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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.

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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 une 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 necessairement les opinions de la section de psychologie de la santé ou la société canadienne de psychologie, ses officers, ses directeurs, ou ses employés. Le rédacteur a le droit d'éditer toutes soumissions.

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

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

This is the tenth issue of the Canadian Health Psychologist. As such it marks what will possibly be the penultimate issue under my editorship. After five years it is time to make way for someone else. I am sure that many members have a variety of ideas of how they would like to see the CHP develop. Now is the opportunity to put these ideas into practice. If any member, or group of members, would like to take on the role of Editor they should contact me to discuss the details.

This issue includes a variety of papers which are largely the result of various presentations made by Section members at the Annual Convention in Toronto. The most substantial is that by David Aboussafy and his colleagues from McGill. This paper won the Annual Student Award for 1997. There then follow two shorter papers by Gail Gauthier and colleagues from Montreal and Keith Wilson and colleagues from Ottawa. These two short articles were presented in Toronto as part of a symposium on "Psychosocial interventions for medical patients: empirical results" which was organized by Patricia Dobkin.

Finally, I am also pleased to include a special article by Juaane Clarke and Ross Gray on the supposed epidemic of prostate cancer. I hope you enjoy the articles.

Overall, the Toronto Convention was a very successful affair for the Section. Members should now be making plans for the 1998 Convention which is to be held in Edmonton. If they would like any advice on papers, posters or symposia they would like to present at this convention they should contact me or one of the other officers as soon as possible.

Ceci est le dixième numéro du Psychologue canadien de la santé. Il est aussi peut-être le penultième numéro dont je serai le rédacteur en chef. En effet, après cinq ans à ce poste, il est temps de laisser la chance à une autre personne de continuer à développer le PCS. Je suis certain que beaucoup de nos membres au sein de la section ont beaucoup à contribuer à notre revue et voici leur chance de s'impliquer. Si certains membres sont intéressés à devenir rédacteur en chef, je les invite à me contacter à ce sujet.

Ce numéro inclut une variété d'articles qui résultent en majeure partie de présentations offertes par des membres de la section à la convention annuelle qui a eu lieu à Toronto. À noter particulièrement, la présentation de David Aboussafy et ses collègues de McGill qui s'est méritée le Prix Étudiant annuel de 1997. Cet article est suivi de deux articles plus brefs. L'un de Gail Gauthier et ses collègues de Montreal, l'autre de Keith Wilson et ses collègues d'Ottawa. Ces deux articles brefs étaient présentés à Toronto comme partie d'un symposium sur "Des interventions psychosociales pour des patients médicaux: résultats empiriques" lequel est organisé par Patricia Dobkin.

Enfin, je suis très content d'inclure un article spécial par Juaane Clarke et Ross Gray sur la soi-disant épidémie de cancer de la prostate. J'espère que vous aimez ces articles.

Dans l'ensemble, la convention de Toronto a été une réussite pour la section. Nos membres devraient maintenant planifier leur participation à la convention de 1998 à Edmonton. J'invite tous les membres qui désirent de l'information ou des suggestions sur cette convention ou sur les différentes sortes de présentations qu'il est possible de faire à me contacter ou à contacter l'un des membres du comité exécutif.

Michael Murray

Chair's Letter/Lettre de la Présidente

AS the new Chair of the Health Psychology section of CPA I have much to share with you. First, I would like to take the opportunity to thank Dr. Michael Murray, who served as Chair for three consecutive terms. Michael has devoted himself to making this section the second largest in CPA. He has accomplished this task by being visible in many ways: at cocktail parties, maintaining contact with CPA, making our existence known in the CPA newsletter, as well as singlehandedly editing the Health Psychology newsletter, which you have received twice yearly since 1993. He has been the lone ranger in Newfoundland who has not been discouraged by the large distances which separate us or the differences between us. Fortunately he will remain among us as Past Chair on our executive board.

There are five elected members of the executive board; let me briefly describe their functions. The Chair oversees all current activities such as publication of the newsletter, organization of the convention meetings, membership, finances, correspondence with CPA and other health psychology groups, Web site, and other communications stemming from our section (e.g., survey on training sites in Health Psychology in Canada). The Past Chair assists the current Chair by sharing his experiences and continuing to participate in decision making. The Secretary-Treasurer, Dr. Gordon Butler (who has agreed to serve for a second term), is responsible for managing the section's resources, distributing minutes from meetings, updating the membership list, and maintaining the web site. The Chair-Elect, Dr. Joel Katz, is "groomed" for the position of Chair by participating in all activities as well as taking responsibility for the organization of the next conference meeting, including student awards.

En tant que nouvelle Présidente de la section de psychologie de la santé de la SCP, je suis heureuse de vous adresser ces quelques mots. Tout d'abord, je voudrais remercier Dr. Michael Murray, Président de cette section durant trois mandats consécutifs. Grâce à ses efforts, la section de psychologie de la santé est la deuxième en importance au sein de la SCP. Michael a accompli ce tour de force en étant présent de diverses façons: en assistant à des rencontres sociales, en gardant des liens avec la SCP, en faisant connaître cette section par l'entremise du bulletin de la SCP, et en assumant à lui seul le rôle d'éditeur du bulletin de la section de psychologie de la santé que vous recevez deux fois l'an depuis 1993. Établi à Terre-Neuve, Michael ne s'est pas laissé décourager ni par les distances qui nous séparent, ni par les différences entre nous. Nous sommes heureux de le garder au sein du comité exécutif en tant qu'Ancien Président.

Il y a cinq membres élus au comité exécutif, dont je voudrais brièvement décrire les fonctions. La Présidente coordonne toutes les activités de la section telles la publication du bulletin, l'organisation des assemblées, l'adhésion des membres à la section, les finances, les liens avec la SCP et avec d'autres groupes impliqués en psychologies de la santé, le site électronique et les affaires découlant des activités de notre section (par ex.: le sondage sur les programmes d'études et de recherche en psychologie de la santé au Canada). L'Ancien Président seconde la Présidente dans ses fonctions en partageant avec elle son expérience et en étant impliqué dans la prise des décisions. Le Secrétaire-Trésorier, Dr. Gordon Butler (qui a accepté un deuxième mandat) gère les finances de la section, distribue les procès verbaux des assemblées, garde à jour la liste des membres ainsi que le site électronique.

This year we have added to the executive board a Student Representative, Sophie Beugnot, a Ph.D. candidate at the University of Windsor. She will look out for student's interests and needs.

Now that we are established ourselves as a significant section I would like to make our top priority in the coming year STUDENTS. The future for them looks rather bleak and I think it's important that we take our role as mentors seriously. To survive in the current climate they need to know the ropes to weather the storms. Sophie will be encouraged to explore with all of you how we can ensure that students find their niche when they graduate.

I would like us to keep abreast with what is happening in health psychology around the world. Our Web site, erected by our secretary, Gordon Butler, is one means of doing this. I will keep abreast of current events in the following organizations: Society of Behavioral Medicine, the American Psychosomatic Society, and the Health Psychology section of APA. If you have links to other organizations please keep us informed. Finally, I encourage you to communicate with us what you think is important for us to do together in the next year to make being a member of the Health Psychology section worthwhile. I look forward to serving this section in 1997-98.

Le Futur Président, Dr. Joel Katz, est initié à la fonction de Président en participant aux activités de la section et en étant responsable de l'organisation de la prochaine assemblée et de la planification des prix aux étudiants. Cette année, le comité exécutif s'est adjoint une représentante étudiante, Sophie Beugnot, étudiante au doctorat à Windsor University. Elle veillera aux besoins et intérêts des étudiants au sein de la section.

Maintenant que la section est bien établie au sein de la SCP, je voudrais cette année que notre priorité soit les étudiants. L'avenir peut leur sembler décourageant et je crois qu'il est important de leur servir de guide. Il faut aider les étudiants à développer les meilleurs moyens de survivre dans le contexte actuel. Sophie explorera de quelles façons nous pouvons aider les étudiants diplômés à intégrer le marché du travail. J'aimerais que nous soyons informés de ce qui se passe en psychologie de la santé à travers le monde. Notre site électronique est un moyen idéal pour atteindre ce but. Pour ma part, je suivrai de près les activités des organisations suivantes: Society of Behavioral Medicine, the American Psychosomatic Society et la section de psychologie de la santé de l'APA. Si vous avez des liens avec d'autres organisations, je vous invite à nous informer de leurs activités. En terminant, je vous invite à nous communiquer vos suggestions sur ce que nous devrions, entreprendre ensemble cette année. Vous nous aiderez ainsi à mieux répondre à vos besoins en tant que membres de cette section. Je me réjouis de cette occasion de vous servir au sein de cette section pour l'année 1997-98.

Patricia Dobkin

Stress, Coping and Self-Efficacy in Asthma Control

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Abstract

Purpose: Many asthmatics have poor asthma control despite receiving appropriate treatment and asthma education. It was predicted that asthmatics with high stress, low asthma self-efficacy and poor coping skills would have poor asthma quality of life and ventilatory function. **Methods:** 132 adult asthmatics, followed at a hospital-based asthma clinic completed the Coping Inventory for Stressful Situations (CISS), an asthma self-efficacy scale (ASE), a checklist of major stressful events in the past year (LES), Juniper's Asthma Quality of Life Scale (AQL), and pulmonary function tests (FVCP and FEVP). **Results:** ASE was highly positively correlated with AQL. Task-coping was positively correlated with the spirometric measure FEVP. Life event stress and emotion-coping were both negatively correlated with AQL. Together, stress, task-coping and ASE accounted for considerable variance in AQL. When split into subsamples based on coping, the stress - FEVP correlations were significantly higher in subgroups with either low task, high emotion or high avoidant-coping and the stress - AQL correlation was very high in the low task-coping subsample. **Conclusions:** Individual differences in coping style appear to identify asthmatics whose symptoms and ventilatory function are associated with life stress. In particular, a task-oriented coping style may facilitate health behavior (such as appropriate responses to asthma-related crises) that contribute to better asthma control. While prospective studies must be completed, this suggests that for some asthmatics, stress management may be a useful adjunct to pharmacologic treatment. Furthermore, these results emphasize the importance of a problem-solving approach in effective asthma self-management.

Résumé

But: Un grand nombre d'asthmatiques éprouvent de la difficulté à contrôler leur asthme malgré le fait qu'ils ont reçu un traitement approprié, ainsi qu'une formation sur l'asthme. La prédiction était que les asthmatiques avec un taux élevé de stress, un taux bas d'asthme self-efficacy, et une basse capacité de coping auraient une basse qualité de vie asthmatique et fonction ventilatoire. **Méthodologie:** 132 adultes asthmatiques suivis par une clinique d'asthme dans un hôpital ont rempli le questionnaire sur le Coping (CISS), le questionnaire sur l'Asthme Self-Efficacy (ASE), un questionnaire sur les Événements Stressants (LES), l'échelle Juniper portant sur l'Asthme et la Qualité de Vie (AQL), ainsi que des mesures de Fonctionnement Pulmonaire (FVCP et FEVP). **Resultats:** Il y avait une forte corrélation positive entre le ASE et le AQL. Le task-coping se trouvait aussi en corrélation positive avec la mesure spirométrique FEVP. Les événements stressants de la vie ainsi que le coping des émotions se trouvaient en corrélation négative avec le AQL. Ensemble, le stress, le task-coping et le ASE justifiaient une partie considérable de la variance dans le AQL. Lors de la sous-division des groupes à partir du coping, les corrélations de stress- FEVP étaient significativement plus élevées, soit dans les sous-groupes avec un taux bas de task-coping, un taux élevé en émotions ou élevé en coping d'évitement, et la corrélation de stress- AQL était très élevée dans le sous-groupe avec un bas task-coping. **Conclusions:** Les différences individuelles au niveau du style de coping semblent identifier les asthmatiques qui ont des symptômes ainsi qu'une fonction ventilatoire associés avec le stress de vie. Particulièrement, il se pourrait qu'un style de coping orienté vers les tâches puisse faciliter un comportement sain (tel que des réactions appropriées aux crises reliées à l'asthme) qui pourrait contribuer à un meilleur contrôle de l'asthme. Alors que des études prospectives sont davantage nécessaires, celle-ci suggère que pour certains asthmatiques, la gestion du stress pourrait être un adjuvant utile au traitement pharmacologique. De plus, ces résultats soulignent l'importance d'une approche de résolution de problème pour une gestion individuelle efficace de l'asthme.

Keywords: asthma, stress, coping, self-efficacy, quality of life, ventilatory function

Introduction

Asthma is a chronic condition whose prevalence and mortality are increasing despite advances in medical treatment. In North America, 5 percent of the population are estimated to be asthmatic an increase of over 40 percent in the past decade (National Center for Health Statistics, 1996). The age-adjusted death rate from asthma has also increased 40% from 1982 to 1991 (Morbidity and Mortality Weekly Report, 1995). Asthma is associated with greater loss of productivity and death, with mortality doubling since 1978. Rising mortality has been linked to air, especially indoor air, pollution and overuse of certain medications. Many asthmatics receiving appropriate medical treatment have poor control over their symptoms. In part, this may be because a large number of asthmatics do not use their medication correctly or avoid known triggers, even after they have been educated about their illness and its management.

Asthma is a respiratory disorder characterized by variable airflow limitation which can result in recurring symptoms, such as wheezing, coughing, shortness of breath and chest tightness (Ernst, Fitzgerald & Spier, 1996). Asthma symptoms can develop over time as a result of inflammation and production of mucous which plug the airways (Hegele & Hogg, 1996). Asthma symptoms may also result from acute bronchoconstriction, an immediate tightening of the muscles which surround the airways. Unlike other respiratory diseases, the airflow limitation in asthma is usually intermittent and reversible over time or with treatment. Broadly, asthma can be conceptualized as an inability to maintain normal airway tone which may result from an underlying autonomic and immunological dysfunction.

Two categories of medication are used to treat asthma: bronchodilator ("relievers" or "rescue" medications) and anti-inflammatory ("controllers" or "preventers"). Beta-agonist bronchodilators such as salbutamol, albuterol, and salmetrol, rapidly relax bronchial muscles. While useful in acute attacks, their actions may be short-lived and have side effects such as heart palpitations, dizziness, and tremulousness. Heavy use of these inhaled adrenalin-like bronchodilators is associated with increased risk of

death or near death from asthma, loss of lung function and overuse of hospital emergency rooms (Suisa, Blais, & Ernst, 1994).

Recent reviews have suggested that psychological stressors play a significant role in asthma (Busse, Kiecolt-Glaser, Coe, Martin, Weiss, & Parker, 1995; Lehrer, Isenberg & Hochron, 1993) and may do so in at least five different ways. 1) Bronchoconstriction may be triggered directly by a vagus nerve mediated parasympathetic nervous system response to acute stressors. Unlike non-asthmatics, whose airways dilate when exposed to an acute stressor, asthmatics may do the opposite (Porges, 1995; Lemanske & Kaliner, 1990). 2) Stress may activate specific immune system activity, such as cytokine production, which results in airway hypersensitivity and subsequent inflammation (Koh & Hong, 1993). 3) Stress may trigger the initial development of asthma after respiratory infections (Gustafsson, Bjoksten, & Kjellman, 1994). 4) Distress may increase respiratory drive which can lead to both hyperventilation, panic and subsequent exacerbation of asthma symptoms and greater risk of attacks (Carr, Lehrer, Hochron, & Jackson, 1996; Klein, 1993). 5) Stress may decrease the likelihood of appropriate health behaviour (Noeker, 1996). Here, a distressed asthmatics may be too preoccupied by their emotional reactions to respond appropriately to early warning signs of an asthma attack or may use "rescue" medications when their use is not warranted.

A few studies have suggested an association between high stress and asthma in at least some asthmatics (Brantley & Jones, 1993). Hyland (1990) found that three of ten asthmatics had symptoms and lung function that were negatively correlated with distress. Goreczny (1988) found that life event stress and lung function were related in 15 out of 39 asthmatics in his sample. Steptoe and Holmes (1985) found significant correlations between mood and lung function in three of seven asthmatics. It is possible that individual differences in the style of coping with stressful situations account for the high stress-asthma correlations found in some asthmatics and but not in others. Laboratory research by Nouwen, Freeston, Cournoyer, Deschesnes, and Boulet (1994) suggests that some asthmatics do not perceive asthma symptoms accurately and mistake distress for actual bronchial closing. It is possible that differences in perceptual or coping styles play a role in asthmatics' symptom perception and subsequent health behaviour.

A model of asthmatic health behaviour incorporating stress, coping, and self-efficacy may explain earlier findings and have important clinical implications. It has been suggested that experiencing asthma, especially asthma attacks, intensifies experiences of threat and helplessness (Noeker, 1996). These feelings of threat could make emotion regulation, as opposed to problem solving, more likely during episodes of asthma. This could result in continued deficits in asthma management and a lack of confidence in a person's ability to control their asthma symptoms. This low asthma self-efficacy could reduce treatment motivation and adherence, which could then result in greater risk of attacks and worsening symptoms. The symptoms could then lead to more stress and decrease the likelihood of effective coping. This study tests this model by measuring life event stress, coping style, asthma self-efficacy and assessing their relationship with subjective measures of asthma quality of life and with objective measures of ventilatory function.

It was hypothesized that individual differences in coping with stress and in asthma self-efficacy might identify asthmatics with the lowest quality of life, poorest lung function and whose asthma was most responsive to psychological stress. Tested in this exploratory, cross-sectional study were the following specific hypotheses: 1. Major life event stress in the past year will be associated with poorer reported asthma quality of life and lung function. 2. Emotion-oriented and avoidant-oriented coping will be associated with poor asthma quality of life and lung function. 3. Task-oriented coping and asthma self-efficacy will be associated with better asthma quality of life and lung function. 4. Asthma self-efficacy, task-oriented coping, emotion-oriented coping and avoidant-oriented coping will therefore help identify asthmatics whose reported quality of life and lung function are more responsive to stressful events. Specifically, the stress-asthma association will be greater for asthmatics with poorer coping styles.

Methods

Five hundred and seventy-four adult patients of the Respiratory Division, Montreal General Hospital's Asthma Clinic were approached and informed about the study. Two hundred and thirty-six of these patients agreed to complete the questionnaires and grant the researchers access to their medical file which included that day's pulmonary function test results. Diagnosis of

asthma was confirmed by: 1) the presence of reversibility of airway obstruction after bronchodilator (ventolin) inhalation; 2) significant drop in forced expiratory airflow volume in one second (FEV) after small amounts of an irritant, methacholine, were inhaled, indicating airway hyperresponsivity. Asthmatics treated at the clinic received medical treatment in accordance with Canadian Thoracic Society Asthma Treatment Guidelines (Ernst, Fitzgerald & Spier, 1996) and received asthma education from the unit's respiratory therapists. One hundred and thirty-two (78 women and 54 men, ranging in age from 18 to 68; mean age 31.6 years) of those who consented met all inclusion criteria (confirmed asthma diagnosis, medical treatment and asthma education) and completed the questionnaires prior to their pulmonary function tests.

A. Asthma Measures: 1) The Asthma Quality of Life Questionnaire (AQLQ) (Juniper, Guyatt, Epstein, Ferrie, Jaeschke, & Hiller, 1992). Asthma quality of life refers to the subjective impact of asthma on a person's daily life. This concept incorporates symptom severity, activity limitation, asthma-related distress, and dangerousness of environmental triggers. This 32-item questionnaire includes items on activity limitation (on five activities endorsed by the asthmatic), symptom severity (e.g., coughing, wheezing, chest tightness), environmental triggers (e.g., dust, cigarette smoke) and distress caused by asthma (e.g., worry caused by chest tightness).

2) Ventilatory Function tests were carried out in the Pulmonary Function Laboratory of the Respiratory Division of the Montreal General Hospital. Spirometric indicators included: forced expiratory airflow volume in one second (FEV1) - which is the volume of air forcefully expelled in one second, and forced vital capacity (FVC) as measured by the total volume of air expelled from the lungs. Crude FEV and FVC scores are converted into percentages of normal FEV and FVC (FEVP and FVCP) expected for each subject's age, sex, height and weight.

B. Stress Measure: The Life Experiences Survey (Sarason, Johnson, & Siegel, 1979) is adapted from an instrument developed by Holmes and Rahe (1968) to quantify individual differences in the amount of stress experienced in the past year. This questionnaire is a checklist of major stressful life events which assigned a set number of life change units to each major life stressor. Sarason et al (1979) modified the measure by replacing these change units with a respondent's rating of the perceived impact, positive and negative, of each of the

stressful life events experienced (LES). Negative impact totals were used in these analyses.

C. The Coping Inventory for Stressful Situations (CISS) (Endler & Parker, 1990).

Coping is defined as how an individual tends to appraise the demands posed by their environment and assess their resources to deal with the threat (Folkman & Lazarus, 1988). In Endler and Parker's (1990) view, a person's coping style can be defined as their characteristic way of responding to stressful situations. The CISS is a self-report, 48-item questionnaire which assesses the likelihood of choosing particular coping strategies during stressful situations. Sixteen items assess task-oriented coping (e.g., "work to schedule my time better"), 16 items assess emotion-oriented coping (e.g., "freeze and not know what to do"), and 16 items assess avoidant-oriented coping (e.g., "go see a movie to try and forget about it").

D. The Asthma Self-Efficacy Questionnaire (ASE) (Tobin, Wigal, Winder, Holroyd & Creer, 1987). Self-efficacy can be defined as a person's belief in their power to effect events in their environment (Bandura, 1978). Asthma self-efficacy can be defined as an asthmatics' belief in their ability to control symptoms or attacks when

they occur (Tobin, et al., 1987). The 80-item ASE questionnaire examines the confidence of asthmatics in being able to avoid an asthma attack or asthma symptoms in various triggering situations (e.g., "when exposed to pollen" or "when angry or upset").

Results

In this cross-sectional exploratory study, Pearson product moment correlations were calculated between variables specified a-priori. Concerning the hypothesis that life stress and asthma severity would be related, life event stress was found to be negatively correlated with AQL ($r = -.32, p < .01$) but not significantly correlated with FVCP ($r = -.13, ns$) or FEVP ($r = -.16, ns$). Similarly, concerning the hypothesis that emotion and avoidant-oriented coping would be associated with poor asthma control, emotion-oriented coping was found to be negatively correlated with AQL ($r = -.32, p < .01$) and avoidant-coping negatively correlated with AQL ($r = .19, p < .05$) but neither was associated with the ventilatory function measures (see Table 1).

Table 1. Life Event Stress, Coping Style Asthma Self-Efficacy and Asthma

	Indicators of Asthma Severity		
	AQL	FEVP	FVCP
Life stress (neg impact)	-.32**	-.13	-.16
Emotion-orienting coping	-.32**	.00	-.05
Avoidant-oriented coping	-.19*	.08	.15
Task-oriented coping	-.02	.30**	.12
Asthma self-efficacy	.45***	.23*	.25*

Note: AQL = Asthma Quality of Life, FEVP = percentage of predicted forced expiratory airflow volume in one second, FVCP = percentage predicted forced vital capacity

* $p < .05$, ** $p < .01$, *** $p < .001$

With regard to the hypothesis that ASE and task-oriented coping would be associated with good asthma control, asthma self-efficacy was found to be associated with both the subjective and objective measures of asthma. ASE was highly positively correlated with AQL ($r=.45$, $p<.01$). That shared method variance accounted for this high correlation was a possibility as both the ASE and AQL had subscales dealing with specific environmental triggers. However, correlation between the similar subscales was no greater than the overall ASE - AQL correlation. ASE was also significantly positively associated with FEVP ($r=.23$, $p<.05$) and FVCP ($r=.25$, $p<.05$). Task-oriented coping was significantly positively correlated only with FEVP ($r=.30$, $p<.01$).

Stepwise multiple regression analyses using forward selection were conducted using AQL as a dependent measure. Life event stress (LES), Coping (Task, Emotion and Avoidant) and ASE were included as independent variables in the equation. The final step created an equation with three variables: ASE, LES and Task-coping ($R\text{-square}=.39$; $p<.05$), with ASE accounting for the majority of the variance in AQL ($Beta=.53$, $t=5.53$, $p<.001$). This suggests that together, ASE, LES and Task-oriented coping account for 39% of the variance in AQL.

In order to test the hypothesis that certain subgroups of asthmatics, identified on the basis of their coping strategies, would exhibit significantly greater stress-asthma correlations, analyses were conducted to compare the correlations of subsamples split at the medians for ASE and for task, emotion or avoidant coping ($n=66$ for each subsample). T-tests were conducted after Fisher z transformations of the correlation coefficients. A high correlation of $r=.48$ ($p<.01$) was found between LES and FEVP in the high avoidant-oriented coping subsample, whereas the same correlation in the corresponding low avoidant-coping was negligible. Similarly, the high emotion-oriented coping subjects had a significantly larger negative correlation between LES and FEVP ($r = -.26$ compared to $r = -.09$, $p<.05$). There was no difference in the correlations of stress and AQL among the emotion and avoidant subgroups. In contrast, the low task-oriented group was found to have significantly larger negative correlations both between LES and AQL ($r = -.40$ vs $r = -.26$; $p<.01$) and between LES and FEVP ($r = -.26$ vs $r = -.01$; $p<.01$). ASE subgroups did not differ in their stress-asthma correlations.

Discussion

The hypothesis that major life stress and asthma quality of life would be negatively associated was supported. Those who reported more negative life stress in the past year tended to experience the greatest impact of asthma on their life, though they did not necessarily have the worst lung function. This could be explained by the prediction that the occurrence of many negative stressors prevents the health behaviour crucial to control of asthma. However, a number of alternative explanations are also possible. Perhaps those who are limited in their activities due to asthma are more likely to experience other negative events (financial, interpersonal, professional). Alternatively, the type of people who report negative stressful life events may also report more symptoms (Cohen & Herbert, 1996). Future longitudinal research is required to determine which explanation best accounts for this finding.

The hypothesis that major life stress would be negatively associated with lung function was not supported. It is possible that if only a subpopulation of asthmatics are "stress responders," the magnitude of the ventilatory function-life stress correlation of all the subjects was lowered by that of the non-responders. Note that the subgroup analyses uncovered significant stress-ventilatory function correlations for the low task, high emotion and high avoidant-oriented coping subgroups. These subgroups appear to be particularly vulnerable to stress. It is also possible that there is no association between life event stress and relatively stable measures of ventilatory function.

Use of emotion and avoidant-oriented coping was associated with lower asthma quality of life, suggesting that these coping styles are associated with either: a) deficits in the ability to cope effectively with a chronic illness such as asthma; or b) the tendency to exaggerate the impact of their illness on their life.

The high correlation between asthma self-efficacy and asthma quality of life suggests that confidence in one's ability to deal effectively with asthma symptoms and attacks plays a large role in a person's overall subjective assessment of asthma severity. Asthmatics with high self-efficacy may minimize the subjective impact of their disease, reporting fewer symptoms and limitation, and/or be more likely to exhibit appropriate health behaviour which then results in better asthma control and less reported asthma severity. Alternatively, high asthma self-

With regard to the hypothesis that ASE and task-oriented coping would be associated with good asthma control, asthma self-efficacy was found to be associated with both the subjective and objective measures of asthma. ASE was highly positively correlated with AQL ($r=.45$, $p<.01$). That shared method variance accounted for this high correlation was a possibility as both the ASE and AQL had subscales dealing with specific environmental triggers. However, correlation between the similar subscales was no greater than the overall ASE - AQL correlation. ASE was also significantly positively associated with FEVP ($r=.23$, $p<.05$) and FVCP ($r=.25$, $p<.05$). Task-oriented coping was significantly positively correlated only with FEVP ($r=.30$, $p<.01$).

Stepwise multiple regression analyses using forward selection were conducted using AQL as a dependent measure. Life event stress (LES), Coping (Task, Emotion and Avoidant) and ASE were included as independent variables in the equation. The final step created an equation with three variables: ASE, LES and Task-coping ($R\text{-square}=.39$; $p<.05$), with ASE accounting for the majority of the variance in AQL (Beta=.53, $t=5.53$, $p<.001$). This suggests that together, ASE, LES and Task-oriented coping account for 39% of the variance in AQL.

In order to test the hypothesis that certain subgroups of asthmatics, identified on the basis of their coping strategies, would exhibit significantly greater stress-asthma correlations, analyses were conducted to compare the correlations of subsamples split at the medians for ASE and for task, emotion or avoidant coping ($n=66$ for each subsample). T-tests were conducted after Fisher z transformations of the correlation coefficients. A high correlation of $r=.48$ ($p<.01$) was found between LES and FEVP in the high avoidant-oriented coping subsample, whereas the same correlation in the corresponding low avoidant-coping was negligible. Similarly, the high emotion-oriented coping subjects had a significantly larger negative correlation between LES and FEVP ($r = -.26$ compared to $r = -.09$, $p<.05$). There was no difference in the correlations of stress and AQL among the emotion and avoidant subgroups. In contrast, the low task-oriented group was found to have significantly larger negative correlations both between LES and AQL ($r = -.40$ vs $r = -.26$; $p<.01$) and between LES and FEVP ($r = -.26$ vs $r = -.01$; $p<.01$). ASE subgroups did not differ in their stress-asthma correlations.

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efficacy may simply be a result of experiencing less severe asthma. The finding that asthma self-efficacy was also positively associated with ventilatory function suggests that there is a relationship between self-efficacy and objective measures of asthma severity. However, it cannot be inferred from these data whether the asthma self-efficacy leads to health behaviour which then results in better asthma control or is simply a consequence of less impaired lung function.

Interestingly, task-oriented coping was associated with a measure of ventilatory function but not with asthma quality of life. It is possible that a task-oriented coping style is associated with more appropriate health behaviour which then results in improved lung function. Asthmatics who score high on task-oriented coping may have a realistic assessment of how asthma impacts on their life and neither exaggerate nor minimize subjective reports of asthma severity. Task-oriented coping may be associated with a greater propensity for the health behaviour, such as medication compliance and trigger avoidance which directly affect ventilatory function. The fact that task-coping emerged as one of the variables in the multiple regression equation predicting asthma quality of life suggests it may buffer the effect of stress or bolster the effect of self-efficacy on subjective measures of asthma control.

A limitation of this study is its reliance on questionnaire and ventilatory function data from one time only. Therefore, no conclusions about causal links or directionality can be inferred. Our ongoing prospective studies are addressing issues of directionality, temporal links and the influence on variables such as daily "rescue" medication use (Aboussafy, Ernst, Aboud, & Rodrigues, 1997; Aboussafy, Ernst, Aboud & Katz, 1997).

In terms of clinical implications, this study suggests that facilitation of a problem-solving approach toward managing asthma should be an important part of asthma treatment and education programs. Additionally, the subgroup analyses suggests that for asthmatics with ineffective coping, stress management could be a useful adjunct to appropriate medical treatment.

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Examining Factors that may Affect Drop-out in Addictions Treatment: A Look at the Assessment and Engagement Process

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Abstract: Research on addictions treatment outcome reveals a high early drop-out rate which may be attributed to a complex interaction of client and treatment characteristics. Client/treatment matching is based on the premise that a thorough understanding of the client's problems will lead to appropriate treatment recommendations and enhanced therapy outcomes. The objective of this study was to evaluate the impact of an intensive initial assessment phase of therapy on the 90-day drop-out rates in a substance abuse clinic. Rates of retention in treatment for 238 clients assessed at the Addictions Unit of the Montreal General Hospital between April, 1993 and November 1994 receiving the standard approach were compared with retention rates for 119 clients assessed between November, 1994 and July, 1995 receiving the more intensive approach. The standard approach consisted of an initial assessment and referral to group therapy or in-patient treatment. The new approach consisted of an assessment phase lasting over 4 - 6 weeks, including once weekly group therapy and individual weekly sessions after which referral was made to longer term group therapy or other treatment. Results indicated that the new assessment and engagement procedures did not significantly alter the three month retention rate of approximately 50%. This surprising finding is discussed in the context of program evaluation in addictions treatment

Introduction

Description of the Addictions Unit

The Addictions Unit is part of the psychiatry department of the Montreal General Hospital, a teaching hospital affiliated with the Faculty of Medicine at McGill University. The service is mainly out-patient with a four bed capacity for in-patient detoxification. Group therapy, which is eclectic, consisting of psychoeducational, supportive, cognitive-behavioural and psychodynamic orientation is the main therapeutic modality. Groups are conducted by mental health professionals of different disciplines, most work part-time and the full-time equivalent of these therapists is 4.3. A general practitioner and two psychiatrists provide evaluation, consultation and pharmacotherapy. A full-time psychologist conducts and co-ordinates research. The Clinic follows from 350-380 clients per year. The length of treatment recommended is one year. The Addictions Unit is officially designated as an English-language facility and services Montreal and the surrounding metropolitan area. The treatment model is abstinence oriented.

Background of Study

An initial pilot study of 238 clients admitted to the Unit revealed that the highest rate of attrition was in the first month (Joe, Brown, & Simpson, 1995). There are a multitude of reasons that could explain this finding, many of which might be related to client characteristics (Agosti et al, 1991; Roberts et al, 1996; Soghoian & Gill, 1993). The information about the drop out rate coincided with therapists wondering if our standard assessment and procedures for initiation into therapy were effective. We wondered if treatment design and delivery could in any way affect the early drop-out rate (Addenbrook & Rathod, 1990; Carroll et al; Kang et al, 1991; Keaney et al, 1995; Hoffman et al, 1993; Roberts & Nishimoto, 1996).

A committee consisting of the senior psychiatrist, psychologist researcher, and three team therapists met every two to four weeks over ten months in order to carry out a literature review, consult with other treatment programs about their organization and methods of treatment, and to keep open communication between the committee and other team members. The committee then designed, and several months later, launched the new intensive assessment process. The goals of the new approach were to reduce the drop-out rate in the first month of therapy and to increase longer-term retention by

improved client/treatment matching as a result of more thorough assessment in the initial phase.

The Standard Approach

The standard approach consisted of the following procedure. A client who called to be admitted to the program was placed on the waiting list, which was usually between eight to twelve weeks before he or she was seen for initial assessment. On the day of assessment, the client was first interviewed by a team therapist, who then summarized and related this information to a psychiatrist and several other team therapists. The client was then interviewed by the psychiatrist, with team therapists present, for a brief psychiatric evaluation and to answer additional questions. At the end of the interview, a plan was formulated and the client was referred to a therapy group, a short waiting list for in-patient detoxification, or another treatment center. If a client was referred to a therapy group, he or she would remain in the same group and be followed by the same primary therapist for the duration of treatment. Evening groups met once weekly for one and a half hours, day groups met twice weekly for the same amount of time. Clients admitted for in-patient detoxification were assigned to out-patient therapy groups after this was completed or referred to residential treatment programs in some cases. Recommended length of treatment was one year. All clients participated in the random urine screening program.

The Intensive Assessment Approach

The following procedures were instituted in the new assessment approach. As before, those that called for treatment were put on the waiting list, which remained between eight to twelve weeks. Soon after the telephone screening, they were mailed a brief description of the therapy program and procedures involved in treatment. On the day of initial assessment, the client was seen by the assessment therapist and sometimes by a psychiatrist as well. The client completed the Beck Depression Inventory and the Symptom Checklist-90. The major change in the treatment program was that it was now divided into two separate phases. Phase I was the initial assessment and engagement period lasting up to 6 weeks during which time the client's primary therapist was the assessment therapist, who continued to provide the individual and group sessions. Phase II consisted of the usual group therapy program which clients would attend, on average for 10 months to one year, with a new primary

therapist after completion of Phase I.

During Phase I the client had individual meetings following assessment for three weeks with the same therapist who gathered additional information, provided feedback, and worked on motivation (Miller & Rollnick, 1991). In addition the client attended once weekly group meetings of a psychoeducational orientation led by the same therapist. At the second or third week, the client was also seen by the general practitioner in order to review medical history, complete a physical examination and follow pharmacotherapy for out-patient detoxification if necessary. A psychiatric interview was set up if this was determined necessary by the assessing therapist. The first individual interview after initial assessment involved a brief meeting with the therapist and the client completed the computerized DISSI. The second individual session consisted of a brief cognitive screening (Trial A,B, Shipley "Institute of Living Scale") and update of progress with the therapist. The third individual session with the therapist was a feedback session and designed to make future treatment plans. These plans could consist of referral to another treatment center, admission for in-patient detoxification, referral to Phase II of the Addictions Unit program, or if necessary, two more weeks in the Phase I group to determine the plan.

At the end of Phase I if the recommendation was continued therapy in the Addictions Unit (based on the client's attendance, motivation, ability to achieve abstinence from drugs), he or she was assigned to a new primary therapist for Phase II group therapy until completion of treatment ten months to one year later.

The same random urine screening procedure as in the standard approach was used throughout the therapy.

The Study Samples

The Standard Treatment Approach consisted of the initial pilot study of 238 clients assessed at the Addictions Unit between April, 1993 and November, 1994 who received the standard treatment approach.

The Intensive Assessment Approach A total of 119 clients who were assessed at the Addictions Unit between November, 1994 and July, 1995 who received the intensive assessment approach comprised this sample.

Tables 1 - 3 provide demographic, substance abuse and self-reported psychiatric histories of the two groups of clients.

Table 1 DEMOGRAPHIC CHARACTERISTICS

	Standard	Intensive
Age	38.9 years	38.1 years
Gender (%)	67.6 male	70.6 male
Race (%)	91.9 Caucasian	94.9 Caucasian
Reason for Tx (%)	36.1 health 15.5 family	34.5 health 25.0 family
Education (%)	24.4 secondary 24.9 higher	58.1 secondary 39.3 higher
Employment (%)	46.8 unemployed 33.8 full time	47.5 unemployed 37.3 full time
Marital Status (%)	42.9 single 33.0 married 21.5 divorced	38.5 single 26.5 married 33.3 divorced
Living Arrangements (%)	34.6 spouse 22.4 parents 32.1 alone	28.1 spouse 21.1 parents 38.6 alone

There were no significant differences between samples on any variable

Table 2 SUBSTANCE ABUSE HISTORY

	Standard	Intensive
Age 1st use	21.8 ± 0.7	19.9 ± 0.8
# years problem use	10.6 ± 0.5	11.3 ± 0.8
% using daily	67.7	55.8 **
% abusing 2nd drug	58.0	53.8
# prior in-patient Tx	0.49 ± 0.09	0.55 ± 0.09
# prior out-patient Tx	0.77 ± 0.055	1.18 ± 0.1 **
% repeated admission	17.1	6.8 **
% self-referred	40.0	17.2 **

**significantly different (p<0.05) by Students t-test or Chi-square analysis

Table 3 SELF-REPORTED PSYCHIATRIC HISTORY

Psychiatric Symptomatology	Standard	Intensive
Mood disorder (%)	71.7	77.0
Anxiety (%)	58.4	45.5 **
Psychosis (%)	25.8	29.4
Suicidal Behaviour (%)	64.1	56.9
Violent Behaviour (%)	41.2	50.9
Cognitive Impairment (%)	58.3	72.8 **

**sample significantly different by Chi-square analysis, p < 0.05

Table 4 TREATMENT OUTCOME

	Standard	Intensive
Mean length of stay in treatment (days)	101.3 ± 4.7	87.19 ± 6.6
% referred out	11.9	12.6
% drop-outs	67.7	64.7
% positive urine screens	34.1 ± 2.8	41.5 ± 3.8
# individual therapy sessions	5.92 ± 0.32	6.6 ± 0.49
# group therapy sessions	9.8 ± 0.7	8.1 ± 1.0

Outcome

Table 4 summarizes the outcome of the treatment for the two groups.

Survival curves at 180 days comparing the standard versus the intensive approach showed no significant differences between the two groups (Fig. 1). The change in the assessment and engagement approach did not reduce the early or overall drop-out rate.

Discussion

This study raises a number of interesting questions regarding therapy for addiction and program evaluation. Although the design of the new assessment and engagement procedure was for the client to have more individual sessions, clients did not, in fact, attend more sessions. In the new approach, we still lost approximately 20% of clients after the initial assessment and continued to lose clients at approximately the same rate as the standard approach over the six month period. Therefore, we are not really evaluating the effectiveness of a more intensive engagement approach since clients overall, did not attend more therapy.

An additional goal of the more intensive assessment approach was to learn more about client characteristics and match these to treatment approach. We have a long way to go in this area, but the study did provide some information that distinguishes between those that stayed in treatment and those that dropped out. The completers reported more initial health problems, had more education and were more often employed. It is possible that this group were motivated for treatment, having identified health problems and also possessed the resources to engage in therapy. Another factor that was significant was the level of depression as measured by the BECK Depression Inventory at assessment. Those with a BECK score of greater than 18 tended to drop out of therapy more quickly as well as more overall compared to those with lower BECK scores (Fig. 2). This analysis was only possible for the intensive assessment approach.

There were no significant differences found between completers and non-completers in terms of cognitive screening. However, since this screening was carried out in the third week (second week after initial assessment), we may have already lost a proportion of those who would have shown cognitive deficits.

Fig 1

RETENTION IN TREATMENT TO 6 MONTHS OF FOLLOW-UP STANDARD VS INTENSIVE TREATMENT

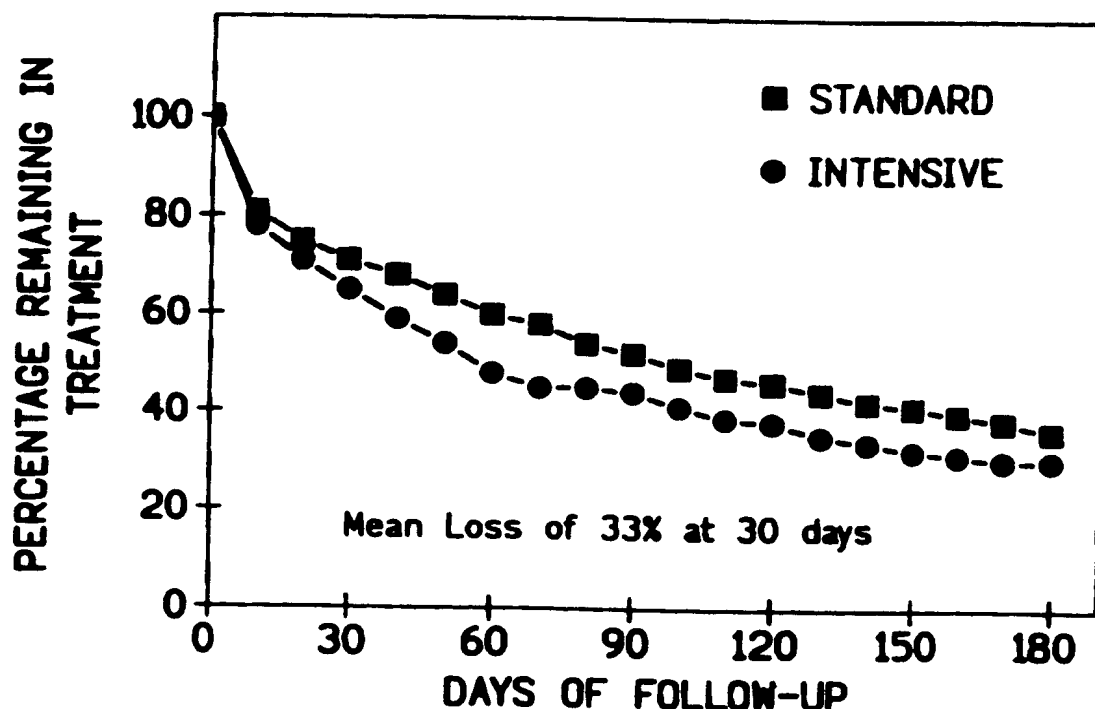
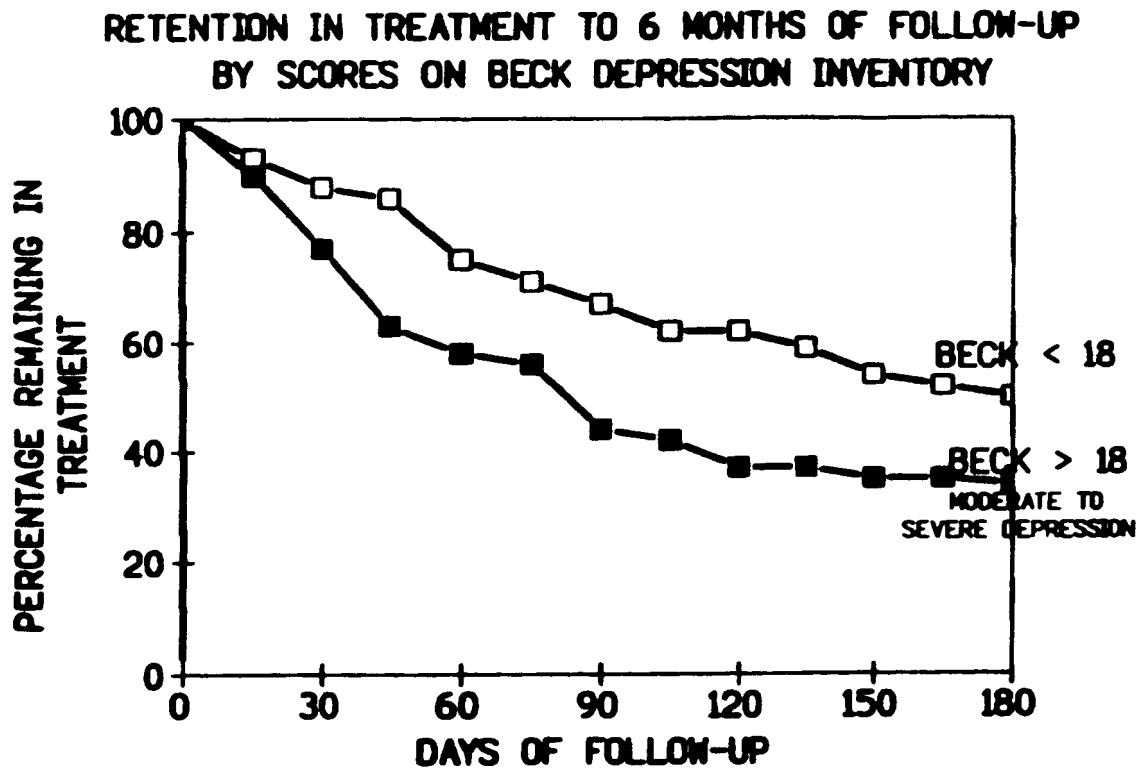


Fig. 2



Retention in treatment was also significantly different between drug groups. The alcohol group showed a median survival of 135 days in treatment; the opiate group a median survival of 49 days. There was a loss of close to 30% of opiate users after the initial assessment, compared to 15% loss of alcohol users after initial assessment.

Clearly, these differences indicate that one standard assessment approach may not be possible to reduce attrition in addiction treatment but this study has allowed us to more carefully examine certain groups that may need a different approach for enhancing engagement and commitment to therapy.

The findings also serve to question some of the assumptions that are often made about therapy, especially that more is better. Those that leave treatment are still, in fact, receiving some type of intervention and feedback and it will be interesting to find out in our follow-up studies, the differences in outcome between completers and non-completers. The completers received a mean number of 10 individual and 20 group sessions; a total of 30 sessions. The non-completers, however, received a mean number of 5 individual sessions and 6 group sessions, a total of 11 sessions. What we need to learn more about is the impact of limited intervention on the outcome of drug use as

compared to those who stay in treatment longer.

Questions about readiness for change related to the Stages of Change Model developed by Prochaska and Di Clemente (Prochaska et al., 1992) and level of motivation when entering treatment could also be part of the picture not examined in this study. It is possible that no matter what the approach, a certain percentage of clients will not be ready to embark on the "action" stage of change and will decide not to follow through with treatment. We have not measured any movement from one stage to another using this model, but studies to evaluate this in the context of use of motivational interviewing techniques might provide some enlightening information.

In summary, the new program design did not affect length of stay in treatment, but the more thorough assessment may in the long run guide us in designing approaches that will address the needs of those that we lose early in treatment. This study will also lead to more research into treatment outcome based on shorter periods of intervention and address questions about differences in perception between what the therapist views as treatment completion versus the client's view of what is enough and what is effective in addressing the problems of addiction.

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Reliable Individual Change in Cognitive-Behavioural Group Therapy for Chronic Pain

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INTRODUCTION

As clinicians are being called on increasingly to demonstrate the effectiveness of their work, program evaluators have begun to develop new methodologies that bridge the gap between statistical criteria for assessing treatment outcomes, and the more clinically focussed assessment of change in individual patients. The "reliable change index" is one recent development in this context (Speer, 1994). To measure reliable change, the test-retest reliability of an outcome measure is used to construct confidence intervals around a patient's pre-therapy assessment score. The confidence intervals define the limits within which post-therapy scores might be expected to fluctuate by chance. Post-therapy scores that fall outside of this predicted range represent statistically reliable individual changes (at $p < .05$). Two important advantages of the reliable change index are that: (1) statistically significant changes can be identified for individual patients, which is helpful for case management and clinical evaluation, and; (2) both improvement and deterioration rates can be calculated, which provides an intuitively meaningful description of a program's effectiveness that may be less apparent in presentations of group means.

The present study demonstrates the use of reliable change indices in the evaluation of a cognitive behaviour therapy (CBT) program for patients with chronic pain.

METHOD

Subjects, Measures, and Treatment

In order to determine the test-retest reliabilities of the outcome measures, 30 patients (14 males and 16 females) with chronic pain complaints completed a battery of questionnaires on two occasions (nine weeks apart) while they were on a pre-treatment waiting list. The measures

included the Medication Quantification Scale (MQS: Steedman et al, 1992), the McGill Pain Questionnaire - Short Form (MPQ-SF: Melzack, 1987) a modified version of the Roland-Morris Disability Questionnaire (RMDQ: Roland & Morris, 1983), a Pain Knowledge Quiz (PKQ: a 20-item multiple choice test of knowledge about pain management, which was developed for this evaluation) and the Beck Depression Inventory (BDI: Beck & Steer, 1987).

For the outcome evaluation, 72 different patients (19 males and 53 females) completed the same measures before and after participating in a nine-week course of group CBT. The groups comprised weekly two-hour sessions, and addressed such issues as psychological influences on pain, medication use, activity pacing, relaxation and stress management.

RESULTS

Test-Retest Reliabilities

The test-retest reliabilities for the wait-list patients ranged from $r = .48$ for the MPQ-SF to $r = .89$ for the BDI. The other measures exhibited moderate to good stability over the nine-week period (MQS: $r = .67$; RMDQ: $r = .82$; PKQ: $r = .73$).

Treatment Outcome: Group Means

Paired t-tests comparing pre-therapy and post-therapy mean scores indicated that, as a group, patients reduced their medication use, $t(70) = 2.90$, $p = .005$, showed significant decreases in BDI scores, $t(68) = 2.43$, $p = .018$, and had enhanced knowledge about pain management on the PKQ, $t(69) = -9.81$, $p < .001$. However, pain intensity did not change on the MPQ-SF, nor did RMDQ self-reports of disability ($ps > .10$).

Reliable Change Indices

Whereas the foregoing analyses focussed on outcomes at the level of group means, the reliable change analyses focussed on outcomes for individual patients. The

computational steps involved in the calculation of confidence intervals and reliable change indices are described by Speer (1994).

Across the five different outcome measures, rates of statistically reliable individual improvement ranged from 0% (pain intensity on the MPQ-SF) to 36.4% (knowledge of pain management on the PKQ) of patients, with other measures falling in between (MQS: 27.0%; RMDQ: 18.3%; BDI: 23.5%). Overall, 31 patients (44.3%) showed statistically reliable improvements on at least one outcome measure, and 14 patients (20.0%) improved on at least two. However, nine patients (12.9%) also showed deterioration on at least one measure.

DISCUSSION

The analysis of reliable change indices can be a valuable component of program evaluation, providing information about individual patients that complements the statistical analysis of aggregate group data. Meaningful application of this methodology requires the use of measures that have good test-retest reliability. For constructs that are inherently variable (i.e., pain intensity in the present study), reliable change may be more difficult to document. In this evaluation, the reliable change indices were also useful for identifying specific areas of intervention that seem to require greater emphasis. One alternative that is currently being pursued is the integration of CBT with a physiotherapy conditioning program, in an effort to achieve a greater impact on pain-related functional disability. The extent to which this results in better outcomes for more patients can then be determined in future evaluation projects.

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The Prostate Cancer "Epidemic"

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Prostate cancer is presently in the process of becoming highly politicized. It is now on the public agenda as a disease worthy of disease-specific financial investment. Support groups, including two based originally in the US, Man to Man and Us Too, as well as the indigenous PSA, (which stands for both Prostate Support and Awareness and the newly available test for prostate cancer - the Prostate Specific Antigen) and a number of unnamed locally-based support groups have sprung up across the country since 1990. By 1997 there was a national forum, held in Toronto (February 27 to March 2) with the explicit goal of bringing together stakeholders to develop a consensus on directions for the future of research, communication and advocacy activities related to prostate cancer. Those in attendance included prostate cancer support group members, representatives of drug companies, urologists and other physicians, researchers, and policy makers from various government bodies as well as the Canadian Cancer Society and the National Cancer Institute of Canada.

Following the Forum, a National Support Group Conference was held. This was for support group leaders and members who had been working together in a year and a half year old fledgling group called the Canadian Prostate Cancer Network. It was a foundational meeting, where the year and half old CPCN established itself as a national network of support groups whose mandate is one voice in advocacy, fundraising and public awareness. The approximately sixty or more support groups under the umbrella of CPCN, including upwards of several thousand men, intend to continue to develop and provide their main focus -support for patients and their families over the duration of the disease. The CPCN is to undertake national-level tasks such as fundraising and

increasing awareness.

The purpose of this paper is to discuss the processes of mobilization and politicization related to prostate cancer in Canada, and to compare this to research on the processes that other diseases may have passed through in their struggles for national recognition, financial investment, supportive care and ultimately prevention and eradication. A number of social theorists and researchers have examined the 'popularization' and politicization of several different diseases including sudden infant death syndrome, polio and cancer and AIDS (Sills, 1957; Barber, 1968; Strickland, 1972; Kunitz, 1974; Lally 1977; Altman, 1986; Weston and Jeffrey, 1994; Sontag, 1989). To summarize, among the variables suggested as important in the politicization of a given disease are the following: (1) the morbidity and mortality and consequent costs for the treatment of each disease; (2) the publicly perceived and portrayed socio-demographic and gendered profile of sufferers; (3) the 'meanings' of the disease; (4) the actual social characteristics of patients including characteristics such as gender, age, ethnicity/race, and socio-economic status; (5) public awareness as reflected in media reports; (6) the effectiveness of national organizations; (7) the extent to which the disease is thought of as a major problem by influentials in national (disease-related) policy-making bodies; and (8) the assessment by influential scientists of the feasibility and promise of research. Each of these proposed factors will be discussed in turn. Figure 1 provides a portrayal of the 'model' under discussion.

Figure 1
Literature-Based Model

Morbidity & Mortality
Perceived SES and other Social -
Demographic Characteristics of Sufferers
Meanings of the Disease
SES and other Social-Demographic
Characteristics of Sufferers
Public Awareness of Disease
National Organization
National Influentials
Potential of Research



Disease
Politicization

EXPLANATIONS

First: Morbidity and Mortality Rates

By 1995, prostate cancer was recognized as the second (after lung cancer) most common cause of cancer-related death among Canadian men (National Cancer Institute of Canada, 1995). There has also been a dramatic increase in incidence, prevalence and morbidity. As the incidence and mortality rates for two of the major competitors for the chief cause of death and serious life-threatening illness (i.e. heart disease and lung cancer) have declined in their toll on the population, the existence and the significance of prostate cancer has grown. Between 1970 and 1990 the disease grew at a rate of 3% annually and the mortality rate grew 1% annually (Levy, 1994). In 1990 it became the most frequently diagnosed cancer in men, surpassing lung cancer. Age specific mortality did not increase over this period except possibly in the very oldest group of men.

Second and Third: Disease Perception and Meaning

There has been little discussion about prostate cancer in the media until very recently. In fact it is often recounted that many men do not even know that they have a prostate gland, nor where it is or what it does. There are few descriptions of the social characteristics of men with the disease. Those who are profiled in the media tend to be middle aged or older, and white. In fact, when we interviewed some of the leaders of the burgeoning prostate cancer movement they emphasized the importance of finding Canadian "heroes" who would be willing to come out of the closet about having had prostate cancer and argued that such men should be

macho and big, and preferably already well known or be sports celebrities. Race/ethnicity was not mentioned. (from other related descriptions, it may be safe to assume that we are talking about white males.) A recent study of the meanings associated with prostate cancer in select print media indicate that it is associated with masculinity in specific ways. "Articles focus on prostate cancer, not merely as a neutral, mechanical, physiological occurrence that happens to a particular organ, the prostate gland, but as a disease with particular masculine attributes and consequences"(Clarke, 1997a). The focus is on the threat to manhood, to sexuality and to machismo, rather than to life itself. Men are exhorted to become like women with breast cancer, active in fighting for research funds, and, to come out of the metaphorical closet, as people who are no longer ashamed of themselves or of an aspect of their identity. It is a one-sided, gendered portrayal that stereotypes men. It does not reflect the ambiguity about the value of knowing of a early stage diagnosis in the context of treatments that are of uncertain value and often significant side-effects.

Fourth: Social Characteristics of the Diagnosis

Prostate cancer is a male disease. It also has tended to be a disease of older males. For example, in Canada the number of potential years of life lost due to prostate cancer, even though the mortality rate is comparable to that of breast cancer, is 30,000 years. The comparative figure for women with breast cancer is 90,000 years of life lost. This figure is a reflection of the average age of death of the two diseases. Prostate cancer appears to be more frequent among African-Canadians. The reasons for

this are unknown. No association of this disease with socio-economic status has been reported, but it is probable that the growing incidence is related to early detection, which in turn is positively correlated with education and social class. There is ample evidence that the utilization of physicians for other early detection tests is related to education and SES.

Fifth: Public Awareness

There is presently very little widespread awareness of the disease but this is changing. In 1975-1976 there were no articles on prostate cancer in the Canadian mass media. The peak number until the 1990's was 9 in 1987. By 1991 there were 44 and in 1992 and 1993 there were 40 and 40 respectively. It is also instructive to note here how relatively few articles there are when compared to breast cancer (Clarke, 1997b).

Sixth: National Organization

A fully national organization of support groups was just formed in 1997. This is building on the first meeting of 11 support groups from across Canada in November of 1995. In the early 1990s, individual men brought information and start up packages of materials to Canada from the United States. These materials represented two different groups that had been started in the United States in the early to mid 1980s called US TOO and MAN to MAN. British Columbia has a provincial network of support groups called PSA. This network was established in about 1993 and has grown to include more than 14 support groups, a province-wide newsletter and has received some assistance from the Canadian Cancer Society and the British Columbia Cancer Agency in the form of mailing services and costs and the provision of meeting spaces. Their main goals are to raise awareness about prostate cancer, including the availability and accessibility of the PSA test and to assist men with prostate cancer by providing peer support and information. For the past three years they have organized an annual prostate awareness campaign. Each group has its own executive board. Approximately 30 to 100 people attend meetings in Vancouver and 50 to 150 in Victoria. Their meetings generally include spouses.

In about 1993 Norm Oman started a group in Winnipeg. This was based, at first, on US TOO a prostate self help organization started in 1990 in the US by Ed Kapps, with the help of the American Foundation of Urological Diseases. Mr. Kapps visited several Canadian cities in the early 1990s. Norm Oman started under the US TOO

umbrella but has moved beyond its particular goals. After establishing the group in Winnipeg, Oman set off across the country with the moral, practical and financial support of Zeneca pharmaceuticals and the Canadian Cancer Society and helped to establish support groups, usually with the assistance of local urologists, who invited the men in their practices who had been diagnosed with prostate cancer to meetings.

Another major contribution to the national support group profile is the MAN to MAN group started in 1992, after Wally Hamilton attended Man to Man groups in Florida and then brought the idea to Toronto. In 1994, Man to Man began bi-monthly general assembly and information meetings in Toronto. Presently there are some 700 men on the mailing list and an average of approximately 150 men attend meetings. This group rents a community hall so as not to be associated with a hospital. They have an executive, large educational, informational meetings that generally include a talk by physicians, small support groups, meetings for wives called Side by Side and a medical advisory board. They have provided Toronto area physicians with information about prostate cancer through direct mail campaigns. The organization also has a phone line.

Seventh: Views of Influential People

Prostate cancer is increasingly thought to be an important disease by influential people and organizations in Canada. Note for example, the recent National Forum on Prostate Cancer which was followed by the National Support Group Conference. Sponsors of the forum included Health Canada, Zeneca Pharmaceuticals, Pharmacia and Upjohn and involved representatives of the National Cancer Institute of Canada, the Canadian Cancer Society support groups from across the country, representatives from the Uro-oncology group, the Canadian Prostate Cancer Foundation and others. Clearly all of the most important players in research, support, policy making and clinical work were represented.

A brief look at the names and mandates of a number of the recently established organizations gives added weight to the argument that national influentials are increasingly involved in prostate cancer. For instance, the Canadian Uro-Oncology Group was formed in 1989 as an affiliate of the Canadian Urology Foundation; the Canadian Prostate Health Council was recently established and published a quarterly newsletter (Prostate Update) as of November 1994, as well as a number of related booklets

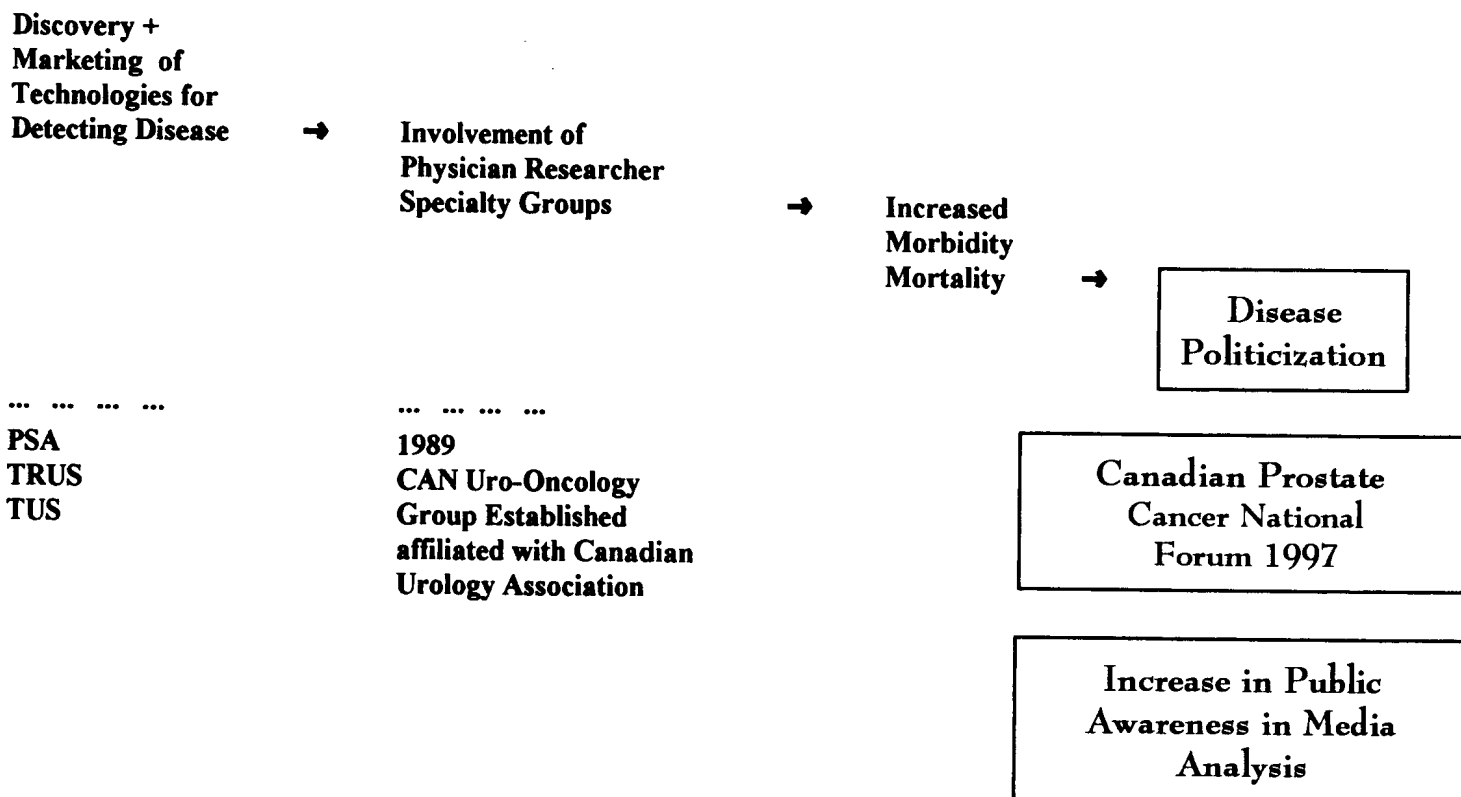
for physicians and lay people. The Canadian Prostate Cancer Foundation was established in 1996 to support various kinds of research and to increase public awareness. The Canadian Prostate Cancer Research Fund was established in 1994, also to raise funds for prostate cancer education and research. Abbott Laboratories created a national awareness campaign and within the past year began publishing a magazine on prostate cancer called *Our Voice/Entre Nous*. Schering Canada Inc. now sponsors speakers and a range of informational pamphlets. Several other pharmaceutical companies are presently making major thrusts into the prostate cancer arena including Pharmacia & Upjohn, Hoechst Marion Roussel Canada Inc., Janssen-Ortho, Berlex Canada Inc., Amersham Canada Ltd., Bristol Meyers Squibb Canada Inc. and Mentor Medical Systems Canada.

Eighth: Assessment of Feasibility and Promise of Research

The national forum on prostate cancer endorsed a call for more funds for prostate cancer research. In 1993 there was a major meeting of researchers in this field and a special publication resulted (Fradet and Meyer, 1994). Undoubtedly the involvement of the major national influentials and the medical device and pharmaceutical companies will mean an increase in research related to prostate cancer.

All of the eight factors proposed by previous research are evident as causal or correlated factors in the politicization of prostate cancer. There is, however, one important factor that has been neglected. As we continued to try to understand the rapid politicization of prostate cancer the role of technology became increasingly evident. An emerging model is suggested by Figure 2.

**Figure 2
Emerging Model**



Discussion:

The widening gap between incidence and mortality of prostate cancer suggests that the increased incidence reflects either earlier detection or more effective treatment (Levy, 1994). Since 1990, the rates of prostate cancer have grown even more dramatically at about 10-15% annually on average in Saskatchewan, Alberta and Ontario. This finding suggests the impact of new diagnostic procedures. Indeed since 1990, the PSA test, available since 1986, and the transrectal ultrasound which allows for a more effective guided biopsy, have been more widely utilized (Levy, 1994). Another reason for the increasing diagnosis is the growth in frequency of a type of surgery indicated for benign prostate disease, the transurethral resection. This is due to the fact that tissue samples were more likely to have been, once retrieved and tested, found to have carcinoma of the prostate. This evidence points to the importance of the early diagnosis in the rising rates of prostate cancer. So, too, does the fact that there are more men with early and very early stage disease while the incidence of late stage disease has not changed substantially.

The increasing use of PSA, of transurethral resection (for benign prostate disease) and of the transrectal ultrasound have also meant increased costs associated with prostate cancer. For instance, in British Columbia, 53,764 PSA tests were conducted at \$25.62 each for a total of \$1,377,433.68 in the fiscal year 1992-1993. Moreover the apparent increasing incidence that is associated with these early detection related techniques has meant increasing costs from associated surgery and radiation. It may be important to note here that these treatments are also associated with high rates of both incontinence and impotence (and the social and material costs associated with these side-effects). Moreover the evidence is not clear yet that early surgical or radiation intervention has beneficial consequences for the cure of the disease or for longer life after diagnosis. As one physician researcher Bassett (1994) has stated "40% of men over the age of 50 will have indications of, at least, early stage prostate cancer while only 1 in 400 will die of the disease".

There is no doubt that prostate cancer has become politicized as a disease worthy of disease-specific financial investment in areas related to prevention, early detection and treatment. A causal analysis of this process would not allow us to forget the importance of the discovery of and the subsequent marketing of medical tests and interventions such as the PSA, the TRUS and the TUS in the subsequent incidence rates. Nor is it possible to ignore

that some of the early group organizing was initiated by pharmaceutical companies, who approached physicians to invite their patients with prostate cancer to organizing meetings of support groups across the country. Therefore, understanding prostate cancer's politicization must include understanding what appear to be the important roles played by pharmaceutical companies as well as physicians and physician specialty groups.

In conclusion, then, there is a burgeoning prostate cancer movement growing fast on the heels of the breast cancer movement of the late 1980s and early 1990s. It follows the reputed great success of the AIDS movement. There are numerous questions that need to be raised about the growth of such disease-based social movements. Is the prostate cancer movement just one more in what will be a long line of disease-specific social movements? Is it a grass roots movement or are the members led by the more organized, financially secure, politically and economically powerful, medical community and pharmaceutical and medical device industries? How different from and how alike is it to the breast cancer movement? What are the causes and the consequences of this and other disease-specific social movements? Why prostate and breast cancer and AIDS? Why not arthritis, epilepsy and multiple sclerosis? What indicates politicization? How valuable is politicization in changing the direction of research, in attracting more dollars for treatment and research and in reaching other explicit and implicit goals.

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INTERNATIONAL UNION OF PSYCHOLOGICAL SCIENCES AND THE WORLD HEALTH ORGANIZATION LIAISON

Robert Martin
University of Manitoba

Both the World Health Organization and the International Union of Psychological Sciences understand that a closer relationship between the two organizations would be to their mutual advantage. WHO, a leader in defining health to include mental well-being and in recognizing the role of behavioral science in matters of health, needs up-to-date psychological expertise for their global programs. For its part, the International Union of Psychological Science, as the most representative international organization of psychology, can promote human welfare and advance psychology by participating in WHO's global programs. I was invited by WHO and IUPsyS to learn of WHO's current activities relating to psychology and to explore how to establish a closer liaison between the two organizations. I was able to spend part of November and December and early January at WHO headquarters in Geneva and met with Professor Gery d' Ydewalle, President of International Union of Psychological Sciences, in Leuven, Belgium to discuss IUPsyS's commitment.

Dr. John Orley, Program Manager for the Program on Mental Health, arranged the visit for my discussion with key individuals at WHO. The discussions concerned the role of psychology in WHO's current activities as well as identifying areas requiring increased involvement. I was impressed by the sophisticated awareness of the contributions psychology had made to WHO as well as a readiness for greater participation.

A good example of the value WHO attaches to psychology is its series of Behavioural Science Modules, reported in the winter issue of this newsletter. C. David Jenkins, Ph.D., and his colleagues in collaboration with WHO developed a series of modules which show how behaviour influences health and teach skills in promoting healthy behaviour. The series is designed for use in health education settings, such as medical schools. The continuous development of this series can be furthered by a global network of psychologists who can evaluate it and modify it for various cultural and geographic settings.

IUPsyS can provide just such a network.

Other WHO initiatives need to be more widely known by the psychological community. For example, a WHO program on life skills focuses on the schools capacity to help children develop responsibility for their health and social well being, a program of interest to developmental and educational psychologists.

The range of opportunities for psychologists' contribution is large and includes such diverse activities as developing instruments to assess the neuropsychological status of children affected by heavy industrial pollution in Eastern Europe and devising counselling and preventative programs for individuals with AIDS and their families in underserved areas.

As a result of the consultations in Geneva, it has been recommended that IUPsyS begin the required process by which non-governmental organizations establish "formal relations" with WHO. Such a relationship will enable psychology to contribute to WHO's mission of global health. In this role, as readers of this newsletter know, psychology must be truly international and cross-cultural.

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CPA HEALTH PSYCHOLOGY SECTION AGM MINUTES, TORONTO, JUNE 13, 1997

Patricia Dobkin, Ph.D., Chair

Michael Murray, Ph.D., Past Chair

Gordon Butler, Ph.D., Secretary/Treasurer

Meeting began at 12:00 p.m.

1. **Agenda approved.**
2. **Minutes of the August 1996 AGM accepted.**
3. **Section Chair's Report** Michael Murray reported that the executive had met several times by teleconference since the 1996 AGM to attend to section business. Activities over the past year included publication of two newsletters and setting up two symposium and a conversation session for the CPA convention. Interactions with the federal government included correspondence with the Minister of Finance regarding government support for health research, and obtaining copies of the Report on the Health of Canadians (prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health) for section members. The newsletter is now indexed by two services. During 1997, those members of the AIDS/HIV Significant Interest Group (SIG) who had not joined the section were dropped from the mailing list. The SIG had been carried as a subsection of the Health Section for the previous two years.
4. **Secretary/Treasurer's Report** Section membership currently consists of 129 Members, 35 Student members, and 9 Associate Members, making the section the 2nd largest in the CPA.

The 1996-1997 Financial Report and the 1997-1998 Budget were presented. In 1996-1997, revenues exceeded expenditures by \$410.73. However, this did not include the costs of the newsletter which was mailed out just prior to the AGM, and so a small (approximately \$80.00) deficit for the year is expected. The budget actually predicted a loss of \$1115.00 for 1996-1997 but this was offset by lower printing costs and greater revenue from membership dues.

The 1997-1998 Budgets projects a deficit of \$1015.00 with the cost of the newsletter, membership directory, and the AGM expenses accounting for 80% of projected expenses. Despite the higher expenditures of the past few years, the Health Psychology Section will still have approximately \$5500.00 in its account at the end of the 1998 fiscal year as the result of a build up of assets over several years of inactivity. As in previous years, the executive believes that the recent expenses are necessary to attract new members to the section, and if the attempt to attract new members is unsuccessful, the Newsletter and other expensive items will be scaled back accordingly.

The World Wide Web site for the Health Psychology Section of the CPA (<http://is.dal.ca/~hlthpsyc/hlthhome.htm>) which was launched in 1996, continues

to grow, with close to 1000 "hits" over the past year.

5. **Greetings from CPA.** Dr. Richard Allon brought greetings from the CPA. He thanked the Health Section for its input into various CPA initiatives over the preceding year. He also informed the section of the non-fee revenue generation initiative of the CPA, which includes CPA sponsorship and organization for presentations directed at non-psychologists. He invited the section to consider developing such a workshop or presentation. Gordon Butler (Health Psychology Section Secretary/Treasurer) sits on the review committee.

6. **Election Results:** The following positions were filled by acclamation: Chair Elect-Joel Katz, Secretary/Treasurer - Gordon Butler (2nd Term). In her incoming statement, Patricia Dobkin thanked Michael Murray for his work in single-handedly reviving the newsletter and putting much hard work into the section over the past 4 years. She indicated that her areas of focus for the next year would be establishing global links with other health psychologists, enhancing links to other CPA sections, and raising the profile of students in the section.

7. **Section Awards** As the Health Psychology poster display was not scheduled until the day after the AGM, the winner of the Student Award was not announced during the AGM. (*Note: The Student Award was made the following day during the Health Psychology Poster Session. David Aboussafy, McGill University was the winner.*)

8. **Other Business** John Berry suggested that the section consider sponsoring a symposium at next years AGM titled "Things to do with your Health Psychology

degree." The purpose of the symposium would be to give students ideas of possible job markets.

There was also discussion about collaboration between sections (e.g. with the clinical or cross-cultural sections) to interest psychologists who may be on the periphery of one or more sections.

Both ideas were discussed and approved in principle. The executive will discuss the ideas further.

9. **Adjournment** Meeting adjourned at 1:05 p.m..

Respectfully submitted,

Gordon Butler, Ph.D.
Secretary/Treasurer

RECEPTION

The AGM was followed by a reception.

TRAINING ISSUES IN HEALTH PSYCHOLOGY

Summary of Conversation Hour convened by Gordon Butler at the CPA Annual Convention Toronto, 1997

Although there is no sub-specialty designation for psychologists in Canada, many psychologists identify themselves as health psychologists and many clinical and academic programs offer training in health psychology. This conversation session was convened to discuss issues in health psychology training. What is the current state of "training in health psychology?" What should it be? Should a common core curriculum be developed? What is the relationship between academic and clinical training? What gaps exist in academic training? . . . in clinical training? What priorities should be established with respect to training? The conversation participants represented clinical programs, academic programs, and students.

Over the past two years, an area of focus for the Health Psychology Section Executive has been student and training issues. Just over a year ago, the Section completed a survey of health training opportunities in Canada (a summary can be found on the section webpage at <http://is.dal.ca/~hlthpsyc/hlthhome.htm>) and this year a student representative was added to the executive. This conversation session is another effort to address training issues. Each participant was provided with 5 minutes to address any issue related to training, and this was followed by a discussion with the audience.

Fred Boland (Queens) addressed the difficulties university programs sometime face maintaining a component of health psychology in graduate training. As the result of cutbacks, Queen's university lost a full time faculty member position and several adjunct positions involved with health psychology training. The health psychology comprehensive examination, which had been quite popular, had to be dropped. In order to obtain course work in health related topics, psychology graduate students can take certain graduate courses from other disciplines (e.g. nursing) for credit.

Michael Murray (Memorial) reported that students often ask him "Where can I go for training in health psychology?", but noted that there are no true training programs in health psychology training often get it as part of a clinical graduate degree, but this is not always

the case. Funding for psychosocial research appears to be on the increase from a variety of health and disease related foundations.

Kenneth Prkachin (Northern BC) reminded us that health psychology should not be considered a subset of clinical psychology and emphasized that health psychology training also occurs in non-clinical programs. He stressed the need for more health training for health psychologists and liked the idea of training with different disciplines as was being done at Queens. He felt that rather than a core curriculum, students need to be exposed to a variety of health areas, including epidemiology and community health and analysis.

Jeanne Ridgley (Toronto) reported on the evolution of health psychology rotations at the Toronto Hospital. She noted that the biggest changes have been the increased importance placed on exposing students to research (1/2 day per week) and expanding goals to include increased knowledge of specific diseases and disease processes. Specific internship goals could include aspects such as risk perception, adherence, and use of the scientist-practitioner model.

Dean Snow (New Brunswick) provided the student perspective. He reported that he found it helpful when a program allowed students flexibility in designing their course work, for example developing their own reading lists. He noted that clinical training often emphasized psychopathology, and that this did not prepare students well for dealing with the range of normal reactions to medical problems. He believes that university programs in general appear to be lagging behind internship programs with respect to training in health psychology.

Following the presentations, there was discussion among the panelists and the audience. The general consensus appeared to be: agreement that health psychology is not a sub-set of clinical psychology; that exposure to training in areas in addition to psychology is desirable; that greater interdisciplinary training may be desirable; and that students are not always aware of the types of funding opportunities that might be available.

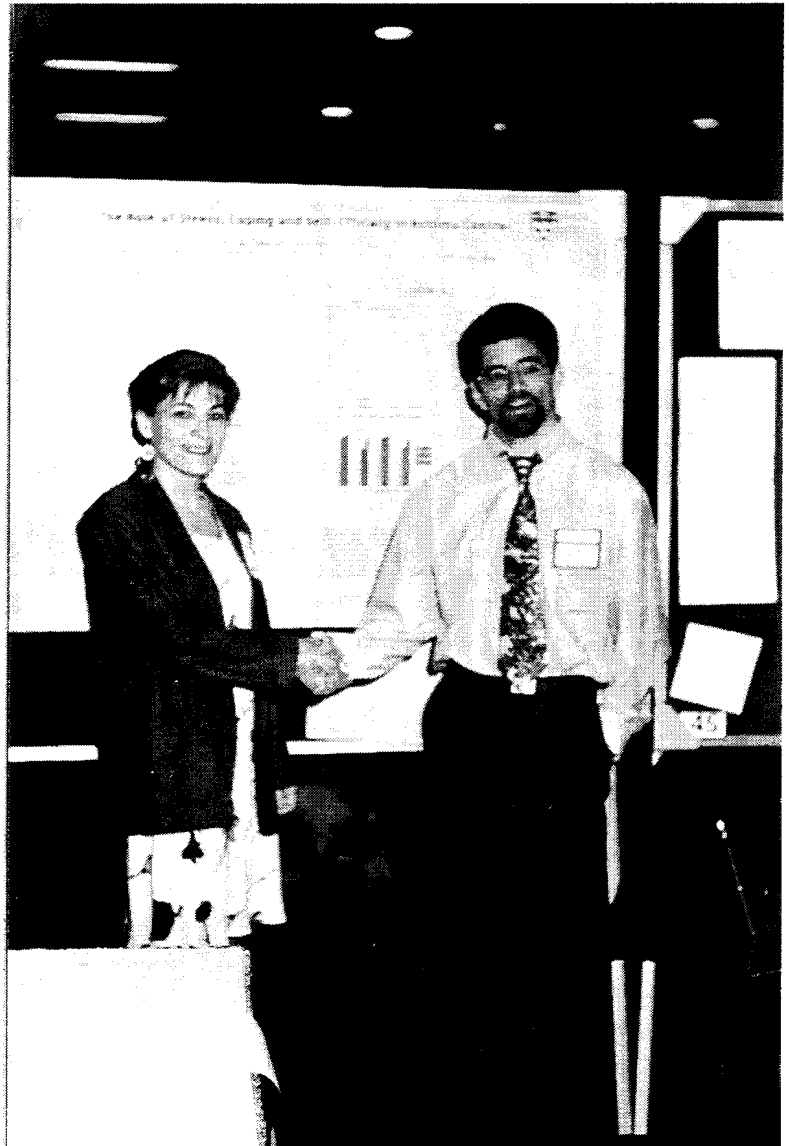
STUDENT NEWS/NOUVELLES DES ÉTUDIANT(E)S

The section is pleased to announce that it will award two prizes for the best poster presentation by a student at the Edmonton conference.

The student must be a fully paid-up member of the section to be considered for the prize.

Non-Dues Income Workshops

The Ad-Hoc Committee on Non-Dues Income of the CPA has been developing a programme to provide workshops and other continuing education events to non-psychologist audiences such as business people, lawyers, educators, non-psychologist mental health professionals, physicians and nurses. The CPA will take responsibility for advertising and promotion for such workshops and will handle room-rental, audio-visual equipment, etc. Workshop presenters are compensated at market rates for time spent developing and presenting the material. Profits revert to the CPA general revenue fund. Any CPA member interested in presenting a workshop should contact the CPA Head Office with a request for Workshop Application Form.



Above: Dr. P. Dobkin (Section Chair) presents the Annual Student Award to David Aboussafy, at the CPA Convention in Toronto, 1997.

Letter from the Student Representative/ Lettre de la Représentante aux Étudiants

As the first student representative for the health psychology section of CPA, I look forward to serving the needs of our student members and being an active spokesperson on their behalf. I would like to thank Dr. Patricia Dobkin, president of the section and all members on the executive board for giving me this opportunity to get involved. I have several objectives for this year. First, I would like to encourage student input into our planning of activities by giving them the opportunity to communicate with us directly or via surveys and by keeping them informed through our newsletter and website. Getting suggestions and feedback from students will make my job more rewarding and will ensure that I am truly representing their interests. A second objective is to provide students with information about the future of health psychology as a profession, the role of health psychologists in health care, and means by which graduating students can ensure themselves a position in today's job market. Conversation hours at CPA meetings, website announcements, and newsletter articles are means by which such information can be provided to our members. Finally, I will be actively involved in promoting and organizing student awards for presentations given at CPA meetings in an effort to encourage student participation at these events. I encourage you all to communicate with me about your needs, ideas, or concerns and I will do my best to respond to them. I look forward to working together with our members to ensure a prosperous future for our profession.

En tant que première représentante aux étudiants pour la section de psychologie de la santé de la SCP, je suis heureuse de servir de porte-parole aux étudiants et j'espère répondre à leurs besoins. J'aimerais remercier Dr. Patricia Dobkin, présidente de la section, ainsi que tous les membres du comité exécutif pour cette occasion qui m'est offerte de m'impliquer au sein de cette section. Je voudrais remplir plusieurs objectifs cette année. Tout d'abord, j'aimerais encourager la participation étudiante dans la planification de nos activités en donnant les moyens aux étudiants de nous communiquer leurs opinions directement ou par l'entremise de sondages et en les gardant informés de nos activités avec l'aide de notre bulletin et de notre site électronique. Je vois mon rôle de représentante enrichi par cet échange d'idées avec les étudiants tout en assurant que je serve adéquatement leurs intérêts. Un deuxième objectif est de rendre disponible aux étudiants de l'information sur l'avenir de la psychologie de la santé comme profession, le rôle des psychologues dans le système de la santé, et les moyens par lesquels les finissants peuvent s'introduire sur le marché du travail. Cette information sera transmise via des conversations aux réunions de la SCP, des articles dans notre bulletin et des annonces faites sur notre site électronique. En terminant, j'attache beaucoup d'importance à l'organisation de prix étudiants pour des présentations à la réunion de la SCP afin d'encourager la participation étudiante à cet événement annuel. Je vous invite à communiquer avec moi et à me faire part de vos idées et suggestions. Je ferai de mon mieux pour répondre à vos besoins. Je me rejouis de cette occasion de travailler ensemble pour assurer un avenir prospère à notre profession.

Sophie Beugnot

CANADIAN PSYCHOLOGICAL ASSOCIATION/ SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

HEALTH PSYCHOLOGY SECTION/ SECTION DE PSYCHOLOGIE DE LA SANTÉ

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