

**Bearing the Brunt:
The Canadian Medical System, COVID-19, the Impacts on the Chronically Ill
Community, and What We Can Do as Therapists**

by

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Abstract

Using literature, research, and lived experiences, this capstone works to highlight the current state of the Canadian medical care system, how the system has been impacted by the COVID-19 pandemic, and how the chronically ill community has been impacted by these challenges. Both the intersections where the chronically ill community are further distressed and the places where the community's resilience is evident are explored. This capstone shines a light on the ongoing issues with our Canadian health care system and gives voice to the burgeoning issues of chronic illness and mental health care due to the damage done by the COVID-19 pandemic. Indeed, one of the gaps this capstone aims to start to fill is the impacts of COVID-19 upon the mental health field and the chronically ill population. The second gap is the lack of awareness in the medical and mental health field. Beyond filling these gaps, this paper works to offer hope of how mental health therapists can be better educated and equipped to go into the field and advocate for better education and care for those with a chronic illness.

Keywords: chronic illness, COVID-19, Long COVID, resilience, stigma.

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The Canadian Medical System, COVID-19, the Impacts on the Chronically Ill Community, and What We Can Do as Therapists

Chapter 1: Introduction

Topic Overview

Chronic illnesses are both a current and worsening issue for the healthcare and broader community to navigate. Moreover, chronic illnesses impact all age demographics and populations. While children are not the population this capstone focuses on, it is worth mentioning that they are one of the populations more impacted than the general public would expect. According to research by Blackwell et al. (2019), the prevalence of children being diagnosed with chronic illness, in the United States, continues to rise to about one in five. For Canadian children, research by Queenan et al. (2021) has found that 22% of children below eighteen have at least one chronic illness with the rates jumping to 65% once over nineteen. Without question, these numbers are concerning and therefore provided the impetus to dive further into this research. Specifically, the research pointed the way to two other key problem areas. The first being the current state of healthcare in Canada. The second being the initial and ongoing damage done by the COVID-19 pandemic.

Importantly, amidst the distressing updates there are improvements for those diagnosed with chronic illnesses. Blackwell et al. (2019) outline how medical advances have made chronic conditions more treatable than fatal. Cancer, for example, is now often considered more of a chronic illness than a death notice. However, the deep cracks within the system are one of the first challenges folks with chronic diseases need to manage. The authors explain how the traditional care models in use remain non-holistic and more limited in scope. According to research by Rosenbaum and Mincer (2021), current care offered has barriers such as limited

resources and inadequate training. The researchers explain that, in a world recovering from COVID-19, the World Health Organization has put forth a plan to both increase care and better monitor care in communities. However, as the researchers express, the mental health needs of those with COVID-19 and long COVID will need to be established and then met. Telehealth, as McLoone et al. (2022) posit, has been one of the few positives of the pandemic, allowing for increased access to communities that previously struggled. Moreover, from interviews of concerned parents, the researchers explain how telehealth options provide care that is more convenient, reduces travel burdens and illness, enhances care across states, and limits the risk of exposure to COVID-19. Nevertheless, much like traditional models of care, there are still barriers to overcome. Specifically, researchers list the need for more evidence that telehealth models of care are equivalent to face-to-face care. Also, for families wherein the diagnosis of chronic illness is new or who lack a good bond with their clinical team, telehealth may not be the appropriate vehicle of care. In a medical health system with clear issues, telehealth may solve some of the issues. Nevertheless, as echoed by many other researchers including Gürhan et al. (2019) and Blackwell et al. (2019), holistic care is being called for as the much-needed answer to the current state of medical care and care of the chronic illness community.

A more damning take on our current medical health system is in the article by Shojania (2022) which asks “What problems in health care quality should we target as the world burns around us?” Equal parts snarky and honest, this article speaks to the very real issues currently at play in our healthcare system – issues that are still being worsened by COVID-19. Shojania (2022) goes on to say the median of inappropriate care is 30%, both for over and under use. Furthermore, Shojania (2022) adds that critical tests for chronic illnesses, such as glycosylated hemoglobin (HbA1c), are some of the most underused tests. Stigma and access also worsen care.

Sibley and Glazier (2010) express how care needs not being met are linked to availability of services at 54.9%, acceptability at 42.8%, and accessibility at 12.7%. Stigma also rears its ugly head in the medical field, especially for marginalized populations. Earnshaw and Quinn (2011) highlight how people who are chronically ill have reduced rates of accessing care and experience a lessened quality of life will anticipate, experience, or internalize stigma. Moreover, Shojanian (2022) lists that outside of COVID-19 that other threats to the healthcare system include the climate crisis, economic divides, the opioid epidemic, and systemic racism. This variety of challenges paints a bleak picture of the medical system and speaks to the challenges the chronically ill population must deal with. Regarding improving the system, Shojanian offers the quip “the impacts these crises have on both the health systems and population health make promoting the uptake of practice guidelines seem like rearranging desk chairs on the Titanic” (2022, p. 312).

Adding on to the water on the deck of the Titanic, so to speak, is the implications of long COVID. From work by Cimellaro et al. (2022), long COVID is a disease that impacts multiple systems and has a variety of symptoms such as shortness of breath and dysfunction of senses. The lack of clarity around this disease only worsens treatment. Worryingly, we know COVID-19 at its baseline has already interrupted the prevention of chronic diseases and negatively impacted disease management (Hacker et al., 2021). Therefore, the question arises as to the damage another onslaught of chronic illness will cause, especially one that is not yet well understood. It was this ominous concern that served as the catalyst for this research – the state of medical care was concerning, COVID-19 had worsened it, and now with another legitimate concern to further derail care for the chronically ill, the need to pay attention, analyze the situation, and hopefully start finding better solutions was clear.

Purpose Statements

Upon research, reflection, and revision, the purpose of this capstone pivoted to honing in on the ailing state of Canada's health care system, how this impacts those who are chronically ill, especially those who are marginalized, how COVID-19 is worsening the system and those within it, and how those of us in the mental health field may be able to help. This capstone aims to show a current snapshot of Canada's medical system and then zoom out to the populations it impacts. Unsurprisingly, as the focus shifted, the research question changed as well. As it stands, the research question is: considering the current state of Canada's medical system, and the impacts of COVID-19, how is the chronically ill community navigating their diagnoses and how can therapists do more to assist this community?

To get to this purpose statement and research question, this capstone has gone through many iterations. Initially, it began with a focus on those with chronic illnesses post-diagnosis, the care those patients received, the success of that care, and how mental health workers can be better involved in the process. However, as I began to pull the veil back on the current state of medical system that began to take more of a precedent. The initial focus on youth and solely diabetes also began to change due to limited research and findings on what mental health treatments were available for folks with post-diabetic diagnoses and post-chronic illness diagnosis. Finally, much like it did to the rest of the world, COVID-19 proved to change my plans. Its impact on the medical system and folks with chronic illness simply cannot be understated. I hope this capstone can serve, to some extent, as an exploration and call to action for how therapists can help this underserved and marginalized population.

Conceptual Framework

The overarching frameworks for this capstone were two-fold. The first, is an integrative approach. This approach is in reference to the various levels and moving parts of the medical system that is being analyzed. This multilevel analysis is seen in the consideration of systems approaches, holistic approaches to care, and grassroots approaches to medical aid. Overall, the research speaks to the need for more integrative care and it is within that ethos that this paper is written. Specifically, the call for integration is seen at the level of medical care such as family doctors, the level of grassroots medical interventions, and the broader level of the need to better include therapists within the system.

The second overarching framework is intersectionality. This term is far more specific and was coined in 1989 by Dr. Kimberlé Crenshaw to describe how characteristics, such as race, gender, and class, “intersect” with each other (Coaston, 2019). Despite right-wing criticism, as Coaston (2019) highlights in her interview with Crenshaw, the goal of intersectionality was never to reorder the hierarchy to put Black women at top but to destruct the racial hierarchy all together. For my purposes, this term was important as the crumbling systems and attempts to create integrative care are only one piece of the puzzle. The reality is that the broken medical system is that much more broken for certain populations. Specifically, this capstone highlights how Indigenous folks residing in Canada have been poorly served, historically and currently, by the medical system. Critically, this is only scraping the surface of the intersections impacted by medical care. Being darker-skinned, transgender, and other such intersections can and should be considered in future studies. Historical relevance and higher incidences of reported chronic illnesses are what led to Indigenous folks being the main intersection considered.

Contribution to the Field

This research's applicability to the field is two-fold. First, it works to fill a gap in the research. I would attribute this gap in research to the lack of awareness and research around chronic illnesses for therapists and unfortunately, often within the medical field itself. A prime example of this is endometriosis. This chronic illness is defined as a gynaecological conditional which has a varied symptomology including infertility, painful sex, and chronic pelvic pain (Hudson, 2022). Worryingly, Hudson (2022) goes on to outline how cases are skyrocketing while simultaneously the etiology of the disease remains unclear and neither diagnosis nor treatment is consistent. Medical professionals seem inadequate at helping those with this complicated diagnosis. Equally dire, seems to be the patients' understanding of the illness. Seear (2014), describes a haunting moment with her first interviewee, Wanda, who is twenty-six, been diagnosed as a teenager, and has already had six surgeries. Wanda confesses to not truly knowing what endometriosis was and asking for an explanation. Despite years of suffering and multiple surgeries, Wanda did not fully understand her ailment. With these troublingly wide gaps in knowledge and research, even for those directly impacted, it is perhaps unsurprising there is gaps for therapists in treatment of chronic illnesses. One of the most damning examples of this, for me, remains the absolute dearth of education around chronic illness and therapeutic treatment even at the level of an accredited master's program. While I did locate guides around treating the chronically ill, such as therapy utilizing the modality of acceptance and commitment therapy, it remains that this is not common knowledge. This poses the concern of whether those with chronic illnesses will be mistreated, misdiagnosed, or face other slights.

The second reason this research is applicable is that I have stumbled upon a very current and burgeoning problem. COVID-19 has left an indelible impact upon all levels of society, but especially the medical system, therapeutic spaces, and those who are chronically ill. This is

demonstrated by issues such as a lack of cancer screenings in medical settings due to overburdened systems (Hacker et al., 2021) and immunocompromised states, often associated with chronic illnesses, requiring isolation but resulting in worsening mental health (Lindsay, 2022). COVID-19 has also caused problems at intersections of health. For example, as highlighted by Lindsay (2022), for someone with a diagnosis of schizophrenia there is a higher risk of death, if they get COVID-19. However, we equally have a lack of understanding about how much more of an impact there will be now and further down the years. As I write this, vaccinations for COVID-19, as well as the flu, have restarted on October 10th with the intention to target the Omicron XBB.1.5 subvariant as well as EG.5, XBB.1.16, and BA.2.86 (Ruttle, 2023). However, the long-term impacts of these variations and the new vaccines remain woefully unclear. There remains vaccine resistance and outcry against COVID-19, as seen in the comment section on Ruttle's article. All the while, amidst the dissent, the numbers of long COVID increase (Hacker et al., 2021). With an influx of chronically ill being put upon an unprepared medical and mental health system, this research contributes to analyzing the dangers we face and aims to explore the possibilities and hope ahead.

Reflexivity and Positionality Statement

To position myself in this paper, I am a twenty-eight-year-old, bisexual, and cisgender woman. I am mixed race, with my father's side being an European mix of Irish, Scottish, and more while my mother's side hails from Sri Lanka. I have a background in both Psychology and Sociology, meaning that this paper intentionally tries to look at both individual issues as well as the broader social scope. I am also passionate about social justice and you will find it woven throughout this capstone.

Without question, the impetus for choosing this research topic is a personal one. In late 2011, I began rapidly losing weight seemingly without cause. It was chalked up to exam stress but I opted to ask for some blood tests and such just to check. The tests found oddly high blood sugars with few other issues. However, there was no evident cause as to the high blood sugars which had my doctor concerned. A flurry of medical practitioners, including doctors, nurses, specialists, endocrinologists, and more, all tried to diagnose me. The vague diagnosis offered was diabetes type 1.5. To be clear, this is a placeholder name for an, as of writing this paper, undiagnosable form of diabetes. The doctors have argued I am not type 2 due to not being the right weight or age. I am also, however, not type 1 due to the milder reactions to higher doses of sugar and lack of severe reactions overall. My unclear and unpredictable symptomology has made diagnosis a nightmare.

Post “diagnosis,” little has changed. I remain without a concrete diagnosis and have little more of a treatment plan than to exercise and eat well. The lack of oversight has also complicated things, as I have been reduced to dangerous weights, including below 80 pounds in the pursuit of “eating well.” One of the interesting challenges I have faced moving forward is my age and appearance. Due to looking young and healthy, I am often assumed to be less disabled than I am. While I am grateful for my young age and youthful appearance, it is a double-edged sword in being taken seriously as someone who is chronically ill. Social class is another complicating factor. As a graduate student, it will be a while before I will have a healthy income. Fears of the cost of medical tools such as a continuous glucose monitor or insulin weigh heavily on my mind. Indeed, it is the horror stories around insulin and poor chronic illness treatment that also had a part in inspiring this research. Sable-Smith (2018) tells the story of Alec Raeshawn Smith who died less than one month after his mother’s insurance ran out, at the age of twenty-

six, with an empty insulin pen that they believe he was rationing due to his insulin being \$1,300 a month. The story is eerily familiar to that of Josh Wilkerson, as told by Olivo (2019), who died at twenty-seven after aging out of his stepfather's health plan and no longer being able to afford the prescription brand of insulin he required. As well, echoed in the story of Jesimya David Schrerer-Radcliffe, as told by Jones (2019), who died at only twenty-one and who was also rationing insulin. Nicole Smith-Holt, the mother of yet another child killed by a lack of insulin, is quoted by Jones (2019, para. 4) saying "... The cause of death should actually be on their death certificates, corporate greed." While the focus of this paper has skewed from just diabetes and diabetics, it is undeniable that the chronic illness of diabetes is a challenging and at times fatal experience. For myself, I too aged out of my mother's health plan by about twenty-five and will have to foot future bills for insulin or other medical supplies. In good news, generally, Canada has lesser costs for such medical supplies. However, in bad news, it fluctuates greatly depending on province, insurance coverage, and more. For example, out of pocket costs for type 1 diabetes in Alberta can be as low as \$78.00 but as high as \$18,306.00 in New Brunswick (Diabetes Canada, 2023). Geopolitical location is yet another factor that impacts care. I am grateful to be in Canada and mindful of the privilege of being white-passing, young, and non-intimidating.

I want to ensure, despite the aforementioned challenges, that I express my own gratitude for my health. The gradual decline of my diagnosis coupled with my own advocacy and resilience has proven to help enable me to navigate a struggling health care system. I also want to clarify that I know my own experience is not a monolith. Thus, I explored how others have been mistreated and if others had better treatment. Indeed, it is this stubborn hope that built up in me - that there should and could be better. Moreover, if there was not better, how could I help, even in a small way, to make it better. Despite my health woes, this hope has continued to fuel my

research. This being said, I know I am biased against the current system of treatment. One of the most damning points being that I was never offered mental health care at any point in my over twelve years of fighting with this chronic illness. Therefore, I have done my due diligence to equally report on what successes have been found, what changes are occurring, and what unsurpassable challenges the system is facing. I also wanted to challenge the stereotype that those with more serious chronic illness have no agency. I want this research to be honest to the grievances and challenges found within the medical system while also honouring the positives discovered along this process.

Key Terms

To preface the literature review, there are a few terms that require definition.

Chronic Illness or Chronic Disease

Chronic illness or chronic disease are used interchangeably and are broadly defined as a condition that lasts over a year and that either limits daily living, requires medical support, or both (CDC, n.d.). Sosa et al. (2022) suggest that it is a disease that is slow in progression but has a long duration and has no cure. Notably, due to the range of chronic illnesses, there are always exceptions. Heart disease, fibromyalgia, diabetes, endometriosis, and multiple sclerosis are all example of chronic illnesses. Some forms of cancer, due to medical advancements, can also be included in this list. As researchers often define the specific illnesses differently, as per their populations, I will try and include the different definitions of each illness, in each article, in the literature review. It is worth noting that chronic illnesses and diseases are not synonymous with chronic pain. While many do include chronic pain, such as endometriosis or irritable bowel syndrome (IBS), it is not a requirement for an illness to be deemed a chronic illness or disease.

COVID-19

COVID-19 takes up a large portion of this paper due to its current and subsequent impacts. The World Health Organization (n.d.), defines COVID-19 as an infectious disease, linked to the SARS-CoV-2 virus, associated with mild to moderate respiratory illness that can, in severe cases, lead to hospitalization.

Long COVID

Long COVID is one of the newest chronic illnesses added and does not have one clear cut definition. However, for our purposes, I am pulling from research by Cimellaro et al. (2022), wherein it is a disease that impacts multiple systems, can persist weeks after one believes they are recovered, and currently has an incidence rate of about 10-35%. Importantly, as the authors say, the range of symptoms and severity can fluctuate.

Intergenerational trauma

Intergenerational trauma is defined as the trauma that is passed from survivor to descendant (Marschall, 2022). While it impacts many cultures, in this study the focus remains on Indigenous folks who reside in Canada.

Mental Health Intervention

A mental health intervention is variable and can include physical, mental, and social health (Millaci, 2019). As Millaci (2019) outlines, interventions could include individual therapy, group therapy, support groups, online therapy, and more. For our purposes, it is whatever mental health intervention that is offered post-chronic illness diagnosis in an attempt to support the well-being of the individual that has been diagnosed. This concept is most present in Chapter three.

Resilience

Resilience is the ability to cope with and recover from adversity, a mediator of successful coping, and can be linked to hardiness, control, commitment, and seeing change as a challenge (Lau et al., 2021). Excitement about new lifestyle changes or confidence in being able to navigate the diagnosis would be examples of resilience.

Stigma

The term stigma involves social devaluation or discrediting (Earnshaw & Quinn, 2011). Earnshaw and Quinn (2011) explain that stigma can be internalized and an intrapersonal phenomenon, externalized which is the amount one perceives stereotyping, discrimination, and prejudice, or anticipated which is the amount one expects stereotyping, discrimination, and prejudice. Examples would include phrases like “you don’t look sick” and “you’re too young to be so sick” or confusing symptoms of a medical problem, like a stroke, with alcoholism or other unrelated ailments due to the individual’s race or culture.

Outline of Chapters

The next section of this capstone is a literature review stemming from the research question: considering the current state of Canada’s medical system, and the impacts of COVID-19, how is the chronically ill community navigating their diagnoses and how can therapists do more to assist this community? Therefore, the literature review begins with an overview of the current state of the medical system. Importantly, pre-COVID-19 and current conditions are discussed. How a systems approach would better serve Canadians is discussed as well as the challenges to that approach. Grassroots approaches to solve the issues, for example by paramedics, are discussed next. How Indigenous folks are poorly served and the historical context behind that is next. Then, a deep dive is done into how COVID-19 has worsened care. The impacts of COVID-19 on the chronically ill, pre and post-COVID-19 are then explored.

Building upon this, the plausible impacts of long-term COVID-19 are discussed. Alternatively, ways to improve our struggling systems are offered. Specifically, community centered, technologically driven, and self-sufficient solutions are considered. The chapter wraps up with the dangers of resiliency and explores possible next steps for therapists.

Chapter three begins by taking readers along the same journey I have gone on with this research. Despite international acclaim, I break down some of the cracks in Canada's health care system. Both what is stalling improvement and how certain populations have been impacted more by COVID-19 are discussed. The calls for improvement are also highlighted, both from the medical system and the chronically ill people within the system. Those solutions are further extrapolated to express the community-based, technology-based, and self-sufficient solutions arising. The challenge of resiliency is then discussed. Following this, I dive into the ethical requirements of therapists doing more. This ethical piece is, firstly, to answer to the British Columbia Association of Clinical Counsellors (BCACC) ethical code. Secondly, it is to help start the process of improving the holistic care counsellors can offer. Relevant principles from the code and their connection to better counselling are laid out. Following this, I lay out further reasons as to why this increase of integrated care is needed, ultimately, positing it as a life and death situation.

The second part of chapter three lays out ways for therapists to become more aware of and educated on chronic illness. This is done via a learning module, intended to bridge the gaps of knowledge currently running rampant in caring for the chronically ill. The module lays out types of chronic illnesses, therapeutic lenses to view them through, and the medications to be aware of when case conceptualizing and going along the therapeutic journey. Suggestions for how to take the education further and advocate for a more integrative treatment model is the

summation of the module. Indeed, despite the bleakness of much of this work, chapter three ends on a high note of hoping for more and envisioning what a better future could be.

Chapter 2: Literature Review

Literature Review Introduction and Structure

In this chapter, via a wide breadth of research, the reality of having a chronic illness and receiving care are explored. The chapter begins with an illuminating look at Canada's current health care status, an environment so many who are chronically ill must reside in temporarily or permanently. A systems approach is posited as the way to remedy much of the current systemic woes; however, researchers outline issues with this and why even integrated care has yet to be achieved. As solutions stagnate, I explore grassroots models that have sprung up. Then, a marginalized population who is more impacted is discussed. After this, the conversation returns to the harm COVID-19 has waged upon the medical system and the variety of ways it has impacted the chronically ill community. Next, the conversation shifts to the dangers long COVID represents to an already buckling system. In response to this ominous prediction, solutions are offered on the bigger systemic level as well as via smaller technology, community, and self-sufficient routes. As suggested by the latter route, questions of whether resiliency is celebratory or cause for further condemnation of the system are asked. The chapter finishes with a query around just what the capability of therapists is to intervene and offer support.

Current State of Canadian Health Care

At Breaking Point

As of early 2023, Canada is facing down multiple crises. Examples such as the cost-of-living crisis and COVID-19 are prominent in many Canadians' minds. It is the latter that has fuelled much of the concerns around another crisis in Canada – the state of our health care system. It is ironic, in many ways, to see the reprehensible state of Canada's health care system. Generally, Canada is referred to as a leader in the medical world. 'Universal', 'publicly funded',

‘decentralized’ and more are the shiny buzzwords used to describe the current system. However, Canada’s health care system has been damaged deeply by the COVID-19 crises and concerningly, was already in a state of decay prior to the latest crises. In a poignant quote, Canadian Medical Association president Dr. Katherine Smart says “we are at a complete breaking point” going on to express fears around how much longer medical practitioners will be able to keep going and highlighting that an exodus has already begun (Duong, 2021, para. 4). In the article by Duong (2021), a concerning statistic is offered that three out of four doctors are reporting burnout. The article calls for both circuit breakers such as lockdowns as well as immediate relief including a waiving of jurisdictional limits to allow professionals from across Canada to work together. As Smart warns, “if we don’t take action now, we are going to decimate the health care system” (Duong, 2021, para. 8).

Pre-COVID-19 Care Status

However, the cracks in the shiny veneer of Canada’s health system were present long before COVID-19. Allin et al. (2020) wrote a damning piece that speaks to the overarching issues within the care system. In fairness, the authors list positives such as zero user fees as well as half as much spending with significantly better outcomes. Nevertheless, the issues are abundant. The authors, Allin et al. (2020), list limited financial access to many services, pharmaceutical coverage that is both unequal and less generous, the longest waits for both specialists and surgical services, and that one third of Canadians without supplemental coverage have struggled or been unable to access dental care. Indeed, the authors offer the statistic that 41% of Canadians have skipped dental care, check-up appointments, or both due to dental costs. The most pertinent issues for this paper, however, are two-fold. The first is that Canada is stagnant in the updating and adapting changes in service delivery and overall innovations to care.

The second is that there are serious and detrimental gaps to health for populations across Canada, specifically the Indigenous communities. In further research, this is also worsened at the intersections of identity such as Indigenous folks who are chronically ill. Prior to that, I expand upon the two major issues impacting Canada's health care system and putting barriers in front of progress.

Systems Thinking as the Alternative

From an article by Zukowski et al. (2019), systems thinking is an approach which requires a pivot from isolated and linear views of a system to a view that recognizes patterns, interactions, and various behaviours that emerge. Akin to the quote the sum is greater than its parts, the authors argue that a system cannot be grasped fully by only looking at the parts and instead one must consider the numerous elements that interact with each other. The authors push for a move away from working in silos or considering one cause and instead suggest that health problems stem from systemic issues, socio-ecological levels, multiple sectors, and varying elements of the adaptive systems in place. Mahamoud et al. (2013) use a quantitative model to test the social determinants of health. The authors took insight and feedback from various stakeholders, in different sectors, and created a model that simulated changes in determinants such as health status and social disparities. The model focused on the city of Toronto, for a 40-year period, and looked at five different risk factors, behaviour, health care access, housing, income, and social cohesion. The model simulated that, over a 40-year period, the greatest impact would be found in both an improvement of 30% in social cohesion as well as a 30% improvement in housing that is adverse across income levels.

Issues with Systems Thinking

The model set forth by Mahoumoud et al. (2013) provides a clear blueprint for ways to utilize systems thinking so as to improve the state of our health care system. Specifically, the authors suggestions can inform interventions, re-design policies that thus far have been policy resistant, and enable conversation between stakeholders as to where action needs to be focused and with what intensity. However, I am behooved to note that this study is from back in 2013 and that despite its promise there remain gaps in health strategies and the push to make health strategies has stalled if not become worse. Zukowski et al. (2019) point out three main causes of these gaps. The first is that the process facilitates but also requires engagement across varying and numerous sectors and stakeholders. This is often a challenge as it is context-specific, can lack a common mandate or goal, and lack connection between sectors. The second is that partnerships need to be both established and invested in which can require an abundance of time. This is due to what the authors refer to as “lag time” which is the time required for those involved to get used to and adopt new and innovative ways of working. Additionally, it can take both time and space for concepts to be processed and shift to more divergent thinking. Third, quite simply, the process can be both confusing and messy. This is a result of the diversity of perspectives along with the reality that these more complex systems are emergent and non-linear. To adopt this process requires practitioners to be dynamic, flexible, and reflective.

Issues with Integrated Care

With a systems approach as the gold standard, it is pertinent to say there are cracks even in providing integrated care by any one facet of the care system. Ideally, integrated care would provide care that is adaptive, flexible, coordinated to individuals, communities, social contexts, geographical contexts, and the overall population’s health (Allana et al., 2022). However, this is very much not the state of health care being provided across Canada. Allana et al. (2022) explain

that some of the barriers to even this level of integration includes a top-down governance, an approach described as “command and control,” and an inflexible understanding of the messiness and uncertainty involved in the complex systems required. From the research, the authors clarify that network governance alongside complex thinking would help navigate the tensions between different levels of leadership, the call for innovation, the need for standardization, and the place of policies and regulation. As seen by the lone study for systems approaches however, these authors also highlight the lack of examples and therefore the lack of guidance on how to implement these needed principles into practice. Thus, integrated care or any move to more systems-based approaches appears to be at a standstill.

Grassroots Response

In response to this stagnation, there have been grassroot models. An example of these models is described by Allana et al. (2022), wherein paramedics are creatively offering new services to meet the care needs across Ontario. Specifically, the authors state that paramedics are now “providing a growing list of preventative, community-based, and chronic disease care” which is “nebulously termed community paramedicine” (p. 2). However, as the authors say, whether these interventions are examples of improvements that push towards integrated care or more band-aids for a broken system remains a question for many. Nevertheless, the number and variety of different models currently being incorporated is impressive.

Grassroots Models

From Allana et al.’s (2022) work, there are eight different models being utilized. The first is to manage chronic disease and aging at home. This involves both primary and home care teams that provide preventative as well as emergent care. Specific populations supported by this initiative include those with chronic illnesses such as diabetics or those with lung disease. The

second is harm reduction and community outreach. This includes programs such as mobile clinics, community housing, and shelters that serve a broad population including undocumented folks, seniors, and our street entrenched neighbours. Lower to low acuity care is the third branch of this model. This encapsulates care that is unscheduled and not an emergency which involves minor illnesses, wounds, and injuries in an attempt to initiate follow up care without the unneeded inclusion of the emergency department. Fourth in this model is situational crises or mental health crises. This branch involves the use of crisis response teams, which can include police, paramedics, nurses, and social workers, to combat crises. This can streamline care and allow for transfer of clients to the necessary mental health facilities. Palliative care is the fifth branch. This involves care that is 24-hours, manages symptoms, and is provided at home so as to avoid a hospital trip as the patient's life ends. The sixth branch is public health and vaccines. These vaccinations can be provided on-site or at home. This branch also includes public education and the distribution of naloxone kits. The seventh branch is tri-fold including system navigation, case finding, and needs assessment. This branch speaks to the idea that by initiating home visits, unmet needs and requirements for referrals can be better found. Services to be connected to can include case management, primary care teams, and services to better address social inequities such as nutrition or income. The eighth, and last, branch is a transition to home post-discharge from hospital. Serving as a bridging service, paramedics provide in-home assessments as well as wellness checks to ensure what can be treated at home is. Again, this branch works to meet thus far unmet health and social needs. Overall, the authors list the program goals as: bettering client experiences, lessening the pressure on both emergency services as well as hospitals, handling the needs that occur after hours and on-demand, filling the gaps in local services, and working to address the current inequities in case access. The authors

list successes, such as a drop in 911 calls due to availability of other services. Yet, the Ministry and other bureaucracies prove to continue to stand in the way of progress. As one paramedic the researchers interviewed said, “It's like always sticking a square peg into a round hole because the one size doesn't fit all” (Allana et al., 2022, p. 8).

Greater Impact of Poor Care on Marginalized Populations

Poorer Care for Indigenous Populations

One community particularly in need of better care is the Indigenous community. While Canada's worsening health care system impacts everyone, Indigenous communities have faced some of the worst ramifications of poor care and treatment. One of the most damning reports about this was from Dr. Turpel Lafond (2020) who spoke of the widespread racism, prejudice, and discrimination present in our health care systems. The researcher spoke to how this has widespread negative harm up to and including the death of Indigenous folks. This report was inspired by claims about a “Price is Right” game allegedly played by health care workers, in emergency departments, where the blood alcohol level of patients was being guessed. While not substantiated as a coordinated or targeted treatment to only Indigenous patients, episodic and anecdotal evidence was found. Notably, this behaviour is not a secret but efforts to fix these issues are not strong and lack a systemic foundation. Via interviews and reviews, the researcher reported stereotyping, poorer quality of care, a lack of feeling safe to access services, and negative interactions with healthcare providers. Indigenous women were found to be the most unsafe. Indigenous workers within the system also spoke to being afraid to speak up due to fear of reprisal. Workers added that not enough time, attention, or resources in organizations were given to resolving this issue. Further issues listed included tokenism, exclusion, improper discharge of patients, information being withheld, and more. Emergency departments were also

listed as one of the worst locations for care. This is especially a problem in Canada where there are less and less family doctors and more patients are forced to rely on emergency departments for healthcare. Stereotyping was also listed as a critical problem wherein Indigenous patients are considered less than and therefore receive subpar care such as being physically manhandled, sexually assaulted, and other non-consensual and harmful care. Furthermore, stereotypes negatively impact the chronically ill population. Misdiagnoses and medical mistakes were found to be at a staggering 16% with long term illnesses such as diabetes being misinterpreted or Parkinson's being missed all together. Illnesses, such as liver disease, were also commonly misattributed and linked to drinking. Pain management and treatment are also heinous with treatment and medications often withheld due to the belief that Indigenous people are drug seeking or somehow feel pain differently. Denial of medications was reported by one half of Indigenous folks versus one fifth of non-Indigenous. Indeed, participants refer to these hospitals as "Death Hospitals" due to the poor service and likelihood of being thrown back in the street. In a struggling health care system, Indigenous folks with any health issues but especially chronic health issues face an uphill battle to be seen never mind receiving medications and proper treatment.

Historical and Medical Context

Further causes for this poorer treatment is seen both historically and medically. Historically, from research by Richardson and Boozary (2021), this worsened health status comes from residential schools and their ongoing impacts. Key to the worsening health statuses, as the researchers explain, is that the schools had emotional, physical, and sexual abuse alongside substandard living conditions and nutritional provisions. Moreover, there was non-consensual scientific research and increased transmission of diseases such as tuberculosis. The

impacts of these atrocities are still felt today. Specifically, the researchers list that increased incarceration, increased presence in child welfare, increased mental illness, and increased substance abuse are all results of the abuse and intergenerational trauma. Critical to this paper, increased chronic illnesses are another ongoing impact of the past atrocities and present effects. Heartbreakingly, today many Indigenous folks are at an increased risk for a variety of chronic illnesses. Pulling from one study by Hardy et al. (2020), it is this heartbreaking history of colonization along with current marginalization that has resulted in disproportionate rates of obesity, type two diabetes mellitus (T2DM), and other chronic illnesses. Diabetes alone, as the researchers state, is three to five times higher in Indigenous populations than in the national average.

Barriers to Care

Troublingly, access to care is worsened for the Indigenous population as well. One cause of this is distance as a barrier to traditional care. Causes for this, as listed by Redvers et al. (2019), include a lack of traditional services within northern health teams, policies do not consider Indigenous centered care, and funding does not go directly to Indigenous nations and communities. Disparities in training are another serious barrier to care, with both doctors and mental health professionals ill-equipped. From a study by Jager et al. (2020), doctors in the Netherlands reported language barriers and a lack of cultural awareness as serious issues. The doctors went on to report a desire for training in cultural competence. As chronic illnesses such as type 2 diabetes are more prevalent in ethnic minorities, as stated by the researchers, this inability to receive care is an issue. Similar results are echoed in a study by Stoutenberg et al. (2023), wherein American undergraduate students were surveyed and it was found that while over 92% of students reported it was of high or very high importance they reported zero or one to

five hours of formal training on chronic illnesses. For mental health practitioners, chronic illness is rarely even included in the regular curriculum of study never mind the intersectionality and further struggles posed against minorities with chronic illnesses. Positively, there are an array of courses to be taken post-graduate studies and a wide variety of suggested modalities, including cognitive behavioural therapy and acceptance and commitment therapy, for therapists to utilize in the treatment of chronic diseases in therapy. However, there remains a disconnect in connecting those in need of therapy post-diagnosis. While it is heartening to see the array of training and offerings of care, there remains a need to better link the systems of health care and mental health care so as to ensure therapy is available at times of great need for those receiving chronic illness diagnoses, during treatments and maintenance, or struggling as the illness worsens.

Impacts of COVID-19 Upon Canada

Impacts of COVID-19 on Canada's Health Care System

Upon an already struggling medical care system, COVID-19 has dealt an incredibly hard blow. Critical to those who are chronically ill, is the placement and subsequent removal of many safety precautions that were put in place. At the height of COVID-19, some safety measures included medical masks for patients, medical masks along with eye protection for health care workers, active screenings of new and current patients, transparent barriers to protect screeners, physical distancing, and prevention of visitors (Government of Canada, 2021). Today, precautions vary globally and even across Canada as to what is being required. The mask mandate was dropped in April of 2023. For hospitals, changes included visitors not needing to be vaccinated or prove vaccination status, not requiring visitors to wear masks to the hospital unless required due to risk of infection, and no more active screening (Interior Health, n.d.). To say

many with chronic illnesses were outraged may be an understatement. With the removal of precautions, there is an abundance of fear and anger. Martin (2022) argues that to many immunocompromised patients, the pandemic is still an existential threat. While the researcher agrees choosing when or when not to loosen restrictions is a complicated one, the choice to loosen restrictions has resulted in frustration and seeming resignation to what will be an ongoing battle. Jeffrey Sparks, an associate physician at Brigham and Women's Hospital as well as Harvard Medical School, speaks in Martin's (2022) article to the seeming losing battle wherein people are frustrated both by ongoing mask requirements and removing mask requirements. Seemingly, hospitals are in a no-win situation. Sparks goes on to speak about the positives being an increased toolbox of options to prevent COVID-19, including booster shots, monoclonal antibody therapies, antiviral medications, and pre-exposure prophylaxis (PrEP). Nevertheless, he points out the need for empathy and awareness as most medical practitioners are not able to fully grasp the emotional state of those with a chronic illness or increased risk to COVID-19. Alas, the COVID-19 precautions did also pose challenges for those with chronic illnesses. Reporter Erin Brohman (2020) depicts the story of young Hallie Thiessen, a one-year-old, who was forced to make dozens of trips to the emergency room only to often be sent home and have her mother, Cari Thiessen, navigate surgical wound care, bleeding, and pain. Cari is quoted as saying "it just does not make sense to me that we are trying to protect a population from getting sick by taking away health care from the chronically ill..." (Brohman, 2020, para. 38).

"Post-Pandemic" Pains for the Chronically Ill

From a medical perspective, Hacker et al. (2021) outline that there are two categories wherein the chronically ill have been impacted - during and post-pandemic. Despite the pandemic being deemed over, researchers explain that issues remain in the areas of preventing

disease, managing ongoing conditions, and receiving required health care in a safe manner. Post-pandemic, or so-called post-pandemic, the authors say that the other three areas are prevention, identification, and management. As the authors outline, routine or emergent medical care has been avoided, cancer screenings have been avoided, less cancers and pre-cancers have been diagnosed, and more. In heartbreaking statistics, the researchers cite that modelling studies have come back with estimates of near 10,000 preventable deaths occurring due to a lack of screening and treatment for both breast and colorectal cancer. Prevention has also been stagnated or stopped, as the researchers say, for issues such as substance abuse and mental health. As therapists, it is deeply worrying to hear that the already poor connection between chronic illness and mental health care is worsening not improving.

Emotional Impacts on the Chronically Ill

On the more emotional side, the one two punch of chronic illness and COVID-19 has wielded serious emotional damage for those struggling with chronic illness. A news article from KEZI News (2022) in Oregon, speaks to some of the major struggles including hypervigilance, isolation, and job loss. Indeed, it seems to be a two-fold problem, as the researchers highlight, of both being vigilant about one's own protection as well as vigilant about where you are entering into and how the people there are or are not protecting your safety. From first-hand accounts, so many immunocompromised folks have been impacted. A nurse, Kate Baum, speaks in the article to feeling unsafe, isolated, and scared as she had to leave her job due to the risks of working while undergoing chemotherapy for stage three cancer. The precautions were deemed too low and the risk was deemed too high. Jonathan Hill, a kidney transplant recipient, speaks to the lack of empathy, amidst understandable fatigue, and the burden on loved ones who have to take on tasks out of the home such as grocery shopping. Jay Lundy, who has chronic pain and polycystic

ovary syndrome, speaks to the grief, sadness, and anger that they have been navigating. Overall themes the news article touches on is a feeling of being devalued by others or simply lumped in and forgotten with the elderly. Jennifer Taft, who has rheumatoid arthritis, speaks to feeling like an afterthought during the vaccine roll outs, the tension with loved ones in discussing masking, vaccines, and more, as well as the mental gymnastics involved in the consistent weighing of risks and benefits. In a particularly relevant quote, Taft says "this whole time I have felt very ignored by the CDC facts. It's devastating in some ways because you're already in a mindset of a little bit of a dark place sometimes" (KEZI News, 2022, para. 48). Taft's frustrations echo exactly the need for better mental health care for those with chronic illnesses, especially after COVID-19 has further damaged the mental health of so many.

Impacts of Long COVID

In reading through the multitude of firsthand encounters coupled with devastating statistics, three facts become more and more apparent. The first, being that the state of medical health supports, for the chronically ill and otherwise, are in dire straits. The second, being that the pandemic has only worsened the already poor state of care, especially for those who are chronically ill. Third, the lack of wraparound care causes those at various stages within their chronic illness, such as at time of diagnosis and when managing conditions, to feel bereft of proper mental health care. Unfortunately, further worsening this situation is the influx of new chronically ill folks due to long COVID. Long COVID is an initially self-diagnosed illness that is slowly gaining credence among the medical and research community. In a study by Cimellaro et al. (2022), they describe the phenomenon as a multisystem disease, or a disease that impacts multiple body systems, that persists weeks after recovery, and has an incidence rate of 10-35%. While the researchers clarify symptoms can be both subjective and vague, common ones include

a shortness of breath, palpitations, neuropsychiatric disorders, dysfunction of senses, and severe fatigue. Then, as the researchers say, cardiovascular, gastrointestinal, and respiratory disorders can occur. While limited due to self-reporting, Sudre et al. (2021) found that predictors of long COVID included older age, female sex, and number of symptoms in the first week of illness. The burgeoning question with the concerning impacts being reported due to long COVID, is how does this impact the chronically ill community? Hacker et al. (2021) poses that exact question wondering if COVID-19 has created a new influx of chronically ill patients, if its worsened or increased diseases, and if it has increased the presence and prevalence of chronic diseases at a population level due to challenges from the pandemic such as food insecurity.

Proposed Solutions for Influx of Chronically Ill Patients

The idea that there is an incoming influx of more chronically ill patients, on a system already struggling to stay afloat, is a foreboding one. Nevertheless, suggestions are being posed to lessen the possible danger. The first, suggested by Hacker et al. (2021), is to raise awareness. The researchers say the first step to this is lessening people's fears around returning to health care. Second, Hacker et al. say to stress the prevention and care of chronic diseases and emphasize the safety and mitigation efforts. There is also work to be done in increasing access and faith in the COVID-19 vaccine among this community. More data and research around health inequities is also needed. Indeed, Dr. Amesh Adalja is quoted as saying "people don't need a public health emergency to take something seriously" (Kritz, 2023), a statement that feels optimistic to the point of untrue as one delves further into the research. Nevertheless, next, Hacker et al. (2021) speaks to the critical need for collaboration at an individual level as well as a systems level incorporating smaller coalitions and community groups to make change. Bigger parties such as governments and insurers down to smaller groups such as schools and faith-based

groups are encouraged by the researchers to participate and be change agents. Hacker et al. call for bidirectional conversations, engagement, outreach, and transparency to rebuild trust in the health care system and public health system. The third call, from the researchers, is to utilize creative and innovative solutions. Specifically, Hacker et al. call for four different solutions. The first is the use of technology to expand the reach of health care via programs like telemedicine or mobile applications. Second, is the provision of more services within community settings. Third, is increasing the use of community health workers in both navigating current circumstances as well as connecting to more community resources. Fourth, is the increase and improvement of access to and availability of services, such as cancer screenings, and monitoring, such as blood sugar or blood pressure. The researchers do however warn that in expansion, care must be taken to not further health inequities already at play. Care must be in multiple languages, accessible to different forms of technology, and culturally appropriate while taking into consideration food insecurity, limited transportation, social isolation, substance misuses, and unemployment.

Proposed Multi-Level Solutions for the Breaks in the System

Solutions at the Systemic Level

Hacker et al. (2021) state bluntly that there is an enormous amount of work to do to recover from the pandemic in terms of COVID-19's impact on the chronically ill. Unfortunately, this is a phrase that resonates across the health care system. However, this is not to say that solutions are not being offered in an attempt to fix the failing system. Allin et al. (2020) list that needed improvements include: reducing the fragmentation of care, increasing coverage available for healthcare, reducing the cost of pharmaceutical medications, navigating barriers to accessing prescription medications, improved pharmacare plans, reduce costs of specialized care, improve primary care, and overall improved coordination across sectors. Across articles, one of the

critical recommendations remains that there needs to be better wrap around care available for patients. Achan et al. (2021) speaks to this integration requiring changes such as services that are comprehensive, healthcare coverage of all of Canada, a culture of organization, and a structure of health governance. It is these requirements, the authors say, that speak to the need to include Indigenous care into the current health system. More specifically, the researchers highlight, a move from a purely colonial and biomedical model to one that is balanced, integrative, and holistic. Participants in the study speak to the need for inclusion of Elders, better funding, the use of traditional medicines and healers, far more respect and recognition of Indigenous ways of healing, and an overall call for more spirituality. In a poignant quote, one participant says "... the spiritual aspect is so important and so strong, because there is such a history of colonization, the residential schools, all that soul sickness ... I believe that we have to look at the strengths of the community." (Achan, 2021, p.4). A study on paramedicine, by Allana et al. (2022), echoes this need for community and adaptive, integrated, and responsive health systems. On a larger scale, stakeholder dialogues are discussing how to improve care. For chronic pain sufferers in Canada, some of the key issues are the burden it causes on health care systems, management of the pain has inconsistent access, the way the system itself is arranged limits pain management, and a lack of coordinated approaches to implement guidelines. Out of dialogues among stakeholders, the authors reported the findings were a need for a national network as well as national pain strategy.

Community-Based Solutions

Nevertheless, government and institutional change is slow going. In the interim, community-based, technologically focused, and self-sufficient solutions to the medical system problem are also cropping up. For community-based solutions, one particular success story comes out of the Canadian Arctic. Mead et al. (2013) describes the intervention, called Healthy

Foods North, as a community-based intervention that is multi-institutional as well as lifestyle and nutritional focused. The program was twelve months long and, as the researchers clarify, is based off social cognitive theory and social ecological model. The authors go on to describe how the community was collaborated with, via recruiting stores, community workshops, and implementation of cultural norms and values. The key aims of the project, as illustrated by the authors, were raising physical activity, increasing dietary adequacy, and reducing the risk of chronic disease in Inuit and Inuvialuit communities. The researchers involved then did a quasi-experimental pre and post the Healthy Foods North intervention and found, despite needing more follow-up, more men, and a lack of change in food knowledge and preparation, that the study was overall a success. High retention rates, improved diets, healthier diet, less unhealthy food, and better self-efficacy were all reported by the researchers. Excitingly, as the authors report, these results are echoed in programs like the ZATPD (Zhiwaapenewin Akino'maagewin: Teaching to Prevent Diabetes) in Ontario. Sometimes, however, community-based programs come with more controversy. One such example is a point-of-care screening program set up in rural and remote Indigenous communities in Manitoba with the goal of both identifying and treating chronic kidney disease, diabetes, and hypertension (Frejuk et al., 2021). Critically, the program itself was successful. Frejuk et al. (2021) reported success in a variety of ways including accessing appropriate care, medication to modify children's diseases, increased visits to primary and specialized care, and an increase in follow-up tests. The issue comes in that, due to historical and current mistreatment, Indigenous populations can be averse to such measures as screening and outside prevention. Connecting back to COVID-19, this was seen recently with vaccine hesitancy within Indigenous populations. Sullivan et al. (2023) express how due to historical and current colonization and historical acts such as medical experimentation and forced

sterilizations, there are legitimate reasons Indigenous people are hesitant around vaccines. Via social media posts and sharing circles, researchers sought ways to improve this with suggestions such as more attention and focus on Indigenous self-led solutions, a need for empathy, and a need for statistics and accurate medical information and education. With such a heartbreaking history with western medicine, I fear the ramifications of increasing outside screening and interventions. Nevertheless, as explained by Hardy et al. (2020), due to those same histories of colonization, Indigenous populations are unfairly and disproportionately burdened with many chronic illnesses including type two diabetes mellitus. It is these intersections and histories that make simply increasing screening or adding more mental health support more complicated and not a simple one-part solution.

Technology-Based Solutions

For technology there have been more and more possible solutions arising, undoubtedly increased by COVID-19 and aiming to fill gaps in the system. With this in mind, Lau et al. (2020) went on to do a systematic review of the current internet interventions or eHealth and mobile health apps or mHealth to consider their efficacy, among other considerations. The researchers found five main results. The first was that immediately posttreatment, there was evidence of improvements in participants physical health and psychosocially. Second, at longer term follow ups of up to and over three months, there was evidence of maintenance of gains from treatment. Third, cognitive behavioural interventions that were computerized were the most prevalent. Fourth, the levels of psychosocial support from staff on forums just as text or private online boards varied. Fifth, there were critical methodical limitations such as a lack of treatment groups to compare and a lack of blinded outcomes to assess. Further research and gaps are also highlighted, including a need for more self-direction, how to intervene for nonspecific or

transdiagnostic patients, better analytics on what is causing the behaviour change, and ongoing assessment of new and novel technologies. Nevertheless, there seems to be promise and momentum behind virtual supports in healthcare.

Self-Sufficient Solutions

Those who are chronically ill are not without agency, which is seen in the variety of more self-led interventions and supports coming from within the community. To preface this, there is danger in self-management and not every intervention is successful. From a study by Jerant et al. (2009), Homing in on Health (HIOH), a Chronic Disease Self-Management Program, was put through its paces in a randomized control trial of one year with less than ideal. When delivered in home, at six weeks and six months, the researchers found HIOH did show improvements in self-efficacy but did not show improvements at one year. Jerant et al. (2009), also only found significant effects on one secondary outcome, the Visual Analog Scale (EQ VAS). For the researchers, their findings bring into question the cost-effectiveness of these types of programs. Moreover, for our purposes, it does offer a warning that self-led interventions cannot and may not be able to be a miracle cure for the ailing medical system. Nevertheless, self-led care and strengths have proven to be beneficial for some chronically ill folks. Kristjansdottir et al. (2018) used individual and group interviews with chronically ill folks navigating chronic respiratory disease, morbid obesity, and chronic pain and studied what strengths those people felt impacted their health and well-being. The researchers' results were categorized into three domains of inner and external strengths as well as self-management strategies. For the former, some of the listed strengths were persistence and endurance, retaining a positive outlook, being caring and kind, feeling positive emotions, being in nature, engaging in work or education, being kind to oneself, adjusting one's ambitions, having courage, and reconciling oneself with the situation at hand.

Some of the external strengths listed include good relationships with health-care providers, good relationships with family and friends, being and talking to peers with the same illness, and being in an environment that could support a healthy lifestyle. As for self-management strategies, the most commonly mentioned included being active, exercising, getting enough rest, and reducing stress. The next level of mentioned strategies included planning and prioritizing, setting and adjusting goals, taking things slowly, and working towards one's goals. Strategies to manage symptoms, such as breathing exercises, distraction techniques, reflective writing, and visualizations were discussed. How to navigate inevitable stress was also discussed, with strategies including seeking help and knowledge, ways to manage difficult thoughts, the use of humour, and seeking out others going through their illnesses too.

Echoing the power of reflective writing, Bertrand (2021) offers an autoethnographic account of how writing helped her to self-reconstruct post-diagnosis of Fibromyalgia (FM). In her article, Bertrand pulls from work by Danoff-Burg et al. (2006) that suggests writing can lower pain levels for people with physical illness, from Norman et al. (2004) that suggests when women with chronic pelvic pain wrote about their stressful experience they had lower pain ratings, and from Smyth et al. (1999), that when writing, patients with mild to moderately severe asthma and rheumatoid arthritis showed improvements in health status that were clinically relevant. Throughout Bertrand's piece she discusses the fragmentation of identity, the deep grief, and the shattering of her assumptive world. Nevertheless, she refers to Charmaz's (1995) stages of adapting to one's impairment and how she was able to, via writing, move herself from a loss orientation to one of restoration. While this is simply one qualitative piece, the author offers a more creative way to navigate the pain one feels post-diagnosis.

Resiliency - a Solution or Complication?

When considering the power of self-management, the concept of resiliency continues to be raised. Resiliency is generally described as the ability of someone to bounce back and keep going despite adversity. For many with chronic illnesses, it is a requirement to navigate day to day life. From the study by Kristjansdottir et al. (2018), this is exemplified by the participant who states: “when I’m at rock bottom there’s only one way to go, and that’s up. Then I tell myself: now you have to shape up. Now you need to move on, and you have to do it yourself” (p. 790). However, I argue that the use of resilience as a necessary coping strategy is a double-edged sword. On one hand, it is celebratory in that it aids those who are chronically ill post-diagnosis and throughout the management and treatment of their illness. However, as we turn to more self-sufficient forms of treatment, such as eHealth, it bears the question of how much of a crutch the patient’s resiliency has become as the medical health system continues to crumble. It is in this grey area I point to the ongoing lack of mental health supports offered or considered in caring for the chronically ill, despite a multitude of possible therapies. With the ailing medical health system and a risk of overusing the power resilience, where can therapists and other mental health professionals step in to do more?

Summary and Key Themes

In this chapter four key themes and a variety of sub-themes are explored. The first key theme is the current state of the Canadian health care system. This leads into sub-themes including a brief look at pre-COVID-19 care, alternative care models, issues with current systems thinking models, and the grassroot responses that have arisen. The second key theme is the poorer care being given to marginalized populations, in this case specifically Indigenous populations. This was a key issue for me to include due to the high incidence of chronic illness among Indigenous populations and to maintain an intersectional lens. Sub-themes explored in

this section include historical and medical contexts as well as a deeper dive into barriers to care. The third key theme is the impact COVID-19 has had on Canada. Sub-themes explored in this section include impacts on the health care system at large, impacts specifically for those who are chronically ill, the heart wrenching emotional impacts for those who are chronically ill and their families, how this connects to long COVID, and possible solutions to lessen the impacts of long COVID. The fourth key theme is solutions, at a multitude of levels, for the current broken aspects of the system. The sub-themes include solutions at the broader systemic level, solutions at the community-based level, solutions at a technology-focused level, and solutions at a self-sufficient level. Finally, the chapter ends with an open-ended question of what therapists can do to improve the state of care for the chronically ill.

Chapter 3: Discussion and Application

Introduction

This chapter begins with exploring the research starting with the state of the Canadian medical system, to what continues to stall progress, to the impacts of COVID-19, and then to the progress being fought for both by the medical community and members within the community. This research ultimately led up to the reality that researcher after researcher was calling for more holistic care and yet a gap remained between those calls and therapists' answers. After positing the desperate need to answer that question, both to be ethically sound and to protect the lives of the chronically ill community, I have created a learning module to try and answer the call. A multi-step module, the process involves both education and advocacy. Amidst challenges and worsening healthcare conditions, I believe in therapists' ability to do more and do better.

Discussion

When beginning my research, I had a few core topics I aimed to delve into. The first was the state of our medical health system as it stands. The short answer – not good. The longer answer is, of course, more complicated. It is important to note that despite positive beliefs in Canada's health care system, the reality is far more fractured and inaccessible. Prior to COVID-19, the system was broken with cries of burn out and understaffing. Allin et. al (2020) speak to the detriment of issues such as long surgical waits and uneven access to pharmaceuticals. In response to the struggles, there have been calls for systems-based approaches and integrated care. However, Canada's top-down governance model of medical care has stalled these calls. Despite standalone grassroots models, forward momentum has yet to occur. Without question, this has impacted the chronically ill population. Pulling in the intersectional and sociological angles, it has particularly impacted the Indigenous populations residing in Canada. For example,

pulling from work by Dr. Turpel-Lafond (2020), a horrifying rate of 16% was found for misdiagnoses and medical mistakes with long term illnesses, such as diabetes, being misinterpreted or being missed all together. This is especially damning information as Indigenous populations are a higher rate of chronic illness. COVID-19 then came along and caused further strife. For the chronically ill, a reduction in precautions has caused real stress coupled with worsening care, such as less screenings, and a high emotional cost.

However, and this is the critical point, this is not to say those involved in providing care and those who are chronically ill have not worked to combat these challenges, even as it can feel like a David and Goliath battle. Specifically for COVID-19, researchers such as Hacker et al. (2021), suggest tools such as raising awareness and fighting vaccine hesitancy. Overall, researcher after researcher calls for holistic and wrap around care. More specifically, researchers such as Allin et al. (2020) list out that needed improvements should include reducing the fragmentation of care, increasing coverage available for healthcare, and navigating barriers to accessing prescription medications, among other suggestions.

From the dark state of medical care, three types of solutions are being reported. First, are community-based solutions. Examples of this stem from research by Mead et al. (2013) who speak to the success of programs like the ZATPD (Zhiwaapenewin Akino'maagewin: Teaching to Prevent Diabetes) in Ontario and Healthy Foods North. Next, is technology-based solutions. Research by Lau et al. (2020) holds hope for the future of eHealth and mHealth. The authors clarify that there is further research needed, such as improving analytics on what is resulting in the behaviour change and a better grasp on the new and novel technologies that are coming forward. Nevertheless, positive changes were seen by the researchers such as improvements immediately post-treatment and those gains maintained at later dates. Third is self-sufficient

solutions. Critically, these can be dangerous and should not be entered into without careful consideration and oversight. For example, from the study by Jerant et al. (2009), there was the Homing in on Health (HIOH), a Chronic Disease Self-Management Program which was deemed unsuccessful. However, this is not to say self-sufficient solutions do not have their merits. From individual and group interviews, Kristjansdottir et al. (2018) found solutions such as reconciling with the situation, talking to peers with similar struggles, and how to manage future stress were all helpful. In a particularly evocative piece, Bertrand (2021) speaks to the power of writing in her struggles to reclaim herself post-diagnosis of Fibromyalgia (FM). What this piece really lays the groundwork for is the power of resiliency. However, I would challenge this idea. As someone who is chronically ill myself, the level of unseen emotional labour and physical resiliency expected of those who are chronically ill can make resilience a double-edged sword. Solely because I can be resilient does not mean I should have that expectation placed upon myself, especially as it is in the lapse of care available that these expectations are being set. These expectations are just another piece of evidence calling for the creation and provision of more holistic care. This is seen by researchers such as Achan et al. (2021), Zukowski et al. (2019), and Mahamoud et al. (2013). However, that call for holistic care has not yet been extended quite as far as counsellors. It is this gap in literature that I hope to start to cross via this capstone.

The Why

Ethical Imperative

Between my own mistreatment, the gaps in literature, and the absence of holistic treatment available for those who are diagnosed with a chronic illness, there are many reasons why better and more inclusive health models are needed. However, I wish to highlight two key reasons why therapists or other licensed mental health practitioners are a critical addition to the

model. The first is the ethical code of conduct therapists must follow. The governing body for mental health practitioners is the B.C. Association of Clinical Counsellors (BCACC). The BCACC (2014) has four principles to follow: Respect for the dignity of all persons and peoples, responsible caring, integrity in relationships, and responsibility to society. While all four are critical, it is the last one that is the most relevant for our purposes. Responsibility to society is defined by the BCACC as “a responsibility to the society in which they live and work and have dedicated themselves to the well being of human beings in that society” (2014, p.9). Our work must carry far further than the walls of our agencies or private practices.

To extrapolate further, there are five components of the fourth principle that are especially relevant. First is number six, in which the BCACC (2014) says to best serve the broader community mental health practitioners must collaborate with other individuals, agencies, and professional disciplines. Much like health care practices should not be siloed, mental health care professionals should not be solo. The next relevant principle is number seven, which the BCACC states is the need to take responsibility of being aware and increasing one’s knowledge, both scientifically and professionally, in efforts to promote the well-being of society. By researching and understanding the chronically ill, a marginalized population, mental health professionals will be better suited to serve society. As mentioned previously, there is little to no training on chronically ill populations for medical carers and next to none for mental health practitioners. This is a clear absence of knowledge both scientifically and professionally. The third relevant principle is number eight, in which the BCACC expresses the need to take responsibility in both fighting and changing the oppressive laws and structural pieces in place in society. Importantly, neither our clients nor we are immune to oppression in society and poor treatment in medical facilities and mental health care are definite examples of this oppression,

oppression we are ethically obligated to fight against. The fourth relevant principle is number nine wherein the BCACC states as the need to promote ethical principles in professional capacities such as research and educational components. For our purposes, a great example would be a panel of experts on chronic illness coming into master's classes to educate the next generation of care providers. The fifth, and final, relevant principle is number four where the BCACC states a commitment to ongoing improvement via being aware of the impact of their actions, being open to feedback and new ideas, and then subsequently correcting their incorrect behaviour. In many ways this echoes the call by Allana et al. (2022), where integrated medical care needs to be more adaptive and flexible and far more coordinated to various populations, social contexts, and geographical locations. I think of Indigenous populations in northern Canada for example, who will need varying and adaptive care. Overall, from the ethical guidelines that govern our profession, there are clear reasons as to why an inclusion of chronically ill people, amongst other marginalized populations, is necessary.

Suicide Rates

Outside of ethics, there is another pivotal reason why better consideration of the chronically ill is necessary for medical and mental health practitioners: suicide rates. From the Government of Canada (2023), suicide rates across Canada are at approximately 4,500 a year meaning twelve people per day. Much like medical care, COVID-19 also impacted suicide rates. It is suggested the rate of adults considering is 4.2% but the impact of these risen rates is yet to be seen. From research by Rogers et al. (2021), suicide rates are elevated for folks with chronic illness - up to about two to four times higher. The researchers go on to list possible causes for this elevated risk, including believing they are a burden or that they do not belong. Importantly, the causes of suicide go beyond mental health concerns and the researchers call for further

consideration. Moreover, they highlight how many more chronically ill patients access health care over mental health care and encourage that primary care settings could be utilized as screening areas for suicide risk. As the researchers say, it is worth noting the efficacy of these screenings is under question and future research is needed. Nevertheless, going through primary care settings could allow for easier access to screenings and initial interventions. One can use different frameworks, such as the University of Washington Risk Assessment Protocol (Linehan et al., 2012), and create safety plans for the client. Rogers et al. (2021) then go on to suggest two specific psychotherapies. The first is Acceptance and Commitment Therapy (ACT), which while it has not been specifically tested against suicidal ideation it has proven to show encouraging evidence. The second therapy is Interpersonal Psychotherapy for Depression (IPT) which has lessened depression in those with chronic illness and has modules for chronic depression as well as depression that has suicidal features. Ultimately, as the researchers say in closing their article, as the chronically ill population has such heightened suicide rates the level of suicidality deserves more research and attention in clinical settings.

Application

Education Module for Therapists

At this point, I would argue it is clear why chronically ill folks require better mental health supports. To actually achieve this, of course, is far more complicated. While imperfect, I propose a three-pronged solution in an attempt to match the needs of the chronically ill at varying points in their care. The first place is within the education setting. Currently, the lack of training around chronic illness leaves young therapists woefully unprepared. I acknowledge that future training is an obvious asset, but I firmly believe there should be education prior to graduation with the option to pursue further education after. I am also conscious, however, of

how little time there already is in most master's programs and the many important subjects vying for time within curriculums. Therefore, I propose the inclusion of a chronic illness module within an already required course – Psychopathology and Psychopharmacology. This would be a four-part introduction enabling students to get enough of an idea to be safely competent when placed in practicums. The first part of the module would include an overview of chronic illnesses, within the lens of psychopathology. I recommend covering the ten most common chronic illnesses as stated by the list from the Government of Canada (2019) of the prevalence of chronic diseases that are found amongst Canadian adults. First is hypertension, or overly high blood pressure. Second is osteoarthritis, or a degenerative disease where the tissues in your joints break down. Third are mood disorders and anxiety disorders. The former refers to someone's mood escalating or deescalating too intensely and the latter refers to feelings of anxiety, to the point of fear, which are overly elevated and continue over long periods of time. Fourth is osteoporosis, a form of bone disease where the mineral density and mass decrease or the overall structure of the bone changes. Fifth is diabetes, where your body either cannot produce enough insulin or is unable to properly use the insulin your body does produce. Sixth is asthma, wherein breathing is difficult often due to narrowed airway passages or an excess of mucus. Seventh is chronic obstructive pulmonary disease (COPD), which is actually a group of diseases, such as emphysema and chronic bronchitis, all of which include airway blockage and general problems breathing (CDC, n.d.). Eighth is ischemic heart disease, or heart problems caused by narrowed coronary arteries (American Heart Association, n.d.). Ninth is cancer, which is a disease that can occur anywhere in the body and is caused by the abnormal growth and spread of cells in the body. Tenth is dementia, which is an umbrella term for diseases that include lessened ability to think, remember, or make decisions (CDC, n.d.). I would also argue for the inclusion of two

more chronic illnesses. The first being long COVID. The impetus for this is the amount that COVID-19 is showing up in therapy rooms. Indeed, public health crises are associated, to a disproportionate amount, with increased suffering and mental health burdens especially for those who are psychologically vulnerable (Roudini et al., 2017). As we are just barely scratching the surface on what the psychological damage will be post-COVID-19, it would be prudent to keep new therapists aware of the incoming changes. The second chronic illness I would add is endometriosis. Marked as being a modern epidemic by Seear (2016) and as it is most seen in young women, the population that attends therapy the most, I purport this is a useful chronic illness to add to the list. An overview of the medical presentation and the psychological comorbidities would cover this part of the module.

The next part of the module would focus more on the therapeutic aspect of these chronic illnesses. For this, I propose two main aspects. The first is an inclusion of therapeutic lenses. First, is an acceptance and commitment therapy (ACT) lens. The reason for this is that evidence has already been found around success with chronic pain patients and success lessening self-harm and suicidal ideation (Rogers et al., 2021). Two other possible lenses are mindfulness-based stress reduction (MSBR) and cognitive behavioural therapy (CBT), both of which were found to have positive results including improved physical functioning along with lessened depression and chronic pain (Khoo et al., 2019). Other suggestions from Nathansan (2021) include: guided imagery, hypnosis, meditation, and relaxation. The second aspect includes a focus on the grief and loss of self involved in chronic illness. As Bertrand (2021) so eloquently speaks to, there is a shattering of one's idea of themselves and the world when faced with a chronic illness. In an interview by Byrne (2022), Lori Gottlieb, who is a therapist with a chronic illness, echoes this idea as she speaks to the turning down of social events, the assumptions of

laziness, loss of close relationships, and the loss and grief attached to having to accept a new form of reality. Understanding these elements will make for better therapeutic care, which is essential as poor therapeutic care is another barrier chronically ill folks should not have to navigate.

The third portion of this module is an overview of the various medications involved, specifically the ones prescribed for chronic illnesses that can help result in psychiatric side effects. There are sixteen in total, as pulled from research by Tango (2003). First is Baclofen, prescribed as a muscle relaxant for multiple sclerosis (MS), which can cause anxiety, depression, and psychotic symptoms. Second are beta blockers, prescribed to manage heart rhythms that are abnormal, which can cause anxiety, depression, mania, and psychotic symptoms. Third is bromocriptine, prescribed for diabetes and Parkinson's, which can cause anxiety, mania, and psychotic symptoms. Fourth is clonidine, prescribed for high blood pressure, which can cause anxiety, depression, mania, and psychotic symptoms. Fifth is corticosteroids, prescribed for arthritis, asthma, autoimmune diseases, and lupus, which can cause anxiety, depression, mania, and psychotic symptoms. Sixth is digoxin, prescribed for cardiac diseases, which can cause depression, mania, and psychotic symptoms. Seventh is interferon- α , prescribed for different cancers and virus infections, which can cause anxiety, depression, mania, and psychotic symptoms. Eighth is levodopa, prescribed for Parkinson's, which can cause anxiety, depression, mania, and psychotic symptoms. Ninth is lidocaine, prescribed for irregular heartbeats and pain relief, which can cause anxiety, depression, mania, and psychotic symptoms. Tenth is methyldopa, prescribed for high blood pressure, which can cause anxiety, depression, and psychotic symptoms. Eleventh is metoclopramide, prescribed for anti-nausea, which can cause anxiety, depression, and mania. Twelfth is opioids, prescribed for pain relief, which can cause

anxiety, depression, mania, and psychotic symptoms. Thirteenth is prednisone, prescribed for inflammation and steroids, which can cause anxiety, depression, mania, and psychotic symptoms. Fourteenth is procainamide, prescribed for problems with the heart's rhythm, which can cause anxiety, depression, mania, and psychotic symptoms. Fifteenth is quinidine, prescribed for problems with the heart's rhythm, which can cause anxiety and psychotic symptoms. Sixteenth is thiazide diuretics, prescribed to decrease accumulations of fluid and lower blood pressure, which can cause depression. Akin to how medicines for depression are presented and their effects and side effects are discussed, medicines for chronic illnesses should similarly be discussed. This is especially critical due to the high presence of psychotic symptoms as a side effect.

The fourth portion of this is more abstract and falls more under the advocacy portion of our ethical requirements. As inspired by Rogers et al. (2021) and the many researchers who have been calling for more holistic care, I encourage an increased focus on chronic illness and mental wellness in two more places. First, post-diagnosis of chronic illness would be a prime time to screen for mental health care access and advocate for patients to receive mental health supports. Coming from an interview by Byrne (2022), Lori Gottlieb, a therapist, explains that doctors have the best intentions but a blind spot remains around chronic illness, especially for women and people of colour. Therefore, upon diagnosis, there needs to be better screening processes for mental health access. Secondly, as diagnosis takes so long, I want to ensure therapists are involved in wrap around care so they have a doctor or medical team to send those who believe they are chronically ill but have yet to receive a diagnosis. As Gottlieb (2022, para. 19) says, "if you don't get diagnosed and treated, you start to become depressed and anxious. You start to feel defeated and helpless."

Personal Learnings

Without question, this capstone has been a labour of love. It has been especially challenging being as close to the personal material as I am and due to the magnitude of this topic and the many challenges that kept being unearthed as I dug deeper into the topic. One of the issues that stalled me initially was the challenge around providing more screenings for Indigenous populations. In theory, a great solution to the issues of a higher rate of chronic illness. With more context and consideration, a good reminder of the need to ensure care is decolonialized and holistic. I would argue it is that latter idea that has stuck out the most to me in doing this research. Care cannot be provided to its best extent if we continue to silo the care providers. This research has shown me, a firm advocate for community, the need to look at the broader system and tackle this issue at varying levels. There were days writing this when I truly wondered if I would find a workable solution to the issue I have proposed. Nevertheless, I am pleased as to the solution I have raised. I hope to see a future with better trained counsellors, better holistic care between medical and mental health providers, and better served chronically ill populations. It is this hope that has kept me writing and sees me eager to implement what I have learned in this process.

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Appendix A

Chronic Illness Education Module for Therapists

Goals of This Module

The aim of this module is to offer an introductory education for master's level therapy students.

The hope is they leave these classes feeling well-versed in the basics of chronic illnesses and chronic illness care. Moreover, it hopes to inspire the next generation of therapists to advocate for better education and care around chronic illnesses.

Each step of the module is created to fit into the timeline of many master's level classes.

Furthermore, it is created to fit into the already set structure of Psychopathology and Psychopharmacology so as to be as easy as possible to fit into the already full curriculums of Masters students.

Class 1: Chronic Illness Overview

This class serves as a comprehensive introduction to the world of chronic illnesses. The illnesses covered are the ten most common, as stated by the Government of Canada (2019), along with two underdiscussed illnesses.

The twelve illnesses covered are:

- 1) Hypertension
- 2) Osteoarthritis
- 3) Mood and Anxiety Disorders
- 4) Osteoporosis
- 5) Diabetes

- 6) Asthma
- 7) Chronic Obstructive Pulmonary Disease (COPD)
- 8) Ischemic Heart Disease
- 9) Cancer
- 10) Dementia
- 11) Long COVID
- 12) Endometriosis

A definition of each illness, as outlined by the World Health Organization (WHO) (n.d.) is provided along with some of their psychological comorbidities:

- 1) Hypertension is defined as high blood pressure which entails a blood pressure of 140/90mmHg or higher. While common, it can be serious if not treated. Risk factors to be aware of include genetics, older age, being overweight or obese, lack of physical activity, too much salt in one's diet, and too much alcohol. Other chronic illnesses, such as diabetes or kidney disease, can also be risk factors. Depression, anxiety, and symptoms aligned with anxiety, such as chest pain or severe headaches, can also be associated with hypertension.
- 2) Osteoarthritis is defined as a degenerative condition in one's joints, most commonly seen in the hands, hips, knees, and spine. One's ability to move freely is limited and pain is felt along with swelling and stiffness. Risk factors to be aware of include injuries to joints, pre-existing joint diseases, metabolic diseases, obesity, genetics, and certain sociodemographic factors including age and sex. Osteoarthritis can also cause other chronic illnesses such as cardiovascular diseases and diabetes. It reduces quality of life

and is expected to cause mental health issues. WHO recommends a tailored self-care plan.

- 3) Mood and anxiety disorders are broad umbrella type disorders that students are likely to have already covered in previous classes. For our sakes, the former encapsulates depression and bipolar disorders while the latter includes generalized anxiety disorder, panic disorder, social anxiety disorder, separation anxiety disorder, and more. It is important to note that mood and anxiety disorders both fall under the scope of chronic illnesses and can arise in tandem with other chronic illnesses.
- 4) Osteoporosis is defined as a progressive disease wherein one's bones become weaker and weaker. Menopause is its onset, caused by hormonal changes. Risks to be aware of include being a woman, over the age of fifty, Asian or Caucasian, habits such as smoking or drinking too much caffeine, prior gastric surgery, lower body weight, other chronic diseases, maternal history, and premature menopause. It can limit independence and greatly impact quality of life. Notably, as Myers (2013) outlines, there can be early-onset osteoporosis as well which can be caused by celiac, Crohn's disease, cancer treatments, eating disorders, smoking, certain birth control medications, and more.
- 5) Diabetes is defined as a chronic and metabolic disease most associated with elevated levels of blood sugar. This elevated blood glucose can lead to damage to the blood vessels, eyes, heart, kidneys, and nerves. Type 1 means the body does not produce enough insulin by itself. Type 2 means the body does not produce enough or is resistant to insulin. Type 1's symptoms include consistent thirst and hunger, over urination, weight loss, changes to vision quality, and fatigue. Type 2 is similar but is often less marked. Depression and anxiety are common with this illness.

- 6) Asthma is defined as a chronic lung disease and a major noncommunicable disease (NCD). Symptoms can look like a persistent cough, wheezing when exhaling (and sometimes when inhaling), shortness of breath, difficulty breathing, and overall chest tightness. A single cause is hard to trace but ideas include family members having it, other allergies, urbanization, premature weight, being overweight, and exposure to smoke or pollution both as a child and adult. Anxiety and depression are commonly associated with asthma.
- 7) COPD is defined as a common and chronic lung disease that restricts one's airflow and causes problems with one's breathing. Symptoms include lungs clogged with phlegm, coughing, wheezing, tiredness, and challenges with breathing. It is not curable and is often caused by a combination of active smoking or exposure to second-hand smoke, occupational exposure to pollution, indoor air pollution such as coal, early life issues such as being born premature, asthma at a young age, and alpha-1 antitrypsin deficiency. COPD can cause further chronic illness, other illnesses such as lung infections, and mental health issues such as anxiety and depression.
- 8) Ischemic heart disease is defined as heart problems as the result of reduced blood flow to one's heart (Advocate Health Care, n.d.). It is often due to coronary artery disease and can cause higher risk of abnormal heart rhythms, blood clots, heart failure, and heart valve disease. There may be no symptoms but as the condition worsens possible symptoms include chest pain, dizziness, swollen feet and ankles fainting, shortness of breath, and heart palpitations. Depression and anxiety can both make this condition worse and result as an aftereffect of an episode.

- 9) Cancer is another broader umbrella term. For our purposes, cancer is defined as an abnormal growth of cells in any organ and tissue wherein the cells expand beyond the boundaries and go into other body parts, tissues, and organs. Symptoms naturally vary with the cancer but can include anything from unexplained pains, urinal bleeding, unexplained lumps, and weight loss. Risk factors can include tobacco use, an unhealthy diet, air pollution, unsafe sex, and other chronic diseases. Anxiety, depression, suicidal thoughts, post-traumatic stress disorder (PTSD), and dissociation are all possible mental health symptoms (Cancer Research UK, n.d.)
- 10) Dementia is a cluster of diseases that all impact one's memory, thinking, and ability to carry out daily life activities. Symptoms can include losing things, misplacing things, getting lost when out of the house, losing track of time, problems following conversations and more. Note that this disease is progressive and can lead to worsening symptoms including not recognizing family, losing bladder and bowel control, trouble eating and drinking, and switches to far more aggressive behaviour. While age is a risk factor, early onset dementia is a possibility. Physical inactivity, smoking, harmful alcohol use, being overweight, unhealthy diet, depression, social isolation, unhealthy blood pressure, unhealthy blood sugar, unhealthy cholesterol, and cognitive inactivity are all other risk factors. Lower quality of life and depression are mental health concerns. This disease is one of the ones that has a heavy impact on family and friends as well. It is also worth noting human rights and freedoms are reported as being denied to people with dementia, so safety is a concern for clients.
- 11) Long COVID has yet to have a standard definition as it is still in the early stages of being recognized. For our purposes, the definition comes from Cimellaro et al. (2022)

who state that it is a chronic disease that impacts multiple systems in the body. The researchers list off the varied and vague symptoms as including fatigue, shortness of breath, palpitations, neuropsychiatric disorders, and sensorial dysfunction. Clinically significant disorders, that are respiratory, cardiovascular, and gastrointestinal in nature can also occur. Examples include post-embolic lung disease, diarrhea, and dysrhythmia. Sudre et al. (2021) found risks included being female, being older, and the reported number of symptoms in the first week of illness.

As a note for the professor or facilitator, as a developing chronic illness this section will likely need regular updates and more careful consideration of changes.

12) Endometriosis is a chronic disease wherein tissue similar to the lining of the uterus ends up growing on the outside of the uterus leading to inflammation and the growth of scar tissue. It is associated with severe pain, can start with a first period, and can last until menopause and beyond. Outside of periods, the pain can occur during bowel movements, urination, sexual intercourse, abdominal bloating, nausea, and fatigue. There is no one clear cause but it has been linked to three factors. The first is retrograde menstruation where menstrual blood flows back through the fallopian tubes to the pelvic cavity while blood is simultaneously flowing back out. The second is cellular metaplasia where cells outside the uterus turn into endometrial-like cells. The third is stem cells which can cause endometriosis through blood and lymphatic vessels. Currently, there is no cure. It is linked to anxiety and depression. Mental health struggles can also arise due to the issues it can cause with pregnancy, even resulting in infertility.

These descriptors are intended to cover the basics but discussion and sharing of lived experience within the class is encouraged. Additionally, it is important that despite the risk factors listed, this is not intended as a shaming piece. Reminding students of the sociodemographic factors, such as poverty, that could increase one's risk is recommended.

Class 2: Therapeutic Lens

As an opening to this section, it is encouraged to see what ideas and thoughts the class may already have towards what approaches they would follow to treat folks with chronic illness. Break out groups with a return to a full class discussion is one suggestion but by no means the only way.

It is worth noting that by the point this module is delivered, there is a high likelihood students are well-aware of the following modalities. Further or lesser explanation is at the discretion of the professor or facilitator.

From the literature, the first recommendation is acceptance and commitment therapy (ACT). The creation of Steven Hayes, ACT works to encourage the acceptance of life experiences. By understanding that something like illness is an unavoidable aspect of life, psychological flexibility can be gained allowing for an acceptance of the chronic illness.

The second recommendation is mindfulness-based stress reduction (MSBR). The creation of Jon-Kabat Zinn, the approach uses mindfulness meditation and yoga to help those struggling.

Interestingly, it was initially created for hospital patients and has been shown to help with asthma, cancer, fibromyalgia, high blood pressure, and chronic illnesses in general.

The third recommendation is cognitive behaviour therapy (CBT). The creation of Aaron Beck, the approach works to change thinking and behavioural patterns. Collaboratively, the therapist and patient work together to discern the problems and how best to resolve it.

Importantly, each different method works to embrace the changes in the person's life, in this case a chronic illness diagnosis, change in symptoms, or something similar, and works to improve their quality of life.

Other ideas include guided imagery, hypnosis, meditation, and relaxation.

After discussing the three options, as well as the suggested additions, the class should be readdressed if their positions have changed, if any of the suggestions surprised them, and if they have differing ideas.

The second half of this class is intended to be a more open discussion of grief and loss of self. It is important to note the deep pain that can be associated with a loss of self, particularly when that loss of self may be associated with debilitating pain. Much like with the loss of someone else, in the diagnosis and losing parts of themselves there is a need to accept and reorient to an entirely new way of life. Ultimately, this is a form of disenfranchised grief or the grief that is not acknowledged or validated by society.

More personal media is recommended to highlight this experience. On the more academic side, Bertand (2021) writes of her experience with loss of self and chronic illness. Less academically, Instagram accounts such as @_jemma_bella share about the struggles of long COVID. Her blog is full of other's stories and shares as well, at www.jemmabellablog.com. Another wonderful Instagram resource is @Chronicloveclub, with a community of over 56,000 members.

Class 3: Medications and Side Effects

From research by Tango (2003), a list of sixteen medications has been created that are pertinent as they are prescribed to folks with chronic illnesses and have the possibility of creating psychiatric side effects. For our clients' safety, it is important for young practitioners to be aware of the possible dangers especially if any of them are looking to move forward to be psychologists.

Below, is a list of the medications to go over, what they may be prescribed for, and the mental illnesses they are associated with.

- 1) Baclofen, prescribed as a muscle relaxant for multiple sclerosis, associated with anxiety, depression, and psychotic symptoms
- 2) Beta blockers, prescribed for abnormal heart rhythms, associated with anxiety, depression, mania, and psychotic symptoms

- 3) Bromocriptine, prescribed for diabetes and Parkinson's, associated with anxiety, mania, and psychotic symptoms
- 4) Clonidine, prescribed for high blood pressure, associated with anxiety, depression, mania, and psychotic symptoms
- 5) Corticosteroids, prescribed for arthritis, asthma, autoimmune diseases, and lupus, associated with anxiety, depression, mania, and psychotic symptoms
- 6) Digoxin, prescribed for cardiac diseases, associated with depression, mania, and psychotic symptoms
- 7) Interferon- α , prescribed for different cancers and virus infections, associated with anxiety, depression, mania, and psychotic symptoms
- 8) Levodopa, prescribed for Parkinson's, associated with anxiety, depression, mania, and psychotic symptoms
- 9) Lidocaine, prescribed for irregular heartbeats and pain relief, associated with anxiety, depression, mania, and psychotic symptoms
- 10) Methyldopa, prescribed for high blood pressure, associated with anxiety, depression, and psychotic symptoms
- 11) Metoclopramide, prescribed for anti-nausea, associated with anxiety, depression, and mania
- 12) Opioids, prescribed for pain relief, associated with anxiety, depression, mania, and psychotic symptoms
- 13) Prednisone, prescribed for inflammation and steroids, associated with anxiety, depression, mania, and psychotic symptoms

- 14) Procainamide, prescribed for problems with the heart's rhythm, associated with anxiety, depression, mania, and psychotic symptoms
- 15) Quinidine, prescribed for problems with the heart's rhythm, associated with anxiety and psychotic symptoms
- 16) Thiazide diuretics, prescribed to decrease accumulations of fluid and lower blood pressure, associated with depression

Importantly, all of these drugs should be presented without stigma. They are lifesaving medicines that can have dangerous side effects that can deeply alter a client's mental health.

Class 4: Advocacy Beyond the Classroom

The last class serves three purposes. The first is as a point of clarification and summary. There is a large quantity of material covered over the previous three classes, so any further explanation or sharing of information should be undertaken to ensure the material has been taken in by the students.

The second purpose is to convey the need for advocacy, around chronic illnesses, beyond the classroom. To do this, ways to better care for this community are shared. The two points of entry shared are pre and post-diagnosis. Pre-diagnosis is important as we know that Canada's health care system is struggling and it can take a while to receive diagnosis. Therefore, while clients wait for diagnosis, therapists can advocate for their patients via referrals to doctors, discussing the excruciating wait time, and other similar methods. Post-diagnosis is equally critical as the

link back to mental health supports is often still missing. Therefore, therapists in a medical setting can work to improve the connection to mental health supports upon diagnosis.

The third purpose is a call to action. How do the students feel they can better advocate for this marginalized community? For example, could they pursue further education and advertise specifically to folks who are pre-diagnosis. Moreover, what challenges do they expect in this advocacy? For example, Indigenous populations who have been harmed by the medical system, now and in the past, may be more reticent to receive mental health supports post-diagnosis.

No idea is too outlandish. Welcome the students' ideas and encourage them to foster new and creative pursuits to improve mental health access for the chronically ill community.