

BC Partners for
Mental Health and
Addictions Information

Visions

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Cognitive-Behavioural Therapy



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bc partners

Seven provincial mental health and addictions non-profit agencies are working together as the BC Partners for Mental Health and Addictions Information. We represent Anxiety BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health, Jessie's Hope Society and the Mood Disorders Association of BC. By working together we have a greater ability to provide useful, accurate and good quality information on mental health, mental illness, substance use, and addictions including how to prevent, recognize, treat and manage these issues. Our goal is to help people feel empowered and improve quality of life.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

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When my anxiety disorder was finally diagnosed as an adult, I was on the list for 12 sessions of one-on-one CBT. I felt truly lucky when a spot opened up.

CBT remains one of the hardest things I've ever done. It was so simple—and yet so hard. I had to do everything my intuition had been telling me not to do for more than 15 years. But intuition isn't always trustworthy. You see, my mind and body had conspired together to find a way to cope all those years—unhealthy ways to cope that didn't really work well—but it was coping nonetheless and those patterns of survival, well, are hard to break. I did it in baby steps, but the hardest part was bringing on the anxious feelings for homework. My husband would spin me in a chair at home, nightly, until I got nauseous. I would breathe through those brown plastic coffee stir sticks until I was gasping for air and then keep doing it for 10 more seconds. My family couldn't quite understand why I was doing things that made me feel bad, but I trusted the process. And it worked, and still does.

My clinician used a manual to teach me the techniques. But I did all the work. There's something both empowering and scary in healing yourself. Scary because success was up to me. Sometimes that power made me wonder if maybe I was to blame for my disorder since I could essentially get rid of it on my own. But then I thought of people with physiotherapists. They are taught strength and strengthening exercises to relieve and prevent pain, but we don't doubt their pain or blame them. They just need tools to feel better. Like I did.

As I studied the dramatic pre- and post-scores of my CBT, I felt guilty too. There are tens of thousands of people on waitlists, or without any free CBT option in their community. People who could transform their lives in a few short weeks and months. Our guest editor is right. If there were a cheap, effective, side-effect-free treatment for any physical illness, policy makers would be falling over themselves to make it available and have MSP cover it. Thankfully, that's starting to change, but still too slowly for my taste. Maybe the powers-that-be have a few thinking traps of their own they need to work on.

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

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contact us

Mail: Visions Editor
 c/o 1200 - 1111 Melville Street
 Vancouver, BC V6E 3V6

Tel: 1-800-661-2121 or 604-669-7600
 Fax: 604-688-3236
 Email: bcpartners@heretohelp.bc.ca
 Web: www.heretohelp.bc.ca

editorial board | Representatives from each BC Partners member agency
editor | Sarah Hamid-Balma
structural editor | Vicki McCullough
editorial assistant | Stephanie Wilson
design/layout | Kailey Willetts
issn | 1490-2494

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The Time Is Now

Let's improve access to CBT services in BC



**Mark A. Lau,
PhD, RPsych**

Mark is a clinical psychologist, a research scientist and Director of the BC Cognitive Behaviour Therapy Network at BC Mental Health and Addiction Services. He's also an Associate Professor of Psychiatry at UBC and a Founding Fellow of the Academy of Cognitive Therapy

** For more information on the BC CBT Network, see the article on p. 25*

Mental health problems such as depression, anxiety disorders and substance use issues take a huge personal, economic and social toll on British Columbians. For the one in five people who will suffer from a mental illness in their lifetime,¹ this means they may have problems in their family and/or work lives, along with the distress of their mental illness.

Fortunately, there are treatments that can help people who suffer from mental illness. For example, many people find medication to be helpful. But there are those who find that the medications don't work. Others cannot put up with the side effects of medication. And many people simply prefer talk therapy to deal with their problems.

Research shows that several talk therapies can help people who suffer from mental illness. Cognitive-behavioural therapy (CBT) is the talk therapy with the greatest amount of evidence that it works. Over the past 25 years, hundreds of research studies have shown CBT to be helpful in treating many different mental disorders.²⁻³ It can help in treating depression, anxiety and problem substance use, to name just a few. These studies have also shown that, in many cases, CBT is as good as medication.^{4,5} In a few cases, it's even better than medication.⁶ CBT has also been shown to cost less over the long term than medications, in some cases.⁷⁻⁸

What is CBT?

CBT is a form of talk therapy that focuses on how a person's thoughts about themselves, the world and others relate to how they feel and how they act. In CBT, people learn to become aware of how their thoughts can affect how they feel and behave in the here and now. They also learn skills and techniques to experiment with new ways of looking at things and/or new ways of behaving. These changes can help us to feel

better in the present and can be used to help prevent future problems.

...but not everyone in BC can get CBT

One of the biggest challenges with CBT is that not everyone in BC who would like to get CBT can do so. Unfortunately, at the present time, there are very few areas in BC that offer specialized CBT services. What does this mean for someone who could be helped by CBT but can't access it?



Let me give you an example by telling you quickly about a client I treated for panic disorder early on in my career. The good news was that after about 10 sessions of CBT, she was no longer having panic attacks. At the same time, she asked me why she'd had to suffer for eight years before she could get a treatment that worked.

Let's pause for a moment to think about this. Could you ever imagine a situation where researchers had discovered a new effective cancer treatment but it wasn't made

CBT is the talk therapy with the greatest amount of evidence that it works

available to all the cancer sufferers who needed it? Of course not. New effective treatments are made available to those who need them fairly quickly. Yet this is not the case when it comes to CBT in BC and the rest of Canada.

Making CBT equally available to everyone in BC

A big part of the reason why patients can't get CBT is that there are too few mental health providers who've been properly trained in CBT to meet the demand. But it doesn't have to be this way. Over the last few years, other countries around the world have started projects to improve access to CBT. For example, in the United Kingdom, the government has provided roughly \$600 million to train 3,600 CBT therapists over the next three years.⁹

footnotes

visit heretohelp.bc.ca/publications/visions for Mark's complete footnotes or contact us by phone, fax or e-mail (see page 3)

Here in BC, there is hope for improving access to CBT. BC Mental Health & Addiction Services (BCMHAS), an agency of the Provincial Health Services Authority, along with the BC provincial government and the five regional health authorities, are working together to close the treatment gap. All recognize the need for improved quality and availability of CBT for mental health and addictions across our province.

Just last year, BCMHAS established the BC Cognitive Behaviour Therapy Network* to support system-wide efforts to increase the number of people who are trained to deliver CBT in BC. The goal of the CBT Network is that every person in BC will have equal access to high-quality CBT no matter where they live. This will lead to better care and treatment for people with mental health problems.

If you want to know more about CBT...

In this issue devoted to CBT, you can learn more about what CBT is, who it works for and why. You will get the perspectives of individuals who've had experience with CBT. You will learn about some of the exciting new developments in this field. And finally, you will learn about some of the CBT resources that are available in BC.

It's my hope that, after reading this issue, you will share in my excitement about the potential benefits of CBT to help improve the lives of BC residents suffering from mental illness. The desire to see that all British Columbians are able to access this treatment is what keeps me going in my work. Perhaps it will also motivate you to talk to service providers and friends about the benefits of CBT. **i**

As a former frequent cannabis consumer, I—along with many of my former (some still) cannabis-consuming peers who I've bumped into these last dozen years or so—can attest to the permanent damage that marijuana can cause to the consumer's body and mind.

Scientific proof of such potential damage? For one, there are the startling facts published in an article last September 17, in London's *Guardian* newspaper; it was authored by professor of psychiatry at the Institute of Psychiatry and hospital consultant, Robin Murray: "In the mid-90s, a Dutch psychiatrist named Don Lintzen, from the University Clinic in Amsterdam, noted that people with schizophrenia who consumed a lot of cannabis had a much worse outcome than those who didn't. This was confirmed by other studies, including a four-year follow-up at the Maudsley Hospital. Those who continued to smoke cannabis were three times more likely to develop a chronic illness than those who did not consume the drug," Murray learned. "Why does cannabis exacerbate psychosis? In schizophrenia, the hallucinations result from an excess of a brain chemical called dopamine. All of the drugs that cause psychosis—amphetamines, cocaine and cannabis—increase the release of dopamine in the brain. In this way, they are distinct from illicit drugs such as heroin or morphine, which do not make psychosis worse."

If pro-pot people propose legalizing cannabis possession for practical reasons—e.g., less pressure on already-overburdened law-enforcement and justice systems—that's a clear and perhaps debatable motive; however, there's simply way too much of the media-propagated misinformation out there implying—or outright declaring—to our impressionable youth that cannabis consumption is harmless.

—Frank G. Sterle, Jr., White Rock, BC

we want your feedback!

If you have a comment about something you've read in Visions that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.

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Footnotes Reminder: If you see a superscripted number in an article, that means there is a footnote attached to that point. Sometimes the footnote is more explanation. In most cases, this is a bibliographic reference. To see the complete footnotes for all the articles, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 3.

Correction Notice



In the Cannabis edition of Visions, figure 2 in the article "Tobacco and Alcohol Use in Canada," located on page 13, erroneously reported the costs of alcohol-related enforcement to Canadian society. The correct number is \$3,072.2 million. Please see the online version for the corrected graph at heretohelp.bc.ca/publications/visions

When you have depression, anxiety or other disorders, you often have patterns of negative thinking. For example, you might automatically believe that you're "never good enough" when one tiny part of a project doesn't work out the way you planned. These thoughts can make you feel even more depressed or anxious. The negative thinking patterns listed below are common thinking patterns that can contribute to depression, anxiety and other troubling symptoms.

All-or-nothing thinking	You see things in black-or-white categories. If a situation falls short of perfect you see it as a total failure.
Overgeneralization	You see a single negative event, such as a romantic rejection or a career reversal, as a never-ending pattern of defeat by using words such as "always" or "never" when you think about it.
Mental filter	You pick out a single negative detail and dwell on it exclusively, so that your vision of all of reality becomes darkened, like the drop of ink that discolours a beaker of water.
Discounting the positive	You reject positive experiences by insisting that they "don't count." If you do a good job, you may tell yourself that it wasn't good enough or that anyone could have done as well. Discounting the positive takes the joy out of life and makes you feel inadequate and unrewarded.
Jumping to conclusions	You interpret things negatively when there are no facts to support your conclusion.
Mind reading	Without checking it out, you arbitrarily conclude that someone is reacting negatively to you.
Fortune-telling	You predict that things will turn out badly.
Magnification	You exaggerate the importance of your problems and shortcomings, or you minimize the importance of your desirable qualities. This is also called the "binocular trick."
Emotional reasoning	You assume that your negative emotions necessarily reflect the way things really are.
"Should" statements	You tell yourself that things should be the way you hoped or expected them to be.
Labelling	Labelling is an extreme form of all-or-nothing thinking. Instead of saying "I made a mistake," you attach a negative label to yourself.
Personalization and blame	Personalization occurs when you hold yourself personally responsible for an event that isn't entirely under your control.

Source: BC Partners for Mental Health & Addictions Information, *Anxiety Disorders Toolkit*

CBT in Practice

Part science, part art

Michelle Patterson,
PhD, RPsych

Michelle is an Adjunct Professor and clinical psychologist working at the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University

Cognitive-behavioural therapy (CBT) combines basic theories about how people learn (behaviourism) with theories about the way people think about and interpret events in their lives (cognition). CBT is now firmly established as the leading psychological treatment for many mental health conditions. Many research studies have demonstrated its effectiveness.¹ Research shows that the skills people learn through CBT last long after the treatment ends.²

In CBT, the therapist and the client work together to identify unhelpful patterns of thinking and behaviour. For example, someone might only notice the neg-



ative things that happen to them and not notice the positive things. Or someone might set unrealistic standards for themselves, such as "making mistakes at work is unacceptable." It's also important to identify unhelpful behaviours that maintain symptoms, such as avoiding certain situations and withdrawing from others.

The client and therapist also look at how thoughts and behaviours impact feelings. For example, if someone believes that nothing will work out for them in life, they may withdraw from others and avoid new opportunities. This, in turn, can lead to feelings of increased sadness, emptiness and anxiety. This is sometimes called a "vicious circle" of

thoughts, feelings and behaviours.

Carefully constructed exercises are used to help clients evaluate and change their thoughts and behaviours. Some aspects of treatment focus more on thoughts and some aspects focus more on behaviours. If a client has difficulty identifying and challenging negative thoughts, the therapist might focus on addressing behaviours such as avoidance, withdrawal or poor social skills. On the other hand, if such behaviours are not as noticeable, the therapist may focus on challenging unrealistic thinking.

Common CBT interventions include:

- setting realistic goals and learning how to solve problems (e.g., engaging in more social activities, learning how to be assertive)
- learning how to manage stress and anxiety (e.g., learning relaxation techniques such as deep breathing, coping self-talk such as “I’ve done this before, just take deep breaths” and distraction)
- identifying situations that are often avoided and gradually approaching feared situations
- identifying and engaging in enjoyable activities such as hobbies, social activities and exercise
- identifying and challenging negative thoughts (e.g., “Things never work out for me”)
- keeping track of feelings, thoughts and behaviours to become aware of symptoms and to make it easier to change thoughts and behaviours

CBT is most widely applied to mood disorders (such as depression) and anxiety disorders. It is also used to help people with substance use problems, personality disorders, eating disorders, sexual problems and psychosis. It is successfully delivered in individual, group and couples formats.

Applying CBT for depression and problem substance use

Depression

CBT for depression usually starts with education about depression and helping the client understand their symptoms as part of an illness that they can do something about.

Treatment strategies include helping clients to establish structure around daily activities, to become more aware of their mood and challenge negative thoughts, and to engage in pleasurable activities.

The therapist and client work together to challenge negative attitudes the client holds about the self, the world and the future, which may contribute to feelings of hopelessness.

John believed he was “no good” and a “failure” at work, in his romantic relationship and in his friendships. Over the years, he came to expect that bad things would happen and that things would always be difficult for him. This led him to give up on things quickly and believe that there was “no point in trying.” John’s thera-

pist helped him identify these beliefs and look at the evidence for and against them. He was able to learn that he viewed the world in black and white, and started challenging himself to see the middle ground. John also learned to be more assertive and to do more activities that made him feel good about himself.

“Skilled practitioners are able to adapt CBT to a wide variety of people and circumstances”

Substance use disorders

In the area of substance use, CBT was first used as a method to prevent relapse when treating problem drinking. It was later adapted to treat individuals who are addicted to nicotine, cocaine, marijuana and other drugs.

Cognitive-behavioural strategies for substance use disorders are based on the theory that learning processes, such as reinforcement and conditioning, play an important role in the development of addictive behaviours. People learn to identify and change problem behaviours by applying a range of different skills that can be used to reduce or stop drug use. Specific skills include:

- exploring the positive and negative consequences of continued substance use
- self-monitoring to recognize alcohol or drug cravings early on
- identifying high-risk situations for substance use
- developing strategies for coping with and avoiding high-risk situations and the desire to use

The therapist and client work together to anticipate problems and develop effective coping strategies.

Lynn has been struggling with problem drinking for several years. She knew there would be alcohol served at the upcoming company party. She also knew her co-workers sometimes drink too much and pressure her to drink. Lynn and her therapist developed a plan before the party. Lynn decided to avoid punch and only drink what she could measure, have soft drinks until she got a feel for the party, have no more than one alcoholic drink, stay no more than three hours and ask her boyfriend to pick her up.

Does CBT have limitations?

CBT has been criticized as being overly rigid and mechanistic, that is, focused mainly on an educational approach and setting goals. This may prevent an exploration of the big picture, which includes relationships, family of origin issues and emotions.

Also, relatively little is known about the process of matching treatments (including CBT) to individual people. Skilled practitioners, though, are generally able to adapt CBT to a wide variety of people and circumstances. >>

For more information, see CBT—Core Information Document at carmha.ca

* See the article on SUCCESS's adaptation of CBT for BC's Chinese population on p. 23

CBT is not the best approach for all clients, however. Individuals who have a more chronic or recurring illness may need repeated interventions. Or they may need a shift to approaches other than CBT to address early life experiences as well as personality, interpersonal and identity issues. And given that CBT is quite structured and tends to focus on thinking rather than emotions, it may not be the best therapy for people who have strong and immediate emotional reactions. More generally, when a client feels very emotional, a focus on cognition and behaviour is less effective for change.

Although CBT has been used with children as young as seven to nine years old, it's most effective with children over 14. At this age, children have more fully developed cognitive skills. Younger children, or teens and adults with cognitive disabilities, usually respond best to behavioural strategies and structuring of

the environment rather than a focus on thinking.

The development of cultural adaptations to CBT is still in the beginning stages. CBT is largely based on the values supported by the dominant culture. In North America, these values include assertiveness, personal independence, verbal ability, logic and behaviour change. But specific manuals have been developed for adapting CBT to Chinese Americans and Haitian American adolescents.³⁻⁴*

CBT should not be applied as a 'cookie-cutter' approach. The therapist must carefully assess the client's motivations and how to best approach him or her. Otherwise, the client may resist the treatment if they don't accept the model or don't feel the therapist is listening to them.

Clearly, a skilled practitioner must apply CBT within a good working relationship with the client. This is the art, as opposed to the science, of therapy. ■

footnotes

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CBT: What Is It?

Nichole Fairbrother, PhD, RPsych

Nichole is a psychologist and an Assistant Professor with UBC's Island Medical Program and Department of Psychiatry. She has a background in cognitive-behavioural approaches to anxiety and depression. Her research is in the area of reproductive mental health, with a focus on anxiety disorders

Cognitive-behavioural therapy (CBT) is a kind of talk therapy that is used to treat a range of different psychological problems (see sidebar).

CBT is a merging of behaviour therapy and cognitive therapy.¹ Behaviour therapy first emerged in the 1950s and was based on the idea that people can learn to change or modify their behaviour.²⁻³ Cognitive therapy developed in the 1960s. The idea behind cognitive therapy was that how a person thinks about their experience will have a significant impact on how they feel.⁴ Over time, these two approaches merged.

All forms of CBT are based on the idea that both our thoughts and behaviours play an important role in our emotional experience. Sometimes our thoughts and behaviours can contribute to a negative emotional experience. A key assumption behind CBT is that the way we think about events in our life has an important impact on how we experience and respond to those events—that is, how we feel and behave.



The ingredients in CBT will vary depending on the problem being treated, but there are a number of common features.

CBT is evidence-based

There are many different kinds of treatments offered to help people. Some treatments have been scientifically tested and others have not. *Evidence-based treatment* means that a particular treatment has been evaluated in a scientifically sound way and has been found to work well. CBT has been evaluated and found to work well for many different kinds of prob-

lems. It is currently the psychological treatment approach with the most scientific support.

CBT is collaborative

The client and the therapist work together to understand and resolve the client's difficulties.

CBT is educational

All forms of CBT involve some education about the nature of the client's difficulty and the elements of treatment. This education, often called *psychoeducation*, is provided in the first one or two treatment sessions. Sometimes clients are given handouts or other reading materials to provide them with information about their problem and how CBT can help them.

CBT is short-term

Cognitive-behavioural therapy will usually last anywhere from five to 20 sessions. The number of sessions depends on the nature and the severity of the problem being treated. Sometimes more sessions

may be offered, especially if the client needs help with more than one kind of problem.

Additional sessions, sometimes referred to as booster or refresher sessions, may also be included as part of treatment. For example, one or two additional sessions may be scheduled to take place three and/or six months following the end of the weekly therapy sessions. Booster or refresher sessions may also be scheduled by the client on an as-needed basis. Booster sessions can help to ensure that progress in therapy is maintained. Also, any new issues that arise following treatment can be dealt with before significant problems develop.

CBT: becoming your own therapist

One important goal in CBT is to help the client become their own therapist. This is done partly through education and homework exercises. The therapist also teaches coping and other skills. The client learns new ways of doing things and new ways of coping that they can continue to use even after therapy has ended.

CBT is structured

Therapy sessions in CBT are usually focused on reducing the client's current symptoms and improving their functioning. In order to stay focused, the therapist and the client create a plan for the session to make sure that what they cover will be most beneficial to the client.

CBT and homework

CBT aims to teach the client new ways of dealing with their emotions and behaviours. The therapist will ask the client to apply what they learned in the therapy sessions to their life outside of therapy. Typically, the client and the therapist will work together to set homework tasks at the end of the session for the week to come.

CBT focuses on thoughts, behaviours and feelings

In addition to education and skill

development, the client's thoughts, behaviours and feelings are a key focus of therapy.

Thoughts: In CBT, the therapist helps the client examine and evaluate their thoughts in problematic situations. This may involve teaching the client to become aware of their thoughts, monitor their thoughts and come up with ways to test the accuracy of their thoughts. Testing beliefs may take place in the therapy session (e.g., a client with panic disorder may engage in breathing exercises to test the belief that symptoms of panic lead to fainting). Or a client may test beliefs as part of their homework for the week (e.g., disclosing something personal to a friend to test the belief that this will lead to rejection).

Behaviours: Clients sometimes develop certain patterns of behaviour in an effort to experience less distress. These patterns may be helpful in the short-term, but they can be unhelpful in the long-term. For example, it is common for people who feel anxious in social situations to avoid these situations. In the short-term, this approach can help reduce anxiety. But in the long-term, this way can lead to social isolation and worsening anxiety. The therapist's job is to help the client come up with new ways to handle social situations that improve coping and reduce anxiety.

Feelings: Some of the techniques used in CBT focus on directly changing how people feel. For example, relaxation techniques can significantly reduce feelings of tension and stress. Most of the time, however, it is the focus on beliefs and behaviours that lead to important changes in feelings. Even though the goal of therapy is to improve how people feel, CBT tends to

CBT is effective for these problems:

- ⦿ anxiety disorders, such as social phobia, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder
- ⦿ eating disorders
- ⦿ depression
- ⦿ psychosis
- ⦿ substance use problems
- ⦿ personality disorders
- ⦿ anger management
- ⦿ medical conditions, such as chronic pain or cancer
- ⦿ sexual difficulties
- ⦿ stress management
- ⦿ difficulty following through with medical advice
- ⦿ sleep disorders
- ⦿ impulse control disorders, such as pathological gambling

spend most of its time on beliefs and behaviours.

CBT is adaptable

CBT can be delivered in a variety of formats and by a range of providers. For example, CBT can be delivered to individuals or groups. Often, CBT is provided by a trained therapist, but it can also be facilitated by a peer or a coach. Many high-quality CBT self-help materials are also available and may be used on their own or as an adjunct to treatment.

Structured CBT treatments for many different types of problems have been developed. Some variations of CBT have incorporated other therapeutic approaches or techniques. These include mindfulness and acceptance and commitment therapy, which involves a collaborative assessment of the client's values and goals.

CBT is also very well suited to being adapted to each client's specific concerns. Structured protocols can be modified or blended to provide clients with treatment that is tailored to their specific needs. ■

footnotes

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related resources

- ⦿ **Association for Behavioral and Cognitive Therapies**
www.abct.org/dHome
- ⦿ **Society of Clinical Psychology, American Psychological Association**
www.psychology.sunysb.edu/eklonsky/division12

Conversations With Myself

Danielle Raymond

Danielle is a 24-year-old psychology student at Kwantlen Polytechnic University currently living in Maple Ridge. Always a fighter, Danielle has been battling an eating disorder for almost eight years; she has been in treatment for the last four

This article is dedicated to Danielle's little sister Shannon

If you had asked me when I was 16 if I thought I'd be sharing my life with an eating disorder, I'd probably have said not likely. I may have added something about not having the strength or the willpower to defy hunger. I had no idea that within a year I'd be popping diuretics like Tic Tacs and weighing my worth in pounds. Like so many other young women—and men too—I wandered unknowingly into the arms of an eating disorder. We've been inseparable ever since.

I used to believe that if I tried hard enough, I could do anything. Not because I was smart or capable or even creative, but because I was thin. It took me four years of trying to be perfect before I was finally exhausted enough to admit myself into a treatment program. And it has taken another almost four years of working with a multidisciplinary team of professionals—a psychologist, a doctor, a nutritionist and a psychiatrist—to unravel all the years of lies I've been selling myself. But before I talk in depth about my experience, I think it's important for you to understand why I couldn't just eat a pizza and get over it.

Me, the marionette

Life with an eating disorder (if you can call it "life") is basically like a puppet show. You are the dancing, smiling marionette, and your disorder is the puppeteer. It calls the shots; it tells you when you're going to eat and how much. It even writes the script, putting its own values where yours used to be. All of a sudden, you don't care about your health, your friends or your dreams. All you care about is being thin, and you don't even really know how it happened or when or why.

So there you go, smiling as your bony body bounces around onstage, and everyone claps at your slenderness and compliments you on how amazing you are. They don't know that you go backstage and cry because you're tired and hungry and afraid.

CBT vs. the 'puppet master'

If you're in treatment for an eating disorder, chances are pretty high that your recovery will include some form of cognitive-behavioural therapy (CBT). The outpatient treatment program I entered in the fall of 2005 was no different.



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Essentially, CBT operates on the assumption that your thoughts and behaviours are linked. If you change one, the other follows suit.

Now, my treatment team knew that asking me to just change my eating-disordered thinking would be about as successful as asking someone with a brain tumour to change their cancer cells back into healthy ones. This is because the harmful pattern of thinking is so deeply ingrained and so sensitive to anything that might threaten it that you almost have to trick yourself into changing it. Whenever I went to eat something, the eating disorder always had something to say, dictating what I was allowed to eat: “Are you stupid? You can’t eat that!”

From the beginning, my doctor and psychiatrist prescribed medication to help reduce the depression and obsessive thinking patterns that kept me locked into the disorder. At the same time, my therapist (psychologist) helped me challenge my thoughts. Luckily I clicked with her, so I hung in there. But my attitude was: “We can talk about change, but I’m not ready to make changes.” After all, my original motivation for going into treatment was to get information that I could use to further manipulate my diet and sustain my eating disorder.

The treatment team’s plan was to have me make small, manageable changes in my behaviour. Sounds simple, right? Well, it was neither small nor manageable. They asked me to do things that horrified me, like eating regularly whether I was hungry or not. They explained that because I’d been ignoring my body’s hunger signals for so long, the signals weren’t working properly any more. To me, however, eating more often sounded like a quick and dirty recipe for weight gain.

No matter what the treatment team said and how much sense it made, I told myself I could never do any of it. Being thin and perfect was more important.

But they pushed on. My nutritionist said that I was falling asleep in class because I was hungry and needed to eat something. I pushed back. My eating disorder said that I was just being lazy and that my nutritionist was trying to make me fat. My doctor told me that I was getting dizzy at the gym because I wasn’t eating enough to sustain physical activity. My eating disorder told me that I was just being a wimp and that my doctor didn’t know anything about fitness. I firmly convinced myself that if I listened to them, I’d lose all control, gain a million pounds and become a lazy, pathetic and horrible person.

After about a year of this kind of internal arguing and resistance, I was able to admit that I had a problem. I was tired—attending school full-time, holding down three different jobs and working out in the gym seven days a week. The busier I was, the less I had time to eat; but I had no energy and was falling apart. Even worse, despite all of my efforts to avoid it, I’d been gaining weight—I felt that my body had finally betrayed me.

Challenging the mind traps; tripping up the puppeteer

Clearly, my thinking had to change so my behaviour could change.

First I worked with self-monitoring worksheets. When I noticed a sudden shift in my mood, I tried to identify the automatic thoughts by noting what the situation was, how I felt and what I was thinking. For instance: I could be at the store buying food, when suddenly I feel a need to go work out for two hours. I was able to discern that the thinking part had to do with seeing a magazine cover glaring something about cellulite and weight. My therapist and I did a lot of talking about what was on my sheet.

Then my therapist helped me learn to identify what are called *mind traps*.^{*} I was a big “black and white” thinker: “If I’m not size zero, then I’m obese.”

I was also very good at “catastrophic” thinking: “If I don’t get an ‘A +’, I might as well have an ‘F’ because I’ll never get into grad school and I’ll be stuck working at some minimum wage job forever.”

My therapist would guide me to play out the ‘logic’ of my thinking. For instance, if I told myself that I deserved to die because I’d gained five pounds, she might ask me to take a third-person point of view. “What if your friend gained five pounds? Would you tell her she deserved to die?” And, of course, I wouldn’t; I’d never think that way about others.

My therapist sometimes had me play devil’s advocate and talk about why I felt that I deserved to die for gaining five pounds. Then she’d point out that, according to my own logic, *everyone* who gained five pounds deserved to die. “No,” I would say, “it’s *only me* that deserves to die.” But when she asked me to explain, I couldn’t because I knew it didn’t make any sense.

At first, this CBT process felt like barrelling through untamed woods: you don’t get anywhere. I had to keep going over and over the same path to forge a trail and shift my thinking. It’s taken years, but slowly I’ve been able to reconnect with myself and push the eating disorder aside.

Many strings severed; more to go

Every single day I work hard at recovery. I’m still in treatment—I see the therapist every two or three weeks now, instead of weekly. I’m learning to accept my vivaciousness, my sensitivity and my own humanness. I don’t have to be size zero, it’s okay if I don’t get an A+ in every course I take in school and I’m not going to die if I have a chocolate bar. My ultimate goal is not to have to rationalize every perceived “failure.”

When things get tough, however, the marionette version of myself—that negative, eating-disordered voice—still comes around. Most of the puppet strings have been severed, but not all. Even though I’m not cured, I am definitely getting better. ■



^{*} See chart of negative thinking patterns on p.6

From Pain to PTSD

Running the gamut of CBT

Lynda Marie Neilson

Lynda worked in hotel management and the software industry before she had a workplace accident. She's been diagnosed with post-traumatic stress disorder, major depression, a spinal injury and myofascial pain. Lynda studies part-time at BCIT and UBC. She aims to earn a BAdmin before she's 50

I had a serious motor vehicle accident nine years ago while working for a very high-paced software company. I was in Ottawa—far from my home in Vancouver—driving to a client's suburban location. Another driver wasn't paying attention when changing lanes and rear-ended me at high speed. I ended up in a multi-car accident involving nine vehicles. Numerous ambulances and fire trucks were called. I had to wait on the side of the road in the minus 40 degree weather, hearing sirens wail and wail as they tried to get through the backed-up traffic.

I continued to work after the accident, even though I had shooting pain and numbness in my right forearm and hand as well as poor concentration. The pain increasingly affected my work output, so the Workers' Compensation Board (WCB) [now called WorkSafeBC] sent me to a psychologist for pain management techniques. That was the start of my cognitive-behavioural therapy (CBT) treatments.

From CBT for pain...

CBT deals with changing a person's thought patterns so they have a better and more positive understanding of things that have happened to them. In these sessions, the psychologist and I looked at behaviour, physical symptoms and thoughts. We talked about how there is a psychological aspect to pain and that we can change our experience of the pain by changing our thoughts and behaviours in response to the pain.



66 I was having nightmares—
images of my accident constantly
replayed in my mind 99

For homework, I had to log my experience of pain so we could see what the flare-up patterns might be. The psychologist also trained me to do imaging; that is, make mental images to call up when my pain is severe. I bring up an image of a beach I visit in Maui; this mental 'retreat' helps ease the pain. The psychologist also taught me breathing exercises to do when the pain is strong. So, for instance, in a meeting at work, I could deal with a surge in the intensity of my constant pain by changing my breathing pattern.

In talking about my pain, it became apparent to the psychologist that something more than physical pain was going on. I told him I was quite uncomfortable driving my car. I stayed off highways and took side streets to avoid busy thoroughfares, as these reminded me of my accident. He mentioned this in his case report to WCB, and I was moved to another psychologist who specializes in CBT for post-traumatic stress disorder (PTSD).

to CBT for PTSD...

The new psychologist diagnosed

me with PTSD; this was about one and a half years post-accident. Not only was I anxious about driving my car, but by now I was having insomnia and nightmares—images of my accident constantly replayed in my mind. I also had intrusive thoughts during the day, where I felt like

I was back there, reliving the accident. I felt angry at the world and had a low tolerance for other people (whereas

before I'd been a super people person). Another thing that had progressively gotten worse was that my arms and hands would involuntarily wave and clap whenever I saw fire trucks, heard sirens or was put in a position of increasing stress. I had to stop driving altogether.

The CBT for PTSD was really intense. It involved exercises like visualizing the accident, writing down the details of the accident, tape recording myself telling the story of my accident and watching tapes of other accidents—over and over. This is called exposure therapy. These exercises were done both within the safe environment of the psychologist's office and at home afterwards.

These tasks are not easy to do; they bring up bad memories of the accident. Working with the brain to change the memory patterns is a long, exhausting process. However, with repeated exposure to the stories of the accident, the incidence of these images and memories has very slowly decreased in frequency.

We also incorporated the imaging and breathing I had previously learned. Plus, the psychologist

grounded me, bringing me back to the present when I'd get lost in the memories of my accident (i.e., was triggered). I then learned to ground myself, by rubbing my legs or the handles of a chair, or running my hands over the keys of my laptop. (This was actually a first taste of mindfulness-based CBT).

to CBT for depression...

In spite of two years of therapy, my PTSD had become chronic (it lasted more than six months). And after being a highly regarded employee for nine years, I suddenly lost my job in March 2003. Major depression ensued. I ended up in Vancouver General Hospital (VGH) before finally being moved to the UBC Hospital mood disorders ward.

While in the hospital, I was considered too fragile for the rigours of CBT. I did a little swimming and walking. This may have been helpful for the depression, but my hospital stay was not good for the PTSD. I wasn't allowed to stay in the hallway at night when I retreated there from nightmares. And another patient in the semi-private room kept startling me at night, which made my insomnia worse.

But we did have group therapy meetings, which was great for me. I had lost contact with people and felt very alone, so it was wonderful to have people to talk with. I was able to realize that I wasn't alone in my depression.

UBC Hospital staff recommended that I take Changeways, an outpatient program for depression offered by the hospital at that time. So, after I was discharged, I took the eight-week, once-a-week program.

We did CBT in a group environment. I learned how to organize my time to reduce my stress. I was accustomed to the high-paced, multi-tasking environment of my former workplace, but learned to look at one task at a time and just one day at a time.

I was still alone in my PTSD, however. No one else in the group had this diagnosis and I was constantly being triggered by comments made

in the group. I only found comfort with my psychologist, because it's clear that the PTSD drives my depression. He continued to work with me on exposure analysis. As homework, I practised increasing my tolerance for walking outside where I was near cars. He also worked with me on the depression in sessions by having me write a task list for the coming week, then having me revise it to be more reasonable.

to mindful CBT for anxiety...

Once my depression was under control, a neuropsychiatrist (UBC Hospital had referred me to him for my arm-waving movement disorder) referred me to VGH's PTSD program. There was a year-and-a-half wait for the program, so the intake psychologist referred me to the VGH outpatient group for generalized anxiety disorder (GAD).

The GAD group was also in a CBT format; however, they were using a technique called mindfulness-based cognitive-behavioural therapy (M-CBT). Mindfulness is about being in the present moment, the here-and-now. Through mindfulness, I was able to start changing my negative self-talk by observing my behaviour and thoughts, and then coaxing the negative behaviours and thoughts to become positive ones. This also helped me deal with my anger.

For example, at home I sometimes find myself getting angry at noise from outside—such as roofers working—and have an impulse to storm out and express that anger. With mindfulness, I will take a moment, bring myself into the present by feeling where I'm sitting and then maybe draw on imaging to feel myself in Maui so that I relax.

I also started knitting, which I learned as a child. This is a form of relaxation I can do anywhere—on the bus, in a car or waiting for appointments.

Another very important tool learned in this group was an anxiety scale from zero to 100, used to self-assess our anxiety levels. A

reasonable range was from 30 to 60. If we thought ourselves higher, then we would draw on our CBT skills to bring our anxiety into a more acceptable range.

to synthesis!

Finally, in the VGH PTSD outpatient group, all the therapy I'd done over the previous seven years came together. I got a grasp on PTSD and began to work with it to enable me to get going with my life.

There were three parts to this program. The first part consisted of one-on-one sessions with a psychiatric nurse to ensure I had the necessary skills for the next phase. The anxiety scale, for example, was one of the tools that was needed, as well as imaging, breathing and basic information about PTSD. Because of my years of CBT therapy, I only needed a few sessions to be ready for the next phase.

The second part of the program was a 28-week group session led by the nurse and a psychiatrist. The group was in M-CBT format like the anxiety group and included relaxation at the end of each session. Stress reduction is very important in PTSD. They compared it to a car engine, which can go from zero to 4,500 revs a minute. A person without PTSD generally idles at about 1,500 rpm, but someone with PTSD idles at 2,500. When a person with PTSD is stressed, they have less room to deal with the stress before reaching 4,500 rpm.

The really powerful aspect of the group session was that, starting about week 12, each group member had to explain their traumatic experience. The facilitators asked us questions so that we'd be triggered and relive the traumatic event—I found out that red car tail

Continued on page 14 >>



When Life's Demands Take Their Toll

Changeways for depression

Pat Merrett

Pat is Media Director for the Mood Disorders Association of BC (MDA). MDA provides support for those living with a mental illness and education to increase awareness and understanding of mental health issues; visit www.mdabc.net

My husband Joe couldn't figure out why this was happening. He was 58 years old and was sitting in the backyard crying. And it wasn't the first time.

In July 2009—seven years later—Joe attended his first session of the Changeways program. This is a weekly group program based on cognitive-behavioural therapy (CBT). It teaches problem-solving and lifestyle management skills as related to negative thoughts, social interaction, stressors and relapse prevention.

In looking back, Joe has come to realize that he has lived with depression for most of his life.

The erosion of good cheer...

Joe's depression never became apparent until after he'd gone through two very stressful years. In 1999, his

mother was diagnosed with a serious illness and then, in 2000, just as she completed her treatment, I was diagnosed with cancer. As an only child and a spouse, it was natural that he became the primary caregiver to both.

Friends and family were very helpful and assisted with the caregiving as much as they could, but nobody recognized that Joe needed help too. The stress and the worry associated with caring for the two people closest to him were taking their toll.

In the year following my recovery, I came to recognize that something was wrong. For the life of me, I

couldn't understand why Joe, who'd been so supportive through my illness, now seemed to hate me and fought with me almost every day.

I feared we were headed for separation, if not divorce. To the rest of the world, he was the same Joe >>



From Pain to PTSD | continued from previous page

lights were a major trigger for me. When I began to dissociate (not to be present mentally), the psychiatrist coached me to apply the M-CBT techniques.

Doing this process actually caused me to be hospitalized at VGH for a couple of weeks during the group due to depression from the PTSD. However, experiencing the trauma in the group setting, the recovery, the sharing, using the anxiety scale—it all did me wonders.

The third part of the program was 40 weeks of a support group led by the nurse. Sometimes we focused on particular topics. But we

always shared and explored our experiences of working with the M-CBT tools in our day-to-day lives.

And now...

I'm now back to one-on-one therapy, seeing a new psychologist for return-to-work issues. We do less cognitive-behavioural work—though I do monitor and log my pain, anxiety and mood—and do more talk about socialization. But the theory behind CBT and M-CBT is really strong. You have to take time daily to practise it, but for those who do, it works to reduce the stress of living with PTSD.

While going through the ther-

apy process, I never thought CBT would work for me. Back when I was recording stories of my accident, I felt I was getting worse rather than better. But now I feel that it's been a success. When triggered, I can acknowledge the PTSD images, rather than pushing them away. This has lessened my arm movements, as I'm managing my stress better. I can walk more often on a busy street and am more at ease in cars, though I'm still not driving. I volunteer, go to appointments, run errands and work at living a stress-free life. My next steps: getting back to work and getting my degree! ■

they'd always known, though maybe a bit grumpy on occasion.

As good luck would have it, I began volunteering with the Mood Disorders Association of BC and happened to read an information sheet that listed the symptoms of depression. It was Joe!

When our next argument took place, I thrust the sheet at him and told him to read it. When we discussed it later, he admitted that almost all the symptoms applied to him—lack of energy, withdrawal from friends, aches and pains, pessimism, irritability and anger, and problems sleeping. Since I'd been expected to go the doctor for treatment when I was diagnosed with cancer, I expected Joe to do the same. He agreed.

The doctor was surprised to find that Joe had a mental illness and said that if Joe hadn't come in with that list he would never have diagnosed him with depression. Joe had never told the doctor that he wasn't feeling well. And, because Joe always appeared so cheerful, the doctor never asked; Joe masked his depression well. But the doctor prescribed an antidepressant.

Once he was on a treatment plan with medication that worked for him, Joe realized how good he could feel—not super happy, but okay. He described it as being “level” or “in the middle” and said he couldn't remember ever feeling like that before. With some adjustments over the years, the medication has helped Joe live with his illness.

CBT skills are helping

Joe is now 65 years old and realizes that he'll have to deal with his depression for the remainder of his life. Although he continues to take medication, he's accepted that perhaps he needs further help dealing with day-to-day situations that can send him into a depressive state.

I encouraged him to go to Changeways. Many MDA members have taken the program and found it benefited them. I had also heard of encouraging research into CBT as a treatment for depression.

After discussing it with his doctor, who also encouraged him to attend the program, Joe contacted the Share Community and Family Services Society office in Port Moody, where a Changeways program was being offered. He was pleased that a program was being offered in our community. Joe inquired about the availability, cost, waiting time and referral process, and was surprised to find that the cost was covered by Fraser Health.

All he had to do was contact the Tri-Cities Mental Health Team for a telephone interview. They asked him some basic identification information and who his doctor was.

After the mental health team had checked with the family doctor, Joe was placed on the list for the next class. The group is run as often as there's demand for

it, with a waiting time of about two months. Sure enough, two months later Share contacted him and, at the time of writing this, he had attended four of the eight sessions.

Initially Joe had second thoughts about attending the program; he'd never belonged to a support group and wasn't sure how it would work. And, because it's quite a diverse group of people, he wondered how much would actually apply to him.

But Joe is discovering that he's benefiting from the program. His classmates are both male and female, with a range of ages. Like him, they're willing to discuss their reactions to those everyday events that sometimes trigger and aggravate their depression and anxiety. For Joe, it's concerns such as unfamiliar social situations, his aging mother, the economy and future financial security, his and the family's health and severe illnesses of life-long friends. Discussing possible reasons for his reactions and learning skills to minimize the negative effects of these reactions is proving to be a positive influence in Joe's relationships with family and friends.

He feels comfortable with the instructors because they listen thoughtfully and encourage, but do not require, participation. Though he's still a bit uncertain about the format, he's optimistic that the program, along with his medication, will help him to better live with his mental illness. ■

how to access mental health programs



You can ask your family doctor, psychiatrist, mental health team, the outpatient psychiatry program at your local hospital or your therapist about mental health programs.

For tips on talking to your doctor about mental health problems, see the Getting Help for Mental Disorders fact sheet at www.heretohelp.bc.ca/publications/factsheets/help-md.

Here are some resources to help you find programs or courses in your area:

Here to Help

www.heretohelp.bc.ca

Ask for local resources, or share CBT programs or information, on the message board

HealthLink BC

811 or visit www.healthlinkbc.ca

Provides information on services in BC

Canadian Mental Health Association

www.cmha.bc.ca

Provides information, resources and links to CMHA branch offices across the province

Kelty Resource Centre

1-800-665-1822 or 604-875-2084 (Vancouver)

Provides mental health and substance use information, referrals and support for children, youth and their families.

Mood Disorders Association of BC

604-873-0103 or visit www.mdabc.net

Offers support groups throughout the province, including family, young adult and faith-based groups. There are also free education evenings by experts in the field.

The LEAF Program

Peer-led group CBT

Shelly Jones

Shelly is the President of the board of directors of AnxietyBC. The organization is committed to increasing awareness, promoting education and improving access to programs that work for those suffering from anxiety disorders. She has co-led LEAF groups since 2005

In 2004, I was diagnosed with generalized anxiety disorder (GAD) at the Anxiety Disorders Clinic at UBC Hospital. I was fortunate to be referred to a group for GAD based on cognitive-behavioural therapy (CBT), led by three psychology residents specializing in CBT and anxiety. By the end of the 14-week group program, I felt like I'd been given my life back. So I asked if there were any volunteer opportunities to help others struggling with anxiety. AnxietyBC was seeking volunteers for their LEAF program.

The LEAF (Living Effectively with Anxiety and Fear) program is for people with mild to moderate panic disorder. It was developed by AnxietyBC in 2002. It has since offered CBT-based, peer-led panic management groups in various locations throughout BC, including Kamloops, Kelowna, Delta, Surrey and the Tri-Cities (Coquitlam, Port Coquitlam and Port Moody).

The LEAF group leaders are former anxiety sufferers who received cognitive-behavioural therapy to manage their anxiety. So leaders have first-hand knowledge of successfully overcoming problem anxiety using CBT techniques. Although I was diagnosed with GAD rather than panic disorder, the feelings of being overwhelmed by anxiety, the muscle tension and stomach distress, worry and avoidance are common to both disorders.

The peer-leader training involved an intensive two-day workshop. We learned how to conduct exposure to feared situations, how to challenge anxious thoughts and

how to manage anxious feelings in the body. We were also instructed in the use of a 10-week group program manual.

We continue to receive weekly phone supervision from one of the



clinicians/CBT specialists to troubleshoot any difficulties that may have arisen in the group and to review material for the upcoming session.

How the group works

Throughout the 10-session program, LEAF leaders teach and model evidence-based CBT strategies that will help group members manage their panic symptoms.

Twelve people is the optimal group size. The groups are co-ed (although women predominate, as anxiety tends to be more prevalent in women than in men) and multicultural. Young adults as well as seniors have been represented.

There are always two group leaders, both with the peer-leader training, to share the tasks of presenting the material and demonstrating techniques. Each leader has their own unique anxiety experiences and will answer group questions a little differently. This provides participants with a broader perspective on anxiety and cop-

ing strategies. And, it's been my experience that group members tend to look to one particular co-leader for support, perhaps feeling that person is more in tune with their situation.

At the first session, we share our experiences with anxiety. As leaders, we are open about our own struggles and the successful treatment we've received. When the group members hear the personal stories of the leaders and how they've been able to overcome their fears with the help of CBT, they realize that it's possible to manage anxiety, whatever its form. And, as a result of our openness, group members are more willing to share their own experiences

For many, this is the first time they have openly talked about their struggles. A group participant once said to me, "When I speak with my doctor, I know that he doesn't have any idea what I'm talking about and cannot possibly understand what I go through. But you do because you've been there."

In the first session, we also provide factual information about panic attacks and panic disorder so group members can begin thinking rationally, rather than emotionally, about what is happening to them when they have a panic attack. And they are given a book about anxiety and panic disorder (*10 Simple Solutions to Panic: How to Overcome Panic Attacks, Calm Physical Symptoms, and Reclaim Your Life* by Martin M. Anthony and Randi E. McCabe).

In week two we introduce relaxed breathing, and deep muscle

relaxation is introduced in week four. These are useful skills for reducing overall anxiety. The group leaders always demonstrate each behaviour or technique prior to asking the members to join in.

At the end of each group session, the participants are given “homework.” Homework gives participants the opportunity to master the skills they’ve learned during sessions. They may be asked to read a chapter or two in the book they received. They work through exercises in a workbook to help them identify and overcome their personal fears. They learn to challenge some of the common types of thoughts that arise during a panic episode and identify a calming thought that can be substituted in place of the panic thoughts. They set goals they can work towards as the program progresses. And they are asked to continue with the relaxed breathing and deep muscle relaxation on a daily basis to “dial down” their general level of anxiety.

Homework is always reviewed at the following group and participants are encouraged to share. There is always reluctance at first. But as group members hear the experiences of others and discover that they’re not unlike their own, some of the stigma is removed and they begin to participate. Oftentimes, group members begin to brainstorm coping strategies for each other. This is very exciting because they are beginning to move from purely emotional thinking to more analytical and cognitive thought processes.

The most challenging session occurs about halfway through the program, when participants are asked to bring on the bodily sensations they fear. People with panic disorder may be afraid of sensations like a racing heart, light-headedness, dizziness and shortness of breath.

First, group leaders demonstrate bringing on these uncomfortable physical sensations, in a calm and matter-of-fact manner. For example, we might cause light-headedness by hyperventilating or

make ourselves dizzy by spinning around, all the while explaining what we’re feeling. We acknowledge that, while we’ve made ourselves uncomfortable, what we’ve done is not dangerous. In fact, we’re able to report that, not long after we’ve stopped, all sensations are gone.

This exercise can be scary for many group members, but when we ask them to bring on a particular sensation along with us, very few refuse to do so. This is an important step for participants in understanding, experientially, that the physical sensations they fear aren’t dangerous.

The remainder of the program focuses on gradual and repeated exposure to feared situations, moving from the easiest towards the most feared. These are situations that have mostly been avoided in the past, such as driving over bridges or taking public transit. We also ask the group members to start thinking about a life outside of panic, where “harm avoidance” is not the primary focus.

At the final group, we usually end with a celebration. People bring food to share and many times members share upcoming events they have planned that wouldn’t have been considered before taking part in the group, like taking a trip that involves flying somewhere. We encourage participants not to let their panic management tools get rusty. We ask them to think about what they knew about anxiety at the beginning of the group and what they now know at the end. I also like to let them know that, in practising anxiety management techniques with them, I’m helping myself as well. In many ways, leading a group is my therapy.

LEAF has a positive impact

Data collected over the years shows that the LEAF program successfully reduces symptoms of panic, anxiety and associated depression



66

We ask group members to start thinking about a life outside of panic, where ‘harm avoidance’ is not the primary focus

99

in people who complete the program.¹ Group participants fill out pre-treatment and post-treatment questionnaires. The majority, if not all the participants, have reported that the LEAF program helped them manage their panic and anxiety symptoms more effectively. Most participants would also recommend the program to others suffering from panic disorder.

Unfortunately, this program has not been offered on a regular basis due to inconsistent funding from the local health authorities. This is a situation I hope will change. Peer-led groups are a very cost-effective way to help people before their problems become more severe and they begin to access the health care system more frequently.

I’ve met many brave and wonderful people who’ve been struggling for years and who finally see a light at the end of the tunnel. They are my inspiration to continue helping those who haven’t yet benefited from any form of treatment and struggle to cope day by day. ■

footnotes
visit [heretohelp bc.ca/publications/visions](http://heretohelp.bc.ca/publications/visions)
for Shelly’s complete footnotes or contact us by phone, fax or e-mail (see page 3)

related resource

🔗 AnxietyBC
www.anxietybc.com

The Cognitive-Behavioural Approach to Treating Individuals with Eating Disorders

Ron Manley, PhD, RPsych

Ron is a psychologist with the Provincial Specialized Eating Disorders Program for Children and Adolescents at BC Children's Hospital. He has worked in the field of eating disorders for over 25 years

Ron thanks his colleague Dr. Karina O'Brien for her helpful comments on an earlier draft of this article

* pseudonym

Betty's* challenge Betty had been diagnosed with bulimia nervosa (BN). She was depressed and terrified about gaining weight. One day she didn't attend her scheduled therapy session.

When I phoned to follow up, Betty explained that she couldn't come because she knew other people on the bus would be thinking about how "fat" she was.

We took this issue up in our next session, when Betty was able to get a ride in with her mother. Over the course of the session, we discussed body image distortion. This is when a person actually sees and/or feels their body to be larger than it really is. That is, their perception of their size is distorted.

I was able to gently challenge how realistic her thoughts about taking the bus were. At the same time, it was essential for me to accept that her beliefs and concerns were very real for her.

I asked Betty how likely it was that anyone would really notice her in a negative sense. She was able to see just how improbable it was that anyone on the bus would think badly about her or her appearance. Betty was also able to appreciate that people riding a bus were in general more preoccupied with their own thoughts and tasks for the day than concerned about her appearance.

While this may sound like a common sense approach to take in this situation, it's an example of cognitive-behavioural therapy, or CBT. The "cognitive" refers to thoughts. The "behavioural" refers to the person actually doing real-world things that demonstrate that their thoughts are unhealthy and, ultimately, don't reflect reality.

The CBT model

The CBT view is that people's emotional states are a result of how they think about or interpret different situations and not necessarily an inevitable result of the particular situation.

Let's look at the example of Betty getting on a bus. Due to her marked preoccupation with her weight and shape, it's not unusual that she'd assume others would be similarly preoccupied with her weight. She might get on the bus and notice another passenger looking at her. Her initial tendency might be to conclude: "That person agrees that I'm fat and shouldn't be out in public." This thought would reinforce her belief that she's "fat" and needs to lose weight, and would lead her to feel very badly about herself.

However, in the same situation, a person could alternatively conclude that the passenger looking at them is *admiring* their clothing or appearance. If Betty thought this way, she wouldn't feel badly at all.

So we have two identical situations that resulted in each person feeling very differently later on. Each of these people has attempted to understand, explain and interpret why the person

on the bus was looking at them. But they each thought very differently about the situation.

These types of thoughts are called "automatic thoughts." They are automatic because they happen very quickly. Sometimes they are helpful and allow us to evaluate a situation quickly, but other times they're very negative and unrealistic.

If the thoughts tend to be very self-critical, it's not hard to understand how someone could feel depressed as a result of the thoughts. If the thoughts tend to be threatening and involve the future, we can understand how someone might feel very anxious. With an eating disorder, the thoughts often similarly involve depression and anxiety, but include thoughts related to the person's feelings about their shape and weight.

What is the evidence for CBT in the treatment of eating disorders?

CBT has been researched more than any other psychotherapy in the treatment of eating disorders. This is particularly true in the treatment of bulimia nervosa (BN).¹

As a result, we can say with certainty that CBT is the treatment of choice for adults with BN.² CBT's effi-



cacy in the treatment of people with anorexia nervosa is less clear. It's also unclear whether CBT has the same success with youth suffering from BN, since there's a lack of research and scientific data in this area. In my experience, however, there's little reason to doubt that CBT is equally effective if modified to fit this younger age group.

At the same time, it's important to remember that CBT is not a cure-all for every patient with BN, and further research to increase its effectiveness as a treatment is needed.

Traditional CBT for bulimia in practise

Traditional CBT has long been applied to bulimia nervosa and is often referred to as CBT-BN. The initial goals are to interrupt the symptoms, such as bingeing and purging.³ Later, the main task is to help the patient question and challenge the thoughts and beliefs that maintain the eating disorder.

There are usually a limited number of CBT sessions (19 over 18 weeks),³ and homework is typically assigned at the end of each session. The homework is usually a combination of self-monitoring and behavioural "experiments" to be carried out between therapy sessions.

Self-monitoring is where the patient is asked to keep a log or journal of situations, thoughts and resulting feelings. With Betty, I designed a form she could use to record her negative thoughts and feelings, how these related to particular situations and whether she restricted, binged and/or purged as a result.

This journalling is intended to increase awareness that eating-disordered behaviours take place in a context of thinking and feeling. The patient becomes much more aware of their thinking, which helps to take the eating-disordered behaviours off "automatic pilot."

Self-monitoring must be introduced gradually. Just learning to distinguish between a "thought" and a "feeling" can be very difficult. For some people with eating disorders, learning to tell the difference between certain feelings—distinguishing between hurt and anger, for instance—is an important and crucial step. One may need to begin by learning names for various feeling states. The person can then develop, as would an artist, a more varied palette for expressing and describing their feelings. Disappointment, frustration, boredom, loneliness and more may be identified.

Another goal is to help patients learn to classify their cognitive distortions into different categories. These categories include "all-or-nothing" thinking, "mind reading," "emotional reasoning," "personalization," and so on.** An example of all-or-nothing thinking (also known as "black and white" thinking) is the patient seeing him or herself as only very thin or fat—there are no in-betweens. Being able to classify thought distortions helps patients appreciate that their thoughts are unrealistic.

It's very helpful for a patient to learn strategies for

challenging automatic negative thoughts. For example, we help the patient ask, "What is the evidence?" for negative thoughts related to body image distortion. This can empower the patient to work at diminishing the power these thoughts have.

These thoughts don't simply disappear upon first challenge; they must be challenged repeatedly. Patients also begin to become aware of recurring themes related to their thoughts. Feeling they don't deserve to receive help is an example of such a theme.⁴

On a level deeper than automatic thoughts lie *schemas*, which are more enduring beliefs. These help determine the person's experience of being-in-the-world. An example would be the belief that, "No one would like me if they really got to know me."⁵ And again, the patient can question what evidence there is for their beliefs.

The best way to disprove the apparent truth of negative thoughts and beliefs is through real-world experiments. The patient is asked to collect "data" both in support of and against the belief. For example, Betty will be encouraged to take graduated risks with normalizing her eating behaviour, to test out the eating-disordered thought that she will gain weight in an out-of-control fashion.

Sometimes I use a "courtroom and lawyer" analogy. Negative automatic thoughts tend to have a persecutory quality. I make it clear that the eating disorder is like a prosecutor in court. Patients are aware that cases are thrown out of court when the apparent "evidence" the prosecutor brings forward is seen as insubstantial. CBT helps patients learn to question the "evidence" that the eating disorder brings forward.

Over time, Betty will learn to challenge her eating-disordered thoughts and beliefs on her own. And she'll be able to take increasing charge of her mood. This will help to restore a sense of control, a sense of choice and her self-esteem.

CBT-E and other CBT offshoots show promise

Enhanced CBT, or CBT-E, is a relatively new form of this therapy. A five-year study suggests that CBT-E is "more potent" than CBT-BN.⁶

In CBT-E, the traditional CBT model of bulimia nervosa treatment has been broadened to treat all the eating disorders. It has added modules that target perfectionism, self-esteem issues and relationship challenges. There is also a version for patients less than 18 years of age.

There's further good news. There are many other offshoots of classic CBT that show promise in helping patients with eating disorders. These include dialectical behaviour therapy,⁷ acceptance and commitment therapy⁸ and those approaches derived from the emerging literature on mindfulness.⁸⁻⁹ ■

** See chart of negative thinking patterns on p. 6

footnotes
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Metacognitive Training

Influencing schizophrenia treatment worldwide

Todd S. Woodward, PhD

Todd is an Assistant Professor in Psychiatry at UBC and a research scientist at the BC Mental Health and Addiction Research Institute. He is the co-creator of metacognitive training (MCT) with primary developer Steffen Moritz of the University Medical Centre Hamburg-Eppendorf in Germany. Todd researches the neural and cognitive underpinnings of psychosis and schizophrenia

What is metacognition? “Meta” means *above* and “cognition” refers to *thinking or perceiving*. Thus, *metacognition* is being aware of one’s thoughts—or, thinking about one’s thinking.

About metacognitive training

Metacognitive training (MCT) is a program developed directly from current cognitive neuropsychiatry research findings on schizophrenia and psychosis. MCT shares knowledge gained in research labs to help individuals experiencing psychosis become more aware of the thinking patterns involved in their illness.

The training was developed (and continues to be developed) by Steffen Moritz at the University Medical Centre Hamburg-Eppendorf in Germany and myself. My research, some of which is shared through the MCT, has been carried out through the BC Mental Health and Addictions Research Institute and the University of British Columbia. The first MCT manual was published in 2005. MCT is currently used in more than 40 centres worldwide and has been translated into 14 languages.

The main purpose of the metacognitive training is to help people change the thinking patterns that cause delusions, thereby avoiding relapse into illness or reducing the impact of delusions.

How does MCT work?

Research shows that people with schizophrenia or psychosis tend to think and reason in ways that can help establish delusions.¹ Delusions are false beliefs that aren’t shared by others in the community. For example, the belief that one is being spied on by the CIA is (almost always) an example of a delusion

Psychosis (delusions and hal-

Jumping to Conclusions—a MCT Exercise

This module shows how what appears to be true at first often turns out to be inaccurate once more information is gathered. We will look at parts of a picture and see whether the amount of information we have is enough to decide, or whether we need more information to decide.

- 1 Does this look like a sled or a bowl to you? Is this possible, or probable? Do you need more information, or do you have enough to decide?
- 2 Sled? Rocking chair? Elephant’s head? Do you need more information, or do you have enough to decide?
- 3 Can you now decide this is a rocking chair?
- 4 You’re correct, but it was important that you waited to get all the information before making a strong decision.

Is it a:
 smiling face?
 bowl?
 boat?
 sled?
 rocking chair?
 elephant head?

excluded, improbable, possible, probable, DECISION

lucinations) is not a sudden and instantaneous incident. It often begins with a gradual change in one’s thinking and social environment. Learning to be aware of one’s thoughts can help prevent psychotic breakdown.

The MCT is a group-based program that teaches participants about common thinking patterns to which they may be prone. The program also suggests ways to counter these potentially problematic thought patterns.

Erroneous or distorted thinking patterns may—on their own or in combination with other factors—help establish delusions. Processing emotionally charged information through distorted thinking styles may trigger delusional thoughts.

Common thinking distortions include:

- making strong judgments based on little evidence
- blaming other people rather than circumstances
- being unable to fully consider and accept information provided by other people
- being unable to let go of strongly held positions
- being overconfident that inaccurate memories are in fact accurate

The MCT program aims to raise clients’ awareness of these distortions and to prompt them to critically reflect on, complement and change their current problem-solving tools.

MCT never addresses participants’ specific delusions. However,

individual delusional themes can be addressed in one-to-one therapeutic sessions, such as cognitive-behavioural therapy (CBT). Also, our new MCT+ program,* though based on our group MCT, is more individualized and can be used to supplement CBT (www.uke.de/mkt_plus).

Program sessions

The program is provided in a group program structure because the generation of ideas that results from participant interaction is key to the learning process.

Each cycle of the program is made up of eight modules. Presenting two modules per week, one module each session, is helpful because a full cycle can be completed in one month. There are also two cycles of the program available. They cover the same topics, but the instructional content is different. This is so participants can repeat the training and have a fresh learning experience.

Each session emphasizes the learning objective of the module (“Why are we doing this?”) and the practical relevance to the individual’s experiences (“What does this have to do with psychosis?”).

The module topics are: Attri-

bution—Blaming and Taking Credit; Jumping to Conclusions I; Changing Beliefs; To Empathize I; Memory; To Empathize II; Jumping to Conclusions II; and Self-esteem and Mood.

The sessions are entertaining and designed to capture participants’ attention (see sidebar). Although the exercises are fun, they also challenge problem thinking patterns.

Though MCT is an interactive program, participants are not pressured to be involved. They are asked to participate at their own comfort level.

Discussion about what type of thinking underlies delusions is encouraged—but participants are not required to discuss their individual (possibly delusional) beliefs.

How can you benefit from MCT?

Early research suggests that MCT produces a reduction in the severity of delusions.² And in a feasibility study, the MCT program was rated as more fun and more useful in daily life than an alternative cog-

nitive program administered to a control group.³ Voluntary participation has been excellent, and the participants tend to recommend the program to others.

How can you participate in a session?

The MCT program is not offered publically to a general audience. Members of your care team are encouraged to access all the resources they would need to administer the program themselves. A number of care teams in the Lower Mainland are currently offering this program to their clients.

MCT is available free of charge to any health professional running support groups for people with schizophrenia and psychosis. Information, materials and program modules can be accessed through the University Medical Centre Hamburg-Eppendorf (www.uke.de/mkt). ■

**There is currently only a beta version of MCT+ available in English; otherwise it's available in German.*

related resources



Research articles related to MCT

www3.telus.net/Todd_S_Woodward/cognitive%20bias%20training.htm

Comprehensive articles on the research behind the modules

www3.telus.net/Todd_S_Woodward/metamemory.htm

www3.telus.net/Todd_S_Woodward/schizophrenia.htm

footnotes

visit heretohelp.bc.ca/publications/visions for Todd’s complete footnotes or contact us by phone, fax or e-mail (see page 3)

CBT for Children and Youth in BC

About one in seven—that’s 140,000—children and youth in BC have a mental health problem serious enough to affect their relationships with family and friends and their performance in school. There is also a gap between the need and the availability of mental health services.¹ The Ontario Child Health Study in 1997 determined that only one in six children and youth with mental disorders receive some form of specialized services.²

The Children and Youth Mental Health Plan

The *Child and Youth Mental Health Plan for BC* (CYMH Plan) was introduced by the provincial government in February 2003. The five-year CYMH Plan (2003–2008) presented a new approach to services and supports for children and youth with mental health problems

and their families. Instead of focusing only on children and youth with the most serious mental disorders, the CYMH Plan focused on helping young people earlier, to prevent or reduce their risk for developing mental health problems. Additionally, the plan provided direction for the types of therapy that would be most likely to help children, youth and their families. Before the CYMH Plan, clinical services were a mixture of whatever approaches staff clinicians had to offer.

In developing the CYMH Plan, the Ministry of Children and Family Development (MCFD) committed to using research evidence to make sure the most effective prevention and treatment approaches would be used.

In 2001 to 2002, the Children’s Health Policy Centre at Simon Fraser University reviewed the research literature on behalf of MCFD. MCFD also formed >>

Gayle Read

Gayle is the Senior Mental Health Consultant on the Child and Youth Mental Health Policy Team, Ministry of Children and Family Development. She has worked in mental health for 26 years as a clinician, supervisor, manager and consultant. Gayle and her colleagues developed and implemented the Child and Youth Mental Health Plan for BC

some things you may do as part of CBT are:

- ✓ Learn skills to help you relax and feel more in control, such as deep breathing or meditation.
- ✓ Learn social skills to improve your sense of competence, including how to carry on a conversation with someone you just met.
- ✓ Gradually expose yourself to situations that cause anxiety to learn that fears are often exaggerated—first by thinking and planning to do that activity, and eventually by doing it for a short time. The length of time is gradually increased as you feel more comfortable.
- ✓ Chart task assignments and progress on a daily basis. For instance, you could track the number of times you are able to participate in an activity that makes you feel happy.

expert advisory groups to recommend the best approaches for some particular mental health problems. These included depression, anxiety, behaviour problems and eating disorders. Advisory groups also addressed co-occurring issues of mental health and substance use, and mental health and developmental disabilities.

Recommendations led to training initiatives as part of the CYMH Plan, focusing on cognitive-behavioural therapy, interpersonal psychotherapy, dialectical behavioural therapy, suicide and dual diagnosis.

Cognitive-behavioural therapy (CBT)

was recommended as the most effective approach for anxiety and depression. Anxiety is the most common mental health problem in children and youth, affecting about 6.5% of young people. Depression affects 2.1% of children and youth.¹

The CBT approach

CBT is a counselling approach that requires the active participation of the client. It helps you understand the connections between your thoughts, feelings and behaviours that might contribute to anxiety and depression.

Feelings of anxiety are learned, so fortunately they can also be unlearned. These feelings are often reinforced through direct and indirect experiences. For instance, growing up with a parent who is overprotective or having fearful experiences like being bit by a dog may reinforce the notion that the world is a scary place.

A question a clinician might ask to help you look at some of your anxious thoughts or beliefs could be: Do you notice that when you think that bad things are going to happen, they almost never do? When people with anxiety experience physical sensations like a racing heart or sweaty hands, they often fear they might faint or have a heart attack. These physical sensations, however, are seen by mental health professionals as normal reactions to scary situations. They are not dangerous and often last for only a very short time, then go away. The clinician's task is to help you realize this and devise strategies for managing your reactions to these sensations.

Similarly, in the case of depression, a clinician might ask: Have you felt this way at another time in your life, and did those feelings go away? One would

expect to feel sad or depressed for a short period following a loss or disappointment. But if it lasts several months, a mental health professional can help you learn ways to deal with these feelings.

Parents have a very important role to play in helping their children deal with anxiety or depression. Parents can help by supporting their children to try new behaviours, gently questioning unhelpful beliefs, supervising the charting of tasks and modelling positive behaviour.

Cognitive-behavioural therapy has primarily been used for children and youth ages eight and older, but programs using the principles of CBT have been shown to be effective with younger children as well. FUN FRIENDS, an anxiety prevention program for children aged four to seven, is being piloted this fall in BC. It's an adaptation of the original FRIENDS program that MCFD and school districts have implemented in grades four, five and seven in BC. Another MCFD project based on CBT principles is the self-help depression manual for youth titled *Dealing With Depression: Antidepressant Skills for Teens*. You can find all these programs on the MCFD website (see sidebar next page).

Expanding CBT services in the province

By 2005, MCFD had begun training CYMH clinical staff in CBT to ensure they could use the most effective approaches for helping children and youth with anxiety problems and depression.

MCFD works with CBT Connections,³ a BC company that provides training. They offer a two-day foundational CBT workshop on the principles of CBT as treatment for anxiety disorders, including generalized anxiety, obsessive-compulsive behaviour, phobias, separation anxiety, panic, social anxiety and post-traumatic stress.

The goal is to have all MCFD clinicians in the province take the two-day workshop. Registration for each training session is based on population and socio-economic factors to ensure there are trained clinicians province-wide. There are approximately 500 clinicians in BC, and at present, about three-quarters have done this training.

Clinicians can complete a certification program through CBT Connections and AnxietyBC. In addition to the two-day workshop, they learn in more depth how to use CBT with children and youth who have more complex anxiety disorders. This latter part of the program involves Web-based learning modules and tests, developing case treatment plans and making audio recordings of client sessions for feedback by trainers.

Almost half of all CYMH clinicians have completed the CBT certification for anxiety disorders. There isn't a requirement for all clinicians to complete the certification, though all are encouraged to do so. Some clinicians, however, choose to focus additional training on one of the other approaches recommended in the plan instead.

Some CYMH clinicians have also received additional training in CBT for depression (by Dr. Chris Wilkes, Head, Child and Adolescent Psychiatry in the Calgary Health Region), though there are no plans for further

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training at this time. The principles, however, are similar to those applied to anxiety disorders.

A small group of CYMH clinicians have received training in Trauma-Focused CBT delivered by the Harborview Center for Sexual Assault and Traumatic Stress⁴ in Seattle. They will be better able to help children and youth who have experienced trauma in their lives. There are plans for further training in this area of CBT.

Accessing CBT

MCFD offers free counselling, including CBT, to children and youth with mental health problems and their families. You can access CBT by accessing counselling services through MCFD.

If you have concerns and would like to speak to a mental health clinician, check the MCFD website (see sidebar) for the Child and Youth Mental Health office closest to you. You can also find office locations in the provincial services section of your telephone directory blue pages. **i**

where to find the resources in this article



- Child and Youth Mental Health Plan for BC**
www.mcf.gov.bc.ca/mental_health/mh_publications/cymh_plan.pdf
- Children's Health Policy Centre (SFU) reviews**
www.childhealthpolicy.sfu.ca/research_reports_08
- FRIENDS program**
www.mcf.gov.bc.ca/mental_health/friends.htm
- Dealing With Depression: Antidepressant Skills for Teens**
www.mcf.gov.bc.ca/mental_health/teen.htm
- Children and Youth Mental Health offices**
www.mcf.gov.bc.ca/mental_health/pdf/services.pdf

CBT: Does it work well with the Chinese population in Vancouver?

SUCCESS is a multi-service agency with a mandate of promoting the well-being of all Canadians and immigrants. The organization has offered counselling services to the Chinese community for over 30 years. Cognitive-behavioural counselling (CBT) is widely used by our therapists because it works well with many clients of Chinese cultural background.

CBT and the Chinese population

Most cognitive-behavioural therapies have the following characteristics:

- emotional response is looked at from a cognitive or thinking perspective
- therapy is brief and time-limited
- therapy is structured and provides direction and guidance
- therapy uses a teaching-learning approach
- facts and rational interpretation are used to help clients understand issues

- it's practical—clients are asked to do homework and assignments

All these characteristics work well with most Chinese families. Very often, Chinese clients who



come to counselling expect a quick fix to their problems, expecting practical and immediate solutions. They are also more used to an analysis of their problems based on concrete evidence rather than the sharing of deep-seated feelings. Many Chinese clients don't have experience talk-

ing about their emotions. Emotions tend to be conveyed in terms of physical complaints or complaints about family members.

Chinese families also have great respect for experts and authority. Because of this, a directive counselling approach by an authority figure is well received. Moreover, Chinese clients prefer an educational model because they are used to playing the "student" role while the therapist plays the "teacher" role.

Changeways: adapted for SUCCESS

Changeways (changeways.com) is an evidence-based group program, originally developed by Vancouver psychologists in 1991 for patients who had recently received hospital care. Changeways has since been revised and is now offered to seriously depressed people by hospitals (on an outpatient basis) and community agencies like SUCCESS.

Its approach is primarily >>

Mary Kam, MSc, RCC

Mary is a clinical counsellor. She is the Senior Manager of SUCCESS Family and Youth Services Division in Vancouver. Mary also provides frontline clinical counselling to immigrants

Kelly Ng, MSW, RSW

Kelly joined SUCCESS in 1992 as a Program Director, heading the largest Chinese-speaking counselling team in Western Canada. He conducted the first Changeways stress management program for immigrant men in the Chinese community. Kelly is currently on the Child and Youth Advisory Committee for the Mental Health Commission of Canada

cognitive-behavioural, and the program uses an adult education model to teach participants a variety of self-care skills. These include setting sustainable goals, relaxation techniques, assertiveness skills and rebuilding their social network. The program covers a range of topics, including the CBT aspects of the interconnected triangle of thoughts, emotions and behaviour, and styles of distorted thinking. Stress and depression, sustaining lifestyle and assertiveness are also covered. They help the individual develop positive thinking and behavioural outcomes.

Changeways Clinic director Dr. Randy Paterson assisted in training our facilitators. He also endorsed

our recommendations for making the Changeways Core Program for depression culturally more relevant. The program content was slightly modified to suit the learning style of Chinese participants, and culturally relevant metaphors were added (see sidebar).

We offered the program to the adult Chinese community from 2000 to 2007, calling it the Changeways Stress Management Course. To address stress, relaxation exercises from the Changeways Relaxation Program were added to each session.

We ran five groups for men and seven groups for both men and women. We targeted the program more at men because it's generally much harder to engage them in training programs. We also wanted to encourage them to develop social support; women generally have less problem reaching out to others.

Participants used a slightly adapted version of the Changeways participant handbook that was translated into Chinese.

Feedback from the participants—from self-reporting forms that are integral to the Changeways program—revealed that many aspects of the program were very relevant to their needs.

The practical relaxation exercise in each session, the facilitated group discussion, participant manuals in Chinese and “teaching” how to overcome negative thoughts were all rated highly.

The introduction to the concept of assertiveness—a concept that has no direct translation in Chinese—was highly relevant to participants' needs. We framed it as “standing firm” with one's opinion and values while not offending others. Immigrant participants also found it very helpful to evaluate the experience of having a shrunken social network.

The SUCCESS experience: a good fit

The program received overwhelmingly positive response from the community. Most groups were full, with a waiting list.

In our estimation, Changeways has been well-received by the Chinese participants because its psycho-educational model fits well with their preferred “student” role and learning style. The relaxation exercises they learned in the session and practised at home were practical. The paper-and-pencil exercises in the participant handbook were another concrete activity. The ‘lectures’ on facts, theories and specific topics provided a concrete base from which participants could draw on relevant personal life experience and take part in group discussion.

Since Changeways is CBT based, it follows that CBT is compatible with the expectations of our Chinese clients. CBT is psychoeducational (helps people learn about mental illness) and promotes self-help. Chinese clients welcomed the teaching of new coping skills to manage stress problems. The flexible structure of CBT also allowed us to incorporate the many factors related to cultural background and immigration that affect the psychological well-being of our clients.

It's never our intent, however, to generalize our observations to the diverse Chinese population in Vancouver. Many factors, such as years of living in Canada, place of birth, level of integration and former exposure to Western education may all affect how clients interact with different counselling approaches.

SUCCESS could not fund the Changeways program after 2007, but we plan to offer it again if we can find a funding source. We consistently receive requests for this program.

For more information on the counselling programs currently offered at SUCCESS (which include counsellors who use CBT), visit www.success.bc.ca and click on “Counselling” or “Family.” ■

cultural metaphors used in SUCCESS' changeways program

忍 The Chinese character of “tolerate”

The traditional Chinese culture emphasizes maintaining harmony in human relations. This results in tolerance of unfair treatment, especially by those in authority, to the point of depression for some people. The Chinese character “tolerate” resembles a knife over the heart. We put ourselves at risk if we tolerate too hard and for too long. The knife will stab into our heart and cause bleeding. The only way out is to take away the knife—be it thought or emotion—that deeply hurts us as we plunge into depression. This can be achieved by learning new coping strategies.

The “toothpick container”

Toothpicks cannot come out of the container if too many of them are packed together inside. We have to drop or let go of some of them, or else the toothpick won't be able to fulfill the function it's designed for. An important stress management strategy is not to allow stress to accumulate. Seek help when signs and symptoms of stress begin to arise; don't wait. And instead of being entrenched in chronic worry, we can isolate the worry to certain times of the day; that is, deal with one “toothpick” a time.

危機 The Chinese meaning of “crisis”

It means there's a new opportunity behind the danger/risk. The experience of depression and of joining the Changeways program helps us adopt new ways of achieving a healthy life balance.

Cognitive-Behavioural Therapy for Adults With Mental Health Problems

Working to improve access in BC

Accessing cognitive-behavioural therapy (CBT) is not easy for many adults in British Columbia who have mental health problems. Because of this, BC Mental Health & Addiction Services (BCMHAS), an agency of the Provincial Health Services Authority, formed the BC Cognitive Behaviour Therapy Network in late 2008. The intent is to improve access to CBT across the province and to strengthen province-wide collaboration.

The BC CBT Network is made up of clinical and administrative representatives from BCMHAS, the Ministry of Health Services (MoHS), the Ministry of Children and Family Development and each of the five regional health authorities. These representatives meet regularly to advise and coordinate initiatives to build CBT capacity throughout BC.

The work of the BC CBT Network is guided in part by a provincial CBT service framework that was drafted by BCMHAS and MoHS in early 2009.¹ This framework outlines a broad-based plan for strengthening CBT services in BC.

The vision of the BC CBT Network is that every person in BC will have equal access to high-quality CBT, no matter where they live. This will lead to better care and treatment for people with mental health problems.

What do we know about CBT services for adults in BC?

We know that CBT is an effective psychotherapy for treating a wide range of mental health problems. For many mental health problems, CBT is as effective as medications and more cost-effective over the long term.²⁻³

However, we also know that BC doesn't have enough professionals trained in CBT to meet the needs of the people. Therefore, medications continue to be the primary or sole method for treating mental health problems in BC. Since some people don't want to take psychiatric medications and some can't afford to, the

result is high rates of untreated mental health problems in the province.

BC does not currently have a system in place to train, supervise and accredit mental health professionals in CBT. And the CBT expertise that is available in BC is unequally distributed across the province, as services tend to be concentrated in urban areas. This creates countless missed opportunities to intervene with adults before mental health problems become severe, debilitating and costly. We know that we need to work hard across BC to improve the availability, accessibility and affordability of CBT services for adults who have mental health problems.



“For many mental health problems, CBT is as effective as medications”

What is low-intensity CBT and how do you access it?

People often think of CBT as face-to-face,

one-on-one counselling. However, low-intensity CBT emphasizes self-help and can be highly effective for many people who experience mild to moderate levels of distress. There are two types of low-intensity CBT: pure self-help and guided self-help.

Pure self-help refers to people managing their mental health problems on their own. They learn about coping skills and strategies through books, workbooks, DVDs, computer software or Internet-based programs.

Guided self-help refers to people learning about and using CBT strategies with the guidance and support of a trained professional, such as a general practitioner (GP) or community coach. Bounce Back: Reclaim Your Health is one example of a BC program that uses a guided self-help approach.*

In BC, you may be able to obtain information about low-intensity CBT resources through your GP. Efforts are underway to provide BC physicians with CBT training and resources so that they can identify, >>

Jamie Livingston,
BC Mental Health &
Addiction Services
(BCMHAS), Provincial
Health Services Authority
(PHSA)

Mark Lau, BCMHAS, PHSA

Dolores Escudero,
Ministry of Health
Services

Eric Ochs, Vancouver
Island Health Authority

Gayle Read, Ministry
of Children and Family
Development

Pam Whiting,
BCMHAS, PHSA

Maureen Whittal,
Vancouver CBT Centre

Chris Wilson, Interior
Health Authority

*The contributing authors
are all founding members
of the BC Cognitive
Behaviour Therapy
Network*

* For more information on
the Bounce Back program,
see the article on p. 31



guide and support patients with mental health problems.⁴ The *Antidepressant Skills Workbook*⁵ and the *Cognitive Behavioural Interpersonal Skills Manual*⁶ are examples of self-help CBT resources that some physicians are using. At present, however, many GPs may be unaware of low-intensity CBT resources. You can also get information from either a non-profit mental health agency (such as the Canadian Mental Health Association) or through the Internet.

Internet based examples of low-intensity CBT that can be accessed at no cost include the self help resources listed in the sidebar. The BC CBT Network is currently working with several non-profit mental health agencies (e.g., AnxietyBC, Canadian Mental Health Association's BC Division) to increase awareness of and access to low-intensity CBT resources in BC.

What about high-intensity CBT?

High-intensity CBT refers to formal, face-to-face services delivered by a trained therapist, such as a clinical psychologist or counsellor. These services are generally suited to people with moderate to severe levels of distress related to mental health problems.

In BC, high-intensity CBT for adults is provided in either the public or private health care sectors. As mentioned earlier, high-intensity CBT services in the public health sector are difficult to access in BC. You can contact your local GP, nurse practitioner or mental health service provider to ask how to get information about these services, whether high-intensity CBT services are available in your area and, if so, whether you qualify to access these services. A long-term goal of the BC CBT Network is to dramatically increase the number of practitioners in the public health sector who are appropriately trained to provide high-intensity CBT.

You can also find out more about the cost and availability of high-intensity CBT in the private health sector through your workplace employment assist-

ance program or by contacting a local psychotherapist through a professional organization (see sidebar).

Choosing a CBT practitioner

When choosing a practitioner in BC, it's important to know that it's unlikely they will be accredited in CBT. In fact, no Canadian province or territory has established standards for accrediting CBT practitioners. Only a small number of trained CBT practitioners in BC are accredited through the US-based Academy of Cognitive Therapy, which is the only registry of accredited CBT practitioners in North America.

The BC CBT Network is working towards establishing standards for accrediting practitioners that provide CBT services in BC. But for now, there is no easy way for people who are seeking treatment to find out how qualified or skilled a particular practitioner is in CBT.

Some useful background questions to ask before you decide to receive CBT from a particular practitioner may include whether they've received specialized training in CBT, how long they've been providing CBT and how much experience they've had treating people similar to yourself with CBT. It's also important to check how much financial coverage your workplace employee assistance program or extended health plan provides for CBT. **i**

footnotes
visit [heretohelp.bc.ca/
publications/visions](http://heretohelp.bc.ca/publications/visions)
for the authors'
complete footnotes
or contact us
by phone, fax or e-mail
(see page 3)

how to find CBT resources



Free online low-intensity CBT resources

- www.bcmhas.ca/Research/ASW
- www.anxietybc.com/resources/introduction.php
- www.heretohelp.bc.ca/skills
- www.changeways.com/scdpintro.shtml
- www.comh.ca/antidepressant-skills/adult
- moodgym.anu.edu.au
- ecouch.anu.edu.au
- www.livinglifetothefull.com

Find a professional to help

- BC Association of Clinical Counsellors**
www.bc-counsellors.org
- BC Psychological Association**
www.psychologists.bc.ca
- BC Association of Social Workers**
www.bcasw.org
- Academy of Cognitive Therapy**
www.academyofct.org
- Association for Behavioral and Cognitive Therapies**
www.abct.org
- Counselling BC**
www.counsellingbc.com

heretohelp
WithinSight
mental health + substance use resources for multicultural communities

Looking for resources to support multicultural communities?
Have them delivered to your inbox every two months.
Sign up at HeretoHelp.bc.ca under Other Languages
or email withinSight@heretohelp.bc.ca.

Help With Mild to Moderate Depression

CBT-based self-management options

As a psychologist in an emergency psychiatric unit, I've seen thousands of people in depressive crisis. I have developed an approach to help these individuals who struggle with the bitter suffering of dark mood and despair. It teaches what is known about depression as well as problem-solving strategies.¹

About 10 years ago, it dawned on me that if the highly depressed patients I was seeing in the hospital didn't have basic knowledge about depression, it was likely that people with less severe depression didn't have this knowledge. This struck me as fundamentally wrong. Surely our health care system could deliver basic knowledge and skills for dealing with one's own mood. Surely we could teach *mood self-management*.

From the moment I recognized this gap in mental health services, I committed to getting knowledge and skills for mood self-management to people who were depressed.

Mood management: CBT to the rescue

A solid body of research shows that providing cognitive-behavioural therapy (CBT)-based self-management material to people dealing with mild depression is an effective intervention.² There's also good evidence that adding the element of support increases the positive impact of self-management workbooks.³

The existing self-management workbooks were either costly, inconsistent with available research, too wordy or just not clearly written.

As a scientist in the Centre for Applied Research in Mental Health and Addiction (CARMHA) research group at Simon Fraser University, I created partnerships and looked

for support to develop new kinds of self-management materials and training. Fortunately, it has been possible to gain the support of various BC health care agencies in developing and distributing self-management tools and related training. These agencies include the Provincial Health Services Authority, BC Ministry of Health Services, BC Ministry of Children and Family Development, Vancouver Coastal Health, BC Medical Association and Michael Smith Foundation for Health Research.

Our CARMHA research group has developed two basic approaches to making self-management knowledge and skills available to the general public.

Self-management workbooks

We have developed four self-management workbooks. They are free, easily accessible, consistent with research evidence, brief and easy to use.

The workbooks are based on CBT principles for the management of depressed mood. CBT focuses on identifying problems with an individual's behaviour and thinking, then teaches evidence-based skills for coping more effectively. It deals with current life challenges and stresses, rather than exploring childhood experiences. It is based on that the idea that:

1. People learn thinking and behavioural coping patterns throughout their lives
2. Some of these patterns are ineffective

in reaching your life goals and may cause suffering

3. These patterns can be changed through learning coping skills in the therapy situation, trying out these skills in your own life and practising new coping patterns

Our self-management workbooks closely track current research evidence regarding effective CBT treatment principles. The CBT-based skills are clearly explained and taught in a step-by-step way. The workbooks include writing exercises, specific goal-setting and illustrative stories that demonstrate application of the skills.

The four workbooks are described below.

- *Antidepressant Skills Workbook* is our basic depression >>

Dan Bilsker, PhD, RPsych

Dan is a psychologist who provides consultation to the Centre for Applied Research in Mental Health and Addiction at SFU. He also works in an emergency psychiatric unit at Vancouver General Hospital. Dan oversees an ongoing project to enhance mental health care through brief behavioural interventions for mood disorders

a supported self-management scenario

Thomas, a 25-year-old man, reports to his family physician that he's been feeling fatigued and low in mood. He's also been avoiding social gatherings over the few months, since a relationship ended. The physician diagnoses a mild depression. Knowing that antidepressant medication is not recommended for mild cases due to low effectiveness in relation to side effects, the physician provides supported self-management.

In the first session, the physician briefly explains the CBT model of depression, gives Tom a copy of the Antidepressant Skills Workbook and encourages him to read the "Behavioural Activation" section. In a second session a week later, the physician helps Thomas set some initial activation goals, including scheduling a time to contact a friend he hasn't seen for a few months.

The physician and Thomas have four more sessions over the next couple of months, focused on encouragement and help with goal setting. Thomas uses the behavioural activation to re-establish connection with friends and family as well as to resume some rewarding activities he had dropped. His depression lifts.

Thomas continues to use these skills in subsequent years to manage his mood.

self-management workbook for adults.

It provides:

- information on how difficult situations, depressive thinking styles, avoidance behaviour, inactivity and other factors can make depression worse
- an overview of effective treatment for depression
- an explanation of three self-management skills that are helpful for managing depression: behavioural activation, realistic thinking and structured problem-solving (see sidebar)

footnotes

visit heretohelp.bc.ca/publications/visions for Dan's complete footnotes or contact us by phone, fax or e-mail (see page 3)

3 self-management skills



Behavioural activation

Depressed people typically become less active. They withdraw from social contacts, reduce their level of self-care activities and become less active in hobbies or other activities. It may seem to the depressed person like a way of conserving strength, but inactivation typically worsens the depressed mood and slows recovery. In behavioural activation, target activities are identified. The person is encouraged to make an activation plan that is specific, realistic and scheduled.



Realistic thinking

This skill addresses the cognitive side of depression—depressed people often think about themselves and their situation in an unrealistically negative way. This can show up as harsh and unfair self-criticism, a pessimistic approach to the current situation and unrealistically negative expectations for the future. The depressed person is shown how to identify these types of depressive thinking. Then the person is shown how to challenge these depressive thoughts and come up with a set of alternative thoughts that are fair and realistic. Fair and realistic thoughts must be practised in situations where the depressed person normally would think in a harsh and negative manner.



Structured problem-solving

Depressed people may have considerable difficulty solving problems. They tend to overestimate the severity of the problem and underestimate their personal resources. In structured problem-solving, the person starts by identifying a particular problem, one that is not too difficult. Then they write out three possible actions and the advantages or disadvantages of each. They then choose one action and make a plan. As problem-solving skills improve, more difficult problems can be addressed.

- *Antidepressant Skills @ Work* is the basic self-management workbook adapted to the challenges of dealing with mood problems in the workplace. It includes information on the effects of depression on work performance—and the impact of workplace stress on depression. It also helps with making decisions such as whether to take time off from your job.
- *Dealing With Depression* is a version of the depression self-management workbook designed for teens.
- *Positive Coping with Health Conditions* is a mood self-management workbook for people suffering from chronic illness. It teaches skills for dealing more effectively with depression, anxiety, anger and social isolation in the context of health conditions.

Each workbook is available for free download from our website at www.carmha.ca/selfcare. Printed copies are also available at a modest cost through a print-on-demand service, contacted through our website. These workbooks have been distributed to approximately 95,000 people.

Supported self-management

Supported self-management is provided by trained primary care practitioners such as family physicians or primary care nurses. They provide access to the self-management workbooks, explain the CBT approach, encourage the patient to give it a try and help the patient to set self-management goals (see sidebar).

The physician or nurse is not required to become a CBT psychotherapist, which requires considerable training and a great deal of clinical time. Instead, the health care provider acts as a coach, encouraging and assisting patients.

At CARMHA, we conducted a research trial several years ago to determine whether family physi-

cians would in fact make use of this intervention with their depressed patients. We delivered a brief and very practical training session in supported self-management to a large number of family physicians. The result was very reassuring—this group of physicians delivered the intervention to a substantial proportion of their depressed patients.⁴⁻⁵ The physicians in our study, and many others we've since trained, report this intervention to be a useful addition to their practice.

An important feature of supported self-management is that it can be carried out in brief visits. The time pressure on family physicians results in typical patient visits of 10 to 15 minutes. Introducing patients to the self-management workbook, explaining its relevance and supporting use of the skills can be done in a series of brief visits.

What's crucial is that the patient is reading and using the workbook between physician visits—in fact, most of the important learning and change occurs in the patient's life outside of the clinic.

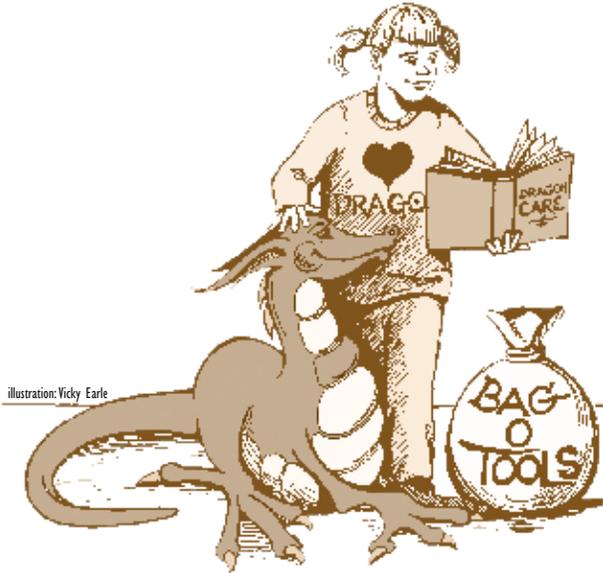
It must be kept in mind, however, that for more serious depression cases, supported self-management will not be enough. CBT for more serious cases requires referral to a CBT psychologist (or other provider well-trained in CBT). Still, supported self-management can be used along with other treatments such as medication or treatment by a CBT clinician.

Self-management and supported self-management have the potential to transform care for mild to moderate depression. Family physicians are pleased to be able to deliver CBT-based interventions to many of their depressed patients. This extends the physician's reach and improves quality of care without significant new health care resources. And patients welcome this new level of access to mental health care.

To download the workbooks, visit www.carmha.ca/selfcare. ■

Taming Worry Dragons

Helping children and youth cope with anxiety



“Wow, you have an amazing imagination! I couldn’t even have thought of that many things that could go wrong! I wonder if you could use your amazing imagination to come up with some solutions.”

– Dr. Garland, in session with a young client

Imagine: from therapist to junior knight trainer

In the early 1990s, Dr. Jane Garland imagined adapting cognitive-behavioural therapy (CBT) to better serve anxious children. CBT is known to be effective for anxiety, but it can be difficult to motivate children to practise the essential skills.

Inspired by one of her young patients, Dr. Garland developed a more playful model of CBT: training a junior knight in “taming worry dragons.” When the Mood and Anxiety Disorders Clinic was developed at BC Children’s Hospital in 1994, Dr. Garland teamed up with Dr. Sandra Clark, a child psychologist with expertise in CBT. Together, they developed these ideas into an engaging group program and training manual to help children and parents cope more effectively with anxiety.

With funding from a Children’s Hospital Foundation Telethon grant, the first Taming Worry Dragons manual was published in 1995.¹ It became very popular with both professionals and families. A children’s workbook, therapist manuals and training videos followed.

The Taming Worry Dragons program is now used

in schools and mental health programs for children throughout BC and across Canada, including at the Children’s Hospital of Eastern Ontario and London Health Sciences Centre. It includes Worry Taming for Teens, written for youth using language and analogies that appeal to this age group.² The Kid’s Guide to Taming Worry Dragons is a pocket-sized book that was developed for classroom use,³ along with a classroom manual for teachers.

Training junior knights

Taming Worry Dragons is a creative approach to CBT and psychoeducation (teaching about mental health conditions) that is designed to help anxious children learn how to cope with their worries. The approach can be adapted by therapists and parents to match the developmental level and interests of the child involved.

We start by positively reframing anxiety problems. Anxiety is presented as a combination of a “talent for creative worrying” and an “oversensitive body alarm system” that work together to magnify worry and distress.

Anxious children may instinctively avoid their difficulties—the hardest part is actually facing their fears. In the worry dragon approach, the child externalizes the problem and views anxiety as separate from him or her self. A young dragon tamer in training shares in the process of naming anxiety—worry dragon, bully, worry virus or whatever appeals to the child’s imagination.

The child teams up with their parents and therapist to gradually face fearful situations. They start with the easier ones (playing at a friend’s home with their own mother present) and build up confidence to tackle more challenging ones (the sleepover birthday party). Verbal (praise) and concrete rewards (such as a star chart or Lego pieces) for brave behaviour can help this process move along.

The imaginative model helps children commit to making changes. It’s fun, interesting and they experience a sense of success as they move forward.

Children learn imaginative tools to trap the worries that are “bossing them around.” Typical tools include trapping the worries (putting them into a worry jar or confining them to a planned worry time) or imagining that you’re pressing the stop button on the worry machine.

They also learn tools to tame the worries so that their feelings and thoughts become helpful signals rather than things that make problems bigger. >>

Noel Gregorowski, MSW

Noel is a social worker and therapist at the Mood and Anxiety Disorders Clinic at BC Children’s Hospital, where she does individual and family work with children and adolescents. Noel is involved in organizing and running the Taming Worry Dragons, as well as an interpersonal therapy group for older teens

E. Jane Garland, MD, FRCP

Dr. Garland is a Clinical Professor of Psychiatry at UBC and Clinical Head of the Mood and Anxiety Disorders Clinic at BC Children’s Hospital. She is actively engaged in research, teaching and consultation. Her focus is on psychopharmacological and cognitive-behavioural treatment of mood and anxiety disorders in young people

listening to your dragons



Ask yourself: What are my worry dragons? Make a list right now. Writing them down can even make them less scary than when they run around in your head. Think to yourself “I am afraid...” and see what comes up. Think to yourself “I am worried...” and see what comes into your mind. The more you know about these worries, the less the dragons can push you around.

Excerpted from *Taming Worry Dragons: A Manual for Children, Parents, and Other Coaches* by E. Jane Garland and Sandra Clark; illustrated by Vicky Earle.

Taming the worries requires more sophisticated tools. Taming means investigating and challenging the self-critical messages or the bad predictions of the worry thoughts, and then developing more realistic thinking.

Children begin to understand that our minds constantly come up with new thoughts, but these thoughts are not reality. They learn to be curious about their own thinking process and learn how to evaluate the worrisome thoughts that arise.

Children also learn to befriend their own body reactions. They come to appreciate how a strong physical response like a fast heartbeat, muscle tightness or fast breathing can be a useful process in the body. They learn how these responses can be helpful for a crisis situation or playing sports. But they need to be able to calm and relax their bodies as well. They learn to use breathing strategies, visualization and/or progressive muscular relaxation to help them calm down.

Children can recognize that a dragon tamer in training needs to get enough sleep, eat well, exercise

and have some fun and balance their lives. Kids also know that to face a challenge, you have to practise to build up the “coping muscles.” Popular fantasy books like the Harry Potter series or movies about the young King Arthur give children plenty of role models for the real work it takes to develop their dragon-taming skills.

Each week there are skills to practise and experiments or “detective” work to do (see example to the left).

‘Round tables’ of young knights and ‘orders’ of parents

Groups are an efficient, cost-effective way to teach children to understand and manage their anxiety, and for them to realize that they’re not alone in this problem. The controlled, encouraging peer setting can engage some of the more reluctant and socially anxious children in practising skills.

There is evidence that children with anxiety do better when their parents are supportive and can reinforce the coping skills and practice at home. Therefore, there is usually a parent group at the same time as the children’s group. This makes economic sense because parents need come to the clinic anyway to bring their children. We find that parents have often also been held hostage (i.e., are unable to go places, are afraid to have expectations for their child) by the child’s worry dragons and need encouragement to make changes to support their child.

Taming Worry Dragons groups are held at the BC Children’s Hospital outpatient clinic. They are also held in many BC communities through the children’s mental health teams and other agencies. **i**

taming worry dragons resources



Taming Worry Dragons materials are available through the C&W Bookstore:

Ambulatory Care Building, Room K2-126
Children’s and Women’s Health Centre

4480 Oak Street, Vancouver

1-800-331-1533 local 3 or

604-875-2345 local 7644

bookstore@cw.bc.ca

edreg.cw.bc.ca/BookStore/public/bookstore

Contact information for AnxietyBC and local children’s mental health teams is available through the Kelty Resource Centre

www.bcmhas.ca/keltyresourcecentre

footnotes

visit heretohelp.bc.ca/publications/visions for Noel and Jane’s complete footnotes or contact us by phone, fax or e-mail (see page 3)

Bounce Back: Reclaim Your Health

Depression and anxiety are the most common of all mental health problems. While everyone has bouts of low mood and excessive worrying, these are temporary for most of us. For others, however, the feelings don't go away on their own and formal help is needed.

Many people are reluctant to take medications for their mental health problems, but family doctors may feel they have little else to offer their patients.

One very effective treatment, however, is cognitive-behavioural therapy (CBT). CBT has been shown to be as effective as medication in the treatment of anxiety and depression.¹ Unfortunately, CBT is not readily available for doctors to access for their patients. There are long waitlists for mental health services and a limited number of mental health clinicians who specialize in CBT.

More help for more people

In 2007, the Ministry of Health Services awarded a grant to the Canadian Mental Health Association BC Division (CMHA BC) to develop CBT services to support family doctors in providing mental health care. The goal of the grant was to increase the availability of CBT. Through this funding, the Bounce Back program was developed.

The provincial launch of Bounce Back took place in the Okanagan in June 2008. The program works with health authorities and other community partners to help primary health care providers respond to the very large number of patients in need of mental health assistance. It was initially designed to support individuals living with a chronic disease or chronic pain. However,

Bounce Back is now available to all patients with mild to moderate depression and anxiety, whether or not they have a physical health condition.

The program is delivered through branch offices of the CMHA and is now offered in 17 locations around the province (see sidebar next page).



Bounce Back: what does it offer?

Bounce Back offers two forms of CBT help. Both are based on the work of Dr. Chris Williams at the University of Glasgow in Scotland.

The first is a self-help DVD titled *Living Life to the Full*. It provides clear tips and strategies to manage your mood. The 45-minute DVD was originally filmed in Scotland and has been adapted for BC. It covers a number of the most useful CBT skills that people can learn to get more enjoyment out of life. The DVD is appropriate for those who aren't ready for a more structured intervention like individual therapy.

The second is a telephone-delivered service. Bounce Back employs 20 community coaches who offer guided self-help over the phone to support people with mild to moderate depression and/or anxiety. The coaches support patients who are working through an effective, short-term mood improvement

program. Their role is to teach new skills, help patients stay motivated, answer questions and monitor patients' progress.

The program is based on the *Overcoming Depression and Low Mood series*² of structured workbooks. The workbooks provide clear information and exercises to help people alter the way they think and act in order to bring about positive changes in how they feel.

Both forms of CBT help are available at no cost to patients. The DVD is available through your family doctor's office. To access the telephone coaching program, a referral from your doctor is required.

Coaching typically involves three to five telephone sessions with a Bounce Back coach, which you can do in the comfort of your home.

Bounce Back coaches: what? who? how? when?

Research has demonstrated the benefits of guided self-help CBT interventions.³ The same research found that guided self-help programs don't need to be delivered by a psychologist—they work just as well when provided by a paraprofessional. In cases of severe mood and anxiety conditions, however, specialist care is required.

Bounce Back coaches are not mental health specialists. Coaches come from a variety of backgrounds, such as nursing, medical office assistance and social work.

The coaches attend a mandatory three-day learning session on the CBT tools before they deliver services in their local community. Training is delivered by BC-based registered psychologists with CBT expertise. >>

Kimberley McEwan, PhD, RPsych

Kimberley is a psychologist and consultant. She has provided consultation for several projects that focus on mental health and primary care. Currently, Kimberley is the Provincial Project Manager for the Canadian Mental Health Association BC Division's Bounce Back program.

After formal training, coaches have weekly telephone consultation sessions with a psychologist. This provides the coaches with clinical support regarding cases and reinforces their CBT knowledge and skill development. In addition, coaches make audio recordings of telephone sessions with clients. These recordings can be reviewed by the psychologists to ensure program quality.

footnotes
visit heretohelp.bc.ca/publications/visions for Kimberly's complete footnotes or contact us by phone, fax or e-mail (see page 3)

Bounce Back: results to date

Bounce Back has distributed over 18,000 self-help DVDs and nearly 2,000 referrals have been made to the program for telephone coaching. Program data from a provincial database shows that program participants generally experience improved mood, reduced anxiety and enhanced quality of life.

This is what would be expected through guided self-help CBT interventions. Early information from family doctors also shows that Bounce Back is considered

a valuable community mental health resource.

The success of the Bounce Back program is being evaluated by independent consultants. An effectiveness study is also planned. Results will be available in 2010.

Bounce Back provides a CBT intervention with the potential to reach a very large segment of the population troubled by depression and anxiety.

For more information, see www.bouncebackbc.ca.

Bounce Back communities

Bounce Back is being delivered through CMHA branches across BC, serving the following communities and surrounding areas:

- ↻ Cariboo/Chilcotin (Williams Lake)
- ↻ North and West Vancouver
- ↻ South Cariboo (100 Mile House)
- ↻ Cowichan Valley (Duncan)
- ↻ Port Alberni
- ↻ South Fraser
- ↻ Kamloops
- ↻ Prince George
- ↻ Vancouver/Burnaby
- ↻ Kelowna
- ↻ Richmond
- ↻ Vernon
- ↻ Kootenays
- ↻ Shuswap/Revelstoke (Salmon Arm)
- ↻ Victoria
- ↻ Mid-Island (Nanaimo)
- ↻ Simon Fraser

The first step of Bounce Back, the DVD, can be made available anywhere in BC, no matter how small the community. To find out if your community is served by the telephone coaching component of the program, call 1-866-639-0522.

Are you an immigrant or refugee with a mental health or substance use story to share?

Our Winter issue of Visions will deal with mental health and substance use issues and experiences of seniors who are immigrants and refugees and their families.

If you have a story idea, please contact us at: bcpartners@heretohelp.bc.ca or call 1-800-661-2121

 **BC Partners for
Mental Health and
Addictions Information**
c/o 1200-1111 Melville St.,
Vancouver, BC Canada V6E 3V6

