2 out their pocket cause you need petrol to get to your work, they’re your pals.

To a large extent, the availability of support, whether statutory or social, was viewed as the factor determining success or failure in independent living. Participants who obtained necessary support managed independent living even without preparation; conversely those lacking ongoing support continued to struggle.

**Psychological ill-health**

For participants without ongoing support, the majority of interviewees, difficulties experienced in living independently became manifested in various ways. Commonly these difficulties resulted in psychological problems, for example:

P2: my confidence just went downhill ‘cause of like bullying in the workplace but nobody’s doing anything about it which of course makes me feel bad and insecure in my job ‘cause nobody’s doing anything about it.

In some cases, the difficulties in addition were perceived as leading to unhealthy behaviours such as self-harming:

I: Do you think you have changed in the way that you handle things?

P1: Sort of but sort of I’ve got difficulties, sort of just cut my arms and that ’cause then I know that.

P5: [My] car was a Ford Mondeo, I crashed that, I was trying to kill myself but it didn’t work out that way.

In such instances the participants viewed themselves as unable to cope with their lives on different levels and as lacking appropriate support to do so. Here lack of preparation for leaving the home and attendant loss of available support appeared to lead to a social vacuum, reflected in psychological ill-health and related behaviours.
Discussion
For the young people in this study, preparation for leaving, availability of support and confidence in their abilities to manage employment and independent accommodation were prime concerns in adjusting to independent life. To that extent, these findings are consistent with those from outcome-based studies that have argued that measures of such factors point to successful transitions. The present findings, however, suggest that individual perceptions of these elements and their relevance are not readily amenable to measurement. All of the participants in this study were managing to live in independent accommodation and the majority were in employment. Yet their individual understandings reflect ongoing problems rather than success. Preparation for leaving was viewed, at best, as limited and hurried, reflecting not lack of availability but rather poor quality of preparation. This was perceived to be quickly followed by the loss of institutional support. While some participants found alternative sources of support, the need to do so and their own efforts are not necessarily reflected in simple broad measures of support in general. Nor is their continuing struggle to cope with independent living, whether experienced as relatively satisfactory or otherwise.

Such findings, of course, are by no means new. Previous writers have pointed to benefits of being in care, such as having feelings of security and support (Dixon & Stein, 2003) and issues involved in leaving care, such as managing accommodation and employment (Stein & Carey, 1986) and finding sources of support (Dixon & Stein, 2003). The higher than average prevalence of self-harm by young people in residential care is also documented (Meltzer et al., 2004).

What, however, requires further exploration is the interlinked and cumulative impact of these factors on individual experiences. As discrete factors, they may potentially be open to measurement; the consequences of individual perceptions of one factor on those of another are less readily assessable. Daniel (2003) uses the term ‘pile-up’ to describe how adolescents in residential care can be overwhelmed when the number of stressors multiplies. For the present participants, inadequate preparations became bound up with loss of support and the need to find alternatives. In turn and together, these impacted greatly on the transition itself and on psychological health and actions. There is no direct measurable relationship but the outcomes in terms of successful or unsuccessful transitions to independence were experienced as no less real.

These findings, of course, come from a small-scale exploratory study and cannot necessarily be generalised to all instances of children leaving care; more work is needed to investigate further how individuals understand the process of transition, the factors involved and the consequences for their own lived experiences. Nevertheless the findings suggest that, despite the improvements in the 2001 legislation, the experience of young people leaving care remains one of continuing struggle and potential health concerns in making the transition to independent life.

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Leaving residential care

References


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Book Reviews

The Power of Belief: Psychosocial Influences on Illness, Disability and Medicine
Peter Halligan & Mansel Aylward (Eds.)

Reviewed by Nicola Davies

Despite a growing acceptance of the biopsychosocial components to health and illness, this approach is still in limited supply in clinical practice. The Power of Belief successfully attempts to highlight a need to close the gap between acceptance and application of the biopsychosocial model of illness. It achieves this by exploring psychosocial influences on illness, disability, and medicine without discrediting the more traditional biomedical model. The title is at first suggestive of pop psychology, so it was a pleasant surprise to be presented with a quality source of both primary and secondary information from prestigious contributors such as Marks, Wade, Horne, and Griffiths, to name a few.

After a detailed introduction on beliefs and their role in the experience and understanding of illness, the book is divided into two parts: conceptual and psychological perspectives, and clinical and occupational perspectives, each part being structured into six chapters.

The first part consists of chapters exploring the cognitive neuroscience of belief and how delusions and belief pathology are likely to be useful in understanding ‘normal’ beliefs. The Langdon and Coltheart (2000) model of belief formation is discussed and offers a beneficial insight into the cognitive processes behind beliefs. Examples of the sheer diversity of illness beliefs are provided via a cognitive anthropological perspective, illustrating the importance of integrating cultural and environmental understanding to the experimental approach of cognitive science. The influence of the placebo response is prominent throughout the text and of particular interest is the notion that health professionals are in fact therapeutic agents for the placebo effect. One chapter in particular was novel in its description of the secondary gains of illness and how these may shape illness beliefs and create the well-known ‘sick role’.

By the second part of the book, discussion expands into public and medical beliefs about mental disorders and their treatment, in particular how these contrasting beliefs may influence patient’s willingness to take evidence-based treatments. This topic is highly relevant to health psychology, whereby the psychological implications of ill health need to be considered alongside the more physical implications. The challenges of non-adherence are explored and the concept of ‘informed adherence’ introduced, this being suggested as a guiding principle to inform solutions to non-adherence. It is explained that this can be achieved in part by ensuring patients understand treatments being offered to them and by challenging any misconceptions about their illness or treatment. Another novel chapter is presented in the form of an exploration of beliefs behind unexplainable symptoms, an issue of huge importance in modern day society where illnesses with no apparent cause are on the increase. The final chapter, ‘Clinician Bias in Diagnosis and Treatment’, raises important questions for health psychology and health care, but its location in the text is questionable. It does not offer a conclusion that leaves the reader feeling satisfied. It would have been more appropriate to conclude with a chapter that brings together all of the main themes covered throughout the two parts of the text, demonstrating the relevance of all chapters...
to the initial pursuit of illustrating the power of belief in the illness experience.

The text is effective in highlighting that the absence of an agreed definition of belief has hindered the study of beliefs when compared with other well developed areas of cognitive neuroscience. The formation of an agreed definition would enhance research direction, thus facilitating shared beliefs among patients, health professionals, and family. This could in turn enhance patient-doctor communication and thus quality of care. Future developments of the biopsychosocial model of illness need to account for beliefs of all the key players involved in the health of an individual.

The Power of Belief is written in a conversational tone, inviting the reader to interact with the book and think beyond merely the information that is being presented. Further to this, it is reader friendly in its endeavour to provide modern day real-life examples for issues discussed.

The core message portrayed throughout the book is the need for a more patient-centred model of care rather than the predominant disease-centred method. A huge contribution to the development of a more patient-centred model of care will be the willingness of health professionals to open themselves up to learning about the actual experiences of illness and the patient beliefs that contribute to these experiences.

I would highly recommend The Power of Belief to anyone wishing to question the experience of illness and health care and to widen their thinking beyond present day research findings. The book is for readers who are focused on the future of health psychology and belief research and will be most accessible to the health professional/researcher. With contributions from a range of experts from neuroscience, rehabilitation and disability medicine, the RRP of £35 is a reasonable price to pay.

Nicola Davies
PhD Researcher, Cranfield University.

Anorexia and Bulimia in the Family: One parent’s practical guide to recovery
Gráinne Smith
John Wiley & Sons Ltd., 2003.

Reviewed by Emma Vince

After years of searching for a practical guide to help her through her journey dealing with her daughter’s eating disorder, Gráinne Smith finally reached the realisation that no such book existed, and, therefore, set out to write a practical supportive book written by a carer for carers. However, it is more than just a mother’s personal story. Gráinne Smith has been involved in the eating disorder field for several years including volunteering for the EDA and being a chairperson and founder member of NEEDS Scotland group (North East eating disorder support). Therefore, the support and advice offered comes from, in the words of Professor Janet Treasure ‘an expert carer’.

The book is divided into two parts; the first broadly covering more factual aspects, and the second offering practical advice and tips, although the difference between the two parts on opening the book is not made explicit in the contents page. Although part one is the more factual half of the book it is not written like your usual text book. Instead it reads as an informative story; personal experience littered with facts, research and a real understanding of the problems faced as an eating disorder carer. The clear, captivating writing is punctuated with enlightening examples, metaphors, quotes and real life stories which serve to aid understanding. It puts the features of the illnesses into real-life situations outlining how the behaviours and attitudes of anorexia and bulimia will affect the sufferer, family life and how they will make the carer feel and behave. The thing that struck me most about reading this book is how the disorders of anorexia and
bulimia are usefully referred to as unwanted visitors with their own personalities and behaviours, and that it is these personalities that cause the problems, rather than the sufferers themselves, so taking the blame away from the sufferer or the carer.

Part two offers the practical advice that carers are searching for. It covers how to cope with the sufferer and their illness, and importantly how to look after themselves. All the tips and advice given come from personal experience and hindsight. The author is not claiming to be an expert, but sharing what she and others found personally to be helpful. She acknowledges that each situation will be different but simply suggests the tips are worth trying in order to help both the sufferer and the carer. This part finishes with a chapter for professionals, and how they can work together with the carer. It provides advice to GP’s on how to spot eating problems and how to approach the topic within a consultation, before touching on specialist service referrals. It finally provides ideas on how to get professionals and the family working together for a successful discharge, and how to help prevent a relapse.

Although I found the book to be a little repetitive at times, this may be beneficial for carers who have no previous knowledge or experience with eating disorders. I also found the book works on the assumption that the carers reading this book have had no prior input concerning anorexia or bulimia, but in contradiction, relies on the reader knowing they are dealing with an eating disorder. I felt the book assumes that readers would be caring exclusively for daughters, which may not be the case. However, all the advice provided is transferable to any gender or relationship, so the reader needs to look past this aspect. I also have reservations about the professional and carers chapter; it didn’t feel like it fitted with the rest of the book in the sense that the chapter opens with advice for GPs, which didn’t seem to fit the ethos of the book.

I found the strengths of this book to be numerous. Firstly, it successfully fills that hole in the market discovered by Gráinne. It is crammed with real life examples and practical advice resulting in an honest book that carers will find they can relate to and gain strength from. Although the distinction of the two parts in terms of content is not clear, the chapters themselves are written in a clear manner with good use of headers, bullet points, and bold typeset to highlight important take-home messages. Additionally, each chapter is short and snappy, and doesn’t take long to read, with a good use of headings so the busy, stressed carer can easily skim read if time doesn’t allow a thorough read! Throughout the book the author acknowledges that she is not an expert, and that the contents of the book are her opinions. However, this is a woman that has done her homework and has read around the subject in an attempt to do the best for her daughter. The result is that professionals who do pick up this book will gain a very heartfelt but realistic insight into the daily struggles and battles the carer faces; they will get to see what it is to cope with a sufferer away from the structured environment they usually get to see such patients in. However, perhaps more importantly I feel this book will really help those faced with the daunting job of caring for someone suffering from an eating disorder. Although it may make tough reading for a carer at the start of the eating disorder journey, it very successfully achieves what it set out to do; this is a book carers will be able to connect with, gain hope and support from in the knowledge that the advice is both professional and also very real.

**Emma Vince**
Research Fellow, Department of Primary Care and General Practice, University of Birmingham.
I once attended a professorial inaugural lecture in which the speaker described how he abandoned psychology for sociology after his undergraduate studies, because ‘psychology did not do culture’. For many, the perception of psychology is of a discipline that believes it can develop universal laws of behaviour, measured objectively, within the context of a (quasi) positivist paradigm. In this context, culture becomes a contaminating variable, a sort of methodological ‘noise’ trespassing on the sacred ground of behavioural science. In health psychology many theories of health-related behaviour that originated from studies of American University students participating in research to earn course credits remain untested in other cultures. When researchers have tested these theories among groups living in multi-cultural environments, culture is invisible, even when the theories explain less of the variance in behavioural outcomes than that explained by other, untested variables. Ethnographic methods that might uncover some of the heretofore, invisible variance in behavioural outcomes, and hence add to the validity of theories of health-related behaviour, are rare in psychology research. So there is some merit in the argument that psychology is a culture-free zone. Malcolm MacLachlan does culture, and on this evidence, he does it in an erudite, accessible manner in a book that has much to offer psychologists practising, teaching and researching in multicultural environments.

MacLachlan is well qualified to write about culture and health having spent much of his career working among different cultural groups. This experience is borne out in the illuminating case studies peppered throughout the book and which add practical value to the concepts the author discusses. A major strength of this book, and one that is lacking in most books of this genre, is the inclusion of guidelines for professional practice at the end of each chapter. In this edition of the book, MacLachlan takes a critical perspective and explores how approaches in health psychology, medical anthropology and medical sociology are interlinked. Inevitably, this finds him taking a social constructionist position, but one he claims that is critical for, as opposed to critical of, other approaches. While initially sceptical of this approach, it seems well suited as the book progresses. One of the weaknesses I found in the first edition of this book was the lack of attention to how gender, sexuality, socio-economic status, for example, influence people’s experiences of health. I am glad to see MacLachalan giving these issues more attention. Another welcome addition to the previous edition is a chapter on global health showing, persuasively, in my view, how the major health issues of today are now global concerns. MacLachlan structures the book in a logical and easy to follow manner; the book begins with a general chapter examining how culture might influence health and proceeds through more specialist chapters showing the applications of culture to mental health, physical health and a chapter devoted to culture and treatment, which I found particularly useful. The book concludes with a reference list of additional resources and a helpful index.

A notable strength of this book is MacLachlan’s un-romanticised view of culture. This is apparent in chapter seven in which the author examines how health services can become more culturally sensitive. This is a current concern of our Department of Health and is a highly topical and controversial issue. Most approaches to this problem advocate an approach that is more motherhood and apple pie than to be of much use to practitioners and users of health services. MacLachlan tries to take it
further, and succeeds mostly. He acknowledges how complex certain issues are, and does not does leave the reader with simplistic and patronising solutions. An excellent example of this is on page 211 when he writes about positive discrimination. Later, on page 217, he revisits this terrain in a section headed *Who treats black and who treats white patients?* In Chapter 2, ‘Understanding Cultural Differences’, MacLachlan introduces the Problem Portrait Technique (PPT), a device to help us understand how people might use words and images to express how they experience ill health. Although MacLachlan uses the PPT with a Chinese man experiencing digestive problems, he goes on to show how this method might have wider applicability. The use of the PPT to develop a measure to rate the different causes attributed to ill health has promise for practitioners, but I am unsure how much it adds to illness representation measures that many health psychologists use.

*Culture and Health: A critical perspective towards global health* is a welcome addition to a list of cultural classics such as Cecil Helman’s *Culture and Health*, J.G. Frazer’s *The Golden Bough* and my favourite, Clifford Geertz’s *The Interpretation of Cultures*. The book’s target audience is students and practitioners of psychology, medicine, nursing, social work, occupational therapy and physiotherapy. As a mental health nurse and health psychologist, I would testify to its merits and would strongly recommend that all of the above keep this book close at hand. However, I would urge health researchers to beg, borrow or steal a copy of this book. The issues MacLachlan addresses should inform the research questions we develop, the methods we use to investigate health concerns, and how we interpret the results of our research.

**Dr Patrick Callaghan**
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**Health, the Individual and Integrated Medicine: Revisiting an Aesthetic of Health Care**  
_David Aldridge_  

Reviewed by Emma Vince

This book is aimed at academics, researchers, and health professionals, who wish to ponder the conceptualisation of health and how the traditional practice of managing illness can be revolutionised through new thinking and methodologies to encourage a potentially more useful understanding of healing and health.

This book could be described more as a collection of thought-provoking ideas and suggestions raised from a research base, rather than an objective, factual text, suggesting that modern and complementary medicine fail to fully grasp what health and illness truly mean both to the individual and to society as a whole, due to the methodologies and approaches that are currently common practice. It is written in a traditional academic style which may be quite daunting to those who aren’t scholarly academics, which I feel is a shame as under the pretentious writing, the messages, ideas and opinions that Aldridge is proposing aren’t particularly difficult to grasp and don’t require an IQ of a genius to appreciate; however, the writing style of this book would lead some to think that this is not the case, and may lead to his book not reaching some of those whom he intends it to.

The book has 14 chapters, which bring together much of Aldridge’s lifetime research interests. At first glance I wondered how the chapters were going to fit together as it looked like an unlikely mismatch of topics, with an apparent emphasis towards music therapy. However, once you get into
the book, the chapters do link better than one would expect from the content list. Chapters 1 and 2 flow nicely together setting the scene for the rest of the book. They are written from an anthropological viewpoint on the perception and coding of illness, discussing how we make sense of illness, perceive our health, and interpret events (including health events) and how these impact on our health/illness perceptions, cognitions and behaviours. Both chapters include good practical real-life examples, which are drawn on throughout the corresponding chapters to aid understanding and clarify the ideas presented.

The book then begins (subtly) its criticism of current research methods used in medicine, with a brief review of clinical trials conducted on acupuncture and asthma. This chapter opens up the ensuing argument that the traditional scientific perspective should not be taught as the gold standard, and that an individual perspective should begin to have a more prominent place in medical research: the strict methodologies of natural science are not always the best for applying to human behaviour and so medical research and practice needs an armoury of methodologies to use that take into account the ‘social and cultural milieu’, as well as focusing on stricter objective outcomes. Unsurprisingly, these chapters are then followed by a section on such less objective aspects of medical practice such as music therapy, prayer and healing and how they have their place in the health care of the individual. The book then ends with a chapter on guidelines for clinical research, which provides a step-by-step guide on how to plan design and execute a research application aimed at clinicians who are not necessarily expert researchers.

Overall, this is not a book that one is likely to read cover to cover, but is more likely to be dipped into depending on ones interests, which is as much to do with the dense text as the varied topics. However, if one can persevere through the academic writing style, and the not necessarily logical order of the chapters, it proves to be a thought provoking book, written from a real desire to alter the perspective of medical research.

Emma Vince
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**Exercise, Health and Mental Health: Emerging Relationships**
Guy E.J. Faulkner & Adrian H. Taylor
Routledge, 2005.

Reviewed by Judith L. Gellatly

With one of the NHS core principles highlighting the need not to look only at the quality of the clinical aspects of care but also to include quality of life and the whole patient experience (NHS Plan, 2000) it is timely to consider and address how exercise can be involved in improving psychological well-being. This book provides a comprehensive collection of eight theoretical and practical systematic reviews written by a number of experts in the UK, Canada and the US, which aim to give insight into specific areas of research and to more inform us as to why we should consider a move towards the psychological role of physical activity.

The reviews that are presented in the book are divided into four broad sections; initially the incorporation of exercise for clinically defined mental health problems is discussed. Three reviews address this issue which look at how exercise can be utilised to help problems that are associated with dementia, schizophrenia and drug and alcohol rehabilitation. The second part of the book focuses on research which draws upon exercise to assist in improving mental health in individuals where remission is unlikely such as heart failure, cancer, HIV and AIDS. The final reviews in the third section look towards describing how, through the use of exercise, we can enhance mental
health in the general public and look into issues concerned with smoking cessation, disturbed sleep and, with respect to political agendas, the use of sport in combating social inclusion and crime. Overall the reviews include a wide range of studies that utilise numerous research methods, although it appears that randomised controlled trials are very much in the minority. They question and provide good supportive examples as to how physical activity can be adopted as a successful mental health promotion strategy in a variety of conditions, with particular emphasis on the more ‘here-and-now’ diseases that have previously been overlooked, e.g. smoking, alcohol abuse and schizophrenia, and on populations.

The book concludes with a well compiled and written chapter that highlights the key findings addressed throughout and, through the use of editorial commentary, discusses further the implications that these findings hold for the future role of exercise in mental health.

Guy Faulkner and Adrian Taylor have provided readers with an excellent collection of expertly written reviews that suitably emphasise how improving the physical health of individuals can have substantial effects upon their mental health. Each is competently written in a language that any reader can engage in and provide us with an inspiring insight into what research evidence currently exists and how, as clinicians or researchers, we can be guided in our own practice or research. The summaries that are contained at the end of each review along with the sections looking at the implications of the findings for researchers and practitioners are particularly useful. Incorporation into policy and practice and health service delivery is discussed in a couple of the reviews and highlight further how such work can have an affect upon already established health promotion strategies.

Overall this book highlights that research looking into physical activity is not only interesting but of great importance. However, as is stressed, although there exists a fair amount of research in this area many questions still remain unanswered. The need for expanding work on lifestyle habits, including physical activity and the impact they have upon mental health and well-being is highlighted and attention drawn to the importance of this to us as researchers, clinicians, members of the public and beyond. While health care is moving from a time where medication was viewed as the primary means of improving someone’s symptoms to one where psychological interventions are adopted more freely this book helps us to appreciate the importance of addressing specific interventions and the impact that they can have in order to come to more affirmative conclusions. The evidence presented is encouraging and will hopefully provide the motivational basis for much research which follows in the imminent future. It was enlightening to read a book that focussed on an under-researched area within psychology and is inspiring for any researcher or health professional who would like to develop their expertise or research in this area.

Judith L. Gellatly
School of Nursing, Midwifery & Social Work, University of Manchester.
This book is a self-help book aimed at people who worry about their health and as the title suggests contains useful chapters on what can be done to help individuals who suffer from health anxiety – a condition that can produce physical effects of its own such as nausea, increased heart rate and muscle tension. The implications for a person suffering from health anxiety can be far reaching and can impact on career and personal relationships, as well as causing a sense of desparation for the individual who may be attempting to live with an unresolved health issue, despite several reassurances from his/her general practitioner.

The first two sections of the book deal with understanding health anxiety with the third and final section providing practical help and advice on how to control health worries. For clarity, the book has been divided into three main sections. Section one is entitled ‘Understanding Health Anxiety’ and encompasses four chapters that take the reader through the relationship between body and brain and how bodily sensations such as nausea are connected to common ailments such as headaches, coughs and colds, etc. This chapter also includes a section that explains signs and symptoms of ailments and contains a worksheet entitled ‘Symptom Interpretation’; which is designed to help the reader evaluate their own health experiences. There is also a discussion on other psychological factors that can accompany health anxiety such as Generalised Anxiety Disorders, and Obsessive Compulsive Disorder. A brief discussion of CBT (Cognitive Behaviour Therapy) and other forms of Psychotherapy is also included.

The second section entitled ‘Breaking the Health Anxiety Cycle’, contains three very detailed chapters that include understanding and managing stress, thoughts that influence anxiety and what to do to change them and behaviours that influence health anxiety and how these can be changed.

The third and final section is entitled ‘Maintaining Your Gains’. This section also contains three detailed chapters and is concerned with providing practical advice on how to find effective ways in which to overcome health anxiety and how to communicate effectively with doctors about a health problem. A chapter on the role of family and friends in helping the individual deal with their health anxiety is also included. The final chapter in this section deals with practical advice on how to deal with any future ‘flare ups’ of Health Anxiety by including a strategy (response plan) to deal with these. In this section there is a practical exercise that contains two parts. Part 1 involves writing down the factors that have caused an individual’s health anxiety and what he or she has learnt from the experience whilst Part 2 involves writing down a step by step approach on how to deal with the ‘flare ups’.

The last section of the book contains a total of 17 worksheets that correspond to the topics discussed in the chapters throughout the book which have been designed to help the reader to understand his/her health anxiety. For example, some of the worksheets in this book include problem solving, how to understand common stress-related bodily reactions, common stressors and short health questionnaires such as the Whitley Index.

This is an excellent book which I would recommend for anyone who suffers from health anxiety or for those individuals who may have concerns in relation to interpreting health symptoms. This is at a diverse audience. It is extremely easy to read and is jargon free, and because it is divided into three sections, this makes it easy for the reader to refer back to the relevant
sections for clarification, once the complete book has been read. The practical exercises form an extremely useful part of the book as they help to provide the reader with an opportunity to gain a better understanding of the factors that may be causing his/her health anxiety. In the remaining pages of the book, the authors have included some useful references for additional reading. A title of a video and a list of websites that contain national organisations are included, together with a list of mainly US-based CBT therapists who specialise in treating health anxiety.

At approximately £8.89 (the book is priced at $16.95) and with a total of 212 pages this book represents good value for money.

Sharon How

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**Book Reviews**

**Study Design and Statistical Analysis: A practical guide for clinicians**

*Mitchell H. Katz*


Reviewed by Dave Peck

There is much to like in this book. It covers the whole of the clinical research process in chronological order, including study design, data management, descriptive statistics, statistical analysis (including multivariate), sample size calculations, diagnostic testing, and publishing. There are convenient wide margins for making notes, and a series of useful ‘Tips’ and other helpful information in boxes. The figures and tables are relevant, well laid out, and comprehensible. The statistics chapters cover not only the basic inferential tests but also cover other topics such as survival analysis and ‘Number needed to treat’ that are unfortunately neglected in other psychology statistics texts.

Many interesting snippets of advice are given, including the assertion that with an N of only seven, a Mann Whitney test is bound to be not significant irrespective of the magnitude of the differences between the groups; and that having a controls:case ratio of more than four adds little incremental gain in statistical power. There are particularly useful sections on how to proceed if your required sample size is impossibly large, on odds ratios and risk ratios, and on cleaning data and recoding variables.

Sceptical readers may be wondering how all this can be fitted into a book of less than 200 pages; they are right to be sceptical. Many of the topics are covered very briefly and superficially, especially multiple and logistic regression and proportional hazards analysis. The author should have simply noted that many topics were too complex for the present book, and referred interested readers to more advanced texts.

The arrangement of the statistics chapters is unconventional, with the tests organised according to the number of variables involved in the analysis, rather than according to the questions being asked. Thus a chapter entitled ‘Univariate Statistics’ is an odd mixture of descriptive statistics and univariate survival curves. The ‘Bivariate Statistics’ chapter describes a ‘pot-pourri’ of chi-squared, Fisher’s Exact, risk ratios and odds ratios, some non-parametric tests, t-tests, ANOVA, correlation, regression, and bivariate survival analysis, amongst others. Apart from the fact that all the tests involve two variables, the additional rationale for putting them in the same chapter is that they all explore ‘associations’, with the tests differing mainly in the level of measurement for which they are appropriate (e.g. dichotomous, nominal, or interval). There may be a logic in this arrangement, but I did not find...
that it enhances understanding; it simply serves to make it more difficult to find your way round the book.

A further problem is that the title of the book is misleading. The word ‘clinicians’ in the title should read ‘medical practitioners’. All the examples are from clinical medicine, with only a few relevant for health or clinical psychology. The medical focus is also apparent in the journals from which illustrative data are taken, the majority being from either the *Journal of the American Medical Association* or the *New England Journal of Medicine*.

Some of the information given is questionable. For example, Katz recommends using multiple t-tests and Bonferroni adjustments to pinpoint differences after an ANOVA, rather than ‘more sophisticated approaches’ such as post hoc tests; and the advantages of Kendall’s Tau over Spearman’s Rho are not mentioned.

The book has been poorly edited and proof-read. For example, on p.62, Figure 5.6 should be 4.6; on p.101 ‘that’ should be ‘than’; the last sentence on p.105 is gibberish; on p.110 ‘standard deviation’ should be ‘standard error’; on p.xii ‘of’ should be ‘or’. The frequency of such typographical errors is inexcusable.

Finally there is too much self-publicity, with an undue number of references (11) to another book on statistics by the same author.

Would I recommend this book? For students, definitely not. But for teachers who are able to sort out the wheat from the chaff, there is enough useful information and advice to warrant at least having a close look.

**Dave Peck**

*University of Edinburgh.*

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**Multivariable analysis: A practical guide for clinicians** (2nd ed.)

*Mitchell H. Katz*


Reviewed by David Clark-Carter

**How is the book laid out?**

The sections of each chapter have headings in the form of questions which are similar to Frequently Asked Questions. An example of this is *Why should I do multivariable analysis?* Such a layout makes the presentation very clear.

**Why multivariable?**

The author is distinguishing between multivariate – having more than one dependent (or outcome) variable, as in MANOVA – from multivariable – involving more than two variables, as in multiple regression.

**What is the book about?**

The book mainly covers three related techniques: multiple linear regression, multiple logistic regression and proportional hazards analysis. However, as the author points out, analysis of variance is simply a variant of the first of the three and this is also covered. In addition, there is a later chapter which introduces mixed-effects models.

**Who is the book aimed at?**

As the sub-title states, it is written for clinicians. In the preface it is shown to be even more specifically targeted ‘to promote the work of clinical researchers early in their careers’.

**What are the good points?**

It relies almost entirely on examples from published work to illustrate the use of the techniques. The left-hand margin contains boxes which provide either definitions of terms or tips. There is a strong emphasis on the assumptions which underlie each technique (a whole chapter), how to check whether they are fulfilled and what to do if they are not. When there is a danger that taking a specific action which could affect the results, such as dealing with outliers or missing values in particular ways, it is...
suggested that more than one analysis is conducted to see what effect such decisions can have on the results and thus how robust they are. This typifies the whole approach: that of trying to understand what your results mean rather than blindly following procedures. Consistent with this is that advice is generally explained rather than handed down *ex cathedra*.

Although statistical significance is discussed, there is more emphasis on effect sizes with confidence intervals to help interpret them. Common practice is discussed, for example in analysis or reporting of results, but it is criticised where necessary. There are frequent exhortations to explain to your reader what you have done, and why, when you report your studies. There is very little mathematics and this should make it accessible to a wider audience. Descriptions aren’t tied to any one statistical package. There is advice on publishing your study and a summary of the stages you would need to go through to conduct multivariable analysis with indications of which section in the book covers that stage.

**What are the negative points?**
These are relatively minor. Sometimes terms are used in the early chapters without much explanation. This could be a particular problem for those who have only met the material which is typically covered on core statistics and research modules for undergraduate psychologists. Therefore, it may be advisable to have another book to hand to define such terms. There is confusion over beta (the probability of committing a type II error – i.e. rejecting a true research hypothesis) and statistical power (the probability of avoiding committing a type II error) which could lead the unwary to conduct some very underpowered studies. Some terminology is not consistent with the way most psychologists would use it: for example, unstandardised regression coefficients are described as beta coefficients, whereas I would only use that term for standardised coefficients. A description is given of how to use a calculator to perform a calculation but with some calculators you would get the wrong answer or no answer if the advice were followed. Chapter 8 has the title ‘Performing the analysis’ but a more appropriate title would be ‘Issues to resolve when performing the analysis’. Sequential techniques aren’t really covered, for example, entering demographic variables at one stage and then psychological variables to see how much extra variance the latter explain. This may just be a reflection of the intended audience.

**Is it worth reading?**
Definitely. It is full of good advice which psychologists would benefit from following more often. It discusses, in an accessible way, techniques which are less familiar to psychologists and could be useful to them. It allows health psychologists to see how medical researchers approach, analyse and report their studies and this should improve communication between the disciplines.

**Who should read it?**
I think that although people doing Stage 1 health psychology training would benefit from reading it they are likely to find it hard going if they only covered core material as undergraduates, and so it might be better to wait until Stage 2 training. From that point it would be worth putting it on the recommended reading list.

**David Clark-Carter**
*Reader in Psychology, Staffordshire University.*
Learning Medicine (17th ed.)
Peter Richards, Simon Stockill, Rosaling Foster & Elizabeth Ingall

Reviewed by John McAlaney

The 17th edition of Learning Medicine is the latest in a successful series of books beginning in 1983 which are aimed at current and prospective medical students; both school leavers and those considering a career change. It has an extensive coverage, dealing not just with the academic aspects of medical school but also the wider issues of entering the medical field and subsequent career development. It is also up-to-date, incorporating changes to medical grades and the introduction of the Foundation Programme. It opens with a discussion on the factors which may lead someone to a medical career, using examples of the desirable experiences a doctor may have and contrasting these to the less than desirable. This challenges the preconceptions individuals may have about being a medical doctor and provokes thought into whether or not a medical career is really something they wish to pursue. This is then followed by practical guides to each stage of a medical career from the entry requirements of medical school all the way through to different possible specializations. The earlier sections deal with the questions a nervous potential applicant will want to know; from what to emphasise in the CV to what to wear at the interview. Some of the later sections are fairly brief but they are comprehensively written, giving the reader a quick and accessible reference of the stages of progression of different medical jobs. The book also anticipates and addresses both the expected and unexpected obstacles a prospective medical student may encounter. This ranges from practicalities such as financial support whilst studying to more personal issues such as the effect that having a disability may have on an applicant’s chances of success. In addition to the sections discussing the life and experiences of medical doctors this book contains extensive and valuable practical information, which is located throughout the text and in a number of useful appendices. This includes items such as an example of a medical student code of conduct, General Medical Council requirements and a list of UK medical schools and their websites. In contrast to previous editions the text also includes an extensive section on the legalities of medical life, including registration, dealing with complaints, obtaining consent and disclosing information.

The key strength of the book is its engaging and informal style. It uses illustrations to humourise the important yet sometimes mundane information being discussed and contains numerous vignettes and personal accounts from medical students and practitioners. This latter technique is particularly effective in giving a real life feel to the text and reinforcing the fact that the authors have first-hand experience of the issues they are discussing. One of the other especially notable points of the book is the balance it strikes between encouraging the reader to consider a medical career and the care it takes in stressing the challenges of entering and working in the field. As such it presents the information in an enjoyable and positive way without overly romanticising a medical career or giving false hope on individuals’ likelihood of success or career progression. It is an indispensable guide to those thinking about entering medicine and a useful resource to those approaching the next stage of a medical career. It is though a book which could also be of use to psychologists who work closely with medical staff. Firstly, it is a quick and easily accessed reference to the fairly complex system of medical grades and specialties. This could be particularly helpful for those who are conducting research in a hospital setting for the first time or have to liaise between different departments. Secondly it provides health psychologists with a degree of insight into how doctors are trained to relate to patients and what they
perceive their role responsibility to be in health care. This is potentially useful information for any researcher investigating the increasingly popular field of the effect of doctor/patient interactions of treatment success and delivery. Overall the book is to be highly recommended to anyone working alongside medical doctors or considering a medical career of their own.

John McAlaney
Department of Psychology, University of Paisley.

Prevention and treatment of suicidal behaviour: From science to practice
Keith Hawton (Ed.)

Reviewed by Roger Paxton

Suicide is relatively rare and the suicide rate in most countries is declining. So why should we be particularly concerned about suicide? One reason is that it depends what you mean by rare. For instance, during the eight years of the Vietnam War many more young American men died through suicide than directly because of the war. Similarly, at the peak of the American AIDS epidemic in the early 1990s as many young men died from suicide as from AIDS. In addition, the overall death rate of about nine per 100,000 in Britain hides wide variation between different groups in the community. Men are several times more likely than women to kill themselves, but even so, suicide is the second most common cause of death worldwide in females aged 15 to 24 years. Similarly, the suicide rate is greatly increased in older people in most countries. Other major risk factors are the presence of depression or other serious mental health problems and being in prison. The single most important risk factor is a history of deliberate self-harm. Therefore, those of us who provide health or other services to many different population groups should be aware of suicide risk and able to assess and manage it.

The purpose of this book is to bring together the main sources of evidence that should underpin efforts to prevent suicide and help those who survive suicide attempts. It achieves this purpose very successfully. The 20 chapters cover a wide range of topics, including the epidemiology, psychology, biology, and genetics of suicide. All explicit in drawing out practical lessons for prevention and/or treatment. There are chapters devoted to suicide risk and prevention with prisoners and with older people. Each chapter summarises relevant evidence before moving to practice implications. This approach is used in the very interesting chapters on the role of volunteers in suicide prevention and working with the relatives and loved ones of people who have committed suicide. Other chapters likely to be of particular interest to readers of this journal are those on the psychology of suicide, elaborating the entrapment model (by Mark Williams and others), the chapter on traumatic stress and suicidal behaviour (by Lars Mehlum) and Keith Hawton’s chapter on psychosocial treatments following attempted suicide. The standard throughout is high. My only criticism is that the ordering of the chapters is mysterious, and it might have been helpful to have clustered them under broader headings such as epidemiology and risk factors, explanatory models, particular population groups, and so on. This is a minor criticism of an excellent book that provides thorough but concise updating and should serve as a very practical reference book for some years.

Dr Roger Paxton
Northumberland, Tyne and Wear NHS Trust.
Social Determinants of Health (2nd ed.)
Michael Marmot & Richard G. Wilkinson

Reviewed by Gail Kinman

It is now firmly established that morbidity and mortality are not only influenced by biology, genetics and individual behaviour, but also social, economic and political factors. This interesting and authoritative book presents research highlighting the gross inequities in health and disease in social groups within the UK population, potential reasons for these inequities and how they might be reduced. The second edition of this book comprises 16 chapters with contributions from acknowledged experts in the fields of epidemiology and public health, population science and fiscal studies. Several new chapters are included that examine how ethnic/racial inequalities in health contribute to differing morbidity and mortality rates, the social determinants of sexual behaviour and sexual health, the inequalities in health experienced by people in older age, and the ways in which the physical and social environments of neighbourhoods impact on residents’ health.

Chapters from the first edition of the book have been revised and updated to take into account up-to-date research findings. They include, for example: an examination of social influences on health status in early life; relationships between health and labour market disadvantages such as unemployment and job insecurity; the physical and mental impact of different types of transport and road accidents and the implications of social support and social cohesion for health and mortality. As an occupational health psychologist, I was particularly interested in a chapter written by Marmot, Siegrist and Theorell on the impact of the psychosocial environment at work on health status. The authors provide strong evidence that certain work features increase the risk of illness in general and make a significant contribution to social inequalities in health status. Two theoretical models of work stress (the demand-control and effort-reward imbalance models) are described that the authors argue hold particular promise in predicting coronary heart disease and other health indicators. Ways by which the quality of working life might be improved and work-related social inequities in health reduced are explored. A further chapter examines diet as an important determinant of health status and explores ways by which public policies might reduce inequalities in food and nutrition that take into account the needs of different populations.

Jarvis and Wardle contribute an interesting chapter that focuses on the social patterning of cigarette smoking. Strong associations are highlighted between smoking and indicators of material and cultural disadvantage such as lone parenting, unemployment and mental illness. The authors explore the reasons why disadvantaged groups are more likely to initiate smoking at a younger age, why they persist with the habit, and why they find it more difficult to quit. Although smoking prevalence has been generally declining in the UK population since 1973, there has been a substantial widening of prevalence rates between different social groups. Potential policy options to promote cessation amongst disadvantaged groups are suggested.

The book is well-written and engaging. It makes an excellent job of acquainting the reader with the state of current knowledge in the field of public health. The importance of introducing public health policies that acknowledge the socio-economic determinants of health is evident. Ways by which research findings might be translated into workable interventions to tackle the gross health inequities in the UK are explored. This book has significance far beyond the realm of public health, however: it should required reading for health psychologists, health promotion specialists and anyone involved in the planning and delivery of health care.

Gail Kinman
Senior Lecturer in Psychology,
University of Bedfordshire.
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

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Forthcoming Events

16–17 November, 2006
**Eating disorders for non-specialists**
Aberdeen Exhibition & Conference Centre.
Registrations fee (including coffee, lunch and conference dinner): £160.
Contact:
Nicola Shand, Conference Secretary, at Fulton Clinic, Royal Cornhill Hospital, Aberdeen, AB25 2ZH.
Tel: 01224 557610;
Fax: 01224 557312;
E-mail: Nicola.shand@gpct.grampian.scot.nhs.uk.
Website: [http://www.edauk.com/sub_conference_and_events.htm](http://www.edauk.com/sub_conference_and_events.htm)

22 November, 2006
**Postgraduate study fair**
The G-Mex Centre, Manchester.
Website:
[http://www.careers.manchester.ac.uk/recruit/profile/fairs/postgrad/](http://www.careers.manchester.ac.uk/recruit/profile/fairs/postgrad/)

27–28 November, 2006
**Risk 2006: 7th Annual Conference**
Examining the Effective Management of Clinical Risk in Everyday Practice
Great George Street, London, UK.
Website:
[https://secure.healthcare-events.co.uk/conferences/confdisplay.asp?id=563](https://secure.healthcare-events.co.uk/conferences/confdisplay.asp?id=563)

29–30 November, 2006
**Orthopaedics and Sports Injuries: Updates on the latest developments, treatments and procedures**
Institute of Physics, London, UK.
Website:
[http://www.mahealthcareevents.co.uk/1098f.html](http://www.mahealthcareevents.co.uk/1098f.html)
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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 Sara Cox (Co-ordinating Editor), Institute of Work, Health & Organisations, University of Nottingham, William Lee Buildings 8, Nottingham Science & Technology Park, University Boulevard, Nottingham NG7 2RQ. E-mail: sara.cox@nottingham.ac.uk
  - Dr Kerri McPherson (Deputy Editor), Queen Margaret University College, Edinburgh EH12 8TS. E-mail: KMcPherson@QMUC.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 and 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

- **Postgraduate issues:** Anna Winterbottom, University of Leeds. E-mail: anna@winterbottom.co.uk

- **Forthcoming events:** Pauline Fox, Dept. of Psychology, The Wolfson Institute of Health Sciences, Thames Valley University, St. Mary's Road, London, W5 5RF. E-mail: pauline.fox@tvu.ac.uk
Contents

1 Editorial
Sara Cox & Kerri McPherson

Individual Articles – Training in Health Psychology

4 Health Psychology Training at City University
Catherine Sykes, David Marks, Clare Eldred, Pamela Gbesemete-Akyeampong, Claire Howard & Eleni Vangeli.

10 The BPS Stage 2 Qualification in Health Psychology:
Being a Health Psychologist in Training
Mark Forshaw

13 Achieving the Stage 2 qualification
Alice Theadom and Emily Buckley

Individual Articles

18 Could the future leaders of primary care research be health psychologists?
Carrie Llewellyn & Markus Themessl-Huber

23 Perceptions and experiences about Chlamydia in young women in Scotland:
Knowledge, condom use and access to health services – a pilot qualitative study
Zoë Chouliara, Athanasios Karatzias, Alison Goulbourne & Helen Smart

28 Canabis use: Implications for health psychologists
Sue McHale

31 Health Baseline Comparison Theory: Adjustment to rheumatoid arthritis
Nicola Davies & Gail Kinman

37 Using narrative analyis to investigate the role of social support in the reconciliation
of traumatic war memories
Karen Burnell, Nigel Hunt & Peter Coleman

41 Successful outcomes or psychological losses? Young people’s experiences of leaving
residential care
Karen Goodall, Chris McVittie & Elinor Snowdon

Regulars

47 Book Reviews

61 Books for Review

62 Forthcoming Events