Commentary

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Are We Reaching Our Potential as Health Psychologists?

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We begin this commentary with the observation that it is of general agreement within professional communities that Psychologists are extremely well trained. We have the highest degree awarded by the university system, we have blended research and clinical training, and we routinely are appreciated by the nonpsychologist colleagues we work with. So, what could we possibly be worried about?

Well, the dominant model of training in our Canadian Clinical Psychology PhD programs continues to be the psychopathology model, which focuses on assessing/diagnosing problems as primarily arising from within the individual. As well, the dominant role function we are trained in is intensive one on one or small group services using evidence-based approaches. While the value of this role (DSM diagnostics, intensive intervention, evidence-based protocols) cannot be disputed, if we step back and ask the question, "what good are we to society", we might be forced to say, "we help the few that can access our care, are able to commit to our intensive work, and who are able to persevere with treatment". Prototypal psychological interventions are effective (Number Needed to Treat = 1.7 – 8.9, (Hunsley et al., 2014)), and we are able to dig deep into issues. However, our reach is limited.

In contrast, public health interventions, and even downloadable apps, that do not dig deep into issues, reach many more people. As long as we restrict our focus to those that require intensive and comprehensive care, as would be true for those with psychopathology, all is good. Yet, as health psychologists we need to question this model of assessment and intervention. What if people with health challenges (either from a preventative perspective or a management perspective) do not display psychopathology and their psychological issues are normative given their condition? Consider, for instance, the experience of someone with COPD who, during an acute episode, cannot breathe. Wouldn't panic be normal for someone suffocating? In such situations, is a diagnosis necessary; it might, in fact add to a person's problem through labelling, a form of stigma.

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Consider these issues of scope in regard to eating difficulties. The National Initiative for Eating Disorders estimates a base rate of 2.3% of Canadians meeting criteria for anorexia nervosa, bulimia nervosa, binge eating disorder, avoidance restrictive food intake disorder and otherwise specified feeding and eating disorders (https://nied.ca/about-eating-disorders-in-canada/). Statistics Canada, on the other hand, reports about 70% of Canadians do not eat sufficient fruits and vegetables (https://www150.statcan.gc.ca/n1/pub/82-625-x/2017001/article/54860-eng.htm). Would psychologists be of value in helping Canadian citizens with the nonpathological eating problems?

Consider also our model of intensive treatment. Now that COVID is being seen as endemic not pandemic, do we wait for Canadians to develop psychopathology so they can be referred to us for treatment, or could we be of value if we educated the public in stress management activities? Given our training, is it possible that our services are too narrowly defined? Further, if our voices are going unheard (ask yourself how many hours of your day you spend behind closed doors in conversations that cannot be shared) are too few people benefitting from our skills? Is it in our best interest to focus on exclusivity (making sure everyone knows how skilled we are) and intensity (e.g., 20 sessions in 16 weeks) or are we at risk of making ourselves inaccessible given our small numbers (compared to nurses, physicians and social workers) and being unaffordable for most (outside of public settings our services not covered by provincial health plans, and for those with private coverage sessions are limited)? Further, what is our responsibility in achieving health equities (Kelly, 2022)?

We also need to be aware of the times in which we live. We are fortunate that mental health issues are being brought out of the dark and into the public eye (consider, for instance, Bell's Let's Talk campaign; https://letstalk.bell.ca/en/). However, with this increased awareness we are seeing many more providers get into the psychological treatment domain, from psychotherapists to health coaches and even the proliferation of mental health apps (see Martinengo et al., 2021). Within health systems, isn't it true that organizations are more inclined to hire social workers than psychologists to address mental health issues outside of mental health-specific services? We are on dangerous territory if we try to make the argument that we should be seen as the preferred provider because we are better trained. After all, we hang our professional hats on evidence-based treatments. But isn't it true that once we operationalize a psychological treatment,

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create treatment manuals and develop competency criteria that expertise in a specific approach is legitimately claimed by those who have been trained, regardless of profession (see Alam et al., 2009)? As well, it may be true that an app can ensure greater fidelity to an intervention than the same protocol in the hands of a clinician, who is subject to preferences and cognitive bias (see Tversky & Kahneman, 1974). Perhaps we should consider coming out of our offices and into the broader world, where we can train other healthcare providers to implement protocol-based interventions and support persons living with chronic disease in how to adjust to their condition and support the integration of psychology into disease management. Perhaps you are comfortable with your claim to competence in cognitive behavioural therapies, acceptance and commitment therapy, emotion focused therapy, psychodynamic protocols, etc. But what about helping individuals and medical care teams navigate disease acceptance, treatment acceptance, and readiness for self-management? Afterall, these are the challenges that those with chronic diseases face and struggles with these issues lead to the emotional and behavioural patterns that result, eventually, in a referral to us (assuming the person is fortunate enough to be in a medical service that has access to someone like us, and who doesn't face a long wait time to see us). In a recent study assessing Diabetes care providers' attitudes towards the importance of 11 psychosocial issues in disease management, between 80 – 97% of respondents reported addressing these issues as very important but many fewer (26 – 61%) reported being confident in addressing these issues themselves (Nichols et al., 2018).

So, if extensive training and intensive skills do not provide a bed of laurels for us to rest upon, what direction might increase our impact on society? We'd like to suggest a reframed approach to our professional role functioning as Health Psychologists. Specifically, we suggest several paths that are not inconsistent with our training but may need nurturing to become more ingrained in our mindset.

First, most psychologists will describe themselves as having expertise in specific psychological issues, such anxiety, depression, trauma, interpersonal functioning, etc. By doing so, we inadvertently promote a psychopathology focus and frame issues out of the context of the drivers of these issues. In contrast, the scope of our work would increase dramatically if we refocused our approach from the underlying issue to the diseases that dominate a person's life; that is, our competency is in disease self-management. Canadians, above all, need help with managing the burden and risks of cardiovascular diseases, obesity, type 2

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diabetes, COPD, etc. The role of medication nonadherence, sedentariness, unhealthful diet, substance use, poor sleep (and more) cannot be emphasized enough as both risk factors for developing chronic disease and as well as pathways for effective disease management (The US Burden of Disease Collaborators, 2018). Presenting ourselves to the professional community and the public as interested and able to improve disease outcomes via psychological intervention (behaviour change, emotion management, interpersonal function, insight, etc.) would increase our relevance. Another positive implication of this shift is that it enables us to put the psychopathology model in context by allowing the quality of life model to dominate (Veit & Ware, 1983). Quality of life can be seen as a balance of distress and well-being. Examining drivers of distress promotes recognition of disease-based distress, problems of living based distress and psychopathology-based distress, while also emphasizing well-being as an independent construct for intervention (optimism, resilience) (Seligman & Csikszentmihalyi, 2000).

Second, our current narrative as psychologists promotes the definition of our competencies as based on method. We describe ourselves as cognitive behavioural, acceptance and commitment based, psychodynamic, etc. Of course, these are important methods, but they are not exclusive to psychologists and may not be well understood by the public. We suggest a reframe from the method we choose to patient experience (after all, isn't it true that we are mostly integrative (Goldfried et al., 2019), with the labels we use to describe ourselves more reflective of the schools we are from than what any given patient needs at any given time?). Specifically, a useful way of thinking about the patient experience of living with chronic disease is that they often face issues associated with disease acceptance, treatment acceptance, and readiness for self-management. It would be valuable to enumerate what percentage of individuals living with chronic disease experience struggles with any of these issues at any time. Certainly, psychologists can lay claim to having the depth of training to address any and all of these issues.

Third, psychologists currently adopt the model of care in which we deliver services ourselves. We can be proud of the competency of this model, but we must admit that such a model of practice cannot be scaled to need. A reframe here would be to promote health psychologists as functioning within a stepped collaborative care model (see Hilty et al., 2018). Imagine supporting the medical team members to become more informed about psychological issues and interventions. Further, psychologists can offer training and supervision in a number of evidence-based interventions that do not require intensive training or skill. So, for instance, if we start with the assumption that COVID-19 was stressful, imagine if we train and support fidelity and competency in nurses, dietitians and social workers in how to implement basic stress reduction techniques into their care plans, within their scope.

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An example of a current opportunity for our profession is the recent reconceptualization of obesity management from placing the responsibility on the person to achieve goal weight by eating less, moving more using willpower, with the assumption that weight is under behavioural control. Recent research has invalidated this perspective, instead identifying how the appetite system is biologically controlled (primarily in the brain) and how weight is determined by neurobiological, genetic and environmental factors. Reclassifying obesity as a chronic disease is leading to the development of better medical management strategies. Obesity Canada has recently released revised Clinical Practice Guidelines that highlight the importance of recognizing and addressing obesity stigma and positioning obesity management as supported by three pillars: psychological and behavioural interventions, medical interventions, and bariatric surgery (Wharton et al., 2020). Within the obesity management community in Canada (in fact, Ireland and Chile have recently adopted/adapted our guidelines for their countries) there is strong acceptance of this model and an identified need for resources to support addressing behavioural and psychological issues associated with weight management. If we health psychologists were to seize on this opportunity we could play an integral role in supporting the millions upon millions of Canadians living with health-impairing adiposity.

Our hope is that we have encouraged the reader to reflect on the reach of their services to Canadians at large, as well as the potential to scale services to better support chronic disease management, and importantly, disease prevention and health promotion via early low intensity interventions in nontraditional (for us) contexts.

References:

Alam, R., Sturt, J., Lall, R., & Winkley, K. (2009). **An updated meta-analysis to assess the effectiveness of psychological interventions delivered by psychological specialists and generalist clinicians on glycaemic control and on psychological status**. *Patient Educ Couns*, 75(1), 25–36. https://doi.org/10.1016/j.pec.2008.08.026

Goldfried, M. R., Pachankis, J. E., & Goodwin, B. J. (2019). **A History of Psychotherapy Integration.** In J. C. Norcross, M. R. Goldfried, J. C. Norcross, & M. R. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (p. 0). Oxford University Press. https://doi.org/10.1093/med-psych/9780190690465.003.0002

Hilty, D. M., Rabinowitz, T., McCarron, R. M., Katzelnick, D. J., Chang, T., Bauer, A. M., & Fortney, J. (2018). **An Update on Telepsychiatry and How It Can Leverage Collaborative, Stepped, and Integrated Services to Primary Care**. *Psychosomatics*, 59(3), 227–250. https://doi.org/10.1016/j.psym.2017.12.005

Hunsley, J., Elliott, K., & Therrien, Z. (2014). **The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders.** *Canadian Psychology / Psychologie Canadienne*, 55(3), 161. https://doi.org/10.1037/a0036933

Kelly, J. F. (2022). **Building a more equitable society: Psychology's role in achieving health equity.** *American Psychologist*, 77(5), 633–645. https://doi.org/10.1037/amp0001019

Martinengo, L., Stona, A.-C., Griva, K., Dazzan, P., Pariante, C. M., von Wangenheim, F., & Car, J. (2021). **Self-guided Cognitive Behavioral Therapy Apps for Depression: Systematic Assessment of Features, Functionality, and Congruence With Evidence.** *Journal of Medical Internet Research*, 23(7), e27619. https://doi.org/10.2196/27619

Nichols, J., Vallis, M., Boutette, S., Gall Casey, C., & Yu, C. H. (2018). **A Canadian Cross-Sectional Survey on Psychosocial Supports for Adults Living With Type 1 or 2 Diabetes: Health-Care Providers' Awareness, Capacity and Motivation.** *Canadian Journal of Diabetes*, 42(4), 389-394.e2. https://doi.org/10.1016/j.jcjd.2017.09.004

Seligman, M. E., & Csikszentmihalyi, M. (2000). **Positive psychology. An introduction.** *Am Psychol*, 55(1), 5–14.

The US Burden of Disease Collaborators. (2018). **The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States**. *JAMA*, 319(14), 1444–1472. https://doi.org/10.1001/jama.2018.0158

Tversky, A., & Kahneman, D. (1974). **Judgment under Uncertainty: Heuristics and Biases.** *Science*, 185(4157), 1124–1131. https://doi.org/10.1126/science.185.4157.1124

Veit, C. T., & Ware, J. E., Jr. (1983). **The structure of psychological distress and well-being in general populations.** *J Consult Clin Psychol*, 51(5), 730–742.

Wharton, S., Lau, D. C. W., Vallis, M., Sharma, A. M., Biertho, L., Campbell-Scherer, D., Adamo, K., Alberga, A., Bell, R., Boulé, N., Boyling, E., Brown, J., Calam, B., Clarke, C., Crowshoe, L., Divalentino, D., Forhan, M., Freedhoff, Y., Gagner, M., ... Wicklum, S. (2020). **Obesity in adults: A clinical practice guideline.** *CMAJ*, 192(31), E875–E891. https://doi.org/10.1503/cmaj.191707