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The Canadian Health Psychologist is produced by the Health Psychology section of the Canadian Psychological Association and distributed to all members of that section. It is designed to serve as a discussion forum for any issues of relevance to psychologists working in the area of physical health. The editor welcomes review articles, research and intervention reports, reports of events, letters, news of members, book reviews and announcements. Articles should ideally be no longer than 2500 words with about ten references. They should preferably include an abstract in English and in French. If possible, articles should be submitted on a computer disk.

The opinions expressed in this newsletter are strictly those of the author and do not necessarily reflect the opinions of the Health Psychology Section or of the Canadian Psychological Association, its officers, directors or employees. This is in no way affected by the right of the editor to edit all copy published.

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Le psychologue canadien de la Santé est produit par la section de psychologie de la santé de la société canadienne de psychologie et est distribué à tous les membres de cette section. Son but est de servir comme un agent de discussion pour des psychologues qui travaillent dans le domaine de la santé physique. Les articles revues, rapports de recherche et d'intervention, rapports d'événements, lettres, nouvelles des membres, des comptes rendus et des annonces sont le bienvenue chez le-rédacteur pour soumission. Idéalement, les articles ne devraient pas dépasser 2,500 mots avec 10 références ou moins et, si possible, incluent un résumé en français et en anglais. Aussi, si possible, les soumissions devraient être présentées sur une disquette.

Les opinions exprimés dans ce bulletin son strictement ceux de l'auteur et ne reflètent pas nécessairement les opinions de la section de psychologie de la santé ou la société canadienne de psychologie, ses officiers, ses directeurs, ou ses employés. Le rédacteur a le droit d'éditer toutes soumissions.

Ce bulletin est publié deux fois par année, c'est-à-dire en printemps et en automne. Les dates limités de soumission sont comme tel: printemps: le 31 Mars; automne: le 31 Octobre.

Les individus qui ne sont pas membres avec la section de psychologie de la santé s'abonner en envoyant 10\$ (payable à SCP Section de la psychologie de la santé).

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**THE CANADIAN HEALTH PSYCHOLOGIST/
LE PSYCHOLOGUE CANADIEN DE LA SANTÉ**
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Editorial/Éditorial

This is the eleventh issue of the Canadian Health Psychologist. It begins with an excellent review article on non-pharmacological treatment of headaches by Hans Ivers and Janel Gauthier. It is indeed a pleasure to include an article co-authored by the President of Canadian Psychological Association clearly demonstrating his support for the activities of the section.

I am also pleased to include an article by Stephen Wright on non-compliance, a contentious issue for clinicians. Stephen as the recent Editor of Health Psychology Forum, the newsletter of the British Health Psychology Section understands the trials of getting people to do things - writing articles or taking medication.

As part of a series on grant opportunities, Ken Prkachin has written a report on potential support available from the Heart and Stroke Foundation. Members who would like some further information should contact the Foundation.

Since this will (may) be my last editorial I thought I should take this opportunity to thank all the various contributors who have responded to my pleas for articles over the past five years. Without your support, the Canadian Health Psychologist would not have existed. Thank you.

And, that's it for now.

Ceci est le onzième numero du Psychologue canadien de la santé. Il s'ouvre sur une revue excellente des traitements non-pharmacologique des céphalées par Hans Ivers et Janel Gauthier. C'est avec plaisir que nous incluons un article écrit par le président de la Société canadienne de psychologie. Ceci est un signe du soutien qu'il porte aux activités de la section.

Je suis aussi enchanté d'inclure un article de Stephen Wright sur le non-respect du traitement, une problème difficile pour les cliniciens. Stephen était le rédacteur en chef de "Health Psychology Forum", le bulletin des psychologues de la santé en Grande-Bretagne. Il sait qu'il est difficile de faire agir les gens, que ce soit de les persuader d'écrire un article ou de prendre leurs médicaments tel que prescrits.

Dans le contexte d'une série d'articles sur les possibilités de bourses, Ken Prkachin écrit sur le soutien financier qui est offert par la Fondation des Maladies Cardiaques. Les membres intéressés sont invités à contacter la Fondation.

Puisque ceci est peut-être mon dernier éditorial, j'aimerais remercier les différents auteurs qui ont répondu à mes appels d'articles pendant les cinq dernières années. Sans votre soutien, le psychologue canadien de la santé ne existerait pas. Merci beaucoup.

Et c'est tout pour le moment.

Michael Murray

Chair's Letter/Lettre de la Présidente

As one of the largest sections in CPA we try to connect health psychologists across Canada via numerous venues. First, we publish and mail out a substantial (about 30 pages) newsletter twice a year; one has a special theme (e.g., pediatric oncology) whereas the other is more general. We also mail out a membership directory which is updated every two years.

Second, we focus on the CPA convention as a means to network and report our work. This year, there will be three symposia, three theory reviews, posters and a conversation hour in two "packed" days; we top it all off with a business meeting and open reception.

Third, we have our own Website, which is linked to CPA. Also, we publish in *Psynopsis* to increase our visibility to the CPA members at large. Our executive committee members meet three times per year via telephone conference calls, and at the convention.

This year we have focused on the future for students; a student representative was added to our executive committee. We would like to develop a mentorship programme whereby students are linked to established health psychologists at the convention. We are financially viable, with a budget "in the black". Overall, we are an active group with the common goal of raising the profile of health psychology across Canada.

La section de Psychologie de la Sante, qui compte le plus grand nombre de membres parmi les sections de la SCP, tente de faciliter les liens entre psychologues de la sante au Canada. Tout d'abord, nous publions et distribuons un bulletin d'environ 30 pages deux fois par annee avec un numero portant sur un sujet specifique (par exemple, l'oncologie pediatrique) et l'autre d'ordre plus general. Nous envoyons de plus a nos membres un inventaire des membres de la section qui est mis a jour tous les deux ans.

Ensuite, nous portons nos efforts sur la convention annuelle de la SCP en tant qu'occasion pour creer de nouveaux liens ainsi que pour faire connaitre nos travaux en psychologie de la sante. Cette annee, trois symposia, trois revues theoriques, des presentations par affiches, ainsi qu'une seance de conversation sont prevus en l'espace de seulement deux jours. Une reunion ainsi qu'une reception suivront ces deux jours tres occupes.

Nous avons aussi notre site internet qui est relie a celui de la SCP. De plus, nous publions regulierement dans le bulletin "Pynopsis" afin d'augmenter notre visibilite au sein des membres de la SCP. Nos membres du comite executif se rencontrent trois fois par annee par conference telefonique ainsi qu'a la convention annuelle de la SCP. Cette annee, nous avons mis l'emphase sur l'avenir des etudiants et un representant aux etudiants a ete ajoute a notre comite executif. Nous visons a developper un programme de guides/conseillers qui facilitera une rencontre lors de la convention entre etudiants et psychologues de la sante deja etablis dans ce domaine. De plus, nous gerons nos finances avec un budget sans deficit. La section est donc un groupe qui agit vers le but commun de faire reconnaitre la psychologie de la sante a travers le Canada.

Patricia Dobkin

Le traitement non-pharmacologique des céphalées d'origine médicamenteuse: considérations empiriques et cliniques

Hans Ivers et Janel G. Gauthier
Université Laval

Résumé

Cet article a pour objectif de réaliser une revue critique de la littérature empirique disponible sur la nature et l'efficacité des interventions non-pharmacologiques dans le soulagement des céphalées induites par la consommation excessive et chronique d'analgésiques, une classe particulière de céphalées d'origine médicamenteuse. Un examen attentif d'études cliniques suggère que les traitements combinant parallèlement le retrait de la médication et l'apprentissage de stratégies non-pharmacologiques de gestion des céphalées présentent des résultats cliniques supérieurs et un taux d'abandon moindre comparativement aux traitements séquentiels, où le sevrage précède le traitement non-pharmacologique. Des recommandations cliniques et empiriques sont dégagées afin de guider l'élaboration d'un programme de traitement combinant parallèlement le retrait de la médication et certaines stratégies non-pharmacologiques dans la gestion des céphalées d'origine médicamenteuse, tout en offrant un bon rapport coûts-bénéfices.

Abstract

The aim of this article is to critically review the empirical literature pertaining to the nature and treatment efficacy of non-pharmacological interventions for analgesic-induced headaches, a subclass of drug-induced headaches. Results from studies suggest that treatment protocols characterized by concurrent administration of medication withdrawal and teaching of non-pharmacological strategies to cope with headaches produced better clinical outcomes and lower drop-out rates than sequential treatment protocols, in which medication withdrawal precedes learning of non-pharmacological strategies. Clinical recommendations are provided to help clinicians in the development of a cost-effective treatment protocol combining concurrent administration of medication withdrawal and non-pharmacological strategies in the management of analgesic-induced headaches.

Mots-clés: céphalées, consommation d'analgésiques, traitement non-pharmacologique.

Keywords: headaches, analgesic-induced, non-pharmacological treatment

Les demandes de tirés-à-part doivent être adressées au
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Introduction

L'évaluation et le traitement des céphalées chroniques constituent un défi clinique pour les intervenants et les chercheurs en psychologie de la santé. De ce groupe relativement hétérogène de céphalées, un type spécifique a particulièrement retenu l'attention des chercheurs dans la dernière décennie: la céphalée d'origine médicamenteuse (COM). Les données disponibles suggèrent qu'environ 1% à 2% des personnes souffrant de céphalées dans la population en général (Diener, 1993), et de 5% à 10% des personnes consultant une clinique spécialisée présentent ce type de céphalées (Diener & Tfelt-Hansen, 1993).

La COM constitue une forme évoluée de céphalée épisodique primaire, comme la migraine (65% à 85% des cas selon Diener & Tfelt-Hansen, 1993 et Granella et al., 1987) qui, avec l'augmentation progressive de la consommation de médication symptomatique, devient plus fréquente, sévère et réfractaire aux traitements pharmacologiques et non-pharmacologiques reconnus (Diener, 1993; Mathew et al., 1982; Silberstein et al., 1994). Parallèlement à cette transformation, une céphalée non-pulsative de faible intensité apparaît généralement entre les épisodes de céphalées primaires et peut se chroniciser jusqu'à devenir quotidienne (Mathew et al., 1987).

La consommation excessive et chronique de médication, principalement des agents analgésiques non-narcotiques, narcotiques et sédatifs, semble constituer le principal facteur de transformation de la céphalée épisodique en céphalée chronique (Mathew et al., 1982; Mathew, 1993). Dans une étude rétrospective, Micieli et al. (1988) ont pu démontrer que 72.9% d'un échantillon de personnes souffrant de COM consommaient de façon excessive des analgésiques lors de la transformation de leurs céphalées épisodiques en céphalées chroniques. Toutefois, la régularité de la consommation excessive de médication semble être plus importante que la quantité dans le processus de chronicisation

et d'aggravation de la céphalée (Silberstein et al., 1994; Wilkinson, 1988).

Considérations diagnostiques

L'évaluation des céphalées est généralement guidée par les critères diagnostiques en vigueur depuis 1988 (Headache Classification Committee of the International Headache Society, 1988). Toutefois, le système actuel de classification des céphalées présente des lacunes importantes en rapport avec le diagnostic de la COM. En effet, plus de la moitié des patients présentant des céphalées chroniques ne peuvent recevoir un diagnostic pour leurs céphalées si les critères de l'IHS sont appliqués de façon stricte (Silberstein et al., 1994). Ces constats ont amené plusieurs auteurs à proposer de nombreuses corrections à la classification actuelle (Diener, 1993; Manzoni et al., 1995; Silberstein et al., 1994; Wilkinson, 1988).

Il existe une variabilité importante entre ces différents auteurs dans les propositions de critères diagnostiques de la COM. Ces propositions se distinguent selon que l'accent est placé: (a) sur les caractéristiques de la médication (e.g., Silberstein et al.) ou des céphalées (e.g., Manzoni et al.); (b) sur la sévérité (e.g., IHS, 1988) ou la chronicité de la consommation excessive de médication (e.g., Silberstein et al.); (c) sur le nombre de jours où les céphalées sont actuellement présentes (e.g., Wilkinson) ou sur l'évolution temporelle des céphalées (e.g., Manzoni et al.); ou (d) sur la présence de céphalées de rebond suite au retrait de la médication (e.g., Diener, Wilkinson). Bien que ces différentes propositions soient généralement appuyées par un ensemble d'observations cliniques et empiriques, aucune d'elles ne semble avoir été adoptée à l'unanimité par la communauté scientifique. Les qualités métriques de ces différents ensembles de critères devront donc être étudiées empiriquement avant de pouvoir produire des recommandations spécifiques sur le diagnostic de la COM.

L'approche non-pharmacologique dans le traitement des COM

Deux études cliniques ont jeté les bases de l'intervention non-pharmacologique auprès des personnes souffrant de COM. Dans une étude classique réalisée auprès de 100 personnes souffrant de COM, Kudrow (1982) a observé que l'introduction d'une prophylaxie pharmacologique efficace pour le traitement des céphalées épisodiques (amitriptyline), sans modification de la consommation initiale d'analgésiques, était associée à une réduction de 30% des céphalées alors que le retrait des analgésiques à l'externe sans support pharmacologique suivi par l'introduction de l'amitriptyline était associé à une réduction moyenne de 72% des céphalées. Cette étude a clairement démontré que le retrait de la médication consommée de façon excessive constitue un prérequis au succès du traitement des COM.

Les travaux de Mitchultka et al. (1989) ont permis d'illustrer l'impact de la consommation excessive de médication sur l'efficacité d'un protocole standard de traitement non-pharmacologique de la COM. Plus spécifiquement, ces auteurs ont observé que 29% des sujets ($n = 51$) présentant une consommation initiale élevée d'analgésiques (ie., plus de 6 comprimés d'analgésique par jour) ont obtenu une réduction cliniquement significative (plus de 50%) de leurs céphalées suite à un programme non-pharmacologique comprenant la relaxation, la bioréaction et la thérapie cognitive, comparativement à 5,5% des sujets ne présentant aucune consommation excessive de médication. Ces données suggèrent qu'une approche non-pharmacologique standard pour les céphalées épisodiques présente une efficacité réduite auprès de cette population. De plus, elles permettent de répliquer et de généraliser les observations de Kudrow (1982) aux populations de personnes qui optent pour un traitement non-pharmacologique de leurs COM.

A notre connaissance, seulement quatre études ont été publiées sur l'efficacité des stratégies

non-pharmacologiques dans le traitement de la COM. Elles sont présentées ci-dessous selon leur approche expérimentale (étude de cas vs. étude de groupe contrôlée). Six études supplémentaires utilisant des stratégies non-pharmacologiques (e.g., relaxation, bioréaction thermique, diète) rencontrent ces critères mais n'ont pas été présentées dans la présente revue pour diverses raisons, dont le fait que l'enseignement des stratégies non-pharmacologiques n'était pas systématique mais au libre choix des cliniciens ($n = 2$ études), les interventions combinaient des stratégies pharmacologiques et non-pharmacologiques ($n = 3$ études), et le sevrage de la médication était assisté d'un protocole pharmacologique de désintoxication ($n = 2$ études).

Les études de cas

Dans une première étude, Blanchard et al. (1992) ont assigné 8 participants souffrant de COM (définies selon les critères de Michultka et al., 1989) à un programme séquentiel de traitement comprenant un retrait graduel des analgésiques sans support pharmacologique, suivi d'un protocole non-pharmacologique de gestion des céphalées, incluant un entraînement à la relaxation, de la bioréaction thermique, et une thérapie cognitive répartis sur 8 à 16 séances individuelles (8 semaines). Le retrait de la médication, réalisé sur une période de 4 semaines, est accompagné de l'entraînement à la relaxation afin de diminuer les symptômes physiologiques et psychologiques associés au sevrage, dont les céphalées de "rebond". Deux autres participants ont reçu toutes les composantes de ce programme administrées de façon parallèle. A la fin du programme, 4 participants (40%) de la première condition et 2 participants (100%) de la seconde condition présentent une réduction cliniquement significative (plus de 50%) de leurs céphalées. De plus, 40% des participants ont réduit de façon significative (plus de 50%) la quantité d'analgésiques consommée. Ces gains thérapeutiques sont maintenus une année après la fin du traitement. Cependant, 4 participants (40%), tous assignés à la première condition (i.e., administration séquentielle

du retrait et du traitement), ont abandonné le programme pendant le retrait des analgésiques.

Dans une seconde étude, Ivers et al. (1996) ont assigné 5 femmes souffrant de COM telles que définies par Wilkinson (1988) (i.e., des céphalées présentes plus de 20 jours par mois associées à une consommation d'analgésiques plus de 20 jours par mois) à un programme de traitement comprenant le retrait graduel des analgésiques sans support pharmacologique accompagné d'un entraînement à la bioréaction de 7 séances individuelles réparties sur deux mois. Parallèlement à l'apprentissage de la bioréaction thermique, les participantes avaient pour instructions de réduire progressivement leur consommation d'analgésiques suivant leur rythme personnel. A la fin du programme, toutes les participantes ont réduit d'au moins 50% leur consommation d'analgésiques, et 60% d'entre elles présentent une réduction cliniquement significative de plus de 80% de leurs céphalées. Après 6 mois, 66% des participantes ont conservé leurs gains thérapeutiques.

Les études de groupe contrôlées

Dans une première étude contrôlée (Scharff & Marcus, 1994), un groupe de participants ($n = 12$) souffrant de céphalées chroniques réfractaires aux traitements pharmacologiques, physiologiques et psychologiques reconnus et consommant de façon excessive des analgésiques, reçoivent un programme de traitement en groupe réparti sur 5 semaines (15 heures) comprenant de l'éducation, une diète, de la physiothérapie et un entraînement à la relaxation et à la gestion du stress. De plus, ces participants reçoivent pour instructions d'interrompre leur consommation d'analgésiques durant le programme et aucun support pharmacologique n'est offert pour contrôler les symptômes associés au sevrage. Le groupe contrôle est composé de 10 sujets rencontrant les mêmes critères diagnostiques mais n'ayant pu participer au programme. A la fin du programme, 67% des sujets du groupe expérimental et 25% des sujets du groupe contrôle présentent une réduction cliniquement significative (plus de 50%)

de leurs céphalées. De plus, 70% des sujets du groupe expérimental ont réduit d'au moins 50% leur consommation d'analgésiques. Le taux d'abandon du programme est inférieur à 10%, et les gains thérapeutiques semblent maintenus au suivi (délai moyen de 7 mois) pour la majorité des sujets du groupe expérimental.

Dans une seconde étude contrôlée (Mathew et al., 1990), plus de 200 patients souffrant de COM sont répartis aléatoirement en 5 conditions expérimentales. Seules deux conditions sont pertinentes à la présente discussion. Dans la première, les participants reçoivent comme instructions de poursuivre leur consommation régulière d'analgésiques et sont assignés à un programme non-pharmacologique de traitement des céphalées, d'une durée de 3 mois, comprenant une diète sans tyramine et caféine ainsi que 10 séances hebdomadaires d'entraînement à la bioréaction thermique et musculaire (EMG) avec pratique quotidienne à la maison. Les participants de la deuxième condition reçoivent pour instructions d'interrompre subitement leur consommation d'analgésiques sans aucun support pharmacologique avant de débiter le même programme, une approche de sevrage très similaire à celle employée par Kudrow (1982). Les résultats démontrent que plus de 50% des participants de la deuxième condition ont quitté le programme avant la fin, mais ceux qui ont terminé le programme de traitement présentent une réduction moyenne de 58% de leurs céphalées. Les participants de la première condition présentent un taux d'abandon moindre (10%) mais obtiennent des gains thérapeutiques significativement plus modestes, soit une réduction moyenne de 21% des céphalées. Aucune donnée de suivi n'est disponible afin d'évaluer le maintien des gains thérapeutiques.

Sommaire des études et recommandations cliniques

Dans un programme de traitement non-pharmacologique, le retrait de la médication sur une base externe sans support pharmacologique semble aider de 30% à 100% des participants souffrant de

COM à réduire leurs céphalées chroniques et leur consommation excessive d'analgésiques à court et à moyen terme. Cependant, des taux d'abandon élevés sont rapportés durant la période de sevrage, variant de 40% à 55% des participants (Blanchard et al., 1992; Kudrow, 1982; Mathew et al., 1990). Ainsi, l'ensemble des données suggère que le sevrage des analgésiques est une condition nécessaire à la réduction des céphalées mais difficile à remplir lorsque réalisé à l'externe sans support pharmacologique pour une proportion significative de personnes souffrant de COM (Kudrow, 1982; Mathew et al., 1990). Conséquemment, même si des bénéfices thérapeutiques importants peuvent être obtenus grâce à un traitement non-pharmacologique (Blanchard et al., 1992; Mathew et al., 1990; Scharff & Marcus, 1994), une difficulté majeure demeure : environ la moitié des personnes souffrant de COM sont incapables de compléter le prérequis que constitue le sevrage afin de pouvoir s'engager dans le programme de traitement non-pharmacologique pour acquérir les habiletés nécessaires à une gestion plus efficace de leurs céphalées.

Cette conclusion est principalement appuyée par des études portant sur l'efficacité des protocoles séquentiels de traitement, où le retrait de la médication doit être complété avant l'administration du traitement non-pharmacologique. Cette conceptualisation de l'intervention auprès des personnes souffrant de COM semble provenir essentiellement de l'application des principes de gestion pharmacologique de la COM inspirés des premiers travaux de Kudrow (1982). Appliqué en milieu hospitalier et assisté par un arsenal pharmacologique relativement complexe et coûteux (Lake et al., 1993), ce type de protocole présente une efficacité clinique appréciable (voir Diener & Tfelt-Hansen, 1993, pour une revue). Toutefois, le modèle conceptuel sous-jacent à cette intervention (i.e., le sevrage doit précéder l'intervention) ne semble pas directement compatible avec une approche non-pharmacologique de la gestion des COM, tel que démontré par les réductions modestes de céphalées et les taux d'abandon importants durant

le sevrage (Blanchard et al., 1992; Kudrow, 1982; Mathew et al., 1990).

Les protocoles de traitement combinant parallèlement le retrait de la médication et l'apprentissage de stratégies non-pharmacologiques de gestion des céphalées présentent des résultats cliniquement supérieurs aux protocoles séquentiels, tout en étant associés à des taux d'abandon pratiquement nuls (Blanchard et al., 1992, pour 2 patients; Ivers et al., 1996; Scharff & Marcus, 1994). Malgré les limites des données actuelles, il apparaît que le choix d'un protocole de traitement de la COM, comprenant simultanément le retrait graduel de la médication et l'administration d'un programme non-pharmacologique de gestion des céphalées, devrait être privilégié. En fait, le principal défi clinique posé par cette population, historiquement identifiée comme réfractaire aux traitements non-pharmacologiques (Michultka et al., 1989; Penzien & Rains, 1995), demeure l'élaboration d'un programme d'intervention qui maximise la probabilité que le patient complète à la fois le retrait de la médication et le traitement non-pharmacologique, tout en présentant un rapport coûts-bénéfices intéressant (Gauthier et al., 1996).

Conclusion

Actuellement, l'approche utilisée par la majorité des cliniciens pour le traitement de la COM est la désintoxication en milieu hospitalier assistée d'un support pharmacologique (Diener & Tfelt-Hansen, 1993). Toutefois, l'administration d'un tel protocole s'étend sur plusieurs jours et représente des coûts directs et indirects importants pour les individus et les compagnies d'assurances (Lake et al., 1993). Le développement de protocoles similaires en clinique externe a permis de réduire significativement ces coûts (Robbins, 1995), mais ce type de traitements demeure onéreux et accessible à une minorité de patients. Il est donc impératif de développer des traitements non seulement efficaces mais aussi accessibles à la majorité des personnes souffrant de COM.

Selon nous, un des principaux obstacles au développement de la recherche clinique dans ce domaine est l'absence d'un modèle théorique permettant d'intégrer les observations physiologiques, psychologiques et sociales sur le développement et le maintien de la COM. Certaines données publiées récemment suggèrent que la consommation excessive d'analgésiques constitue en fait une stratégie inefficace de gestion de la douleur et de la détresse émotionnelle associée aux limitations vécues en raison des céphalées chroniques (Kaiser et al., 1993). De plus, quelques études supportent l'existence d'une relation significative entre plusieurs facteurs psychologiques comme, par exemple, un lieu de contrôle externe associé aux céphalées, une appréhension élevée de vivre de la douleur, et une faible perception d'efficacité personnelle à gérer cette douleur, et la consommation excessive d'analgésiques chez les personnes souffrant de céphalées chroniques (Kaiser et al., 1993; Primavera & Kaiser, 1994; Thibodeau et al., 1998). Conséquemment, l'identification de facteurs psychologiques et physiologiques associés au développement et au maintien de la consommation excessive d'analgésiques devrait, à notre avis, constituer une voie de recherche prioritaire afin de permettre l'élaboration de modèles et de protocoles d'intervention basés sur une conceptualisation biopsychosociale de la COM.

Références

Blanchard, E.B., Taylor, A.E., & Dentinger, M.P. (1992). Preliminary results from the self-regulatory treatment of high-medication-consumption headache. Biofeedback & Self-Regulation, 17, 179-202.

Diener, H.-C. (1993). A personal view of the classification and definition of drug dependence headache. Cephalalgia, 13(suppl. 12), 68-71.

Diener, H.-C., & Tfelt-Hansen, P. (1993). Headache associated with chronic use of substances. Dans J. Olesen, P. Tfelt-Hansen, &

K.M.A. Welch (Eds.), The Headaches (pp. 721-727). New-York: Raven Press.

Gauthier, J., Ivers, H., & Carrier, S. (1996). Nonpharmacological approaches in the management of recurrent headache disorders and their comparison and combination with pharmacotherapy. Clinical Psychology Review, 16, 543-571.

Granella, F., Farina, S., Malferrari, G., & Manzoni, G.C. (1987). Drug abuse in chronic headache: A clinico-epidemiologic study. Cephalalgia, 7, 15-19.

Headache Classification Committee of the International Headache Society. (1988). Classification and diagnostic criteria for headache disorders, cranial neuralgias and facial pain. Cephalalgia, 8(suppl. 7), 9-96.

Ivers, H., Gauthier, J., Roberge, C., Thibodeau, C., & Monfette, M.-E. (1996). Le traitement non-pharmacologique de la céphalée induite par l'abus d'analgésiques : une étude de 5 cas. Résumés des communications du XIX Congrès Annuel de la Société Québécoise pour la Recherche en Psychologie, 167.

Kaiser, R.S., Primavera, J.P., & Schwartz, A.L. (1993). Perceived competence and fear of pain as contributory factors in analgesic rebound headache. Headache, 33, 270-271.

Kudrow, L. (1982). Paradoxical effects of frequent analgesic use. Advances in Neurology, 33, 335-341.

Lake, A.E., Saper, J.R., Madden, S.F., & Kreeger, C. (1993). Comprehensive inpatient treatment for intractable migraine : a prospective long-term outcome study. Headache, 33, 55-62.

Manzoni, G.C., Granella, F., Sandrini, G., Cavallini, A., Zanferrari, C., & Nappi, G. (1995). Classification of chronic daily headache by

- International Headache Society criteria: limits and new proposals. *Cephalalgia*, *15*, 37-43.
- Mathew, N.T. (1993). Chronic refractory headache. *Neurology*, *43*(suppl. 3), S26-S33.
- Mathew, N.T., Kurman, R., & Perez, F. (1990). Drug induced refractory headache : Clinical features and management. *Headache*, *30*, 634-638.
- Mathew, N.T., Reuveni, U., & Perez, F. (1987). Transformed or evolutive migraine. *Headache*, *27*, 102-106.
- Mathew, N.T., Stubits, E., & Nigam, M.P. (1982). Transformation of episodic migraine into daily headache : Analysis of factors. *Headache*, *22*, 66-68.
- Micieli, G., Manzoni, G.C., Granella, F., Martignoni, E., Malferrari, G., & Nappi, G. (1988). Clinical and epidemiological observations on drug abuse in headache patients. Dans H.-C. Diener & M. Wilkinson (Eds.), *Drug-Induced Headache* (pp. 20-28). Berlin: Springer.
- Mitchultka, D.M., Blanchard, E.B., Appelbaum, K.A., Jaccard, J., & Dentinger, M.P. (1989). The refractory headache patient-II. High medication consumption (analgesic rebound) headache. *Behaviour Research and Therapy*, *27*, 411-420.
- Penzien, D.B., & Rains, J.C. (1995). Nonpharmacologic treatment of recurrent headache: A review of the literature characterizing refractory patients. *Headache*, *35*, 303.
- Primavera, J.P., & Kaiser, R.S. (1994). The relationship between locus of control, amount of pre-admission analgesic/ergot overuse, and length of stay for patient admitted for inpatient treatment of chronic headache. *Headache*, *34*, 204-208.
- Robbins, L. (1995). Intravenous DHE and cost saving. *Headache*, *35*, 50.
- Scharff, L., & Marcus, D.A. (1994). Interdisciplinary outpatient group treatment of intractable headache. *Headache*, *34*, 73-78.
- Silberstein, S.D., Lipton, R.B., Solomon, S., & Mathew, N.T. (1994). Classification of daily and near-daily headaches: Proposed revisions to the IHS criteria. *Headache*, *34*, 1-7.
- Thibodeau, C., Gauthier, J., & Ivers, H. (1998). Facteurs psychologiques associés à la consommation excessive d'analgésiques chez les personnes souffrant de céphalées d'origine médicamenteuse. Mémoire de maîtrise non-publié, Ecole de Psychologie, Université Laval.
- Wilkinson, M. (1988). Introduction. Dans H.-C. Diener, & M. Wilkinson (Eds.), *Drug-Induced Headache* (pp. 1-2). New-York: Springer.

“Non-Compliance”: Meaningful Construct or Destructive, Sticky, Stigmatizing Label?*

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My aim in this paper is to critically review the construct of 'compliance/adherence' in terms of published research and my own clinical experience.

The '[non-]compliance' construct: The term 'compliance' has its origins in ancient times and gained currency within a medical context earlier this century. Essentially, it means obeying the doctor's orders. Several criticisms of the concept have been made.

The construct of 'compliance' emerged in an ethos associated with dependence, paternalism and a hierarchical relationship between doctor and patient - in which the doctor presumed, and was presumed, to know what was best for the patient and simply issued orders or commands (and prescriptions). More recent alternative terms include 'adherence' and 'concordance' (Royal Pharmaceutical Society of Great Britain, 1997), both of which suggest greater equality in the doctor-patient relationship - but both of which, like 'compliance', are susceptible to three further criticisms.

First, all of these terms strongly imply that self-management of disease is both unifactorial and unidimensional. The research literature, however, clearly indicates that self-management of disease is multifactorial, with performance on each set of self-care tasks being essentially independent of that on others (e.g. Glasgow *et al.*, 1987/95; Goodall and Halford, 1991; Johnson *et al.*, 1986/90; Orme and Binik, 1989; Schafer *et al.*, 1983). Results from two exemplar studies are summarised in Table 1.

Second, all of these terms necessitate the provision of detailed, behaviourally specific instructions for self-management ... and yet, at least until recently, there has typically been little (supervised) training in self-management skills.

Table 1: Self-care tasks in ESRF (CAPD treatment)

Self-management tasks	Frequency
Weight recording	Daily
Adjusting dialysis regime according to weight	As necessary
Performing peritoneal dialysis bag exchanges safely	4 x daily
Care of peritoneal dialysis catheter exit site	Alternate days
Maintaining oral fluid restrictions	All the time
Maintaining alertness to symptoms of: dehydration, fluid overload, peritonitis, exit site infection	All the time
Maintaining necessary dialysis supplies	Monthly
Regular visits to hospital CAPD clinic	1-4 monthly
Eating a healthy diet (sufficient diet and protein)	All the time
Taking prescribed medication (Anti-hypertensives, phosphate binders, calcium supplements)	As prescribed

Third, any term based on instruction ('compliance') or agreement ('concordance') in a health care context inevitably privileges the position of one health care professional. At a time when most people with a chronic illness typically have contact with various health care professionals (e.g. dieticians, physiotherapists *etc.*), the viability of such a model *demand*s: inter-professional agreement, excellent communication, and consistency in advice giving.

Behaviours involved in self-management of disease: Tables 2 and 3 summarise the key self-care tasks for continuous ambulatory peritoneal dialysis and home haemodialysis patients respectively. Quite clearly, both forms of treatment entail complex and demanding regimes of self-management behaviours. Self-management includes periodic, specific behaviours (e.g. checking catheter exit site, maintaining dialysis supplies, clinic attendance), through more frequent, specific behaviours (e.g. carrying out peritoneal dialysis bag changes safely, taking prescribed medications, adjusting dialysis regime according to weight), to continuous, routine self-care tasks (e.g. maintaining alertness to signs of problems, keeping to fluid restrictions, eating a healthy diet). These self-management behaviours are likely to vary in their perceived intrusiveness according to factors such as employment status, family/social support, comorbidity and mood.

Table 2: Self-care tasks in ESRF (Home haemodialysis treatment)

Self-Management Tasks	Frequency
Performing haemodialysis as required	Thrice weekly
Adjusting dialysis regime according to weight	As necessary
Sending pre-/post-dialysis blood samples to hospital	Three-monthly
Care of vascular access	Alternate days
Maintaining dietary and oral fluid restrictions	All the time
Maintaining alertness to symptoms of: dehydration, fluid overload, access infection, bleeding or clotting	All the time
Maintaining necessary dialysis supplies	Monthly
Regular visits to hospital haemodialysis clinic	1-4 monthly
Eating a healthy diet (sufficient protein and fibre)	All the time
Taking prescribed medication (anti-hypertensives, phosphate binders, calcium supplements)	As prescribed

Assessment problems in published research: Research into self-management of disease has been plagued by problems with the measurement of self-management behaviours. A wide variety of assessment approaches have been used, including self-report methods (e.g. interviews, self-completion questionnaires, daily diaries), pill counts, biological proxy measures and electronic monitoring or 'event recording'.

Self-report techniques, although still widely used, typically overestimate self-management behaviours by a significant margin. Pill counts or pharmacy refills are also liable to manipulation, for the purposes of 'looking good' (e.g. pills being disposed of prior to measurement). Biological proxy measures are also suspect e.g. being prone to the effects of individual differences in drug metabolism. Whilst electronic monitoring offers the most reliable and valid assessment approach, the main disadvantage is its expense, making it impractical (at present) for routine clinical and research purposes. Finally, a growing number of studies have used multiple assessment methods, with the most frequent conclusion being that there is little agreement between different measures of self-management behaviours (Rushe *et al.*, 1997).

Table 3: Intercorrelations of self-management behaviours (in IDDM patients)

Self-care behaviours	Blood glucose testing	Symptom reporting	Safety
Weight control	.00(n=41)	-.18(n=36)	.02(n=40)
Blood glucose testing		.17(n=36)	.05(n=40)
Symptom reporting			.16(n=32)
Safety			

source: Orme C.M. and Binik Y.M. (1989) Consistency of adherence across regimen demands. *Health Psychology*, 8(1), 27-43

Glasgow *et al.* (1989) report correlations between scores on a self-report measure assessing self-care behaviours amongst 127 people with NIDDM in four domains: i) diet; ii) exercise; iii) blood glucose testing; and iv) medication taking.

Correlations amongst self-care composite scores ranged from -.18 to .31, with a mean of $r = .06$

Popular theoretical models developed to account for self-care behaviours:

The Health Belief Model (Becker, 1974; see figure 1) has dominated the recent literature on disease self-management. The HBM proposes that health behaviour is determined by a person's perception of their *susceptibility* to a health problem, their perception of the *seriousness* of the condition, the perceived *benefits* and *costs* involved in taking preventative action, as well as (external or internal) cues to action. However, there has been little consistency across studies using the HBM either in terms of the operationalisation of constructs or in outcomes, and the proportion of variance in self-management behaviours predicted is typically rather small (e.g. 17% [Everett *et al.*, 1993]).

Figure 1 Health Belief Model (after Becker, 1974)

Perceptions / Modifying factors	Assessments	Behavioural Intentions
Demographic variables (age, sex, ethnicity, etc)		
Sociopsychological variables (Personality, social class, peer and reference group pressures, etc.)	Assessed sum of PERCEIVED BENEFITS Minus	
Structural variables (Knowledge about the disease, prior contact with the disease, etc.)	PERCEIVED BARRIERS For preventive action	
PERCEIVED SERIOUSNESS and SUSCEPTIBILITY		LIKELIHOOD OF ACTION
CUES TO ACTION (Mass media campaigns, advice from others, reminder postcard from physician, newspaper or magazine article, etc.)	PERCEIVED THREAT of illness or injury	

One more recent and highly influential conceptual approach is Leventhal *et al.*'s (1980) Self-Regulation Model. The SRM's starting point is patients' illness representations, which are structured around five elements: I) Identity (What is it?); ii) Course (How long will it last?); iii) Cause (What caused it?); iv) Treatment (Can it be controlled or cured and, if so, how?); and v) Consequences (How will it/has it affected me?).

In the context of self-management of disease, an SRM approach combines individual patients' illness and treatment representations in order to predict, understand and (where appropriate) attempt to influence self-management behaviours. The SRM has been used successfully to account for the relatively low rates of consistent self-medication amongst people with hypertension. This phenomenon is primarily attributed to the Identity component of illness representations, since hypertension is essentially asymptomatic.

The SRM can be extremely valuable as a conceptual foundation for clinical interventions within clinical health psychology and I will illustrate its application in the Case Studies to follow. In the first Case Study, the critical issue involved Mary's largely accurate but over-simplified treatment representation i.e. that (all other things being equal) improved blood glucose control would be bought at the price of weight gain. Addressing this directly, negotiating a tolerable level of weight gain and making clear that subsequent weight management would be possible - without surrendering her glycaemic control - via reduced caloric intake and/or increased caloric output, constituted the effective intervention. In Case Study 2, two issues dominate - notably Sally's misrepresentation of her hypertension and her anticipation of 'unpleasant' side-effects of anti-hypertensive medication, as well as a doctor-patient interactional dynamic centred around attributed "non-compliance" and "irresponsibility". My intervention involved negotiating a trial of taking her anti-hypertensive tablets with Sally.

CASE STUDY 1: Mary K.

Mary is a 40 year old married woman, with insulin-dependent diabetes mellitus (IDDM), who was referred due to consistent hyperglycaemia i.e. blood sugar levels well in excess of the 'normal' range (4-7mmol/l). As a likely consequence of Mary's poor glycaemic control, she had developed sight-threatening retinopathy, kidney damage and autonomic neuropathy.

Mary was diagnosed with IDDM at the age of 22 years, soon after the birth of her daughter. She reported having been "chubby" as a child and was frequently teased at school. Weight loss is one of the diagnostic markers of insulin-dependent diabetes and Mary, who is 1.68 metres in height, weighed only 38 killogrammes when she was diagnosed. Eighteen months after starting insulin, Mary reached her peak (non-pregnant) weight of 67 kg. Over the past 15 years, her weight had been at a relatively stable 57 kg and her blood glucose had been consistently high.

Mary obtained scores of 11/21 and 10/21 respectively on the Anxiety and Depression subscales of the HADS indicating moderate 'case/clinical' anxiety and 'borderline' depression. At the end of her assessment and, given that improving her glycaemic control whilst maintaining her current calorie intake would mean taking more insulin and gaining some weight, she was asked what weight gain would be reasonably tolerable for her. Mary indicated that she would be willing to gain up to 3½ kgs. In view of her progressive diabetic complications, she expressed strong intentions to improve her glycaemic control. In collaboration with the referring physician, Mary was encouraged to gradually increase her insulin dose with the aim of keeping her blood sugars largely within the 'normal' range.

She was seen on only three occasions, after assessment, over a 4-month period. During this time, she achieved her aim of normalising her blood glucose levels via increasing her insulin dose and her glycosylated haemoglobin (HbA1c) results improved markedly. She did gain exactly 3½ kgs and, in view of feeling considerably better - both physically (less tired, more energetic) and psychologically (more in control), indicated that she was happy with this. The HADS was readministered and her Anxiety and Depression scores at discharge were 2/21 and 1/21 respectively - both well within 'normal' limits.

CASE STUDY 2: Sally C.

Sally is a 20 year old woman with end-stage renal failure on Unit haemodialysis treatment. She was referred by a consultant nephrologist as a result of "non-compliance" with her medication, particularly anti-hypertensive tablets.

Sally had been under the care of the Renal Unit for several years. She had recently left home and was living with her boyfriend. She had already had two miscarriages and a termination. Sally was described as 'not very bright', 'difficult', 'a young girl' (i.e. irresponsible?) And 'obsessed with the prospect of children'. The psychologist's formulation centred on two elements. First being treated as irresponsible "non-compliant" adolescent, and thus largely deprived of responsibility for self-management, created a self-fulfilling prophecy effect in Sally. Secondly, there were some predictable inaccuracies in her illness representations.

In common with many hypertensives, Sally believed that she could tell when her blood pressure was up on the basis of symptomatology (e.g. a pounding headache) and that her condition (hypertension) was absent except when this symptom occurred. Sally also expressed a belief that taking her medication regularly would lead to unpleasant side-effects. During her last pregnancy, she had also stopped her anti-hypertensive tablets altogether during the early part of the pregnancy and only resumed taking them (on strong medical advice) when her blood pressure rose substantially. She suffered a miscarriage two weeks later and, not surprisingly but almost certainly incorrectly, attributed this to resuming her medication.

The psychologist negotiated with Sally a one month trial period of consistently taking her medication. This period was judged to be long enough both to test out Sally's anxieties about side-effects and to develop taking her anti-hypertensive tablets as a habitual behaviour, but not too long to prevent her from giving her consent. The situation would be reviewed at the end of this period.

One month later, a clear change in Sally's general attitude towards self-management, and in her illness and treatment representations, was evident. She reported that none of the side-effects she had anticipated had actually materialised. She also noted "feeling better". Her blood pressure readings at clinic appointments were significantly better than they had been for several years. There was also a notable change in medical and nursing attitudes and behaviour towards Sally, with her being increasingly treated as a responsible, agentic adult. She had also begun using contraceptives in order to prevent further pregnancies and stated that she had become realistic about having children.

Broader contextual factors in self-management

Three sets of broader influences bear mentioning:

- *Extent to which HCPs follow treatment protocols in their dealings with patients.*
- *Evidence of treatment efficacy.*
- *Family, social and cultural influences.*

Glasgow *et al.* (1995) outline their 'practical working model' of diabetes management and education in terms of four sets of contextual variables: i) community and larger social context; ii) neighbourhood and family context; iii) patient variables (beliefs, self-efficacy); iv) clinic context (patient-provider interactions etc).

Viewing "non-compliance" in terms of prejudice/stereotyping:

"Non-compliance" is a thinly disguised evaluative term - equivalent to disobedience. My clinical observations, based on doctor-patient interactions as well as discussions between doctors and patients' reports, lead me to conclude that unwarranted assumptions about patients' self-management behaviours are common. These focus on the assumption of unifactoriality (i.e. that if self-management behaviour is less than perfect in one respect, that this indicates universally poor self-care). "Non-compliance" provides a convenient means by which to blame the patient/victim for any subsequent health problems encountered. A key feature of applying such an evaluative label is the communication of *disapproval*. The application of such a label is *destructive* because it creates animosity, is guaranteed to sour the doctor-patient relationship and to reduce patient satisfaction (a reliable predictor of self-management behaviours; Ley and Llewelyn, 1995). It can also become a self-fulfilling prophecy - mediated by the psychological construct of *reactance* - whereby the patient reasserts their agency, control and freedom, in response to a perceived restriction of choice, by purposefully *disobeying* instructions. This label is *sticky* because, once applied, it is difficult to remove. After this term has appeared in the patient's medical notes, it offers a professionally-absolving/victim-blaming excuse for subsequent difficulties. Finally, this label

is *stigmatizing* because of its negative, evaluative overtones.

Conclusions: As can be seen from Table 4, Sherbourne *et al.* (1992) demonstrated quite clearly that previous/initial levels of 'adherence' were by far the best predictor of subsequent self-management behaviours in their diabetes, hypertension and heart disease samples. This argues strongly for urgent studies to test the value of interventions targeted at enhancing self-management at this critical time point, with medium- to long-term follow up to evaluate the efficacy of these interventions.

Table 4: Regression coefficients for antecedents of disease-specific 'adherence'

	Diabetes	Hyper-tension	Heart disease
Initial adherence	0.64	0.50	0.56
Heart disease	-	0.05	-
Health distress	-	-0.08	-
Satisfaction with technical quality	-	-	-0.15
Social support	0.10	-	-
Education	-	-	0.17
Age < 45 years	-	-0.15	-0.15
Adjusted R ²	0.46	0.35	0.32

source: Sherbourne C.D. *et al.* (1992)

In conclusion, "non-compliance" is a *mythical* construct because it assumes that self-management behaviours in chronic illness are *unidimensional* and that there is a consistency in self-care across different aspects of the treatment regimen. This assumption is strongly contradicted both by (reflective) common sense and by the research evidence. The continued usage of this term indicates that it serves a function for those health care professionals who still employ it - probably due to

"non-compliance" providing a means by which to blame the patient/victim for untoward medical outcomes.

Health care professionals, patients and researchers would be better served by the more realistic term *self-management behaviours*. The vast majority of people with a chronic illness display effective self-care with regard to some aspects of their treatment regimen, and less effective self-care on other aspects. From a psychological perspective, the aim should surely be to build on and develop each person's strengths whilst recognising that effective self-management of disease is a complex and demanding challenge.

References

- Becker MH (1974) The health belief model and personal health behavior. *Health Education Monographs*, 2, 324-508.
- Everett KD, Sletten C, Carmack C, Brantley PJ, Jones GN & McKnight T (1993) Predicting non-compliance to fluid restrictions in hemodialysis patients. *Dialysis and Transplantation*, 22, 614-621.
- Glasgow RE, McCaul KD & Schafer LD (1987) Self-care behaviors and glycemic control in type I diabetes. *Journal of Chronic Disease*, 40, 399-412.
- Glasgow R.E. *et al.* (1989) Diabetes social learning variables and self-care behaviors amongst people with type II diabetes. *Health Psychology*, 8(3), 285-303
- Glasgow RE, Toobert D, Hampson S & Wilson W (1995) Behavioral research on diabetes at the Oregon Research Institute. *Annals of Behavioral Medicine*, 17(1), 32-40.
- Goodall TA & Halford WK (1991) Self-management of diabetes mellitus: a critical review. *Health Psychology*, 10(1), 1-8.
- Johnson SB, Silverstein J, Rosenbloom A, Carter R & Cunningham W (1986) Assessing daily management in childhood diabetes. *Health Psychology*, 5(6), 545-564.
- Johnson SB, Tomer A, Cunningham W & Henretta J (1990) Adherence in childhood diabetes: results of a confirmatory factor analysis. *Health Psychology*, 9(4), 493-501.
- Leventhal H, Meyer D and Nerenz D (1980) The common sense representation of illness danger. In S Rachman (ed.) *Contributions to Medical Psychology*, vol. 2; chapter 1, pp7-30. Oxford: Pergamon Press.
- Ley P & Llewelyn S (1995) Improving patients' understanding, recall, satisfaction and compliance. In A. Broome & S. Llewelyn (eds) *Health Psychology: Processes and Applications*, 2nd edtn; chapter 5, pp75-98. London: Chapman & Hall.
- Royal Pharmaceutical Society of Great Britain (1997) *From Compliance to Concordance: Towards Shared Goals in Medicine Taking*. London: RPS.
- Rushe H, McGee H, Sheil K and Keogh B (1997) Association of psychosocial factors and dietary adherence in haemodialysis patients. *British Journal of Health Psychology* (in press).
- Schafer LC, Glasgow RE, McCaul KD and Dreher M (1983) Adherence to IDDM regimens: relationship to psycho-social variables and metabolic control. *Diabetes Care*, 6, 493-98.
- Sherbourne CD, Hays RD, Ordway L, DiMatteo MR & Kravitz RL (1992) Antecedents of adherence to medical recommendations: results from the Medical Outcomes CStudy. *Journal of Behavioral Medicine*, 15(5), 447-468.
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Support of Health Psychology by the Heart and Stroke Foundations of Canada

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It is well known that cardiovascular diseases are the leading causes of death in western societies. In Canada in 1995, 79,117 deaths were attributed to cardiovascular disease, representing approximately 37% of all deaths (Heart Disease and Stroke in Canada, 1997). When age at death is taken into account, this class of diseases was responsible for approximately 204,000 potential years of life lost for men and 90,000 for women in 1995 (Heart Disease and Stroke in Canada, 1997).

Research and practice related to heart disease and, to a much lesser extent, stroke have been arguably the most active areas to which health psychologists internationally have devoted their attention. Knowledge that cardiovascular diseases have a number of empirically well-established and controllable behavioural risk factors such as cigarette smoking and sedentarity has made it natural that health psychologists would be drawn to this area. Suspicion and evidence that emotional factors such as stress and anger play a role in the development of heart disease and the triggering of cardiac events have fueled basic research into the psychological and physiological processes through which this might take place. As a chronic disease, with a long development period the prospect that early interventions may significantly postpone the onset of clinical disease has provided the impetus for evaluations of primary prevention programs. Increasing rates of survivorship following clinical events, though comforting, raise the psychosocial issues of emotional adjustment, risk factor control and quality of life.

In Canada, basic and applied research in cardiovascular disease is supported by a variety of agencies such as the Medical Research Council, Health Canada through the National Health Research Development Program and other initiatives, provincial funding agencies such as the BC Health Research Foundation and the provincial Heart and Stroke

Foundations. Although many agencies are involved in the issue, it is the Heart and Stroke foundations that provide the bulk of support for this work. In British Columbia, for example, 82% of the research being conducted into cardiovascular disease is funded by the Heart and Stroke Foundation of B.C. and Yukon. Nationally, in 1997, the Heart and Stroke Foundations invested approximately \$38 million in research. The foundations also play a major leadership role in health promotion, public awareness of issues relating to cardiovascular disease prevention and treatment and advocacy for healthy public policy. Health psychologists have been actively involved in each of these areas.

The Heart and Stroke Foundations are provincially-based, volunteer-driven organizations in which each provincial foundation is responsible for fundraising, health promotion and financial support of research. There is an overarching national organization, the Heart and Stroke Foundation of Canada, which is responsible for, among other things, advocacy on the national scene, and the co-ordination of the scientific peer-review process for Grants-in-Aid of research and a number of personnel support awards. Proposals for research in health psychology are vetted by a committee that reviews applications in the areas of behavioural research, nutrition, community interventions, health education and health promotion, one of eight standing peer review committees. This committee functions according to the same principles that operate in the other scientific areas (e.g., electrophysiology, clinical trials) and has been chaired by a health psychologist for the past 9 years.

For longer than that time, the support of research and other endeavors in the behavioural sciences has been a focal issue for the Foundations. This has largely been a consequence of the impact of the health promotion movement of the 1980's, which brought an increased appreciation of the importance of behaviour and social determinants of health for the prevention and control of

cardiovascular disease, the emergence of psychosocial epidemiology with its identification of new, prospective risk factors for cardiovascular disease and research into the fundamental mechanisms by which psychological events affect cardiovascular processes. It is safe to say that the topic of support of behavioural research by the Foundations has generated considerable debate both within and external to the organization. In the early 1980's, that debate revolved around whether behavioural research was even supported by the Foundations. By the later 1980's that debate had shifted to the question of what is the optimal role for the Foundations in the support of such research? Responses to this question by the provincial and national Foundations have resulted in several initiatives.

In 1991, the Canadian and Ontario Heart and Stroke Foundations collaborated with several partners, including the National Cancer Institutes of Canada, the University of Calgary and the Alberta Heritage Foundation for Medical Research to support the First National Conference on Behavioural Research in Cancer and Cardiovascular Disease, held in Banff, Alberta. This conference brought together a number of Canadian and international researchers and interested parties working in the areas of health psychology, health promotion, and epidemiology to share the findings from their research and to make recommendations to the sponsoring organizations concerning priorities for support of research in behavioural aspects of cardiovascular disease and cancer. The recommendations arising from this meeting are available in a report on the conference (Campbell, Maunsell, Prkachin, Stam, Till & Wielgosz, 1991).

In 1992, the Heart and Stroke Foundation of Ontario, as part of its strategic review process, identified enhancing capacity for research into the behavioural aspects of cardiovascular disease as one of its principal goals. One of the programs through which this goal was operationalized was a special postdoctoral award in behavioural research related to cardiovascular disease.

Also in 1992, the Heart and Stroke Foundation of Canada, in partnership with the Canadian Cardiovascular Society convened the Canadian Task Force on Cardiovascular Science. The goal of the Task Force was to consider the state of all aspects of research into cardiovascular disease in Canada and to make recommendations concerning strategic directions in which the Foundation, Society, government and the private sector could move to enhance research in

cardiovascular science and improve cardiovascular health. Health psychologists participated in a panel on prevention of heart disease. The recommendations of the Task Force at large were published in a special issue of the *Canadian Journal of Cardiology*, in 1993 and those of the prevention science working group can be found in McLean, Brunt & Prkachin (1993) within that issue.

In the area of professional practice in health psychology, the Foundations have also collaborated with the Canadian Register of Health Service Providers in Psychology (CRHSPP) to support their initiative to develop the capacities of practicing psychologists in providing preventive and other services to people at risk of cardiovascular disease. Part of this initiative involved support of a symposium at the 1993 Annual Meeting of the Canadian Cardiovascular Society.

In summary, the Heart and Stroke Foundations have been actively involved in a number of initiatives that relate to the interests and activities of health psychologists. In the realm of health psychology research, this has resulted in a steady increase in the number of investigators and projects supported by the Foundations. In the realm of professional practice the Foundations have been involved in supporting CRHSPP's ventures in the area of cardiovascular disease prevention. In the realm of public education and healthy public policy, many of the initiatives supported by the provincial and national Foundations are informed by the ideas and expertise of health psychologists. I have personally been involved as a volunteer with the provincial and national Foundations in a number of areas pertaining to research, health promotion and advocacy and have found my experience both personally and professionally rewarding.

Further information on the programs of the Heart and Stroke Foundations of Canada can be found at their web-site (www.hsf.ca).

References

- Campbell, H.S., Maunsell, E., Prkachin, K., Stam, H.J., Till, J & Wielgosz, A. (1991). Final report of the organizing committee on the results of the conference "Behavioural research in cancer and cardiovascular disease."
- Heart Disease and Stroke in Canada 1997 (1997). Ottawa: Heart and Stroke Foundation of Canada.
- MacLean, D.R., Brunt, H. & Prkachin, K.M. (1993). Prevention working group--final report. *Canadian Journal of Cardiology*, 9, 724-728.

CANADIAN PSYCHOLOGICAL ASSOCIATION ANNUAL CONVENTION, EDMONTON, 1998

HEALTH PSYCHOLOGY SECTION PROGRAM Salon 13/14, Shaw Conference Centre

Thursday, June 4

8:30 - 10:30

Symposium I

Psychological issues in chronic pain

Convenor: L. Carroll

Presenters:

1. L. Carroll

The prevalence of depression and its relationship to neck and low back pain

2. A. Mercado

Factors associated with coping with chronic pain in a general pain population

3. G. Pancyr

Observational outcomes from an outpatient chronic pain program

10:30 - 11:00

Theory Review I

Psychological aspects of fibromyalgia

Speaker: C. Oke

12:30 - 2:30

Symposium II

Bringing substance abuse into mainstream health psychology

Convenor: P. Dobkin

1. P. Dobkin

Predicting adherence and outcomes in adult substance abuse treatment

2. S.W. Sadava

Problem drinking and health over time

3. R. Cameron

School-based smoking control

4. M. Kirchen

Substance abuse and chronic non-malignant pain

2:30 - 3:00

Theory Review II

Explaining substance abuse among men

Speaker: A.M. Pagliaro

Friday, June 5

- 8:00 - 9:00 Conversation hour
Jobs in health psychology: preparing for the future
Convenor: S. Beugnot
- 9:00 - 11:00 Symposium III
Social influences on pain in children
Convenor: C. L. von Baeyer
Speakers
1. C.L. von Baeyer
Social influences on pain in children: diverse examples and theory
2. P.J. McGrath
The effect of the non-clinical social environment on children's pain
3. K.D. Craig
Impact of parent and clinician judgements of pain
- 9:00 - 11:00 **Poster Session - HALL B**
- 12:30 - 1:00 Theory Review III
Narrative construction of health and illness
Speaker: M. Murray
- 1:00 - 2:00 Section Business Meeting
- 2:00 - 3:00 Section Reception

Letter from the Student Representative/ Lettre de la Representante aux Etudiant(e)s

As student representative for the Health Psychology Section of CPA, I try to address and respond to students' concerns and needs. I am specifically interested in helping students who are planning a career in health psychology to get the information they need in order to facilitate their pursuit. That is why we have put together a conversation session entitled "Jobs in Health Psychology: Preparing for the Future" which will take place on June 5th, 1998 at 8.00am at the CPA convention in Edmonton.

A group of psychologists established in health-related settings and representing a variety of roles within health psychology will come together to discuss several core issues. First, we will discuss expected changes in the health care system and how these changes are likely to affect health psychologists. We will pay specific attention to the kinds of skills/expertise which may be in demand and thus help students plan their training accordingly. A second goal of this conversation will be to provide students with ideas on which settings to approach for jobs and how to approach them in order to create a need for their skills as health psychologists.

Research questions which are likely to become important will also be identified such as the need to show the cost-effectiveness of psychological services in health-related settings. Finally, the panel of psychologists will draw on their own experiences to help identify alternative settings and roles in which health psychologists may make a contribution (for example, being involved in health policy research and development or acting as consultants for Worker's Compensation Boards).

En tant que representante aux etudiants pour la section de Psychologie de la Sante de la SCP, j'ai pour but de repondre aux besoins des etudiants. Je tente, en particulier, d'aider ceux qui veulent pratiquer la psychologie dans des domaines relies a la sante en leur donnant l'information necessaire afin d'atteindre ce but. C'est pourquoi nous avons organise une seance de conversation ayant pour titre "Jobs in Health Psychology: Preparing for the Future" qui aura lieu le 5 juin 1998 a 8.00 am a la convention annuelle de la SCP a Edmonton.

Un groupe de psychologues etablis dans divers domaines relies a la sante et jouant differents roles en tant que psychologues discutera de certains enjeux. Tout d'abords, nous discuteront des changements qui prennent place dans le systeme desante et l'impact de ces changements sur notre profession. Nous tenterons en particulier d'identifier la formation et l'expertise qui seront necessaires aux psychologues travaillant a l'interieur du systeme de sante. Ceci aidera les etudiants a planifier leur formation pour repondre aux besoins du marche du travail. Un autre but de cette conversation sera d'identifier divers milieux de la sante dans lesquels les psychologues de la sante peuvent jouer un role. De plus, nous discuterons des moyens d'approcher ces divers milieux, de creer un besoin pour nos services, et de prouver l'importance de notre contribution.

La discussion portera aussi sur les sujets de recherche qui seront en demande et auxquels nous devons etre en mesure de repondre tel que le besoin de prouver l'efficacite de nos services, particulierement, au point de vue financier. Pour terminer, nos invites se serviront de leur propre

experience pour parler des divers roles que peuvent jouer les psychologues de la sante a l'exterieur du

I would like to encourage all those interested in attending this session to contact me and let me know what questions they have which they would like us to address in addition to the issues outlined above. Our panel of psychologists will also make some time at the end of the session to answer questions from the audience

The health psychology section has also become interested in creating a mentoring program whereby students who seek advice and information about health psychology would be put in contact with psychologists established in the field. We do not know yet how this program would function and we are at a stage where input from students would be very useful. Specifically, we would like to hear about students' needs and what they would like to get from a mentor in order to help us answer questions such as i) what kind of information would be sought from a mentor, ii) how frequently would students need to contact their mentor.

I encourage all those with comments or questions to contact me at beugnot@server.uwindsor.ca. I greatly value students' input as it helps me represent students moreadequately within the section.

milieu hospitalier (par exemple, dans la planification et le developement des programmes de sante ou en tant que conseillers pour divers groupes).

J'aimerais encourager tous ceux qui pensent se joindre a nous lors de cette seance de conversation de me contacter avec leurs questions ou commentaires auxquels ils voudraient que nos invites repondent. Les psychologues invites seront aussi en mesure de repondre aux questions du public apres la seance de conversation.

La section de Psychologie de la Sante est en train de developper un programme de conseillers qui aurait pour but de faire le lien entre etudiants et psychologues deja etablis dans la profession afin de donner aux etudiants interesses une source d'information/conseil en rapport avec la psychologie de la sante. Nous commencons tout juste de developper ce programme et la participation des etudiants a ce stade-ci serait grandement appreciee. En particulier, nous voudrions avoir vos commentaires sur les questions suivantes: a) quel genre d'information les etudiants rechercheraient-ils d'un conseiller?, b) combien de fois par annee serait-il necessaire de contacter le conseiller?

J'encourage tous les etudiants a me contacter avec leurs questions et commentaires a beugnot@server.uwindsor.ca. J'apprecie vos commentaires/conseils car ils me permettent de mieux représenter les interets des etudiants.

Sophie Beugnot

Canadian health psychology: a tale of ten issues

Michael Murray

Memorial University of Newfoundland

When I first decided in the summer of 1992 to establish a section newsletter I had little idea of who was who and what was what within Canadian health psychology. It was partly this ignorance which encouraged me to establish the newsletter - surely there were many other health psychologists across the country who were working in relative isolation and did not know what their colleagues in other universities and hospitals were doing.

In the first issue I set out the aim of the newsletter "to promote the interests of health psychologists throughout Canada by providing a forum for ideas and information about research, teaching and practice". Readers who peruse the index of the past ten issues can judge to what extent this has been achieved.

Simply counting the authors - almost 100 people have written something in the pages of the newsletter. Most of these were section members but many were not. Hopefully, this has increased members awareness of the activities of the large number of psychologists both within and without the section who are interested in psychological aspects of health and illness.

In terms of topics - there were three special issues on Psycho-oncology, Child health psychology, and HIV/AIDS. There were also articles on pain, addiction, diabetes, asthma, complementary medicine, community health, and illness biographies. In each of these areas health psychologists in Canada have made a substantial contribution.

However, without financial support such research is difficult if not impossible. Members need to be aware of the changing sources of support available for research. For this reason I was pleased to include reports from members on potential sources of support within the National Cancer Institute of Canada and the Heart and Stroke Foundation. Section members play an important role within these and other research organizations. The recent expansion of the remit of the Medical Research Council was welcome news for members. From the outset members have played a central role in the new peer review panels. Future issues will need to consider further how members can access support from these and other foundations.

It is important for members to be aware of the activities of their colleagues in other countries. For this reason I was pleased to include reports on activities from Britain, Australia and Cuba. There was also a report from the European Working Party on Health Psychology and another report on activities within the World Health Organization. Hopefully, these reports enabled members to weigh up how the development of health psychology in Canada compares with that in other countries.

Finally, over 20 books have been reviewed. Often, members restrict their reading to journals. Book reviews provide a means of keeping up to date with broader developments and identifying key sources of information.

I hope the next ten and more issues of the Canadian Health Psychologist will continue to promote the interests of health psychologists throughout Canada

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