

Health Notes

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CPA Health Psychology and Behavioural
Medicine Section Newsletter

Edited by Jennifer Gordon, PhD, RD Psych



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Message from the Editor



Jennifer Gordon, PhD, RD Psych

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Dear Health Psychology and Behavioural Medicine Section Members

Ryan and I have a great issue for you to enjoy! It highlights the work of our most recent section presentation award winners from CPA 2022 as well as some exciting research in the area of dysmenorrhea that was recently funded in the CIHR Project Grant competition.

We also have insightful commentaries from our members that will really get you thinking — one piece questions whether health psychologists are reaching their full potential as healthcare professionals, another reflects on the peer review process in academia, and a third piece in French discusses the role of communication in the current era of social media. A Clinician's Corner article is also included, discussing the role of social support in chronic disease.

I'd like to also encourage you all to please consider nominating your early career colleagues (or applying yourself!) for our Section's Early Career Award, and if you haven't done so already, submit your abstracts for the 2023 CPA annual meeting, set to be held in Toronto! Check the newsletter for more details!

Take care and stay healthy!



Ryan Hoggan, BA

Research Coordinator
Athabasca University





Join us for CPA's 2023 Annual General Meeting and Convention!

It's not too late to submit an abstract!!!

Deadline for Abstract Submissions: December 14th, 2022
Conference Location: Sheraton Centre Hotel in Toronto, Ontario
Conference Dates: June 23rd-25th, 2023

Submit an abstract today!

Introducing the Winners

of the Health Section's Presentation Awards from CPA 2022



By Ryan Hoggan (Calgary)

As we rush to get in our abstracts for the upcoming CPA convention in Toronto, let's take a moment to read about some of the amazing work our Section members presented at the 2022 CPA convention in Calgary. These award winners are up to great things!

Best Oral Presentation: Gilla Shapiro, PhD

Presentation Title: The impact of introducing publicly funded school-based immunization programs for boys on human papillomavirus vaccination

About myself:

I am a Psychologist and Clinician-Scientist at Princess Margaret Cancer Centre at the University Health Network. I completed a PhD in clinical and health psychology at McGill University and a dual-degree MPA/MPP at the London School of Economics and Political Science and the Hertie School of Governance. My interests include improving mental health, understanding health behaviour including vaccine decision making, examining the social determinants of health, and promoting health equity, access, and inclusion in diverse populations.



Gilla Shapiro, PhD

About my research:

The research presented at CPA was based on data collected at McGill University during my PhD. My collaborators on this work (and co-authors on the resulting manuscript) are Ovidiu Tatar, Bärbel Knäuper, Gabrielle Griffin-Mathieu, and Zeev Rosberger. This study reports on a longitudinal natural experiment in Canada where the implementation of publicly funded HPV vaccination programs unfolded differently across the ten Canadian provinces. We surveyed parents at two times points (in 2016 and 2017) separated by nine months to examine the impact of introducing publicly funded school-based HPV vaccination programs for boys while concurrently examining important sociodemographic and psychosocial factors. [Access the full publication.](#)

What's next:

My research on vaccines and health behaviour has two focuses. I plan to continue to develop and refine measurement tools with a specific focus on their use in Canada and its diverse populations. I also plan to continue to investigate the behavioural and social drivers of vaccination by exploring a wider range of modifiable determinants, enabling interventions, and systematic barriers.



Best Poster: Brandon Benchimol-Elkaim, MA

Presentation Title: Parent-reported barriers to children wearing masks in school

About myself:

I'm currently a first-year PhD student in Counselling Psychology at McGill University in Montreal. When the pandemic first started, I took an interest in the motivations people had for and against following public health directives. I collaborated with researchers from the Harvard School of Public Health and the University of Calgary to investigate motivations for social distancing, wearing masks, and most recently reasons for and against receiving treatment for COVID-19.



Brandon Benchimol-Elkaim, MA

About my research:

My poster at the conference focused on parent-reported barriers to children wearing masks in school. When we conducted the study, only children over 12 were eligible to be vaccinated, thus masking remained the most accepted and accessible tool to mitigate transmission of the virus in schools. However, we saw heated debates take place regarding the implementation of mask mandates in schools. We surveyed parents from Canada and the United States about their children wearing masks in school. Parents reported five main barriers to children wearing masks in school. Parents were concerned about the negative impact of masks on children's health, and the logistical challenges to implementing mask mandates in schools. They also believed that mask-wearing is not age or developmentally appropriate for kids and that it would interfere with the learning process. They also had misconceptions about masks.

What's next:

Conducting pandemic-related research was more of a passion project but my main graduate research focuses on conducting clinically focused research that can eventually be applied at the point of care. For my PhD, I am investigating whether mindfulness nature-based training using virtual reality is acceptable and performs better than the standard of care in improving pediatric patients' preoperative anxiety. I am co-supervised by Dr. Bassam El-Khoury (McGill Mindfulness Research Lab) and Dr. Argerie Tsimicalis (McGill Ingram School of Nursing and Shriners Hospital for Children). In addition to my research work, I am looking forward to my first doctoral internship next year as I work to complete my training to become a licensed psychologist in Quebec.



Best Poster: Catherine Lowe, MSc

Presentation Title: Canadian's social connections during the COVID-19 pandemic: A thematic analysis

About myself:

I am currently a second-year MSc student at the University of Calgary in the School and Applied Child Psychology program. I am in the unique position of receiving mentorship under the guidance of two expert supervisors, taking an interdisciplinary approach to research on developmental pathways of attention-deficit/hyperactivity disorder (ADHD) as a part of my thesis work alongside my training as a clinician.



Catherine Lowe, MSc

When I am not working on my research, training, or coursework, I am also a mom to three busy children – so you can typically find me working from various sporting center bleachers and school parking lots waiting to drive one of my kids to their next activity! I finished my BA in psychology at Athabasca University in 2021, where I was given the opportunity to participate in a research lab looking at mental health during the onset of the COVID-19 pandemic under the mentorship of Dr. Kharah Ross. In this research lab, I was able to explore the trajectories of mental health outcomes over time during the first nine months of the pandemic, the role of communication technology as a moderator, as well as the impact on social connections for Canadians during the pandemic.

About my research:

The work I presented at CPA was based on an article that was later published in the *Journal of Social and Personal Relationships* (<https://doi.org/10.1177/0254075221113365>), stemming from my work under Dr. Kharah Ross. In this study, we analyzed unrestricted responses to how participating in social distancing or self-isolation during the pandemic impacted their social connections as well as what changes occurred to how they connected socially with friends and family. Uniquely, this work applied a thematic analysis for three distinct time points, giving insight into the effects on social connections, but also how these impacts changed over time, spanning nine months. What we found was that those that were participating in social distancing, or self-isolation during the pandemic, largely reported a negative impact on their social connections (37-45% of responses in each epoch), that loss of social connections was a predominant outcome reported (32-36% of responses in each epoch), but also that Canadians frequently opted into an alternative means of connection, such as using communication technology (26-32%). An interesting trend was that reports of decreased contact and communication nearly doubled into the fall and winter of 2020 compared to earlier points in the pandemic from April to August 2020, paralleling

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the re-implementation of public health restrictions across the country. This work indicated that pandemic-related public health responses had a negative impact on social connections broadly and point to areas to target to mitigate social connection disruption for future pandemics and public health responses.

I am particularly proud of this work, as it allowed us to have insight into how the pandemic disrupted social connections, but also what that disruption meant to the individuals affected, bringing meaning and impact to the population studied. Although we had our subjective experience to draw from as researchers who were also living through the pandemic, it was truly amazing to see the breadth of topics discussed as well as the general themes and trends in those themes as the pandemic progressed, something that qualitative research does an excellent job at capturing.

What's next:

Currently, I am continuing to work on the COVID-19 and mental health project to better understand how the pandemic impacted Canadians over the initial nine months, which we hope will provide valuable knowledge to direct future pandemic-related public health responses and buffer adverse effects captured. Additionally, I am in the process of finishing my MSc this coming summer and am currently applying for admittance to a PhD program in School and Applied Child Psychology at the University of Calgary. I hope to carry forward what I have learned through my work on social connections during the pandemic and take a holistic and ecological approach to my future research endeavors. It was a wonderful experience to participate in the 2022 CPA conference, and I'm looking forward to 2023!



Early Career Section Member Recognised

by the European Health Psychology Society

By Lucas Walters (Ottawa)

Dr. Andrea Patey is a Senior Clinical Research Associate within the Centre for Implementation Research at the Ottawa Hospital Research Institute and an Adjunct Professor at School of Epidemiology and Public Health, University of Ottawa and School of Rehabilitation Therapy, Queen's University. Born and raised in rural Newfoundland, she graduated Memorial University with a Bachelor of Science (Honours) in Behaviour Neuroscience. She went on to graduate Carleton University with a Master of Science in Psychology and she holds a PhD in Health Psychology from City, University of London in the UK. Her research sits at the intersection of behaviour sciences and implementation research applying psychological theory and methods to explain and change health professional behaviours across a range of clinical settings. The broad objectives of her research are to promote the use of theory and rigorous methods to improve the delivery of evidence-based healthcare through the development and evaluation of complex behaviour change interventions. We connected with Dr. Patey to ask a little about their recent award, career path, and advice.



Dr. Andrea Patey
Senior Clinical Research Associate
Centre for Implementation Research
Ottawa Hospital Research Institute

What is the Stan Maes Early Career Award and what does it mean to you to have won this?

The Stan Maes Early Career award recognises outstanding research excellence, contributions made to the EHPS and/or contributions to professional practice made by EHPS members in the first five years post PhD. Professor Stan Maes for whom the award is named, was the founder and first President of the EHPS and was committed to the development of early career health psychologists. I'm honoured to have receive this prestigious award from EHPS, my peers, which recognizes my work applying health psychology to support healthcare professionals and systems to stop engaging in clinical practices that persist despite evidence of low value or even harm (i.e., de-implementation). It's recognition that my work has value and importance.

What is the current focus and scope of your research?

My specific interest centres around whether implementation (starting an evidence-based clinical practice behaviour) and de-implementation (stopping an ineffective or harmful clinical practice behaviour) differ, and correspondingly, whether interventions to target each should also differ. My PhD involved theoretical development work on how psychological theory differentiates between stopping and starting behaviours (Patey et al., 2018) followed up by work identifying whether different intervention approaches exist for de-implementation and implementation (Patey et al., 2021). I also unpacked how and which behaviour change techniques – especially behavioural substitution – may be helpful for promoting de-implementation (Patey et al., 2022).

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Early Career Recognition by the EHPS

What's next in your research?

I plan to continue this work to better understand de-implementation from a behaviour science perspective and how to better design interventions targeting the low value clinical practise behaviours. I'm excited to be working with colleagues to edit a book to help guide those who want to de-implement low value care. I want to continue to advance the application of behavioural theories and the tools we use to improve evidence-based practice, through both implementation and de-implementation, working with healthcare providers, health systems and organizations in Canada.

What important lessons have you learned throughout your career so far?

I'm an older early career researcher; I graduated with my PhD at 40 and perhaps the most important lesson I learned has been, the best path in life is your own path. Don't compare your journey to others' —no one way is better than the other. You got here because this was how you were supposed to get here —I don't think 25-year-old me would have had the opportunities I've had nor would I have had the amazing mentors throughout my PhD and since, had I started my PhD back then.

Another stellar piece of advice was from my grade 12 math and physics teacher —who probably saw an anxious person who sought perfection about to go off to university— when he said the hardest thing he had to learn in university was that he couldn't know everything. That saved me a heap of all-nighters studying incessantly and established a foundation within myself to balance work/academics with life outside of that. Oh and "perfect" is the worst word in the world —completely unattainable!

What's next in your professional career goals?

I really hope to get an academic position in Canada. As I transition into an academic position, my goal is to continue my work to advance theory, methods and application at the intersection between health psychology and implementation science with the network of national and international of colleagues I've been lucky to collaborate. I also hope to continue teaching —it's a part of this work that I surprisingly enjoy. Getting people as passionate about behaviour and implementation sciences as I am, is pretty cool!



Commentary

by Michael Vallis, PhD R Psych, and Tiffany Shepherd, PhD R Psych



Are We Reaching Our Potential as Health Psychologists?

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”. Prototypical 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.



Michael Vallis, PhD R Psych
Family Medicine, Dalhousie University



Tiffany Shepherd, PhD R Psych
Nova Scotia Health Authority

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Are we reaching our potential as health psychologists?



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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Are we at risk of making ourselves inaccessible given our small numbers ... and being unaffordable for most?



Are we reaching our potential as health psychologists?



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? After all, 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 as 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

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...



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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.

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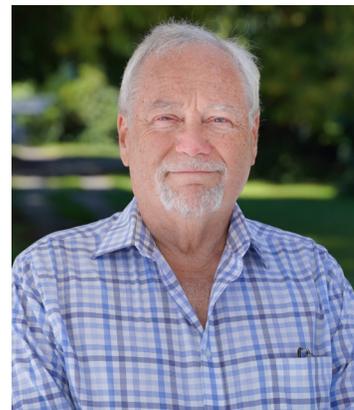
Reflections on Peer Review

A flawed process and... we still own it

By Dr. Wolfgang Linden (Vancouver)

General Observations

A desire to write this essay emerged from over four decades of being a manuscript reviewer and of course needing many reviews myself. It should be obvious but is still noteworthy that both authors and reviewers come from the same pool! They are not principally hostile to each other and each understands the other side. I never tracked how many reviews I have completed (nor how many I needed) but (averaging two to three reviewers per manuscript) I think I wrote over 400 reviews and needed a correspondingly larger number written by my peers (thank you, by the way). Even now, while officially retired, I write 15 to 20 reviews per year. However flawed the system is... and it is! (see Bornmann L, Mutz R, Daniel H-D (2010) A Reliability-Generalization Study of Journal Peer Reviews: A Multilevel Meta-Analysis of Inter-Rater Reliability and Its Determinants, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0014331>)— I found reviewers rarely outright nasty; yes, they occasionally make critical comment on content that they simply read wrong (or missed), and some reviewers are annoying nitpickers... but on the whole I am grateful for how they helped improve the clarity and strength of my work.



Dr. Wolfgang Linden
Emeritus Professor
University of British Columbia

The trends in peer review management are ugly. Friends who are editors or associate editors struggle with finding reviewers, typically needing five attempts or more to recruit a single acceptance. And this trend is worsening. Apparently there is a growing skew in that researchers need a lot of reviews but do not carry their equivalent load while on the other side, being asked to provide reviews. In my opinion, this system is riding on the precipice of collapse and kind acknowledgments and data banks of reviewer activity seem to have little, though not unappreciated, impacts.

Wearing my Reviewer Hat

Should you have the good (or bad, you decide) fortune of having me review your work, be aware of the following. I will make a deliberate effort to find laudable features worth mentioning.

The prime driver of my final recommendations is whether the work is important for real world decisions and/or moves our field forward theoretically. I have limited praise for questionnaire studies in college students because the generalizability is rather low and many findings cannot be replicated elsewhere. On the other hand, I will fight for a high quality replication study and encourage full exploitation of data via secondary analyses provided the methods (which cannot be changed) are a strong match for the study rationale. On a different topic, it pains me having to tell

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Peer Review: A flawed process and... we still own it

authors that their question may be 'an old hat' and despite possibly high internal validity the study is just not interesting any more. Fair enough, this is an opinionated decision but this criticism will keep articles out of highly ranked journals.

My perspective of reviewing has been distinctly shaped by research we did three decades ago (Linden W, Wen FK & Craig KD, (1992), Contributions of reviewer judgments to editorial decision-making for the Canadian Journal of Behavioural Sciences: 1985-1986. *Canadian Journal of Behavioural Sciences*, 24, 433-441). We had analyzed relationships among reviewers' appraisals and ultimate editorial decision-making for 120 manuscripts submitted to the *Canadian Journal of Behavioural Science*. Reviewers' ratings on eight standard evaluation criteria were evaluated for interrater agreement. The same criteria were used to predict the same reviewer's overall recommendation, and the reviewers' ratings were used to predict the editor's final decision to accept, reject, or request revisions. Interrater agreement on specific indices of manuscript quality were quite (and embarrassingly?) low. A principal components analysis revealed that reviewers effectively evaluated two factors: internal validity and importance of scientific contribution. Reviewers' ratings on specific criteria were correlated with moderate strength to their own final recommendation, and their recommendations were predictive of the editor's decision, explaining 63% of the variance. The bottom line here is that reviewers may identify different weaknesses in a given manuscript and that is often a good thing. Such variation does make them look disagreeable, but I find they largely agree on whether a study makes a significant contribution to the field.

The bottom line here is that reviewers may identify different weaknesses in a given manuscript and that is often a good thing.



A maybe odd observation is that younger researchers are generally very good at identifying relevant current literature, largely because they masterfully handle the literature search process on their own computers. I similarly benefit from this because I can get almost any fairly recent article in full length without lifting my butt out of the office chair; however... published articles are entered in electronic archives for only about the last three decades. I occasionally encounter authors who claim that a given study has never been undertaken before except that I know (because I am an old dog) that this is not true; I might have hardcopies of these papers in a drawer (fewer and fewer of course) or remember that 'xxx' and 'yyy' did a string of relevant and informative studies on this very topic in the sixties... but these are not locatable in e-archives.

...cont'd

Peer Review: A flawed process and... we still own it

Here are a few do's and don'ts (to get me suckered in... or thrown off)

Do

- Invest greatly in an introduction that shows the field's status quo about the most important questions, so that the development of the rationale is easy to follow and accept.
- Use the words "effect of" only if you conducted an intervention or controlled experiment.
- Use the term "predict" only if it was truly a longitudinal study with repeated measurements.
- Use structured guidelines for reporting (CONSORT or similar) wherever they exist.
- Write clear and informative abstracts (first impressions); what I first survey in a new manuscript is, in order: [1] the abstract, [2] relevant results tables, and [3] the beginning of the discussion where results are summarized.
- Provide effect sizes even if you stuck a good-old $p < .05$ approach overall.

Do not

- Simply state that your selected questionnaires "are reliable and valid." I see red when I read this. I recall one paper where a two-item questionnaire was used as the main measure to tap into an aspect of spirituality (already a tough concept to quantify) and the reader (me) was told it was reliable and valid; no detail offered. When I challenged the author/s, neither reliability nor validity information was provided in the revised manuscript but instead the reader was told that: "but other researchers have used this before." Guess what? This one went down in flames. As we all learned there are different types of reliability and even more types of validity and there is no consensus how much and what kind of validity is good enough. As for reliability, there is at least some consensus on internal consistency ($> .7$ ok, and $> .8$ good). And, as we were all taught in our undergraduate course on testing, a test cannot be valid when it is not reliable. Aside from these pivotal but generic requirements, authors must justify that their choice of measures is valid for their chosen population and study question.
- Covary out everything just because your stats package allows you to. Justify your choices.
- For the case of secondary analyses, do not report critical information on psychometrics or the design of the original study (upon which your secondary analyses rest) in unpublished work or obscure journals that I cannot locate.
- For a review, do not call it "comprehensive" if you excluded all publications that were not written in English; such a review is selective, not comprehensive. English being my second language, it is one of my pet peeves.

That's it... (for now)! Dialogue welcome.

Funding News

Exploration of Dysmenorrhea and Chronic Pain in Emerging Adolescence



Saskatchewan Researcher Receives CIHR Funding to Explore Dysmenorrhea and Chronic Pain in Emerging Adolescence

Principal Investigator: Dr. Michelle Gagnon

Co-Investigators: Drs. Krista Baerg, Marta C. Erlandson, Jennifer L. Gordon, and Sarah McQuillan



Dr. Michelle Gagnon
Associate Professor
Psychology and Health Studies
University of Saskatchewan

Pain is universal. Pain during the menstrual cycle, however, is not. Dysmenorrhea is characterized by frequent, painful menstrual cramps and commonly begins within a few years of the start of menstruation. This condition can greatly disrupt everyday life for those who experience it, with one in four adolescents who menstruate rating the pain as severe or very severe, and many forced to miss school. While up to ninety percent of adolescents who menstruate experience dysmenorrhea, treatment is limited, and the typical onset and trajectory of dysmenorrhea remain underexplored. There is also a growing body of research suggesting that untreated pain early in life may actually lead to permanent changes to the way a person processes pain in later life. In this way, poorly treated dysmenorrhea may actually increase the risk of other chronic pain conditions later in life.

To directly explore this possibility, Dr. Michelle Gagnon, an Associate professor of Psychology and Health Studies at the University of Saskatchewan, and her team have proposed an observational, longitudinal study of children in early adolescence, successfully funded by CIHR in the spring 2022 project grant competition. This study will use a biopsychosocial approach and be conducted in three phases. Prior to the start of menstruation, the first phase will assess children's health status and psychological and social functioning with the aim of identifying pre-menarche influences of dysmenorrhea. The second phase will follow children until menstruation begins. The third and final phase will re-assess health status, psychological and social functioning, as well as the emergence of any new chronic pain conditions, annually for three years. Following children longitudinally will allow Dr. Gagnon and her team to examine the relationship between pre-existing pain, dysmenorrhea severity, and later development of chronic pain, as well as the trajectory of dysmenorrhea from its onset and any factors that may contribute to the condition.

Investigating dysmenorrhea in emerging adolescence may provide crucial clues as to which children are particularly susceptible to developing this condition. The results of this project may further inform care and aid development of prevention and education programs for parents of children at risk for dysmenorrhea and chronic pain. Says Gagnon: "menstrual pain is so often normalized, especially in youth. Our work is aimed at providing the evidence to show how detrimental ignoring this issue can be to the long-term health of youth who struggle with this pain. I'm thrilled that funders have recognized the value of providing resources to this area of research as we work, ultimately, towards helping youth get the help they need and deserve for their pain."

La communication

à l'ère des médias sociaux : où est l'empathie?



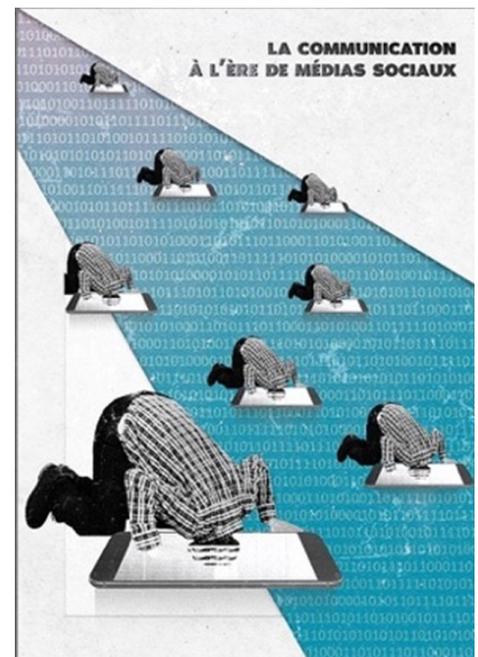
Écrit par Vincent Gosselin-Boucher

Depuis notre entrée dans l'ère pandémique, plusieurs études ont soulevé un paradoxe : nous vivons dans une société étant virtuellement plus connectée que jamais grâce à l'ubiquité de la technologie, mais socialement déconnectée (Clark, Algoe, & Green, 2018). Outre les effets délétères de la COVID-19 sur l'économie et le marché du travail, la santé mentale de la population mondiale s'est aussi vue altérée. En effet, alors que 16 % des individus se sentent plus seuls, 30 % vivent plus d'anxiété et 17 % présentent plus de symptômes dépressifs (Lavoie & Boucher, 2020). Être à l'écoute des autres dans ce contexte extraordinaire est très important. Toutefois, avons-nous toujours cette capacité empathique?

COVID-19 exacerbe toutefois leurs lacunes en montrant qu'ils ne parviennent pas toujours à abolir la distance entre nous (Stuart, O'Donnell, O'Donnell, Scott & Barber, 2021). Le temps serait-il venu de se sortir la tête du sable, ou plutôt des réseaux sociaux, et de réaliser que nous avons un problème collectif de communication, mais surtout d'empathie?

« L'humanité vit un déficit d'empathie », affirmait l'ancien président américain, Barack Obama il y a près de 16 ans, en ajoutant qu'il s'agissait d'un véritable enjeu sociétal (Honigsbaum, 2013). Le terme « empathie » est utilisé dans plusieurs contextes, tant pour décrire un ami qui est attentionné que lors du respect des consignes sanitaires depuis le début de la pandémie de la COVID-19 (Pfattheicher et al., 2020). Certes, il convient de noter que l'empathie est un phénomène complexe (Yu & Kirk, 2008). Il est tantôt décrit comme un trait de personnalité, tantôt comme un processus de communication, ou une compétence, et parfois même comme un état professionnel (Kunyk & Olson, 2001).

Depuis sa première apparition dans la littérature en 1908 (Lanzoni, 2018), plusieurs études ont tenté d'établir une définition de l'empathie (Cuff, Brown, Taylor & Howat, 2016; Hall & Schwartz, 2019; Pedersen, 2009; Teding van Berkhout & Malouff, 2016). L'empathie peut être définie comme une réponse émotionnelle dépendant de notre état et de nos traits personnels qui provient de notre interprétation de l'émotion vécue par une autre personne. En d'autres mots, l'empathie ou l'expression de l'empathie changera dépendant s'il s'agit d'une interaction entretenue avec sa mère ou avec un.e collègue de travail.



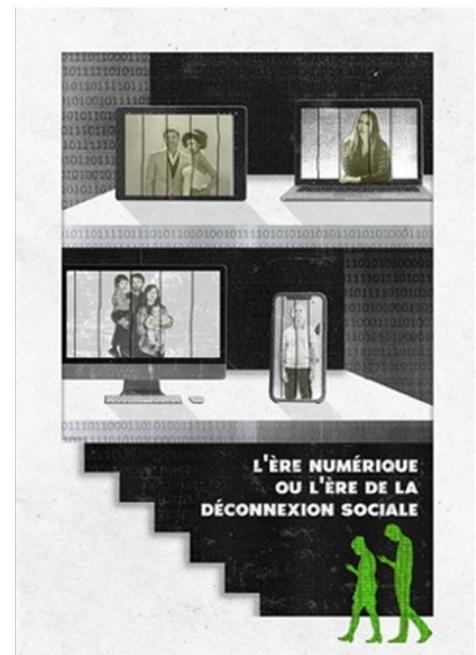
...suite



Plusieurs concepts s'apparentent à l'empathie. Il est important de les distinguer puisqu'ils sont souvent utilisés de manière interchangeable. D'abord, lorsqu'il est question de compathie, il s'agit d'une situation où les sentiments sont partagés en raison de circonstances communes. Par exemple, vous vivez une peine d'amour et votre ami.e, qui vient également de se séparer vous mentionne qu'il comprend ce que vous vivez. Puis, la sympathie se trouve à être une réaction intentionnelle vis-à-vis une situation émotionnelle, où l'on veut le bien de l'autre (Cuff et al., 2016). Cela peut impliquer qu'un.e autre de vos amis vous dise qu'il éprouve du chagrin pour vous tout en versant une larme. Ces concepts diffèrent de l'empathie quant à leur degré de représentation cognitive de l'état émotionnel, à leur niveau de partage des émotions et à leur éventuel maintien d'une distinction entre soi et autrui (Ickes, 2003). À cet effet, mentionnons qu'un.e ami.e ayant une réaction empathique à votre égard pourrait vous dire qu'il est capable de s'imaginer la peine que vous pouvez ressentir depuis votre séparation.

Empathie et réseaux sociaux : qu'est-ce que la recherche en dit

La communication en face-à-face permet rarement un moment de réflexion ou de prise de recul, puisqu'elle implique immédiatement des réactions verbales et non verbales (Carrier, Spradlin, Bunce & Rosen, 2015). L'empathie, quant à elle, s'exprime comme un style de communication où l'auditeur reformule verbalement l'émotion vécue par son interlocuteur tout en ayant une posture d'écoute et d'ouverture à l'autre. Cela peut sembler aux antipodes des communications sur les médias sociaux, où les émotions vécues sont habituellement transmises à l'écrit sans repères auditifs ou visuels (Cares, Hirschel & Williams, 2014). Il est donc possible de dire qu'une distance se crée dans cette connexion virtuelle pouvant atténuer le besoin d'une réelle interaction avec l'autre, et donc les opportunités de développer cette empathie (Dolby, 2014).



...suite

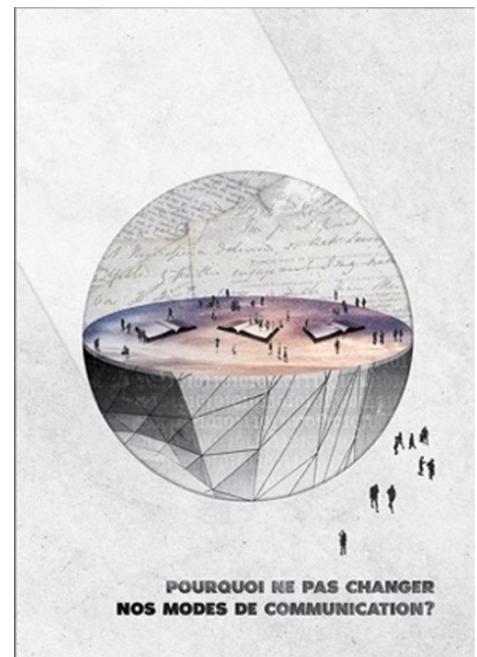


centaines de personnes se sont permis d'insulter les candidats d'occupation double en dessous de leurs publications Instagram, il est fort à parier que ces mêmes personnes se seraient moindrement retenues dans le monde réel. Ainsi, le cyberspace permet l'adoption d'une position confortable où notre caractère moral et éthique peuvent facilement être mis de côté.

D'un autre côté, certaines recherches indiquent que les médias sociaux favorisent les réponses empathiques en raison de la facilité et de la fréquence d'accès aux appareils mobiles (Carrier et al., 2015; Oh et Syn, 2015). Sans compter qu'il est possible d'observer plusieurs comportements empathiques d'individus au sein de groupes de soutien en ligne (Carrier et al., 2015). Il n'y a qu'à penser aux réseaux des survivants du cancer. Par ailleurs, les étudiants ayant vécu un deuil soulèvent qu'en partageant cette épreuve sur les médias sociaux, le nombre de condoléances reçues s'était amplifié pouvant refléter l'empathie de leur réseau virtuel (Wandel, 2009).

Bien que l'utilisation que l'on fait des réseaux sociaux puisse influencer positivement ou négativement nos réponses empathiques, le constat reste le même : le déclin de l'empathie se poursuit (Blakemore et Agllias, 2020). Il est temps de s'arrêter un moment et de réfléchir à notre empathie et aux autres afin de répondre par un changement de comportement individuel et ainsi parvenir à un avenir collectif meilleur. Bien qu'elle soit coûteuse cognitivement, l'empathie peut être travaillée en vue de favoriser son développement (Cameron et al., 2019; Dohrenwend, 2018). Par exemple, l'introspection et l'écriture réflexive permettent de se redécouvrir un instant et d'ouvrir ainsi à notre être et à notre agir nos capacités empathiques. Ici, il n'est pas question de manquer de temps afin de tenter l'expérience, mais bien de prendre le temps et d'évoluer vers une ère de reconnexion à soi et aux autres.

Pourquoi ne pas retourner à la simple connexion humaine?





Auteur : Vincent Gosselin Boucher

PhD, Stagiaire postdoctoral, University of British Columbia. Sa thèse porte sur le développement d'un outil en ligne d'évaluation de la communication chez les médecins. La communication scientifique est omniprésente dans ces implications auprès de Sciences 101, la section Psychologie de la santé et médecine du comportement de la SCP et "Vérité ou Quoi".

Collaboratrice : Brigitte Voisard

Candidate au doctorat en psychologie, UQAM ; Centre de médecine comportementale de Montréal. Sa thèse porte sur la communication entre les professionnels de la santé et leur patient. Par ailleurs diplômée en création littéraire, c'est par la lecture, le cinéma et la nature qu'elle fait le plein d'énergie.

Collaboratrice : Juliette François-Sévigny

Étudiante au doctorat en psychologie. Sa thèse porte sur le stress des parents d'enfants doués et TDAH. Elle se passionne pour la communication scientifique l'amenant à s'impliquer dans divers initiatives étudiants dont Sciences 101 et « Vérité ou Quoi ».

Illustrateur : Osama Jeljeli

Designer franco-tunisien Osama Jeljeli est venu au Canada à la suite de l'obtention de son Diplôme national supérieur d'expression plastique à la Haute école des arts du Rhin (Strasbourg — France) mention didactique visuelle (la pédagogie par l'image). Intéressé en tout temps à la clarification de l'actualité, il applique à l'aide d'outils graphiques, une envie de vulgariser les sujets contemporains. Crise migratoire, rôle des comics dans la communauté LGBTQ+ ou usage de la drogue, il n'hésite pas à exposer ses recherches plastiques au moyen d'informations référencées. Il souhaite faire appel à la réflexion pour éveiller les débats sur les maux de la société.

Révision : Thomas Tisserand, Camille Lavoie, Camille Guimond et Shawn Manuel

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Clinician's Corner

Chronic Disease Management

Fostering Social Support for Improved Chronic Disease Management

*By Jessica C. Kichler, CDCES, PhD, CPsych
Associate Professor, Clinical and Health Psychologist
Certified Diabetes Care and Education Specialist
Department of Psychology, University of Windsor*

In my work with patients with diabetes, I often use Self-Determination Theory (Ryan & Deci, 2000) to conceptualize how individuals enhance their performance and well-being through increased intrinsic motivation and engagement behaviours. This theory is based on the concept that people tend to be driven by a need to grow and gain fulfillment in their lives, and include three components:

1. **Competence** – where a need for growth drives behaviour to gain mastery over tasks and learn new skills for success, which leads to actions to achieve one's goals.
2. **Autonomy** – where one needs to feel in control of their own behaviours and goals, so they have the opportunity to take direct action to make a change (if they choose to do so).
3. **Connectedness/relatedness** – where one needs to experience a sense of belonging and attachment to other people.

Given this SDT framework, there are many therapeutic strategies that we, as health psychologists, regularly utilize to build our client/patient's sense of competence and autonomy in regard to behavioural change around health behaviours include, but are not limited to, the use of motivational interviewing (Vansteenkiste & Sheldon, 2006) and problem-solving skills training (Dattilo & Rusch, 2012). However, as health psychologists, much of our connectedness/relatedness strategies revolve around building our own therapeutic rapport with our client. In addition to providing practitioner-client support in treatment, we also need to help our clients establish other sources of connectedness/relatedness by building their social support (i.e., what type of support they receive from others around them in managing their health and well-being over time).

The evidence for the benefit of receiving social support on one's well-being is clear (Knoll et al., 2019; Wills et al., 2016). Moreover, social support has been shown to buffer many of the negative health outcomes our clients/patients may experience by improving health, recovery, and survival (House et al., 1988; Uchino, 2009). The usefulness of the social support received is often based on the type of help needed, such as emotional (e.g., demonstrating empathy, concern), instrumental (e.g., logistical tasks, financial assistance), and/or informational (giving advice, feedback, or new details). Some research even suggests that simply perceiving that we have access to this social support if we need it, is enough to reap the benefits (Lett et al., 2007).

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Clinician's Corner

Chronic Disease Management

Despite all the health benefits outlined above in regard to social support, it is important to remember that not all social support is the same. In fact, there are times when social support can even be more detrimental than helpful. For example, in diabetes care, certain forms of social support can contribute to a decrease in self-management behaviours (Harris et al., 2008). This can happen when efforts to “help” lead to increased doubts, criticisms, and demands by the helper related to the health behaviour. The client feels shamed and blamed by the helper and attempts to escape these negative emotions by withdrawing from the helper as well as avoiding the health behaviours. This can result in decreased self-management behaviours over time, and increased conflict between the client/patient and their social support member. Whether this social support comes from friends, family members, medical/mental health providers, work/school personnel, and/or others with the similar conditions, one must help their clients be thoughtful about the following:

Helping clients/patients develop effective social support resources outside of the therapeutic relationship, can provide a sense of connectedness, while also allowing the client gain mastery and honour their own autonomy in managing their health behaviours. This allows for high-quality social support to be sustained well after their treatment (and direct therapeutic support) has ended.



- Who they include in their social support network
- What types of social support they would like to receive from them (e.g., emotional, instrumental, informational)
- When they would like to receive this social support
- How they would like to receive this social support

The Social Convoy Model (Antonucci, 1991) suggests that individuals optimize their social networks by overtly selecting different types of people to serve in different social support functions throughout their lifetime. This approach to conceptualizing and constructing social support networks can

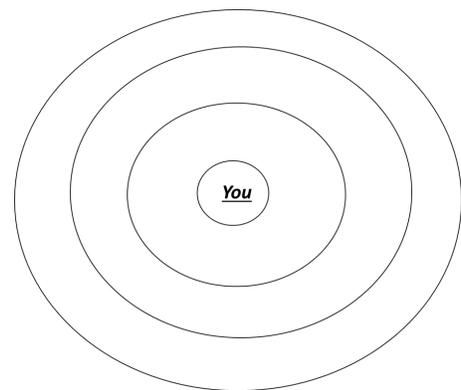
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Clinician's Corner

Chronic Disease Management

be used as a therapeutic tool for health psychologists to help their clients/patients actively build effective social support network in a concrete manner. Therapists can invite their clients to fill in the “rings” from the Social Convoy Model with different members to represent different functions and different levels of engagement (see Figure). Health psychologists should highlight that it is just as important for their client/patient to discuss who should **NOT** be included in this social network “ring” and how important it is to also avoid seeking social support from people who are not going to honour their right to have mastery and autonomy throughout their health care journey.

In such treatment, I have called this the “Tree Ring Exercise” with clients and have found it to be an extremely helpful clinical tool in helping them become more self-aware of their social support network, where there are “holes” to be filled, and empower them to be in more control of how to build high-quality social support resources to help them function more effectively. For example, when working with an older adolescent client/patient with type 1 diabetes, who is transitioning from pediatric to adult health care, one could use this prompt (see below) with follow-up discussions afterward to process the outcome with the client/patient.



Tree Ring Exercise

This tool can be used over multiple sessions and be revisited throughout the course of treatment to help the client/patient take ownership for building their social support network, and ultimately enhance their well-being and health outcomes.

Tree Ring Exercise Sample Verbal Directions:

Fill in the “rings” of the tree in terms of people in your life that can provide you with high-quality support during this transitional period. The level closest to the center is for the people you can rely on more to provide you with emotional/instrumental/informational support and the farther out the less. You can define these rings however you want – they do not have to just be people who you live with, but it also could be who is most helpful to you, and then move further out. Recognize that your relationships with people are dynamic, so some people may move in/out over time. Think about what qualities would help move someone closer in and what would move them out in terms of being able to support you in a way you find helpful. Again, these do not have to be people you would assume it would have to be – if it is not who you live with, then it is not. You can work to improve these relationships over time, if you think that they may be a good source of support in the future, but they may not fully know how to help meet your needs as well as you would like, yet. Be very realistic with yourself about who goes in here. If you are feeling like there are not enough people who you can write down on this worksheet, then let us think about how we can continue seek out new people to build your support team as you enter this next phase of your life.

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Call for Early Career Award Nominations

Rehabilitation Psychologist at Chartier Arnold Shimp & Associates



Dear Health Section members:

Are you an outstanding early career investigator or practitioner in the area of health psychology (or know someone who is) and are a member of the CPA Health Psychology and Behavioural Medicine Section?

Submit an application for our
CPA Health Psychology and Behavioural Medicine Section
Early Career Award!

Applicants must:

1. Be a Canadian resident who is within 8 years from the date of receipt of their highest degree (PhD, not post doc) at the time of application for this award (after taking any leaves of absence into account, e.g., parental leave);
2. Conduct research and/or practice in the field of health psychology or behavioral medicine (or a closely related field);
3. Attend the upcoming annual 2023 CPA conference in Toronto and present a 30-minute talk if awarded.

To be considered, please send the following application materials to:

Dr. Sheila Garland (sheila.garland@mun.ca):

- 1-2 page nomination letter stating how they have made a significant contribution to health psychology and/or behavioral medicine in Canada. Note: you can apply as a nominee or on-behalf of a nominee, but the nomination letter must be written by someone other than the nominee;
- Recent CV (any format); and
- 1 page indicating leaves of absence (optional)

Deadline: December 23rd, 2022

The winner will receive a \$500 cash prize and certificate acknowledging the honour, as well as an opportunity to present their work at the next CPA conference within our Section program.

We look forward to receiving your submissions!

Justin Presseau, PhD

Chair, Health Psychology and Behavioural Medicine Section
Canadian Psychological Association

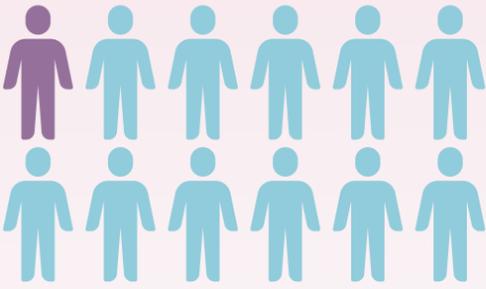
[@JPresseau](#)

PARTNERS IN THE PANDEMIC

The impact of COVID-19 on partner mental health



BACKGROUND



Prior to the COVID-19 pandemic, approximately 8.4% of fathers suffered from paternal depression. Between 4.1% to 16.0% reported high prenatal anxiety.

PRESENT STUDY

The purpose of the present study was to identify the prevalence of clinically significant depression and anxiety in partners of pregnant individuals during the pandemic.



METHODS



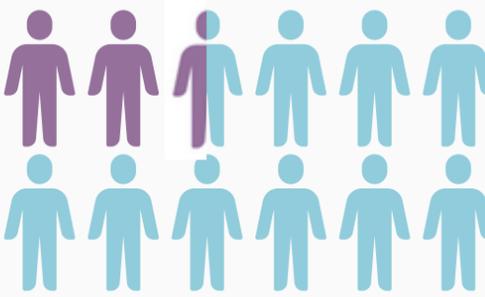
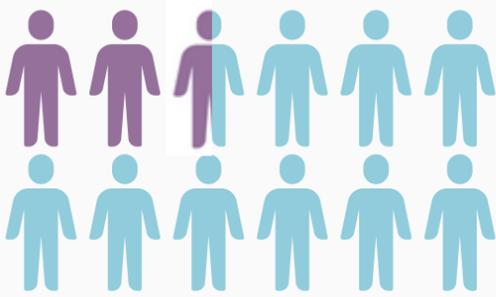
From September 2020 to March 2021, 342 partners of pregnant individuals responded to the survey and completed self-report measures pertaining to depression and anxiety.

RESULTS

Demographic data collected indicated that the mean age of partners was 35.8 years old. The majority were Caucasian (90.4%), had a household income of \$100,000 or greater (77.5%), had attended post secondary (92.4%), and had at least one kid already (67.6%).

During the COVID-19 pandemic, 25.7% of participants reported clinically significant depressive symptoms.

During the COVID-19 pandemic, 24.0% of participants reported clinically significant anxiety symptoms.



The increased prevalence of depressive symptoms during the pandemic is likely significant. Increased depressive and anxiety symptoms correlate with lower social support, couple satisfaction, and resiliency.

CONCLUSION

Given the increased prevalence of depressive and anxiety symptoms during the COVID-19 pandemic, it is critical to explore the effects of various lifestyle moderators and interventions.



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