

*the
Canadian
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de la santé*

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Editorial
Éditorial

**Academic department
of health psychology**
*Une école académique
de psychologie de la santé*

**Canadian Health
Psychology 1993-1994**
*La psychologie canadienne
de la santé 1993-1994*

Annual Report
Rapport annuel

**Plus a special section on
Child Health Psychology**
*Et une section spéciale sur
la psychologie de la santé
en pédiatrie*

Newsletter of the Health Psychology Section
of the Canadian Psychological Association
Bulletin de la Section de psychologie de la santé
de la Société canadienne de psychologie

The Canadian Health Psychologist/ Le psychologue canadien de la santé

Editor/ Rédacteur en chef: Michael Murray

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.

The newsletter is produced two times a year, Spring and Fall. The deadlines for submission of articles are: Spring issue : 31 March; Fall issue : 31 October.

Individuals who do not belong to the Health Psychology Section may subscribe by sending \$10 (payable to CPA Health Psychology Section).

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 redacteur 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 la santé s'abonner en envoyant 10\$ (payable à SCP Section de la psychologie de la santé).

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This is the third year of publication of the *Canadian Health Psychologist* and I am pleased to note that it is beginning to establish itself as a forum for news about health psychology in Canada. In view of the increased number of submitted articles it may be necessary to increase its frequency of publication.

The current issue confirms the extent of interest in the speciality. It begins with a article describing the significant steps taken by psychologists in creating a separate academic department of clinical health psychology in Winnipeg. This is the first such department in Canada and the creation of a separate academic unit is worthy of further discussion among health psychologists. This article is followed by our annual listing of publications by members which confirms the growth of the discipline.

We are also pleased to include our second special section. This year it is devoted to ongoing research into different aspects of child health. Any members who would like to suggest a special section for next year should get in touch.

This is followed by news about section activities. Members should note the activities planned for the forthcoming annual convention in Charlottetown and make a special effort to attend the Annual Meeting there. Please note that the call for section officers.

The next issue is planned for the fall, if not before.

Le psychologue canadien de la santé entre dans sa troisième année de publication et il me fait plaisir de remarquer qu'il commence à s'établir en tant que forum de nouvelles à la psychologie de la santé au Canada. Etant donné l'accroissement du nombre d'articles soumis pour publication, il se peut que l'on doive dorénavant plus publier fréquemment.

Ce numéro confirme l'ampleur de l'intérêt dans la spécialité. Il débute avec un article décrivant les étapes franchies par les psychologues qui ont créé une école séparée de psychologie clinique de la santé à Winnipeg. La création d'une telle école est une première au Canada et mérite de plus amples discussions parmi les psychologues de la santé. Cet article est suivi de notre liste annuelle des articles publiés de nos membres se qui confirme la croissance de la discipline.

Il nous fait aussi plaisir d'inclure notre deuxième section spéciale. Cette année, cette section est dévouée à la recherche concernant divers aspects de la santé chez les enfants. N'hésitez pas à nous faire parvenir toutes suggestions pour une section spéciale pour l'an prochain.

Il y a aussi des nouvelles sur les activités de la section. Les membres devraient prendre note des activités planifiées pour le congrès annuel qui aura lieu à Charlottetown et sont priés de s'efforcer d'être présent pour la réunion annuelle qui s'y tiendra. Veuillez noter l'appel pour la nomination des officiers de section.

Le prochain numéro devrait paraître à l'automne.

Development of a Department of Clinical Health Psychology

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and
Robert D. McIlwraith
University of Manitoba

Abstract: This article describes a historic organizational initiative taken by psychologists in the Faculty of Medicine in the University of Manitoba. For the first time in Canada they have created a separate academic department of clinical health psychology

Résumé: Cet article décrit une initiative organisationnelle historique adoptée par des psychologues de la Faculté de Médecine à l'Université du Manitoba. Pour la première fois au Canada ils ont créé une école séparé de psychologie clinique de la santé.

In May 1994, over the objection of the Head of Psychiatry, the Faculty Executive Council of the University of Manitoba Faculty of Medicine voted overwhelmingly in favour of separating Psychology from Psychiatry and creating a new department for Psychology in the Faculty of Medicine. This development capped several years of hard work by many psychologists at the medical Governors approved the creation of the Department of Clinical Health Psychology in the Faculty of Medicine. The Dean of Medicine instructed that the new Department commence operation in April, 1995.

The fundamental motivation and objective of psychologists in seeking to create an independent department was to establish an administrative system which would facilitate the greatest possible involvement of Psychology in the broadest possible range of areas related to health care education, research, and clinical service. An appropriate degree of diversity of psychological activities was simply not possible to achieve with Psychology organized as a part of the Department of Psychiatry. In that administrative model, Psychology was expected to first meet the priorities of Psychiatry before it attempted to respond to other areas of health even when the other areas had equally important or even more pressing needs from psychology's perspective.

Need for independence

While an independent department of psychology may not be appropriate or desirable in all circumstances, we believe that there are important structural reasons to establish psychology as an administratively independent entity in most health care settings, even when psychology quite satisfactorily coexists with another host department. We believe that only when psychology is administratively independent is it truly capable of evaluating, prioritizing, and responding in an objective manner to the needs of the increasing diversity of health care areas in which psychological expertise is required. An independent departmental structure also provides the greatest potential to ensure that psychology's interns and other trainees are exposed to the whole range of health care experiences which they will increasingly need to draw upon as independent health care practitioners. When psychology is administratively organized within another department, the requirements of the host department inevitably tend to shape and unduly narrow the focus of the activities of psychology.

We placed particular importance on independent departmental status within the University system because we believe that academic credibility and recognition is the single most important cornerstone in legitimizing and ensuring the viability of health psychology in the long run. This appears to be particularly important with the increasing application of program management to health care facilities. While a programmatic model has considerable theoretical appeal because of its potential to enhance interdisciplinary collaboration, it may well present a serious challenge to academic and clinical initiatives which may be best developed, at least initially or in their infancy, along specific disciplinary lines. It is arguable, therefore, that the capacity to maintain and to further develop health psychology within the current health care system is enhanced by its entrenchment as a formal department within a strong educational system such as a Faculty of Medicine.

History

The process of establishing the Department of Clinical Health Psychology began in 1988 with a comprehensive self-study of the available options for administrative renewal. This approach served to both educate staff as well as to facilitate commitment to a change process. External evaluations of psychology were very helpful in reassuring the medical school that the psychology group was sufficiently mature academically for independent departmental status. Over a four-year period several internal committees were struck at the University and one of the two major teaching hospitals to examine the administrative organization of psychology. Each of these committees ultimately concluded that an administratively independent department for psychology was appropriate. A secret ballot of all psychology faculty asking whether we should seek independent department status was unanimous in support of proceeding with this initiative. Each of these factors played a role in an evolving momentum leading to the eventual creation of the new Department.

In our proposal for departmental status we pointed out that it was natural in the evolution of professions for an evolving health profession like psychology to develop within a host department such as Psychiatry and then go on to form its own independent department. We also noted that prior to World War II psychology's role in health care was quite broadly based and not primarily associated with mental health. It was only after the Second World War that psychological activities tended to become focused around mental health in order to assist soldiers focused suffering from emotional problems related to the war.

With the emergence of the field of Health Psychology, psychology has been increasingly involved with such health care areas as chronic pain, the immune system, cardiovascular risk factors, medication adherence, etc. Thus, it became increasingly clear that psychology had an important role to play in the whole domain of health care. Therefore, it was no longer necessarily appropriate or desirable to organize psychology within any specific host department since this inevitably tends to limit the participation of psychology in the broader health care arena.

In our proposal, we thought it important to point out the significant degree of professional and academic maturity of psychology at the present time. Psychologists are clearly perceived by the public as independent and distinct professionals. In addition, psychology is recognized as an autonomous, self-regulating profession under legislation in every Province and Territory in Canada. Psychology has its own education and training programs to the doctoral and post-doctoral levels and maintains a sophisticated self-governing accreditation process. Psychology has a well

developed and enforced code of ethics and maintains its own learned journals and professional associations.

Prior to concluding that health psychology should be organized as an independent department within the Faculty of Medicine, we examined the advantages and disadvantages of alternative approaches. We considered the possibility of a modified and more mature administrative relationship for psychology within the Department of Psychiatry. We also explored the strengths and weaknesses of amalgamating health psychology with the Department of Psychology in the Faculty of Arts on the main University campus. In the end, we concluded that a modified administrative arrangement with Psychiatry (or perhaps with any other single medical department) would not facilitate a broadly-based development of psychology in health care. Furthermore, primary affiliation with the Faculty of Arts Department of Psychology which is several miles from the teaching hospitals where health psychologist work was seen to be impractical. In addition, the Faculty of Arts did not have extensive experience in operating clinical programmes in applied health care settings.

Present

The academic Department of Clinical Health Psychology at the University of Manitoba consists of 20 full-time psychologists based at two major teaching hospitals in addition to several part-time faculty. The Department head reports directly to the Dean of Medicine and is a full voting member of the Faculty of Medicine Executive Council along with all other basic science and clinical department heads within the Faculty. Our primary academic mission revolves around our clinical psychology internship and post-doctoral training programme. In addition, we actively participate in undergraduate and post-graduate medical education in a variety of departments including Pediatrics, Psychiatry, Internal Medicine, Surgery, Rehabilitation Medicine, Anaesthesia, Family Medicine, etc. Psychologists are also active in the administrative operation of the medical school by participating in and, in fact, chairing important educational committees within the Faculty of Medicine.

Future

We plan in the future to enhance the development of health psychology in the broadest possible manner including activities related to both mental health and general health. We look forward to creative initiatives in making psychological services more available to rural and remote areas of Manitoba through a new Northern and Rural Training Program. We are seeking to develop new and expanded collaborative working relationships with the Provincial Government which we expect will enhance the possibilities for expanded health promotion activities as well

as the greater availability of psychological services in the community. We hope to improve for all Manitobans the accessibility and usefulness of the clinical psychological services provided by teaching hospital psychologists since we are the major source of publicly funded psychological services in the Province of Manitoba. We also intend to work toward striking a more appropriate balance in our internship and residency training programmes between mental health and general health training, between tertiary and primary care experiences and between urban and rural practice. The education and training initiatives are of particular importance to us because we fully recognize the importance of ensuring that the next generation of psychologists is appropriately trained to meet the challenges they will face.

Although these are ambitious plans in times of fiscal restraint, we believe that they are possible to achieve. Although some new resources may be required given that the overall funding for psychology in Manitoba has been quite limited relative to other health professionals, we believe that much progress is able to be achieved through a more appropriate utilization of existing resources. Our optimism about the possibility for constructive change is fuelled by the fact that the creation of the new Department of Clinical Health Psychology has enhanced our capacity to work directly with senior administrators in the University, Government, and teaching hospitals. This is expected to facilitate the replacement of outdated and less cost-effective psychological activities with more appropriate and cost-effective initiatives. This renewal process will significantly enhance our capabilities in education, research, and clinical service.

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*Introduction to special section on
Child Health psychology*

Sixty five years ago Anderson (1930) wrote an article in the Journal of the American Medical Association promoting the need for the psychological study of child health. Since then psychologists have gradually become more interested in the topic. Even before health psychology established itself as a separate discipline there was a sustained interest in the psychological dimension of illness in childhood. This was conducted under the name of pediatric psychology. With the rise of health psychology this interest has become more developed.

Ten years ago Health Psychology solicited manuscripts for a special issue on Child Health Psychology. Because of the extent of interest in the topic it was decided to publish a separate volume (Melamed et al, 1988).

In Canada there has been ongoing interest in child health psychology although often conducted by isolated investigators. This special section of the Canadian Health Psychologist provides an opportunity to showcase some of this research. It illustrates the range of perspectives adopted, ranging from experimental style research to more intensive interview based studies.

I would like to thank all the contributors, particularly those who have had to wait so long for their articles to finally arrive in print. Those interested in finding out more about research in this area should note the special symposium on Child and Family Health to be held at this year's annual convention in Charlottetown..

*L'introduction d'une section
speciale en la psychologie de la
sante en pediatrie*

Il y a soixante-cinq ans, Anderson (1930) publia un article dans la "Journal of the American Medical Association" suggérant le besoin d'une étude de la santé en pédiatrie. Depuis cet article, les psychologues sont devenu de plus en plus intéressé à ce sujet. Même avant que la psychologie de la santé s'établisse en tant que discipline séparée, il y avait déjà un intérêt dans l'aspect psychologique de la maladie chez les enfants.

Ce domaine vint à être connu sous le nom de psychologie pédiatrique. Depuis le développement de la psychologie de la santé, l'intérêt dans ce domaine s'est accru.

Il y dix ans, "Health Psychology" sollicitait des soumissions d'articles pour un numéro spécial sur la psychologie de la santé chez l'enfant. Etant donné l'ampleur de l'intérêt pour le sujet, il fut décidé de publier un volume séparé (Melamed et al, 1988).

Il y a eu un intérêt maintenu en psychologie de la santé chez l'enfant au Canada quoique la recherche ait souvent été poursuivie par des chercheurs isolés. Cette section spéciale du Psychologue canadien de la santé permet de faire connaître une partie de cette recherche. Cette section démontre l'étendue de la diversification des perspectives adoptées, allant du style de recherche expérimentale jusqu'à la recherche à base d'interviews intensifs.

J'aimerais remercier tous ceux qui ont contribué à cette section, surtout ceux ont dû attendre si longtemps avant de voir leur article être finalement publié. Ceux qui sont intéressés à obtenir plus d'information au sujet de la recherche dans ce domaine devraient prendre un note la symposium sur la Santé de la famille et de l'enfant qui aura lieu lors du congrès annuel de cette année à Charlottetown.

Michael Murray

Priorities in child health psychology

Barbara G. Melamed

Yeshiva University, New York.

We have made much progress since the agenda we set for ourselves in 1989 (Drotar et al., 1989). High priority child health research issues: adherence to pediatric medical regimens; child health promotion, especially infant and prenatal maternal health care; family influence on child and adolescent health and disease; and stress and coping in childhood illness have been well established successes (LaGreca et al. 1992). Now is the time to extend our concepts of stress and coping to societal problems such as mobilizing the disadvantaged family (Tarnowski, 1991). We need to learn how to better use school and community resources for health education and to train your youth in parenting skills.

Survivors

There are three areas of child psychology that have important implications for health and need our involvement: pain, poverty and survival. Concomitant with the reduction of infectious diseases and improvement in medical technology, we are seeing children who are survivors of previous "terminal" illnesses. These children are dealing with compromises that chronic illness impose upon them directly, on care providers including parents, siblings, and primary care professionals. Yet, we are still unable to measure or adequately manage their pain.

Pain

Pain associated with medical treatments are often done without proper analgesia (Weisman and Schechter, 1991). Health child abuse, i.e. subjecting children to repeated bone marrow aspirations without proper analgesic, shares many similarities with child abuse. The unnecessary pain resulting from these practices, often inflicted over a period of years by a sanctioned agent (parent or doctor), exacerbate a child's pain and increases the burden of illness for all concerned. Soon we will have advanced information through genetic testing that a child just born may inherit AIDS, cystic fibrosis, or juvenile diabetes. When this fact is revealed with little we can do to change the course of events, we have an even more protracted period of chronic stress.

Violence

In addition, societal problems involving poverty and violence impact on the average child, directly or vicariously several times a day. It has been shown that children can develop PTSD by hearing about violence occurring to others they might know (Saigh, 1991). In the inner city, Afro-American youngsters are habituating to everyday violence. Instead of our obsession with "repressed memories" we should attempt to deal with how these traumas are processed at the time. Several psychologists have not turned attention to how inhibited memories of traumatic experience have long term links with impaired health and actual disease (Pennebaker, 1989). A research scheme of looking at painful medical memories has been put forth by Steward (1993). Malignant memories in children exposed to school violence have been found to relate to emotional states and lead to physical illness (Schwarz & Kowalski, 1991).

The leading causes of death among children are accident, abuse and injury, not asthma, heart disease or cancer. Family violence poses serious risk factors for children. In the U.S. it is estimated that over 1.5 million are harmed or endangered by such violence. Levels of violence are higher in single-parent families (greater poverty), and that the prevalence of child maltreatment increases steadily with age, with teenagers at highest risk. Our colleagues are beginning to provide solutions. Lizette Peterson, of the University of Missouri has elucidated a cognitive-developmental model linking unintentional child injury to abuse-neglect research (Peterson & Brown, 1994).

We know that psychological factors are associated to somatic presentation in more than 47% of the children seen in general pediatric clinics (Garralda & Bailey, 1990). We also know that less than 2 percent of children and adolescents in the United States in any year get seen by mental health professionals (Burns, Taupe, & Taupe, 1990). As members of the task force for DSM-IV - primary care physicians, I and other child health psychologists helped refine the categories for pediatricians (American Academy of Pediatrics, 1995) child and adolescent disorders which serve as codes for billing. These recognize environmental and familial stressors as compromising children's health. Environmental factors may include: immediate household, extended family, neighborhood, community and cultural context.

Problems influencing children's mental and physical functioning include acute stressful events, such as the witnessing of violence; chronic circumstances such as marital discord or living in poverty; and conditions have both immediate impact and enduring effects such as the death of a parent. Protective and risk factors are also emphasized, including health, temperament, cognitive status, sociability, family resources, and access to community and health resources. Hopefully the underidentification of these problems will be rectified by the pediatric guidelines for primary care physicians.

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Pain in children and adolescents: The work of the Pain Research Lab in Halifax

Patrick McGrath
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Abstract: Over the past five years a program of research into various aspects of pain in children has been established in Halifax. This article summarizes the details of this program.

Résumé: Au cours des cinq dernières années, un programme de recherche étudiant divers aspects de la douleur chez les enfants a été établi à Halifax. Cet article résume les détails de ce programme

Our research on pain in children is carried in two research labs, one at the IWK Children's Hospital and one at the Department of Psychology, Dalhousie University. Much of our research is interdisciplinary and we are developing collaborations across Canada and in other countries. Although research is the major focus of our work, there is also a strong commitment to education (both professional and public) and to clinical service. This brief article will outline some of our work that is currently underway.

Interdisciplinary research

The major interdisciplinary collaborations include those with Dr. Allen Finley who is an anesthetist at the IWK and Dalhousie and with Dr. Judith Ritchie, the Director of Nursing Research at the IWK and Professor at Dalhousie University. We are also collaborating with a wide variety of

other health professionals at the IWK Hospital. We have also developed collaborative relationships with psychologists at U.B.C, the University of Saskatchewan, and the University of Utrecht, dentists at Marquette University, physiotherapists at University of Ottawa and University of Southern Alabama, and biomedical engineers at Aarhus University.

Our clinical research focusses primarily on three areas. The first is on how parents manage pain. The second is children's coping mechanisms with pain. Finally, we are investigating measures of children's pain.

Role of parents

Although parents are most frequently responsible for postoperative pain in their children, little is known about parent's attitudes and behaviour about their children's pain. We have found that even when parent's recognize that their children are in pain, half do not give their children analgesics to help them. Even though most families have a wide range of over-the-counter analgesic medication in their homes, and they use these medications often, they also have an inaccurate understanding of pain medication. For example, about 30% of parents believe that tolerance will develop for acetaminophen and 15% fear addiction from acetaminophen.

In a recent randomized trial, we found that an educational program in the form of a booklet about children's pain (Pain Pain Go Away) was effective in changing parent's attitudes about pain medication but did not substantially change parent's medication giving.

In another study, we have found that the failure to control pain at home is paralleled by the failure of health professionals to control pain in the hospital. We found that children report they have suffered significant pain while in hospital and that often nobody helped them. Most children were prescribed little medication and they were given very little of what they were prescribed.

Measurement

Measurement of pain has long been an important aspect of our research. We have developed two behavioral measures that are based on molar behaviours such as grimacing, body movements and limb movements. We are now developing two additional scales. In conjunction with Ken Craig and his lab at U.B.C. we are developing a Children's Facial Action Scale for children aged 1-8 years. This work is based on the pioneering work on neonatal pain measurement by Grunau and Craig. We are also developing a measure of long term pain using changes in social and appetitive behaviour which parents use to determine if their child is in pain.

Developmental and epidemiological research

Developmental and epidemiological research is the focus of our research that is located at Dalhousie. Our developmental psychology research is funded by the Social Sciences and Humanities Research Council. This work includes observational studies of children's behaviour in response to everyday pain, surveys of parental behaviour towards children experiencing everyday pain and experimental studies in which children are tested on their understanding of pain. These studies have no direct clinical applications but they may help us understand early processes that may explain later clinical problems.

The occurrence and correlates of everyday pain have been examined in a series of studies in which we observe children while playing in daycare. We have found that children had incidents about once every three hours.

Our studies on children's understanding of pain are carried out in their homes. We have found that children understand the cause of pain and learn how to comfort themselves and others long before previously thought possible. We believe our findings are due in part to the more sensitive methods we have used in interviewing children and the fact that we have used parental diaries and interviewed children in their own homes where they feel most comfortable.

Parents' responses to everyday pain have been studied by using self report of what they do when their children hurt themselves. We are currently doing validity studies on this scale.

Education

The pain lab has undertaken public education ventures. Making Cancer Less Painful is a handbook for parents who have children with cancer. It has been distributed free of charge by a drug company (Astra) to all parents of children with cancer in Canada and the USA. There are French, English Canadian, American, Italian, Swedish and Norwegian editions. Pain, Pain, Go Away is a booklet for parents of children in hospital which was published and distributed by the Association for the Care of Children's Health during Children in Hospitals week this past year.

In terms of professional education, we are now completing the second edition of Pain in children and adolescents which was originally published in 1987. This greatly expanded and completely updated text summarizes the literature on the entire area of pain in children. Our edited book, Pain in Neonates gathered the knowledge on neonatal pain into an accessible format.

In collaboration with an anesthetist/basic scientist in England, we are writing a series of interactive computer modules to teach students and professionals about pain. There will be one basic science module and three clinical modules.

Service

The IWK Children's Hospital has just set up a Pain Service. We anticipate that this multidisciplinary service will play a major role in improving pain management in children in our hospital. It will also provide the venue for increasing the opportunities to teach about pain and to undertake clinical research.

Resources

We have been extremely fortunate in receiving research funding from governmental agencies. In the last few years we have made a concerted effort to pursue research support from drug companies as well as the more traditional funding agencies. We have been moderately successful in this effort but the lack of commercial applications in pediatric pain has made our task difficult.

Our research efforts have been dependant on the very high quality of graduate and undergraduate students that have worked in the pain research lab. Students from psychology, medicine and nursing have participated in our work. Our students provide a level of sophistication, energy and commitment that is remarkable. Many of our students publish research throughout their time as students in our lab. Currently there are 4 Ph.D. students in psychology, 3 medical students/residents and 3 undergraduate students working in our lab.

Conclusion

We will continue to try to engage in both non-clinical and clinical research. We believe that there is a dearth of basic science knowledge in the psychology of pediatric pain. Developmental psychologists, animal behaviour psychologists, behavioral neuroscientists and cognitive psychologists could make important contributions to this field. Although the amount and quality of clinical research in pediatric pain has increased in recent years, there is much to be done.

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Recurrent Abdominal Pain in Children

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Abstract: This paper outlines the character, etiology and treatment options for children with recurrent abdominal pain. Clinical vignettes are used to illustrate treatment plans.

Résumé: Cet article décrit la nature, l'étiologie, et les options de traitement de la douleur abdominale répétitive chez les enfants. Des vignettes cliniques sont utilisées pour illustrer des plans de traitement

When the benefit of the scalpel can be achieved just as well by simply applying a sticking-plaster across the navel, the latter procedure is definitely to be preferred (Moro, 1913, trans. by C.L. von Baeyer).

Moro's article, written in Heidelberg before World War I, described a series of 18 children between the ages of 4 and 14 who suffered from recurrent abdominal pain (RAP). Moro considered the majority of children with such pains to be "neuropathic" and hypersensitive, but he also felt that they were highly responsive to suggestive (nonspecific) treatments such as the umbilical Bandaid.

After 80 years of research and the publication of at

least 200 articles, chapters, and monographs addressing psychological factors in RAP, we know a little more, though the condition remains a fascinating puzzle. Several recent reviews and overviews are of special interest to health psychologists (Feuerstein & Dobkin, 1990; Hodges & Burbach, 1991; McMahon, Harper, & Cruikshank, 1990; Routh, Ernst, & Harper, 1988; Sammons, 1988; Walker, Garber, & Green, 1993). A practical guide for management of RAP by primary care physicians was provided by P.J. McGrath (1983). A very helpful overview of common recurrent pain syndromes and their management can be found in a chapter by P.A. McGrath (1990).

Epidemiology. How common is RAP? Several epidemiological surveys have been done (e.g., Apley, 1975; Oster, 1972). They usually define RAP as three or more episodes of pain occurring over at least three months within the past year, and sufficiently severe as to interfere with normal activities (Apley & Naish, 1958). The syndrome, defined this way, appears to exist in at least 5 percent and as many as 25 per cent of school-age children at any given time. The incidence peaks around the age of 9 years; several studies find a higher incidence in girls than boys after age 10 and a marked decline in incidence after age 15. These prevalence estimates suggest that each regular Canadian elementary school classroom has, on average, as many as three or four children who suffer from frequent stomach aches.

Organic factors. While there are around 100 known medical causes of abdominal pain (Levine & Rappaport, 1984), the vast majority of children with RAP—at least 90%—have none of these known conditions. Among the many possible organic explanations for RAP, recent interest has focused on the following: constipation and motility of the gut; gastric infection by *Helicobacter pylori*, a bacterium which plays a role in ulcers; parasites such as *Giardia*; lactase deficiency; and autonomic instability. However, no single organic cause has ever been shown to account for even a significant minority of cases of RAP. Moreover, the simple presence of one of these conditions does not necessarily explain why the child experiences abdominal pain, since some people have each of these organic conditions without painful symptoms. Since most cases of RAP are unaccounted for by known physical causes, they are likely to be considered psychogenic by health care providers, whether or not there are other signs of psychopathology (Barr & Feuerstein, 1983).

Psychological factors. Do children with RAP show other signs of emotional disturbance? The classic view was that children with RAP are "high strung" or "hypersensitive." Although children with RAP tend to be more anxious than healthy children, they are no more anxious than children who

have abdominal pain with an identified physical cause (Hodges, Kline, Barbero, & Woodruff, 1985; Walker & Green, 1989). There is little evidence for increased depression in most children with RAP, though those referred to mental health professionals sometimes do present as depressed. Other psychological factors which have been studied in relation to RAP include: modelling, stressful life events, difficulty in completing the developmental tasks of latency age, reinforcement of pain behaviour, and family dynamics in the so-called psychosomatic family. However, single-cause psychological explanations of RAP fare no better than the organic explanations: no single psychological condition can be linked to more than a small minority of cases. Thus, Barr & Feuerstein (1983) have emphasized that most cases of RAP are neither organic nor psychogenic. Barr and Feuerstein propose a third category called "dysfunctional" comprising the majority of all cases of RAP in which the pain is understood to be caused by normal physiological processes, not by physical or psychological illness.

As we have seen above, it is difficult to make any valid generalizations about either physical or psychological disorders in children with RAP. Nevertheless, the psychologist can often provide significant help to the child and family distressed by RAP. In the following sections, I provide brief summaries of some of the mechanisms often seen in the development and maintenance of RAP symptoms, together with case examples from my clinical experience.

Stressful events and anxiety. Both anticipated and unexpected unpleasant events can trigger episodes of abdominal pain. Sexual abuse has also been noted as a cause of anxiety in some cases of abdominal pain. Concrete steps to alleviate the stress, such as changes in school program and intervention to stop abuse, as well as training in stress management skills, are helpful targets for consultation by the psychologist.

Ellen, age 14, had missed two months of school due to abdominal pain. She was brought to the emergency room with an acute exacerbation of her pain about 3 hr after she received a phone call from a school administrator telling her that the truant officer would be called in.

Precipitating vs. maintaining factors. Abdominal pain may start with an acute illness (e.g., overeating, 'flu', blow to the abdomen) but continue as a result of psychological factors after the original physical problem is resolved.

Joanne, 9, went swimming in a lake which her mother subsequently learned was contaminated with the Giardia parasite. Her parents were involved in bitter disputes leading to marital separation. By the time Joanne's stomach aches were assessed by a gastroenterologist, there was no evidence of parasitic infection, but the mother remained convinced that this was the initial cause.

Modelling. The child's behaviour seems to mirror that of a parent or other relative, who may have a painful gastrointestinal condition him- or herself. The psychologist may be able to help the parent to see the link between their own behaviour and the child's, and to tone down their own expressions of pain.

Ellen, age 14, was worried about her father who had had cancer of the colon. Her abdominal pain gradually became worse despite his successful recovery following surgery.

Avoidance learning. The pain symptoms may be maintained because the child is able to avoid an unpleasant activity or responsibility by complaining of pain. The psychologist may be able to help parents set reasonable behavioural limits on this way of escaping from responsibility.

Jerry, 10, learned that his father would do his early-morning newspaper route for him if Jerry said he hurt and felt sick when he woke up.

Maintenance of intimacy. The pain symptoms may serve the function of eliciting caring and nurturance from a parent. The psychologist may reframe the misdirected attention as evidence of parental caring, and then help the child and parent to find alternative sources of emotional support.

Kenny, 10, was the son of an unemployed single mother. They were new to town and both felt lonely and isolated. Kenny was not allowed to cross the street by himself to go to school or visit friends. He and his mother frequently had arguments which ended with Kenny getting a stomach ache and then being cuddled by his mother.

Temperamental sensitivity. Sometimes parents identify RAP as part of a pattern of fussiness. The psychologist may be able to help with acceptance of the child's special needs, ensuring that not too many demands are placed on the child.

Annie, age 7, was a colicky baby and had asthma as well as RAP. Her parents described her as prissy, perfectionistic, and shy and said she had "no pain threshold." She had abdominal pain and vomiting only during mornings at school, when she had to do a lot of reading and writing.

Anxiety as a consequence of RAP. Pain impairs concentration, and this may particularly affect school work. Many children with RAP are very receptive to relaxation training, guided imagery, and hypnosis as ways to relieve pain and anxiety and to restore concentration.

Pain vs. handicap. In most cases, there is little relationship between pain and the social or academic impairment attributed to the pain. Improvement may occur in functional behaviour such as school attendance without reported change in the pain. The situational and temperamental factors which maintain the handicap may be quite different from those which underlie the pain itself. Thus, return to school is often a major goal for psychological intervention, whether or not the pain can be successfully altered.

Parents' attributions for RAP. In a followup study of 55 patients seen a year earlier for RAP by a pediatric gastroenterologist (von Baeyer & Bruce, 1994), we found that the most common causes perceived by parents for their children's pain episodes were stress (especially about social and academic difficulties at school) and sensitivity to certain foods. Most parents had accepted reassurance that there was no serious medical cause, but the original problem persisted in over two-thirds of the children. To deal with parents' continuing concerns about possible medical disorders, the psychologist can suggest (a) that medical reassessment be done at regular 6- to 12-month intervals; (b) in addition, that the child be taken to a physician promptly if any "red flag" organic symptoms occur (e.g., fever, weight loss, bleeding); and (c) that in the meantime the RAP be considered a nuisance rather than a sign of illness, and that the focus be on coping with rather than diagnosing the problem.

Pointers for assessment. As in child clinical psychology generally, it is important to get multiple points of view on a RAP problem: self-report, physicians' notes, interviews with parent and teacher, and perhaps observation in the classroom or on the playground. P.A. McGrath's

chapter on recurrent pain (1990) offers sound advice on assessment procedures.

In brief, the psychologist should identify possible triggers of pain; possible sources of reinforcement for pain behaviour; emotional issues which might be expressed indirectly through pain symptoms; and damaging consequences of the pain for the child and family. The results of the assessment will guide the psychologist toward any of the following forms of intervention, among others: education about the nature of pain; training for the child in distraction, relaxation, guided imagery, or self-hypnosis; parental counselling; consultation with the school; family therapy; or individual therapy.

I have found it rewarding to work with children with RAP because a variety of different psychological interventions can be applied successfully in different cases. Moreover, recurrent abdominal pain provides many fascinating lessons in body-mind issues which are a central focus of clinical practice in health psychology.

Author note

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Parent-Adolescent Discourse: The Study of Health Promotion from an Action Theoretical Perspective

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Abstract: In this article, we describe our current research which addresses health promotion through the study of parent-adolescent discourse about health, highlighting the action theoretical perspective and its methods. This perspective and method are being used to understand the intentional processes present in health and health promotion as constituted in conversations between parents and adolescents in Indo-Canadian and Canadian-born families.

Résumé: Dans cet article, nous décrivons notre recherche actuelle qui examine le promotion de la santé au moyen de l'étude du discours parent-adolescent au sujet de la santé. L'emphase est mise sur la perspective théorique de "action" et ces méthodes. Cette perspective et cette méthode sont utilisées pour comprendre les processus intentionnels qui sont présent dans la santé et la promotion de la santé tel qu'apparent dans les conversations entre parents et adolescents de familles Indo-canadiennes et canadiennes.

It is widely accepted that health behaviours and lifestyle patterns, including decision making and risk taking, that influence health status are learned within the context of the

family. Although the influence of many family variables on adolescent health has been documented, most address unintentional influences. In contrast, our research focuses on intentional, goal-directed action, in the form of conversation and discussions, that parents engage in with their adolescent children in health promotion. This research is based on the assumption that parents intend (plan) to a greater or lesser extent to influence the health decisions and health career of their adolescent children. It also assumes that adolescents, to a greater or lesser extent, look to their parents for assistance in their health decisions and their health career. Clearly, health promotion within the family needs to be seen as a reciprocal and interactional process. Thus, this research addresses parent-adolescent dyad or family group as a unit of active, intentional health promotion.

This research is designed to gain information that enables families' abilities to take control over their health and gain insight into family-based processes that influence health decision making. Not only are there clear differences in the way in which this process (the health influence process between parents and adolescents) occurs both within and across cultures, parenting and parental influence are also culturally bound.

A Social Constructionist Framework

At the most general level, this research is grounded on a social constructionist epistemology and understanding of health. Research in this tradition seeks to link the person's perspective with broader social processes that shape the development of such perspectives. What is unique about social constructionism in the study of human behaviour is its focus on "the continuous flow of communicative interaction between human beings, as they cope with each other in different, everyday circumstances" (Shotter, 1993, p.2), in contrast to attention on either the internal dynamics of the self or the characteristics of the external world. Social construction has been used as a framework for the investigation of several medical and health issues, for example, HIV transmission (Maticka-Tyndale, 1992), premenstrual syndrome (Rodin, 1992), anorexia nervosa (Gremillion, 1992), and keeping healthy (Lundeen, 1989).

A social constructionist perspective on health warrants the examination of health as a cultural construct. Kleinman (1978) is one of several theorists (Chrisman, 1977, 1981; Chrisman & Kleinman, 1983) whose work has documented the influences of culture upon individuals' health beliefs and practices and who has also documented the existence of professional cultures. Kleinman argues that the most important form of clinical reality that remains unexamined is health care problems, transactions, and practices in the context of the family.

Adolescent health is also a social construction that has emerged in this century, particularly in North America (Hill & Fortenberry, 1992). One dimension of the construct of adolescent health is that adolescence is a time of increased health risk (e.g., Dryfoos, 1900; Elliott, 1993).

In this research, it is assumed that the development of health related cognitions, attitudes and behaviours occurs mainly in a social context, often through interaction with trusted, more competent partners. The family has traditionally been thought of as one such important social context. The process of socialization of children has as its outcome the adequate functioning of adults in the social group which includes a number of skills, habits, values and motives that impact directly upon health (Maccoby, 1992).

From a constructionist perspective, the degree of parental influence is based on "the relationship that parents have constructed and continually reconstruct with their children (Maccoby, 1992, p. 1014). The influence between parents and adolescents can be considered reciprocal and interactional; family interaction between the parent and the child about important topics are seen as both shaping the relationship and the individuals within it.

The specific problems of parent-adolescent interaction that pertain to important topics such as health include the balance between taking the adolescent's perspective (providing understanding) and maintaining an adult or parental perspective (providing guidance). As Maccoby (1992) notes, there is little known about the process by which parents can maintain multiple perspectives at the same time. Adolescents may also find themselves maintaining multiple perspectives simultaneously such as fostering the relationship with parents and at the same time resisting overly directive advice.

Action Theoretical Perspective

The method employed in this research is rooted in a theoretical tradition that sees knowledge and meanings as negotiated in interaction. This research allows us to see parental participation in the health decisions and health career of their adolescent children not only in their social and cultural specificity, but as negotiated meaning within families. It is this level of understanding that we see as being applied in subsequent intervention programs addressing health promotion.

The basic assumption of this research is that human behaviour can be profitably analyzed as intentional action. This has emerged as an important paradigm in the study of human behaviour (Bruener, 1986). The study of intentional, goal-directed behaviour used by agents is referred to as

action theory (Cranach, Kalbermatten, Indermuehle, & Gugler, 1982). Specifically, it is assumed that health is a social construct which is goal-oriented and personally and socially monitored within a social context. The context, its tacit meaningfulness, and basic presuppositions play an important role in health and health-related encounters.

In this view, health can be seen as both a long-term and a short-term goal-directed activity. Parent-adolescent discussions about health have relevance for the immediate (for example, an on-going discussion about drinking and driving), and the long term health career.

In this research, the intentional actions in the parent-adolescent dyad or family group relative to health and health behaviour are described. This description is not only contextually sensitive, it is empirically grounded, as actual parent-adolescent conversations about health issues constitute the data base for this study.

Our aim in this research is to describe and explain the organization of concrete, goal-directed action in the form of parent-adolescent conversations about health as they occur in normally in family settings. The approach to action taken in this research can be considered as being composed of three classes of concepts:

- 1) the manifest behaviour itself, which in this case will be the conversation between the parent and the adolescent and which is videotaped,
- 2) the conscious cognitions including the thoughts and feelings that actors have about the action while it is taking place, which is accessed through videotape playback (called the self-confrontation interview),
- and 3) the social meaning that the action has for the participants, which is also accessed through videotape playback (Cranach, 1982; Valach, Cranach, & Kalbermatten, 1988). It is assumed that actions are socially meaningful units. Research has frequently addressed one or other dimension of action without considering all of them simultaneously. In this research, the three dimensions form the data sources.

In addition to addressing the individual action of the participants in the conversation, this research will focus on the ways in which the participants jointly construct knowledge and jointly act under the particular conditions of social purpose and interaction described heretofore, that is, parent-adolescent conversations about health in two ethnocultural groups. In this case we are not only discussing cognitions about social phenomena, we are treating the social processes as cognitions. Furthermore, joint action suggests that persons acting together conjointly construct action--in the case of this research, action regarding health. Goal-directed systems are composed not only of individual actions but also

of joint actions and processes. The shift of the study of the action of the dyad represents an emerging trend in social (Larson & Christensen, 1993) and cognitive psychology (Resnick, 1991), and in other branches of the social sciences such as anthropology (Lave & Wenger, 1991), sociology (Schegloff, 1989), and linguistics.

Analysis

The analysis occurs in two phases, the first is researcher guided, the second involves the validation by the participants.

The basic features of the content analysis method relevant to an action-theoretical approach were outlined by Cranach et al. (1982) and adapted by Young et al. (in press). These methods will serve as a point of departure in developing our own system pertinent to the subject matter of this research. The conversation itself is the basis for the analysis. Cognitive processes and social meaning from the self-confrontation are identified separately and used in the overall analysis of the conversation.

The analysis is based on four hierarchically-related dimensions: intentional framework, goals, functional steps, and expressions. Intentional framework refers to the overall general intention of each participant. The organization of the conversation and its sections are subsequently defined by the goals of the participants themselves. The functional steps refer to the intentional means that persons use to reach their goals. Finally, the individual sentences and phrases (expressions) that are actually used in the dialogue are categorized. Expressions are the actual manifest behaviour one is able to observe in the conversation. Although largely non-conscious, they are subject to self-regulation. In the case of language and text, which is the data set in this type of study, manifest behaviour is represented mainly by linguistic expression.

The specific analyses contribute to the writing of two narratives by the researchers, each written from the perspective of one of the participants. These narratives provide an overview of the whole analysis pertinent to the individual, dyad, and health dimensions. They describe the actions and explain what happened during the conversation and are used with the participants for validation purposes.

Focus of Anticipated Results

Results are anticipated in three areas:

1. The socio-cultural embeddedness of the construction of health and health decision making and the parents' participation in this process will be highlighted in this research which addresses Western and non-Western conceptions of health.
2. It will be possible as a result of this research to conceptualize health as a function of the intentional, goal-directed action and to provide specification and empirical support for such a conceptualization.
3. The participation of parents will allow us to identify group (the parent-adolescent dyad) action in the construction of health and health decision making.

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Unintentional Injuries In Children: Why Do Boys Have More Injuries Than Girls?

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Abstract: This article provides a summary of the various factors which contribute to childhood injuries. It also presents some findings from empirical research which considers sex differences in accident rates.

Résumé: Cet article résumé des différents facteurs qui semblent responsable dans les accidents chez les enfants. On présente aussi des résultats de recherche qui expliquent la différence entre les garçons et les filles concernant les accidents.

In this century we have made great advances in industrialized countries to minimize child deaths due to infectious diseases, poor nutrition, and unsanitary conditions. Surprisingly, in most industrialized countries, including Canada, unintentional injuries now rank as the number one cause of death among children 1 to 14 years of age (Canadian Institute of Child Health, 1994; Wilson et al., 1991). Moreover, epidemiological research has revealed that the majority of injuries do not result from random or chance events (i.e., "accidents"). Rather, many injuries to children could have been prevented, had children or their caregivers made other choices in situations that posed some potential or realized threat to the child's safety. Because of this recognition, the term "injury" has come to replace "accident" in the literature, and there have been numerous recent calls for research on the processes that lead to injury outcomes among children

(e.g., Finney, Christophersen, Friman, Kalnins, Maddux, Peterson, et al, 1993; Roberts, 1993). This has been the focus of research my students and I have conducted over the past few years.

Although unintentional injury is a national health problem that affects the lives of children at all ages, in fact, not all children are equally at risk for injuries. Extensive epidemiological research has revealed many correlates of childhood injuries, including: child impulsivity, child activity level, lack of adult supervision, and a variety of parent characteristics that increase the likelihood of poor supervision, such as depression and excessive stress. The correlate we have been most interested in is child gender. Depending on the injury category, beyond 2 years of age there are anywhere from 2 to 4 times more injuries to boys than girls. Although this alarming statistic has been known for years, we have a very limited understanding of why there are differential injury rates for boys and girls.

In the research we have been conducting we have tried to take a broad-based approach and to examine a number of potential factors that may explain the differential injury rates for boys and girls. These factors can be grouped into three categories: child-based factors, family-based factors, and extra-familial factors. Table 1 provides a listing of the factors within each category that we are examining.

Although our research is not aimed at testing an existing theory per se, our work draws upon a number of viewpoints that span several areas of Psychology, including: Health Psychology (Health Beliefs Model), Social Psychology (Ajzen's Theory of Planned Behavior, Bandura's writings on self efficacy and behavior), and Developmental Psychology (e.g., writings of Goodman, Grusec, and others on parenting beliefs and attitudes, and how these influence socialization and parenting practices). In our opinion, the processes that lead to injury outcomes among children are complex and multidetermined. Consequently, we expect that solutions to reduce injuries will have to be similarly complex, addressing multiple contributing factors (i.e., there is not one determinant of injury risk in children) and operating at multiple levels (i.e., not just aimed at child-based factors or parent socialization practices or peer factors). Based on our results to date, we also expect that to be effective, interventions aimed at preventing injuries will have to differ for girls as compared to boys, and to vary also with the child's developmental level.

Although an in depth analysis of the rationale and scope of our work is beyond the limits of this article, in the remaining sections I discuss of some of our findings on the role of child-based factors in childhood injuries.

Table 1
Factors we are examining and believe to influence risk taking and injury risk in children

CHILD-BASED FACTORS

I) Abilities to Perceive Risk:

- visual analysis skills & selective attention (ability to identify actual risk factors that are present)
- ability to make comparative risk judgments (e.g., which way poses less of a threat to safety)
- ratings of absolute risk levels

II) Beliefs related to risk appraisal:

- bias in belief about injury rate for self relative to injury rates for others (i.e., optimism bias)
- self efficacy beliefs (i.e., beliefs about one's own ability to act to prevent an injury outcome)
- bias in beliefs about severity of potential injuries
- bias in attributions for injuries (e.g., badluck vs self)

III) Cognitive factors:

- conceptualization of "injury" events
- appreciation of cause-effect relations (e.g., injury could result from risk-taking behavior)
- cognitive reasoning skills (e.g., ability to weigh benefits relative to potential consequences)
- problem solving skills (ability to generate alternative courses of action)

IV) Injury history (e.g., frequency, type, severity of injuries):

- likelihood of recall of prior injury experiences

SOME FAMILIAL FACTORS THAT MAY INFLUENCE RISK-TAKING & CHILDREN'S BELIEFS ABOUT INJURY RISK

I) Socialization practices:

- encouragement of/tolerance for risk taking
- emphasis on performance/mastery orientation
- education around safety (e.g., balance of proactive to reactive strategies, nature and extent of education efforts)

II) Belief systems communicated within the family:

- bias in beliefs about likelihood of injuries to the child (optimism or pessimism bias with respect to the child)
- bias in attributions for injuries depending on individual beliefs about how child factors (e.g., age, sex, temperament, etc.) relate to injury risk
- beliefs in preventability of injuries to children (self efficacy)

III) Family modelling:

- active efforts to avoid injuries (e.g., seat belt use)
- examples of risk taking in daily living (e.g., no seat belts)

EXTRA-FAMILIAL FACTORS THAT MAY INFLUENCE CHILDREN'S RISK TAKING AND BELIEFS ABOUT INJURY RISK IN SITUATIONS:

I) Peer influences:

- active (verbal) persuasion efforts
- nonverbal persuasion messages (e.g., fear vs confidence)

- ### **II) Community-based influences (e.g., laws, advertising, prevention programs, publicity about injuries to other children)**

In a large-scale study of 6-, 8-, and 10-year-olds, we (Hillier & Morrongiello, manuscript in preparation) focused on a number of child factors that we believed would be relevant to children's judgments about the degree of risk to their safety posed in a variety of naturalistic situations (e.g., bicycling, play on a slide at the playground). Boys and girls at each age were asked to assign ratings of "risk for injury" to color photographs of children engaging in behaviors that varied from no risk to an excessive risk, to identify factors that contributed to risk in the highest-risk photographs, to generate preventive measures to decrease risk levels in the highest-risk photographs, to complete a measure of their attributions for potential injury outcomes ('internal' or personal-responsibility orientation versus 'external' or luck/other-responsibility orientation), to complete a measure of visual-analysis skills (i.e., attention to detail), to complete measures of perceived self-efficacy beliefs to avoid injury, and beliefs about personal vulnerability (likelihood) for injury and the likely degree of severity of any resulting injury.

Although many results were informative, most pertinent to this article, there was a significant sex difference in the predictors of children's ratings of risk-for-injury in the photographs. Boys' risk ratings were best predicted by their beliefs about injury severity (i.e., how hurt might they get if they performed the risk-taking behavior depicted), whereas for girls the best predictor of their risk rating was perceived vulnerability to injury (i.e., how likely it was they would get hurt at all if they performed the behavior depicted). These findings suggest that boys may avoid an injury-risk situation only if they judge the potential injury outcome as severe, in which case they consider the risk-of-injury to be high. By contrast, girls may avoid injury-risk situations if they judge an injury outcome is possible at all, regardless of judged severity. Such a difference in orientation to injury-risk situations could certainly lead to boys more often engaging in risk-taking behaviors in situations where injury outcome (albeit not severe, by their standards-- see below) is likely.

These results also may explain why we find that boys are more likely than girls to engage repeatedly in the same risk-taking behavior, even if they have been hurt previously or know someone else who has been hurt doing the activity (see below). If boys do not feel an injury outcome was severe, then experiencing the injury may not act as a deterrent against repeating the activity, particularly if they judge the injury-risk activity as a fun-filled one (i.e., worth the risk of experiencing minor injuries). In other words, for boys, for an injury to act as a deterrent against repeating an injury-risk activity it may have to be of sufficient severity to be noteworthy by their standards (see below about injury-severity ratings). By contrast, for girls, any injury outcome is likely to be treated as evidence against repeating the risk-taking behavior that led to the injury.

These speculations are supported by a study we have recently completed.

We (Morrongiello, Pelley & Johnston, in preparation) conducted a telephone-diary study in which we interviewed each of 10 girls and 10 boys at 6, 8, and 10 years of age for 14 consecutive days. During each interview, children reported on all the injuries and near-injuries (i.e., almost got hurt but did not) they experienced that day. They also answered a number of questions about each experience they reported that was aimed at determining if they had done the injury-risk behavior before and with what outcome (injured or not), or knew anyone else who had done so (injured or not), what their attributions were about the injury (self, other, luck), their ratings of severity of the injury, and judged likelihood they would repeat the injury-risk activity.

Boys were much more likely than girls to have done the injury-risk behavior before and been hurt (or known someone else who had gotten hurt doing the activity). Consistent with this, boys also were more likely to say they would repeat the behavior (that had resulted in the injury) again, and that they would not worry about injury as a potential outcome.

Boys also rated injuries as lower in severity than did the girls, even though they typically reported the same types of injury events. These results may indicate that boys have a higher pain threshold than girls (i.e., their ratings of severity are true reflections of their pain experiences). In fact, in the adult literature on pain perception, it is a common finding that females have lower pain thresholds and experience pain more quickly than males (e.g., Fransson-Hall & Killborn, 1993). However, whether boys and girls show similar differences in pain perception must await the results of more systematic study. Differential ratings of injury severity also may reflect biases in reporting by males (i.e., reluctance to admit they felt a lot of pain) or females (i.e., a tendency to over-exaggerate the severity of their injuries), although there is no basis for expecting such biases in reporting. Whatever the explanation, sex differences in ratings of injury severity also could explain why boys are more likely to repeat injury-risk behaviors whereas girls are not. Certainly, one would likely be more reluctant to repeat an activity if one believed the potential injury outcome could be severe (girls), than if one thought the injury outcome would be negligible (boys).

Boys and girls differed too in attributions for injuries: Boys generally attributed more injury outcomes to bad luck than females. This also could explain more repetition of injury-risk by boys than by girls: If an injury resulted from bad luck then why would one not repeat the activity again. By contrast, if one feels a sense of personal responsibility for

an injury then one would probably be less likely to repeat the activity, since the outcome would be assumed to be likely to reoccur as well (i.e., get hurt again). We are in the process of analyzing these data further in an effort to statistically model the relationships between children's attributions, injury-severity ratings, and their likelihood of repeating injury-risk activities.

In conclusion, our results to date provide a number of clues as to why males may have more injuries than females. Conceptualization of injury-risk situations in terms of the severity of injury outcome, as opposed to the likelihood of injury, would certainly predispose toward more injury-risk behaviors among males than females. Furthermore, attributions of injuries to luck and low ratings of injury severity both may increase the likelihood of boys, more so than girls, repeating injury-risk behaviours, even if these have previously resulted in injuries. One obvious implication of our results is that we likely need to develop different injury-prevention programs for boys and girls. Hopefully, our ongoing efforts to develop a model to explain child-injury outcomes will help achieve this prevention goal.

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Quality of Life in Pediatric Patients

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Abstract: Assessment of quality of life in pediatric patients is an emerging field because children who survive serious medical illness are often marked by their experiences. They may face physical, neurological, social, emotional, and developmental challenges as a direct consequence of their illness and treatment. Therefore, the necessity of measuring and managing these consequences becomes evident. This article reviews the importance of and methods available for assessing quality of life in children. Moreover, a brief overview of our current work with pediatric oncology survivors is provided.

Résumé: L'évaluation de la qualité de vie chez les enfants atteints d'une maladie chronique est un domaine qui prend de plus en plus d'ampleur car ces jeunes sont souvent marqués par leur expérience. Dans la plupart des cas, ils doivent relever des défis d'ordre physique, neurologique, social, émotif, et de développement qu'entraînent la maladie et les traitements. La nécessité d'évaluer ces conséquences est donc évidente. Cet article explique brièvement l'importance d'évaluer la qualité de vie et les différentes façons de mesurer ce concept. On y retrouve également le résumé d'un projet en cours relativement à la qualité de vie chez les enfants atteints de cancer.

Survival at what cost?

Improved medical technology offers new hope to pediatric patients suffering from various illnesses. For some types of diseases (e.g., cancer) these advances have not only provided symptom relief, but have also afforded a cure in many cases. Encouraging as these results are, it is becoming increasingly important to measure the impact medical treatment has on the quality of life in these patients. Consequently, a new question arises, namely, survival at what cost?

Definition

In order to assess Quality of Life (QoL) in a valid and reliable manner it must be defined adequately. QoL is multidimensional concept including (but not limited to) physical, emotional, and social domains that affect the child's life. Traditionally, physicians' foci have been on physical functioning (e.g., toxicity of medications). Attention has been paid to strength, energy, and the ability to carry out daily activities (such as play). Somatic sensations such as, pain, nausea, or shortness of breath have been considered as well (Schnipper et al., 1990). Other health professionals (e.g., nurses, psychologists, social workers) have addressed emotional and social functioning in pediatric patients since they are often problematic following medical treatments.

A distinction needs to be drawn between QoL and Health-Related QoL. QoL is a broad construct that includes dimensions other than health status such as work/school performance, life satisfaction, etc. In contrast, Health-Related QoL is restricted to physical and psychological well-being.

Why assess QoL?

Quality of life data have the potential to provide a rich, quantifiable description of treatment effects on day-to-day functioning (Bradlyn et al., 1993). The utilization of such measures may influence the choice of treatment for individual patients (Guyatt et al., 1993). In addition, measuring health-related quality of life (HRQoL) can inform medical management and policy decisions. For example, if two pharmaceutical treatments are available which are equal in terms of medical outcome but unequal in terms of psychosocial or monetary costs, QoL data may influence the choice between medications administered (Guyatt et al., 1993).

Assessment of QoL

Measurement of QoL in adults

A literature search conducted by our team spanning the past five years revealed over one thousand references pertaining to the measurement of QoL in adults. Two basic approaches have been used: 1) generic instruments, including a health profile or utility measurement or 2) specific instruments, which may be disease-population-function- or problem-specific (Guyatt et al., 1993). The approach selected reflects both the training and aims of the user. For example, economists interested in a cost-benefit analysis needed to make decisions pertaining to health policy are inclined to obtain a single measure that reflects global functioning (Froberg & Kane, 1989). In contrast, clinicians interested in pre- and post-treatment changes may choose a health profile that details different aspects of QoL (e.g., social functioning, physical symptoms). Others prefer to administer a battery of known instruments that evaluate specific constructs such as neuropsychological functioning or depression (Shumaker et al., 1990). These varied approaches illustrate that QoL is not a unitary concept. Nonetheless, what has been learned with adults can be used to develop means of assessing this construct in pediatric patients.

Measurement of QoL in children

A similar literature search of the measurement of QoL in children located fewer than 40 references. Assessment of QoL, while well-developed in adult patients, is understudied in pediatrics. Apparently it is caused by several factors: first, there are fewer pediatric (oncology) patients than adults; second, children may be viewed as "moving targets" in that they develop rapidly over short periods of time (Rosenbaum et al., 1990). This poses a special challenge for repeated assessment of QoL because changes that may be related to medical treatment may be confounded with development. Also, adults typically report on their own QoL whereas children are unable to do so.

Who is to "speak for" the child (i.e., medical staff, parent of child) is not established, although apparently parents report more problems compared to doctors (Bradlyn et al., 1993). Finally, which aspects of life should be assessed remains unresolved (Harris et al., 1993). As will be evident, this varies considerably across the researchers who have attempted to measure QoL in children. Summarized below are the few attempts found in the literature pertaining to the assessment of pediatric QoL.

The **Play Performance Scale**, developed by Lansky et al., (1987) is a child version of the Karnofsky Scale of Performance which is completed by the patient's parent. Global functioning, rated between 0 and 100 (unresponsive

to fully active, normal) is assessed for children aged one to 16 years. Its psychometric properties are adequate (Mulhern et al., 1990), but it is limited in scope and does not address important aspects of psychological functioning.

The **Quality of Well-Being Scale** (Kaplan et al., 1989) was adapted for children (Bradlyn et al., 1993). It consists of a 15 minute structured interview that is used with the parent of the sick child and the child, if the latter is old enough to understand the questions. It assesses the dimensions of mobility, physical functioning, local activity, and current symptoms. Dimension and total scores can be derived from it. Its psychometric properties appear promising, however, it requires highly trained interviewers to administer it individually to patients or proxies, an expensive and sometimes impractical testing procedure.

Godwin et al. (in press) and Boggs et al. (1993) have developed the **Pediatric Quality of Life Scale**, a 21-item questionnaire that is completed by the patient's parent. This instrument provides a total score and three factor scores that reflect: (1) physical functioning and role restriction, (2) emotional distress, and (3) reaction to current medical treatment. Preliminary results suggest that the measure is valid and reliable although replication is needed before conclusions may be drawn.

Barr, Feeny, Torrance, and colleagues have devised the **Health Utilities Index (HUI)** for survivors of childhood cancer (Barr et al., 1992). Respondents are instructed to assess health status for each of the seven attributes by assigning levels of functioning from one to five, depending on the attribute. For example, a level of one for cognition equals "learns and remembers school work normally for age", whereas a level of four equals "unable to learn and remember". In a pilot study (Feeny et al., 1992) clinicians completed the instrument retrospectively for a sample of children with various types of cancer, most of whom were high-risk Acute Lymphoblastic Leukemia (ALL) patients. While it was possible to identify combinations of sequelae, agreement between raters was only 61%, with disagreements predominating for the attributes pain and emotion. Nevertheless, the degree of disagreement was not large and consensus among raters was readily accomplished. It is conceivable, however, that ratings may be more valid if the parents complete the instrument (Barr et al., 1993).

The instruments reviewed regarding the quantification of QoL in pediatrics represent an essential first step. Each has its strengths and shortcomings; all require further investigation. Other instruments have been constructed but they are of limited value since they are appropriate for restricted age groups or measure only specific aspects of functioning. Among the measures available to date

concerning QoL in children, the HUI is the best suited instrument since it covers many attributes. Furthermore, it possesses these qualities: a summary score is available, it is easy to administer, it is brief, and could be integrated easily into a clinical setting.

Current Work

QoL in pediatric oncology patients.

A study is underway in our laboratory at Ste-Justine Hospital in Montréal to determine empirically a method to identify children at risk for psychosocial sequelae following treatment. Two groups of pediatric patients are being assessed: ALL and other types of cancer; a total of 324 patients will be studied. A secondary aim is to compare the quality of life in patients treated for different types of cancer, during the past 7.5 years. The mothers of these children will be requested to complete questionnaires on one occasion. The Health Utilities Index is the instrument being tested for screening purposes. The Child Behavior Checklist (CBCL), which assesses child psychopathology is the instrument being used to identify cases which require further testing.

In order to determine a cut-off point which identifies risk status a Receiver Operating Characteristic Curve will be computed. Scores from the CBCL Total Problem scale which are above 64 will serve as the criterion for true cases of late effects. Subsequently, the results from the two instruments will be compared across the two groups.

Thus far, 75 mothers have been tested; refusal rates are very low. The staff at the hospital is enthusiastic which facilitates recruitment. The study is relevant to the problem of cancer because little is known about the quality of life of young survivors. Given that these patients often have psychosocial problems following their treatment it is essential that at risk children be identified and offered appropriate services as soon as possible in order to aid their reentry into school and family life. Preliminary data analyses will be presented by the first author at the upcoming CPA conference.

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Children's Health Perceptual Field: A New Model for the Study of Children's Health Socialization

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Abstract: This article briefly presents the research that I have been conducting for several years concerning promotion of children's health, more recently in close collaboration with Ilze Kalnins of the University of Toronto and Sylvie Normandeau of Université de Montréal. It gives a general idea of the conceptual model at the heart of our studies and a few examples of the results concerning children's health-related perceptions, representations, and actions.

Résumé: Cet article présente brièvement la recherche que je poursuis depuis plusieurs années sujet de l'encouragement de la santé chez les enfants, récemment en collaboration avec Ilze Kalnins de l'Université de Toronto et Sylvie Normandeau de l'Université de Montréal. Cet article procure une idée générale du modèle conceptuel au coeur de nos études de mêmes que quelques exemples de résultats concernant les perceptions, représentations et agissements sanitaires des enfants.

The object of our research project is to better understand children's socialization in relation to health, that is the process whereby children acquire the knowledge, skills, and abilities enabling them to "manage" their health more or less effectively. Interrelationships between children and their main socialization agents (family, peers, educators, mass media)

are studied in this context. Our conceptual model is phenomenological, rooted in children's perceptions and personal experience. In the tradition of Combs and Snygg (1959), I have developed the concept of the health perceptual field, defined as the totality of the child's representations pertaining to health, given the main physical and social objects in the child's environment (Jutras & Bisson, 1994).

Thus, we seek to understand how children are socialized in regard to health by studying their perceptual field, examining the distinctive features of the socialization process and its impact or consequences. We describe the dynamics of the perceptual field and try to identify the variables underlying variations in the field, the main ones being children's gender, age, living environment (rural or urban), and socioeconomic level. Instead of relying exclusively on our implicit adult theories about "what children need", we believe that an understanding of the health perceptual field from the child's vantage point should assist in designing health promotion programmes that will be really useful to children.

A Few Words About the Method

Subjects

The sample consisted of 1,674 children (boys = 830; girls = 844) aged 5-6 years old ($n = 559$), 8-9 years old ($n = 564$) and 11-12 years old ($n = 551$) living in a variety of socioeconomic and geographic environments in the Province of Québec. Children from two urban areas were studied: one group living in the Montréal metropolitan area and the other in the Sherbrooke metropolitan area, a city of 140,000 residents. In each of these cities, the sample comprised children from an upper-middle class living environment and children from a lower-class living environment. The sample also included children from three rural areas, chosen to represent differing degrees of disadvantage or vulnerability to socio-economic and health problems as identified by Pampalon (1991).

Materials and procedure

Interviews lasting approximately 30 minutes were conducted with each child. The questionnaire consisted mostly of open-ended questions accompanied by a set of pictures that served as visual prompts, especially for the younger children. The questionnaire touched on many aspects of children's health concept, including the ways in which they care for their own health, their perception of the relative importance of each socialization agent, expectations concerning parental care, etc. Questions dealt with children's everyday experience. All answers were noted verbatim and submitted to a content analysis procedure.

Some interesting results

Data provided by the children are extremely rich and profuse. It is amazing how much children can tell us in just half an hour! We have not yet finished analyzing all the data, but a number of interesting results have already emerged. In the following paragraphs, we will present some of them; however, instead of going into details, we will attempt to give an overall view of the diversity of information generated by a phenomenological study of children. Thus, despite the interest of the findings, we will not detail variations linked to the children's age (main differentiating factor) and other characteristics.

The health perceptual field comprises three levels. The first, the reflexive level, includes children's perceptions concerning their health concept and actions they perform to maintain or improve health. Results show that children's conception of health is tridimensional. The two most important dimensions are: being functional (e.g., doing sports, absence of disease) and adherence to good lifestyle health behaviors (e.g., healthy diet, proper sleeping habits, physical activity) and the third less salient one is mental health (e.g., having energy, harmonious relationships with others).

These dimensions are interwoven in children's responses to questions about the criteria for assessing that someone is healthy and consequences of being healthy, major threats to health, and behaviors essential to maintain health. These main organizers of children's conception of health (functionality, lifestyle behaviors and mental health) are rooted in their daily life experiences. Consistent with our model of the phenomenological field of health which places health in the context of children's experiences, children identified their mother and father as the two most important sources of information of their ideas about health.

Another aspect of the reflexive level which interests us are the everyday actions aimed at staying healthy performed by children in eight specific contexts. Children perceive themselves as engaging in health related actions in all contexts of daily life, but within each context one or two actions predominate. In regard to eating, good dietary habits are of primary importance. In relation to dressing, children talk mostly about the qualities of clothing (e.g. wearing the right clothing for the season, wearing clean clothing). Concerning hygiene, they mention different actions taken to keep the body clean.

Regarding sleep, personal care, activities to quiet down, and getting enough sleep are considered important. In the

classroom, school life routines and rules (e.g. not pushing, sitting up straight), and activities (e.g. playing, gymnastics) dominate the actions children perform to be healthy. Physical activities and sports are the main actions mentioned in relation to recess. Different activities (e.g. sports, dancing, reading, playing with toys) are health-related actions performed by children during leisure time. Children also mentioned doing physical activities when they are on their way to get somewhere. It is noteworthy that some actions, especially those related to eating, keeping clean, physical activity, avoidance of injuries and mental health were mentioned across contexts. Although less frequently mentioned than others, actions relating to mental health are nonetheless present and are aimed at fostering a subjective feeling of well-being or improving the quality of social interactions.

Across all contexts except school, the largest percentage of children stated that they had heard about the health actions they perform from their mother, and to a lesser extent their father and other family members. Children were asked to describe three actions performed by their mother and father to safeguard their own health. Results show that children's health actions closely mirror their parents'.

The second level of the health perceptual field is the proximal transaction level, that reflects the child's perceptions of concrete proximal transactions or interactions with socialization agents. We asked children to describe recent actions aimed at promoting the health of their parents, siblings, and school personnel, and likewise the health-related actions recently directed at the child by these socialization agents.

Our findings show that children do not see themselves solely as receiving assistance from others in regard to health, but also as acting upon other people's health, especially that of family members. Actions exchanged relate mainly to promotion of healthy behavior patterns, but promotion of harmonious interpersonal relationships, helping behaviors, and therapeutic acts are also included in the repertoire. These exchanges are asymmetrical: children perceive the actions they direct at others as different from those directed at them. Results suggest that children perceive mutual help in relation to health as being primarily a family affair, and thus tend to confirm the importance of the family in socializing children with regard to health-related attitudes and behaviours (Akamatsu et al, 1992).

At the third level of the perceptual field, the distal transaction level, the model reflects children's overall perceptions or expectations of transactions with or between various members of the child's more immediate environment. One aspect studied was children's expectations about

measures parents will take when the child feels sick. Children were shown a picture of a child who doesn't feel well and who goes to see his/her parents who are in the living room watching television. The child is then invited to tell a story about what each of the parents will say and do. Children's main expectations center around therapeutic actions (medication and rest) followed by diagnostic actions (examining the child, asking questions).

Other salient expectations concern interactions (mainly reassurance and caring) and consultation of a health professional. One interesting finding is that children do not expect that a greater number of measures of various kinds will be taken by their mothers than by their fathers. However, more children expect the mother than the father to take therapeutic measures. In the other categories of actions, children have much the same expectations of the father as of the mother. It is interesting to note that children expected reassurance and caring just as frequently from the father as from the mother, thereby highlighting a less recognized dimension of the father's role, more commonly attributed to the mother than to the father in popular belief.

At this stage in our analysis, we can come to certain conclusions as to the relevance of our model for the study of perceptions and actions of children in relation to health, particularly for those interested in their health socialization. First, our phenomenological approach, centered on the child, enabled us to bring to light perceptions seldom mentioned in previous studies on children's health concepts or health-related actions, such as concerns about mental health. In addition, our study reveals that children's health-related perceptions and actions are quite coherent and sophisticated.

The fact that the interview focused on concrete situations experienced daily by the children probably favored emergence of these characteristics. Furthermore, the child-centered approach allows children to present themselves as actors not only in relation to their personal health, but also in relation to significant others. The family's preponderant role in health socialization has often been affirmed, but little empirical data has actually been collected to support this contention (Akamatsu et al., 1992); description of the perceptual field makes it possible to compare the importance attributed to various socialization agents according to children's own perceptions. More particularly, the model suggests new directions for reflecting on fathers' role in their children's health socialization, an area which has as yet been little explored (see Tinsley, 1992).

Conclusion

In this brief presentation, we have not discussed the variations amongst children according to age, gender, or living environment. Here again, there were a number of interesting findings, largely due to a research design facilitating multiple comparisons. Perhaps the main asset of the health perceptual field model is that it encourages the researcher to consider a broad range of dimensions assumed to be interrelated, from the vantage point of the child considered as an active agent and not as a recipient who is socialized by people who are supposed to know what health is all about.

Of course, the advantages of research using the health perceptual field model go hand in hand with certain drawbacks: it requires collecting a mass of data covering a series of dimensions that the researcher must seek to relate to one another, as well as being time consuming in regard to data collection and content analysis. However, we believe that the new perspectives offered by the perceptual field model with regard to health promotion for children make this investment of time and energy well worth while.

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ANNUAL REPORT 1994-1995

of the Health Psychology Section

At the 1994 Annual Meeting in Penticton the following were elected section officers: Chair-elect: Michael Murray, Secretary/Treasurer: Cynthia Mathieson. This is the first change in officers for several years and the section had become somewhat moribund. The new officers have had a strong commitment to revitalizing the section through recruiting new members, maintaining a newsletter, and raising the profile of the section at the convention and elsewhere. Over the past year the following activities were conducted:

1. Approval of section by-laws: Although the section has been in existence for several years it has never established its by-laws. The model by-laws provided by CPA were revised as appropriate and were approved by the CPA Committee on Sections.

2. Membership: At last year's convention the section membership was reported at 157. This was the fifth largest in the CPA. As a means of recruiting new members the Chair-elect contacted all those who submitted a paper to the convention, all psychologist members of the Canadian Association of Psychosocial Oncology, and all heads of university psychology departments. He provided them with details of the section and a copy of our newsletter. Membership has steadily increased during the year. Full membership figures will be provided at the Annual Meeting.

3. Convention: A major attempt has been made to increase the profile of the section at this year's convention. We have planned a pre-convention workshop entitled Coping with Loss, Grief and Chronic Illness. As the first workshop organized by the section we are hopeful that it will be well attended by section members.

We have also organized three symposia on Family and Child health, Occupational health and Accidents, and Illness, identity and inter-viewing. There are also a number of theory review papers, conversation hours, and a wide range of posters. Overall, the indication is that health psychology is a growth area in Canada.

4. Student prize: It was agreed at the 1994 Annual Meeting to establish a student prize. All students who submitted a paper on an aspect of health psychology have been invited to apply for this prize which will be presented at the convention.

5. Newsletter: The Canadian Health Psychologist, the section newsletter, is now into its third year of publication. It is steadily increasing in size and variety of content. Two issues were published in 1994, 52 pages in total. The first issue included a special 20 page section on psycho-oncology. This contained eight articles by section members and others who are working in the field of cancer. The overall response to this issue was extremely positive with a large number of enquiries from psychologists south of the border after it was favourably commented on in their newsletter. The second issue included a range of articles on cross-cultural health psychology, health psychology in Australia and the role of hope in health psychology.

The first issue of 1995 has recently been circulated to members. It contains a special section on child health psychology.

6. Psynopsis: A regular column detailing the activities of the section has been included in Psynopsis. This has produced a steady stream of inquiries about the section.

7. Training: There has been a series of enquiries from graduate students about training and employment opportunities. The new executive will need to review this issue.

8. Contacts: Contact has been maintained with the Division of Health Psychology of the American Psychological Association, the Special Group in Health Psychology of the British Psychological Association and the European Health Psychology Society. We have also applied for associate membership of the International Association of Behavioral Medicine.

9. I.U.P.S.: One of our members, Dr. Robert Martin, will be contributing to a special symposium on Health Psychology Around the World at next year's I.U.P.S. meeting in Montreal. Since there will be no C.P.A. meeting next year we will need to consider organizing some meeting during this convention.

Michael Murray,
Chair-elect

Annual Convention 1995

Charlottetown, PEI/ÎPE

This year's convention features a wide range of activities, including symposia, conversation hours, theory reviews and posters. The following is a summary of the main events:

SYMPOSIA

1. Child and Family Health Psychology

Moderator: Michael Murray

- a) **Psychological impact of predictive genetic testing for cancer**
by M. Barrera, D. Malkin, R. Weksberg (Hospital for Sick Children, Toronto)
 - b) **Risk perception and risk-taking judgements in school-age children**
by B. Morrongiello, L. Hillier, S. Christensen (Guelph)
 - c) **The health-related perceptual field: a model for studying children's health representations**
by S. Jutras (UQAM), S. Normandeau (Montreal), & I Kalnins (Toronto)
- #### 2. Occupational Health Psychology: Accidents and risk-taking
- Moderator: Michael Murray
- a) **Relationships of organizational characteristics with nurses' control and knowledge of microbiological hazards** by MP Leiter, & S. Smiley (Acadia)
 - b) **The relationship of risk assessment to job satisfaction and occupational stress in the military** by L Robichaud, & MP Leiter (Acadia)
 - c) **Fishermen talking about accidents and safety**
by M Murray (Memorial)
 - d) **risk homeostasis and individual differences in health and safety habits**
by T Bjorgvinsson, & GJS Wilde (Queen's)

Congrès annuel 1995

Charlottetown, ÎPE

3. Illness, identity, and inter-viewing

Moderator: Cynthia Mathieson

- a) **Identity concerns for young adults with chronic inflammatory bowel disease**
by B Macdonald (Mt St Vincent)
- b) **Identity renegotiation in HIV-positive women**
by M Gurevich (York)
- c) **Cancer stories and gendered lives**
by C Mathieson (Mt St Vincent)

CONVERSATION HOUR

Multi-centre research: a professional challenge

by J Arnett (Manitoba), E Huntsman (BC Children's), G Matzow (U of A Hospitals), E Orrbine, A Schlieer (Children's Hosp of East ON), S Whitsett (Alberta Children's)

THEORY REVIEWS

1. The Euthanasia Debate

by KG Wilson (Ottawa)

2. Assessment of quality of life in pediatrics: a challenge to be met

by P Dobkin, P Robaey, J Trudel, (McGill)

3. A historical and theoretical overview of women's reproductive health care

by JA Mills (Mt St Vincent)

4. Critical review of a qualitatively based instrument to identify middle-aged women's perceptions of barriers to health

by P Fry, V Kuehne, S Sorensen (Victoria)

ANNUAL MEETING

The Annual Meeting is planned for Thursday afternoon, 15 June 1995. This will be followed by a reception. All members are strongly encouraged to attend both events.

ASSEMBLÉE ANNUELLE

L'assemblée annuelle est planifié pour l'après midi de Vendredi, 15 juin 1995. Ceci suivrait par une réception. Toutes les membres sont encouragé à attendre ces événements.

Election Time

Nominations are requested for the positions of Chair-elect and Secretary-Treasurer who will assume office at the 1995 Annual Meeting.

The current officers are Michael Murray (Chair, acting) and Cynthia Mathieson (Secretary-Treasurer).

If you are interested in either of these positions or would like to assist in any way in the running of the section, please contact me.

Le temps d'élection

Des mises en candidature pour les postes de futur-président et de secrétaire-trésorier sont requises. Ces personnes assumeront leurs fonctions lors de l'assemblée annuelle.

Le président courant est Michael Murray et la secrétaire-trésorier est Cynthia Mathieson.

Si vous intéressez à ces postes ou vous voulez d'assister la section, informez-moi s'il vous plaît.

Changing for Good: The Revolutionary Program that Explains the Six Stages of Change and Teaches You How to Free Yourself from Bad Habits

JO Prochaska, JC Norcross
& C DiClemente

William Morrow & Co.
1994, 304 pages
Hardcover, US\$34.95
ISBN 0-688-11263-3

Changing for good is a self-help book with a difference. The difference being the exemplary empirical and theoretical foundation of the principles that are the focus of the book, something found less and less in today's self-help publication industry. Changing for good educates the reader about what the authors, and others, have discovered about how people change unhealthy and unwanted behaviours. They have identified six empirically derived stages which they believe occur in all such behaviour change endeavours (precontemplation, contemplation, preparation, action, maintenance, and termination).

As individuals progress through each stage of change certain behaviour change processes are at work. The authors identify nine behaviour change processes, each of which has particular relevance and potency for a particular stage of change (e.g., consciousness-raising is important at the precontemplation stage; emotional arousal is important at the preparation stage; reward and countering are important at the maintenance stage). Each process of change can be achieved with the application of several psychotherapeutic strategies or techniques drawn liberally from various theoretical domains, hence the

"transtheoretical approach".

The lay person need not care, or be impressed by the fact that the book's authors are three psychologists who have studied and published in the areas of behaviour change and eclectic models of psychotherapy, for years. They need not, but the publishers are counting on the fact that they will. The publishers have done a fine sales job in introducing the book's authors this way:

"Their model for self-change has been recognized worldwide and has been applied in programs sponsored by such organizations as the National Cancer Institute and the National Institute for Drug Abuse. Among them they have written eight books and more than three hundred scientific articles, and have received more than \$35 million for research on helping people change."

This book is divided into two parts. Part one, "The science" consists of three chapters that present the empirical underpinnings of their model of behaviour change. Part two, "The applications", consists of seven more chapters outlining the stages of change referred to in the book's subtitle. The book also has two appendices and a substantial bibliography for a self-help book (four pages, 60 references). The professional reader may choose to pursue one, or more, of the authors' more scholarly works on the topic of behaviour change (e.g., Prochaska & Norcross, 1994). One of the appendices, "A new paradigm", seeks to convince readers that what they are getting is something completely new in the area of behavioural science. This is one of several sections in which the authors unabashedly blow their own horn. The other appendix is a rather pithy sally into the human condition in which the authors present two helpful concepts in understanding client resistance to behaviour change. The authors contrast "foolish freedom" -

when we demand to be in control even when it is obviously self-damaging (e.g., I'll keep smoking because I want to.) versus "responsible freedom" - when we choose to change for the best reasons (i.e., that which is enhancing to life, sense of self, and society).

To which behaviours and bad habits does this book apply? Primarily, health related behaviours such as smoking, drinking alcohol, exercise, losing weight. But the authors believe their model will also extend to other problem areas such as depression, procrastination, and anxiety.

Is this book good value for the consumer? Should I, as a mental health professional, recommend the book to my clients? These questions might best be answered by using Santrock, Minnett, and Campbell's (1994) nine strategies for selecting a self-help book.

1. *Don't select a self-help book because of its cover, its title, or its glitzy advertising campaign, or because it is this year's so-called "breakthrough" book.*

This book has an attractive cover, and perhaps sets a world record for the longest subtitle. It remains to be seen whether it will be touted as this year's (last year's now) breakthrough book.

2. *Select a book that makes realistic rather than grandiose claims.*

The authors caution the reader to steer clear of self-help interventions that promise dramatic changes in a short period of time. They are careful to explain that changing long standing habits can be difficult, frustrating, and time consuming. On the negative side, they claim that their model of change can be applied to most any problem behaviour (e.g., risky sexual behaviour, procrastination). However, I am concerned that the book does not provide enough detail about specific problems to enable average readers to

apply the model of behaviour change to their own particular problems. See item six below.

3. *Examine the evidence reported in the book.*

This is one of the book's major strengths. Changing for good is a first order self-help book because it references scientific literature to substantiate the claims made in the book. The authors have written many of the research papers that provide support for the ideas in the book, papers published in reputable refereed journals. Many of today's self-help books are of the second order in that the authors provide a skimpy bibliography that primarily contains references to other self-help books revealing the authors' failure to go to the source.

4. *Select a self-help book that recognizes that a problem is caused by a number of factors and has alternative solutions.*

This is another solid foundation of this book. The authors do a superb job in identifying how attempting to change a personally problematic behaviour can go wrong, and more importantly, what to do about it when one's initial efforts fail. The book is full of behaviour change techniques tailored for use in particular stages of the behaviour change cycle. Most importantly, the authors take great care in discussing how people move from denying a problem exists, to accepting a problem exists but becoming stuck about what to do next. They also clearly explain how a complete understanding of the behaviour change process must include the notion of relapse, the often inevitable re-cycling through the stages of change (e.g., starting and stopping smoking several times before quitting for good). Recycling is a learning experience, a chance to improve and modify one's self-help plan for permanently changing one's behaviour.

5. *A self-help book that focuses on a*

particular problem is better than one that is a general approach to solving all of your problems.

Prochaska, Norcross, and DiClemente (1994) would probably take issue with Santrock, Minnett, and Campbell as the former write in their book, "You do not need three self-help books, three therapists, or three programs to solve three problems. In fact, there is some evidence that it may be more efficient to apply the processes to more than one problem at a time, rather than to try to change problem behaviours one by one. We are in the process of gathering more data on whether simultaneous or sequential change is more beneficial" (p. 56).

6. *Don't be conned by psychobabble and slick writing.*

Changing for good contains far too much psychological jargon for public consumption as a self-help book (e.g., paradigm, corrective emotional experience, countering, internalization). The book appears to be more appropriate for college and university educated individuals. One section that should have been omitted is the explanation of standard deviation. The authors believe they have discovered a universal law of self-change regarding the relative weighting of an individual's reasons for and against changing a problem behaviour. They introduce the idea that a full standard deviation increase in the pros for change and a half standard deviation drop in the cons for change, is a hallmark of people who are ready to attempt such a change. The concept is not made any easier for the reader who is then instructed to complete a brief questionnaire and calculate their score and compare it to the means.

7. *Check out the author's educational and professional credentials.*

To the extent that an author's educational and professional credentials can be used as an indicator of a self-help book's utility, this book receives a very high rating.

8. *Be wary of authors who complain about or reject the conventional knowledge of mental health professionals.*

Prochaska, Norcross, and DiClemente do take health professionals and their programs to task. They state the vast majority of programs to change problem behaviours are only appropriate for about 20% of the population who are in the action stage, and ready to make behaviour change. Such "action-oriented programs", they argue, miss the majority of people who are in the other five stages of change, hence the primary uniqueness of their program for change.

9. *Use The authoritative guide to self-help books as a resource for selecting good self-help books.*

We will have to see if their book makes a listing in the next edition.

Final thoughts and recommendation:

The main strength and weakness of the book is the science portion of the text. It is great for students of behaviour change (e.g., graduate students in psychology, other health professionals) but likely too complicated, wordy, and full of jargon for the lay reader. Moreover, the attempts to explain these terms was done too briefly in the book, and then the reader must still translate the particular principle to their specific problem.

Other strengths of the book include the helping relationships sections in each chapter that provide advice on how to best solicit the support of others in one's behaviour change program. The authors do a fine job in explaining what to do when one is not yet ready to take action to change. The notion of recycling through the stages of change, and normalizing relapse, although not new to psychologists, may be of great utility to other health professionals, particularly physicians interested in primary prevention efforts. Finally, as a self-help book for

Announcements/Annonces

the public it should have been released in paperback.

I *would not* recommend this book be given to clients or patients unless they have considerable formal education, or are highly intelligent, or unless they are being followed by a behaviour change specialist.

I *would* recommend the book to health care providers interested in helping their clients and patients change problematic, unhealthy behaviours. The book is a very digestible introduction to the authors' transtheoretical approach and may be very useful for psychotherapists struggling to organize an eclectic approach to intervention. Graduate students in clinical psychology, and especially clinical health psychology, will find a great deal of useful clinical information about how, and more importantly when, to apply certain behaviour change techniques with their clients.

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Prochaska, J.O., & Norcross, J.C. (1994). *Systems of psychotherapy: A transtheoretical approach* (3rd ed.). Pacific Cove, CA: Brooks/Cole.

Santrock, J.W., Minnett, A.M., & Campbell, B.D. (1994). *The authoritative guide to self-help books*. New York: Guilford Press.

Acknowledgement

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Books Received/ Livres reçus

R Roy (ed) (1995) **Chronic Pain in Old Age**. University of Toronto Press, Toronto.

HC Traue and JW Pennebaker (eds) (1993) **Emotion, Inhibition and Health**. Hofgrete and Huber, Toronto.

EC Poulton (1994) **Behavioral Decision Theory: A New Approach**. Cambridge University Press, New York.

If you would like to review these or any other books on health psychology get in touch.

Periodicals

Body and Society

Editors: Mike Featherstone and Bryan Turner
Publisher: Sage Publications,
PO Box 5096, Newbury Park,
CA 93159, USA.

International Journal of Stress Management

Editor: PJ McGuigan
U.S. International University,
San Diego, CA.

Psychology, Health and Medicine

Editor: Dr Lorraine Sherr
Department of Public Health,
Royal Free Hospital,
London NW3 2PF, U.K.
Publisher: Carfax, PO Box 25,
Abbingdon, Oxford, OX14 3VE, U.K.

Conference Dates

International Society for Quality in Health Care: 12th World Congress
31 May - 2 June 1995
St. John's, Newfoundland.

Details: Elaine Dyke,
12th ISQua World Congress,
Organizing Secretariat,
Beclin Building,
1118 Topsail Road, PO Box 8234, St.
John's, NF, A1B 3N4.

Atlantic Health Promotion Research Conference

17 - 18 June 1995
Charlottetown, PEI

Details: Atlantic Health Promotion
Research Centre,
Room 5200, Dentistry Building,
Dalhousie University,
5891 University Avenue,
Halifax, NS, B3H 3J5.

6th Canadian Palliative Care Conference

15 - 17 October 1995
Halifax, NS

Details 6th Canadian Palliative Care
Conference, 1335 Queen Street,
Halifax, NS, B3J 2H6.

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