

BC's
Mental
Health
Journal

Visions

Self-Management



artist: Annie Wilkinson

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Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA: the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family, service providers and community members. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal. Please send your letter with your contact information to:

Mail: Visions Editor, CMHA BC Division
1200-1111 Melville Street
Vancouver, BC V6E 3V6

Tel: 1-800-555-8222 or (604) 688-3234

Fax: (604) 688-3236

Email: office@cmha-bc.org

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Illness management, self-care, or just self-management: all of these are terms that describe essentially the same thing. But just what is it? As you read through this issue of *Visions*, some of you may feel that the material sounds familiar, and that we're not talking about anything particularly new. Others may believe that for health conditions as daunting as mental illnesses can be, that a person can't really manage or control their illness in any significant way. Still others may worry that what self-management implies might be an excuse for governments to reduce funding (after all, if people are self-reliant, then they don't really need services — or so we may worry).

Self-management is a term that comes from other health conditions which, like mental illness, may be recurring and perhaps life-long conditions (e.g., diabetes, arthritis, asthma etc.). But the concepts of self-management are embedded in many areas of mental health care, under different names. Whether you're involved in the self-help movement, in psychosocial rehabilitation or with the field of cognitive-behavioural therapy, all of you will recognize the underlying concepts and approaches that we'll talk about in this edition of *Visions*. The value of the self-management concept, then, is not necessarily that it's new, but that it provides a unifying framework for a number of complementary ideas and a framework for harnessing them in the same direction.

What *is* the purpose, then? As the articles and the guest editorial by Dr. Dan Bilsker suggest, self-management means, first of all, having a basic level of knowledge or literacy about mental health and illness, and a degree of know-how when it comes to accessing help when a mental health problem presents itself in one's midst. Next, it involves some more advanced knowledge about the particular health condition in question, the kind of knowledge that can facilitate being able to work in partnership with a health professional to find an approach that works.

Knowledge is also a building block for the skills necessary for managing symptoms outside the mental health professional's office. The kind of skills we're talking about here include the ability to maintain a healthy lifestyle and to manage stressful situations, in order to decrease the chances of a repeat episode. While prevention is the ideal, the skills we're talking about include the ability to recognize early warning signs of relapse, and to develop a plan of action for addressing these if they do appear. As pointed out in more than one article, knowledge leads to skills, but actual self-management abilities depend on confidence and hope that these are actually possible and the belief that they *can* make a difference.

We believe that self-management *is* possible; and that it doesn't mean that a person with mental illness has to go it alone, but instead is a way for the individual to get more out of the services they use. Overall, we see self-management as a powerful framework for a number of complementary approaches that ultimately lead to the same goal: that people with mental illness can control their illness and live the kind of lives they want. We hope you agree.

Eric Macnaughton

corrections from last issue

Visions apologizes for the following oversights and inaccuracies:

- Re: the article "Psychiatric Disabilities Program" by Kathy Smith, on p. 21. We wish to add context to a quote from the noted article, which included the phrase: "people have difficulty maintaining academic standards due to their situation." Enid Weiner wishes to stress that with creative accommodations, students with mental illness *do* succeed academically.
- Re: the article "Supported Education" by Jill Newman. The sentence: "Supported education involves the integration of people with severe mental health disabilities into post-secondary education and the provision of the supports that these individuals require in order to be successful in an education environment" should have been attributed in a footnote as a direct quote from an article by Dr. Karen Unger. The author's name was also misprinted.

subscriptions and back orders

Visions subscriptions are \$25 for four issues. Back issues are available to read on our website at www.cmha-bc.org. Or call us to order hard copies at \$7 apiece. Back issue themes include:

- | | | |
|---------------------------------------|---------------------------------------|-------------------------------|
| ■ Supported Education | ■ Mood Disorders | ■ Community Inclusion |
| ■ Eating Disorders/Disordered Eating | ■ Housing | ■ What is Mental Health? |
| ■ Seniors' Mental Health | ■ Cross Cultural Mental Health | ■ Women's Mental Health |
| ■ Anxiety Disorders in Children/Youth | ■ Sexuality, Intimacy & Relationships | ■ Rehabilitation and Recovery |
| ■ Employment | ■ Poverty, Income & Unemployment | ■ Early Intervention |
| ■ Spirituality and Recovery | ■ Mental Health Accountability | |

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letter to the editor

I was very interested in reading your *Visions* journal this spring in regards to supported education. This issue has been of great concern to many of us in the Fraser Health Authority over the last few years. In an attempt to meet this identified need, our clubhouse, Friendship House, in collaboration with New Westminster School District No. 40 and Douglas College applied to the National Literacy Secretariat and HRDC and was granted an award to develop and supply a program to assist mental health clients to access existing educational services. To accomplish this, we established an advisory committee and delivered two two-hour literacy sessions weekly at Friendship House during the school year. Individualized and small group instruction was provided in Math, English, Science, Social Studies, and Learning and Life Skills. A teacher from the Columbia Square Adult Learning Centre in New Westminster provided the services in-house from November 2000 to June 2001. Of the 21 clients enrolled, many attended on a regular basis and benefited positively from the experience. The project also had a positive impact on the attitude of many of the teachers at the Learning Centre as they became aware of the challenges faced by mental health clients as students. Unfortunately, further funding was not available to continue this worthwhile endeavour and it is our hope that this emphasis can be renewed in the future.

*Jill Bloom, RN
Director of Counseling and Mental Health Services
FraserSide Community Services Society
New Westminster, BC*

Self-Management in the Mental Health Field

Dan Bilsker, PhD



Dan is a psychologist who works in the Psychiatric Assessment Unit at Vancouver Hospital and also serves as a consultant with the Mental Health Evaluation and Community Consultation Unit, a mental health services research group at UBC. His publications have been in the areas of evidence-based mental health practice and emergency psychiatry. He is the co-author of the *Self-Care Depression Program*

Self-management refers to an active engagement of the health care consumer in dealing with his or her disorder, meaning that the person with the disorder is an active participant in care, rather than someone who simply follows recommendations and complies with the treatment plan developed by a health professional. According to an organization that promotes care for chronic disorders, self-management is defined as follows:

Patients must take better care of themselves to keep their chronic illnesses under control, and need to be trained in proven methods of minimizing complications, symptoms and disability... But effective self-management means more than telling patients what to do. It means giving patients a central role in determining their care, one that fosters a sense of responsibility for their own health. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

In order for self-management of a disorder to be possible, the person needs access to appropriate information so that he or she can be sufficiently well-informed to participate actively in managing the disorder. This emphasis on access to health information contrasts with the older model in which the person relies entirely upon the health professional's understanding of the disorder. The health care consumer, including those with mental illness, needs to learn not only the ben-

efits associated with a particular treatment, but also information about potential costs including financial cost and the effort and skills that may be required in order to achieve those benefits.

Financial Costs

Costs include any financial outlay associated with this treatment, as well as the relative expense of this treatment compared to others of equivalent effectiveness. Although a significant proportion of mental health clients have the cost of medications covered by government plans, it remains true that a substantial number of individuals receiving treatment from the mental health system, especially those receiving treatment for depressive or anxiety disorders, must themselves cover all or most of their medication costs. Furthermore, most of the cost of psychotherapeutic treatments such as cognitive-behavioural therapy are covered by individuals receiving the treatment. Therefore, a frank discussion of relative costs of therapeutically-equivalent treatment alternatives is necessary for patients to be able to actively participate in management of their disorder. Rational decision-making relies on balancing the costs and benefits of a course of action.

Skills or Practices Needed to Self-Manage Disorder

Effective self-management is not merely a matter of taking in clinical facts, but of acquiring particular behaviours required to manage an illness. One can readily see this for an illness like diabetes, where the

patient must often learn how to self-administer tests of blood glucose levels. But a similar reasoning applies to mental disorders. There are skills and practices that have been shown in research to significantly enhance management of various psychological and psychiatric disorders such as relapse prevention in bipolar disorder, structured problem-solving in major depression, and relaxation training in generalized anxiety disorder.

In order for a person to be a truly active participant in the disease management process, he or she must also be informed about the rationale for a given option, which entails a clear explanation as to why this particular treatment — or, these treatment alternatives — is likely to be effective. Providing the person with a plausible explanation, even one that acknowledges gaps in our evidence-based knowledge, allows the individual to be an active participant in decision-making and gives a message of respect for this individual's capacity to make important decisions about his or her own health. The role of the health professional in this regard is to give the person reasons to actively participate in treatment, rather than merely to elicit passive compliance with a treatment regimen.

Self-Management Strategies

Self-management strategies are well developed for some mental health problems: the profusion of self-help books for depression and anxiety reflects the number of research

trials showing that self-management strategies can be very helpful for these disorders. In the area of alcohol addiction, research has shown the utility of self-management approaches for those with milder forms of alcoholism. For disorders such as schizophrenia and bipolar disorder, the development of self-management techniques are less developed, but there is an emerging recognition that individuals suffering from these severe disorders have an important role to play in management of the disorder. In particular, a promising approach is to work with affected individuals to identify strategies for recognizing the onset of relapse at an early stage and implement a plan to avert the episode or minimize its severity and impact. For example, a person suffering from bipolar disorder who realizes from warning signs that a manic episode is beginning can mobilize clinical or social support and substantially reduce the negative impact of this episode on his or her life.

Self-management is a crucial component of an approach to health care known as *chronic disease management*. This approach has become very influential over the past decade. It was initially developed to improve the care of chronic disorders such as diabetes, arthritis or asthma, disorders for which the traditional 'cure model' was inadequate. These are disorders where it is not simply a matter of making a diagnosis, applying the appropriate treatment, curing the illness and finally sending the patient on her way; instead, these chronic disorders

involve recurrent episodes of illness, often with residual symptoms between acute episodes. Chronic disorders require an ongoing management plan that includes a coordinated response by health professionals, the patient and their family.

Only in the last few years has the chronic disease management (CDM) model been applied systematically to mental disorders. The first mental disorder to be approached in CDM terms has been major depression, but it can only be a matter of time before the CDM model is applied to anxiety disorders, bipolar disorder and schizophrenia. A number of mental disorders show the characteristics typical of chronic illnesses: recurrent episodes, residual symptoms, management rather than cure, and the need for active self-management by consumers and family members. Perhaps the CDM model will eventually become the dominant framework for mental health intervention.

But mental health problems raise a particular question from a CDM/self-management perspective: *are individuals with psychiatric disorders able to participate meaningfully and effectively in self-management practices?* Can they integrate the often-complex information that is available about mental disorders, make coherent and rational decisions regarding treatment options and acquire the self-care skills needed to manage the disorder? In particular, concern has been raised that individuals with psychological or psychiatric disorders might refuse effective treatments when these treatments would benefit them because of the impact the mental disorder has on their cognitive and emotional function. Concerns of this type have motivated an increase in the availability of involuntary treatment mecha-

nisms such as compulsory community treatment (where an individual suffering from a mental disorder is required to comply with specific treatments in the community). One can argue that recourse to compulsory community treatment lies at the other end of a care continuum from self-management initiatives.

My view is that we must first acknowledge that individuals in the throes of an acute mental health crisis such as severe depression or paranoid psychosis may be incapable *at that time* of grasping relevant information or balancing the costs and benefits of treatment options; furthermore, certain individuals experience a degree of ongoing psychiatric/psychological disturbance that substantially impairs their capacity to actively participate in management of the disorder. However, one must not go too far in doubting the capacity of individuals with mental disorders to engage in self-management. Most people with mental illness, most of the time, are quite able to comprehend clearly-explained information, apply this information to making rational decisions and acquire skills needed to manage their disorders. Individuals with mental disorders have considerable and largely-untapped capacity to engage in self-management practices, to function as an integral part of the disease management process.

In order to show what self-management looks like in practice, let me describe a self-management tool for depression that has been in development for the past two years. The *Self-Care Depression Program* is a self-help manual for depressed individuals written by two psychologists (Dr. Randy Paterson and me), as a way of providing depressed individuals with knowledge of depression and

strategies to gain better control of depressive symptoms. It was developed as a project of the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia. The self-management strategies explained in this manual can be used as a sole approach by individuals with mild to moderate depressive symptoms or used in combination with evidence-based depression treatments, such as antidepressant medication or cognitive-behavioural therapy, for more seriously depressed persons. The *Self-Care Depression Program* was designed to be concise, clearly written, evidence-based, and fairly straightforward to apply in a step-by-step manner.

Besides clearly explaining the biopsychosocial model of depression, the *Self-Care Program* provides instruction in applying the skills of:

- **Activity Scheduling**
Depressed individuals typically reduce their levels of activity in the areas of self-care, social involvement, personal projects and fitness. This can be changed by learning to set action goals that are feasible, specific and gradually increased.
- **Problem-Solving**
Depressed individuals often have difficulty with effective problem-solving, tending to overestimate barriers, underestimate personal resources, and to plan action in an un-systematic way. This can be changed by learning to apply a structured problem-solving strategy.
- **Cognitive Restructuring**
Depressed individuals usually think about themselves, their current situation and their future prospects in an unrealistically negative and unfair manner. This can be changed by a method known as cognitive re-

Individuals with mental disorders have considerable and largely-untapped capacity to engage in self-management practices, to function as an integral part of the disease management process.

structuring, through which one learns to identify these distorted beliefs, challenge them systematically and replace them with more fair and realistic beliefs.

We did not want any depressed person to lack access to this self-management tool because of cost barriers, so we made the manual available free-of-charge and accessible via PDF at www.mheccu.ubc.ca/publications. Furthermore, we encourage any individual or health professional to copy this manual and distribute it as widely as possible.

I predict that someday *all* individuals with psychological or psychiatric disorders will be offered self-management training delivered through manuals or workshops. When individuals who have suffered from mental disorders and their families discover the potential benefits of active participation in care, they may come to expect self-management support from the mental health system. This kind of expectation from consumers of mental health services, combined with gradual implementation of a chronic disease management model, may well revolutionize the delivery of mental health care in this province. ■

Important Notice to *Visions*' Readers

Dear readers and supporters,

I would like to thank you for your support of *Visions: BC's Mental Health Journal*, and to let you know about some changes that we hope will make our publication even stronger than it has become over the past few years. It was back in 1997 that we started the journal as a small, four-page insert to our newsletter. With the completion of this one, we will have completed 18 issues, with an average length of 40 pages per edition. The support we have received over this time, both from our ever-expanding readership and from our contributors, has been truly amazing, and I would like to thank all the people that have helped us to keep going: subscribers, sponsors, writers, and our Editorial Board.

The journal has been a very key part of the Canadian Mental Health Association throughout BC, and we appreciate the support of the Ministry of Health Services over the last several years as the main funder of the publication. We look forward to continued support from our main funder and all of those who have kept us going in the past, as we evolve into a new format as of the next issue.

As you may recall from our the insert in the last issue of *Visions* (#17), we have formed a partnership with other provincially-funded mental health and addictions agencies to provide "accurate, standard, and timely information on mental health, mental disorders, and substance use disorders" and to provide information on "evidence-based services, supports and self-management" in a BC context.

In keeping with this mandate, and with our new partnership, the journal will be renamed *Visions: BC's Mental Health and Addictions Journal* and will be produced under the banner and logo of BC Partners for Mental Health and Addictions Information.

This reflects both a change and a continuation of the previous mandate of *Visions*. Our audience continues to comprise a wide sector of people with mental illness, their significant others, and mental health professionals from various disciplines.

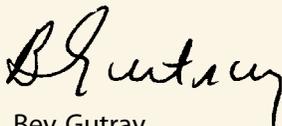
Some of the new words you'll notice in our mandate, such as *evidence-based* and *self-management*, are principles that have always been reflected in our journal. Upcoming issues will reflect a continued and stronger commitment to these concepts as well as a stronger focus on an important issue that so often goes along with mental illness: substance use problems.

In addition, *Visions* will keep you updated as to new initiatives undertaken by the partnership (as we have done on page 41 of this issue). Please feel free to contact us with any feedback you may have on future initiatives and with ideas for topics to be covered under the new journal. With the changes, the journal becomes the first publication of its kind in Canada with such a broad mandate and partnership, and we are pleased to be part of it. Most importantly, we hope you will continue to be part of it, and that you will continue to read *Visions* and pass it on to colleagues and friends.

The journal will continue to be available on our website (www.cmha-bc.org) and single issues will also be free of charge to any individual — within our mandate's target audiences — who wishes to receive a hard copy. Subscribers will be receiving a letter with their next issue as well as a commitment to reimburse the remainder of their subscription, should they now qualify for a complimentary subscription under this new mandate.

Once again, thank you for your support over the past years. I am confident that you will find the new *Visions* even more comprehensive and helpful as we move forward in this new partnership.

Sincerely,



Bev Gutray
Executive Director
Canadian Mental Health Association, BC Division

How Families Can Help in Self-Management of a Mental Disorder

Families of people with serious mental disorders can be an invaluable source of support in management of mental disorders. Many people with serious mental illness either live with their families (including parents, spouses, siblings and children) or have regular ongoing contact with their family.^{1,2}

Family members are often the first to recognize behavioural changes that accompany a mental disorder and can aid a person in getting connected with mental health services. Families of individuals diagnosed with a mental illness also often serve as informal case managers, providing and coordinating care for their relatives. Family members often see the signs of relapse and can encourage their relative to seek help early.

In order to effectively self-manage a mental disorder, consumers may need training in skills to deal with their illness, including taking medications as prescribed, dealing with community and hospital services, learning new ways to cope with symptoms such as auditory hallucinations, anxiety, etc. Skill learning may also be needed in relation to maintaining a healthy lifestyle, including good eating habits, exercise, maintaining an apartment, work, and social life. Other skills that may need to be developed include the ability to deal with emotions and the impact of the illness on their lives. Families can assist by learning what is involved in self-management as well as by learning what they can do to help the person.

The following areas have been identified as ways in which families can assist in management of mental disorders:

- 1 Learning about mental illness and services available.** Families and their ill relative can benefit from education that helps them to understand the often-confusing nature of mental illness. Education should include learning about:
 - behaviours/symptoms that create problems for the individual (and which may be frightening and bizarre to other family members)
 - why a person may not see that there is anything wrong with them
 - why the person may refuse to seek help (e.g., go to a doctor or mental health centre)
 - self-management skills that a person can use to manage their illness
 - why certain medications are used and their side-effects
 - an understanding of the reasons and implications of not taking medications as prescribed or following through with recommended treatment
 - how to determine what services are needed by their relative, what is available in their community, and how they can assist their relative in accessing these services



2 Engaging person in a treatment plan

- learning how to communicate with a person in ways that will encourage them to seek help
- alternative steps families can take (legal procedures under the BC Mental Health Act) when a person does not agree to seek help

3 Identifying warning signs or symptoms of relapse

- learning how to give feedback to their relative about symptoms/signs that indicate a possible relapse
- identifying and minimizing situations that may place too much stress on the person and increase chances of relapse

4 Managing medication

- helping their relative to develop a medication routine
- information on ways to facilitate taking of medication on a regular basis
- learning about ways to deal with side-effects
- assisting the person in working with their doctor around side-effects

5 Working with their relative to develop a crisis plan for relapse

- it is recommended that this emergency plan — also known as advance directives or Ulysses Agreements — include steps to follow when the person feels the onset of illness or episode: these might include increase in medication, contacting the family doctor (or psychiatrist) or taking time off work. The emphasis should be on developing an action plan that enables the situation to be handled as safely as possible
- the plan should also include information about current treatment, the names and contact details of health professionals and the local psychiatric facility, and a series of steps to follow. It should also note the individuals who comprise the person's support network and the role that each should play in the event of a crisis

Nicole Chovil, PhD

Nicole is Director of Programs and Support Services for the British Columbia Schizophrenia Society. She is also Project Manager for the Canadian Family Education Program, a new education program being developed by the Schizophrenia Society of Canada. Nicole is happy to report that her brother, Ian, is successfully managing his schizophrenia.

footnotes

- 1 Clark, R.E. (1996). "Family support for persons with dual disorders." In R.E. Drake & K.T. Mueser (Eds.), *Dual diagnosis of major mental illness and substance abuse: Volume 2 – Recent research and clinical implications.* (pp. 65-78). San Francisco: Jossey-Bass.
- 2 Goldman, H.H. (1984). "The chronically mentally ill: Who are they? Where are they?" In M. Mirabi (Ed.), *The chronically mentally ill: Research and services.* (pp. 33-44). Spectrum Publications.

- the plan should also identify who will take care of financial and other aspects of the person's life should they need to be hospitalized or be unable to care for themselves

6 Helping to foster a lifestyle conducive to recovery and maintenance of good mental health

- providing social support to relative
- encouraging independence
- encouraging engagement in exercise, social activities, work, school, etc.

Mental illness is much like many other illnesses: with proper medical care, management and strong support, people can recover. Families can play a valuable role in supporting persons with mental illness. ■

related resources for families

- Illness self-management strategies** – Corrigan, P.W. (2002). Behavioral Health Recovery Management Project. Illinois. www.bhrm.org/guidelines/illness-self-mgmt.pdf
- Family services for severe mental illness** – Mueser, K.T. (2003). Behavioral Health Recovery Management Project. Illinois. www.bhrm.org/guidelines/Family%20Services.pdf
- Evidence-based practices: A primer** – New York State Office of Mental Health. (2001). www.omh.state.ny.us/omhweb/omhq/q0901/Primer.html
- Expert consensus treatment guidelines for schizophrenia: A guide for patients and families** – (1999). *Journal of Clinical Psychology*, 60(suppl 11). www.psychguides.com/gl-treatment_of_schizophrenia_1999.html
- Dealing with cognitive dysfunction associated with psychiatric disabilities: A handbook for families and friends of individuals with psychiatric disorders** – Medalia, A. & Revheim, N. (2002). New York State Office of Mental Health. www.omh.state.ny.us/omhweb/cogdys_manual/CogDysHndbk.htm
- How to manage 5 common symptoms of schizophrenia** – Jaffe, D.J. Abbreviated version of article by P. Weiden & L. Havens that appeared in May 1995 issue of *Hospital and Community Psychiatry*. www.schizophrenia.com/family/managesymptoms.html
- Psychosocial management of noncompliance** – Weiden P. (1997). *Journal of Practical Psychiatry and Behavioral Health*, 3, 169-186. www.ls.net/~fred/weiden/weiden-1997-05-ho.pdf

Health Literacy and Management of Chronic Health Conditions

An issue related to self-management of chronic health conditions, whatever their nature, is *literacy*, or *health literacy*.

Irving Rootman

Irving is Professor and Michael Smith Foundation for Health Research Distinguished Scholar at the University of Victoria

This article will attempt to describe this relationship and consider its implications for people who are coping with chronic diseases as well as those who are trying to help them help themselves. But first, what do we mean by *literacy* and *health literacy*? Unfortunately, there are many definitions of both concepts, none of which enjoy universal acceptance. However, the definition of *literacy* that is closest to being universally accepted is the one that is used in the International Adult Literacy Survey which defines it as the “ability to understand and employ printed information in daily activities — at home, at work and in the community — to achieve one’s goals and develop one’s knowledge and potential.”¹ This implies that literacy has to do with how one is able to function in the world and seems to be re-

stricted to understanding and using the written word. Others however, suggest that it goes beyond the written word to include the ability to speak meaningfully and understand oral communications. With regard to *health literacy*, a definition that is gaining increasing international credibility is the following one included in the World Health Organization Glossary on Health Promotion which defines it as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health.”² In this case, the sets of skills are wider than those suggested in the definition of literacy and are related to the context of health, broadly defined. There is however some debate over whether or not health literacy is a distinct type of literacy with its own skills or whether it is simply literacy within the health context. I

personally take the view that there are some unique skills associated with the health context (such as the ability to interpret health concepts and to navigate the health care system) that go beyond the basic literacy skills which are needed as well. In any case, it is clear that at the present time at least, health literacy is an increasingly-used concept and one that applies to self-management of chronic health conditions. Kate Lorig, a well-known researcher in the field of self-management, suggests that “illness self-management involves three separate components: basic illness management, emotion management, and role management.”³ But how does this relate to literacy or to health literacy? With regard to *basic illness management*, it is especially clear that it is related to both, but particularly health literacy given that it means “understanding the illness and various strategies of managing symptoms and stressors.”³ That is, it is obvious that

it is difficult, if not impossible, to understand a complex illness and strategies for addressing it without having basic reading, writing and oral communication skills as well as more advanced skills to interpret medical concepts and information. With regard to *emotion management* which involves “coming to terms with the diagnosis, adjusting life expectations in healthy ways, and in the case of mental illness, addressing stigma issues,”³ the relationship with literacy and health literacy is less clear. However, it strikes me that having basic literacy skills as well as health literacy skills is helpful in obtaining information and support needed to manage or cope with the emotional aspects of the illness. Finally, in relation to *role management* which means “developing the ability to function effectively in valued social roles,”³ we know that basic literacy is fundamental to being able to play critical social roles such as student or worker

and health literacy is important in playing such roles within the health care context where many people work. Thus, there is no doubt in my mind that literacy and health literacy are important foundations for self-management of chronic health conditions. Moreover, there is growing evidence that promoting health literacy is an effective strategy for improving self-management in health⁴ and that limited health literacy impedes appropriate self-management for chronic disease.⁵ An implication of this for people

with chronic health conditions is that they need to try to improve their literacy and health literacy skills at the same time as, or before they become involved in, self-management programs. An implication for practitioners is that they need to be aware of the literacy requirement of self-management programs and encourage their clients to upgrade their literacy and health literacy skills. For those of you who are interested in learning more about literacy and health literacy, I suggest that you check out the website

for the National Literacy and Health Program coordinated by the Canadian Public Health Association⁶ as well as links from that site. If you would like to become more involved in these issues in British Columbia, I suggest you contact the Health Literacy Network of BC.⁷ In addition, if you are interested in research on the topic, you may wish to join the Literacy and Health Research Network which is currently under development.⁸ ■

footnotes

- 1 Statistics Canada. (1997). *International adult literacy survey, reading the future: A portrait of literacy in Canada*. Ottawa: Special Survey Division, Cat. 89F0093XIE.
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- 5 Williams, M.V., Baker, D.W., Parker, R.M. & Nurss, J.R. (1998). "Relationship of functional health literacy to patients' knowledge of their chronic disease." *Archives of Internal Medicine*, 158(2), 166-72.
- 6 www.nlhp.cpha.ca
- 7 www.nald.ca/PROVINCE/QUE/litcent/health/finalsum/bd/bd14.html
- 8 A website is currently being developed. In the meantime, you could contact the author irootman@uvic.ca.

Self-Efficacy and the Chronic Disease Self-Management Program



The Chronic Disease Self-Management Program (CDSMP) is a layperson-led patient education program delivered to groups of 10–12 once a week for two-and-a-half hours for six consecutive weeks. The leaders, who have chronic health conditions themselves, complete a four-day training workshop where they learn how to deliver the program. People who take the CDSMP learn new information but most importantly, they learn from each other. People learn new skills and have opportunities to practice new skills, namely:

- ways of getting started with important behaviours such as exercise and healthy eating (people usually know what they are supposed to do but it is difficult getting started and maintaining these behaviours)
- how to problem-solve (people with chronic health problems are continually faced with problems)
- how to communicate effectively with family, friends and health care professionals
- how to effectively work with health care professionals
- how to deal with the anger, fear and frustration that commonly accompany having a chronic health condition
- how to deal with depression
- how to deal with fatigue
- how to evaluate treatment options (media, friends and family members are constantly suggesting new medicines or treatments to try)

The skills taught in the CDSMP are very helpful for persons living with chronic health conditions, but in the CDSMP, people also increase their confidence in being able to manage their health condition. This confidence is referred to as *self-efficacy*—a concept first described by psychologist Albert Bandura in 1977.¹

In his 1986 landmark publication entitled *Social foundations of thought and action: A social cognitive theory*, he defines self-efficacy as:

self-ef-fi-ca-cy \ˈself-ˈe-fi-kə-sē\ n.

“People’s judgement of their capabilities to organize and execute courses of action required to attain designated types of performance. It is concerned not with the skills one has but with judgements of what one can do with whatever skill one possesses.”²

Patrick McGowan, PhD
Patrick is Program Coordinator for the Chronic Disease Self-Management Program in BC. He is also Research Affiliate with the University of Victoria's Centre on Aging.

In other words, self-efficacy depends on the way we *think* about our abilities to perform some activity — in this case, in relation to managing an ongoing health condition — not on the abilities themselves. As Bandura goes on to suggest, this means that “people tend to avoid tasks and situations they believe exceed their capabilities, but . . . undertake and perform assuredly activities they judge themselves capable of handling.” He maintains that a powerful way of improving an individual’s confidence in relation to performing a certain skill or behaviour (e.g. a coping skill) is to observe a successful performance of it carried out by someone else who appears to be similar. As was discussed earlier, this phenomenon — learning and gaining confidence from others — is a major strength of the group or social aspect of the CDSMP.

Research has shown that there is a strong association between health outcomes and how one perceives his or her self-efficacy to perform a specific activity. For example, if someone experiences severe back pain in the evening, by just knowing strategies he or she could use to reduce the pain somehow reduces the pain experienced. People’s belief in their personal efficacy is a central mechanism mediating the effects of psychosocial influence. Unless people believe they can produce desired effects by their actions, they have little incentive to act.

The Chronic Disease Self-management Program uses four different strategies to increase people’s level of self-efficacy. It provides mastery experiences that help participants gain a sense of control over their health-related functioning through enhanced self-efficacy. As explained below, these include guided mastery experiences, acquisition of skills and enhancement of self-confidence through peer modeling, reinterpretation of physiological symptoms, and social persuasion.

Skills Mastery

An important strategy used to enhance self-efficacy is *skills mastery*. In the CDSMP, participants think of a goal they would like to achieve in three to six months and then think of small, achievable steps they can take toward that goal. Each week, they are asked to form an *action plan* to try a behaviour that leads to attaining their goal. Subsequent CDSMP sessions include time for feedback on achieving their action plan and a discussion of problems.

Peer Modeling

Course leaders have chronic health conditions themselves, which enhances assumed similarity between participants and leaders. Assumed similarity enhances the impact of modeling. The program offers structured opportunities for participants to support each other with problem-solving. Thus, participants model for each other and by serving as self-models, enhance their self-efficacy. Finally, program members check in with each other between the sessions to see how each is progressing with his or her individual self-management plan.

Reinterpreting Symptoms

A person’s adaptations to disease are influenced by his or her beliefs about the illness and its symptoms. For example, if a person who experiences fatigue believes this to be a symptom of the disease process, the individual will rest. If it is explained that

fatigue can also be due to de-conditioning, poor nutrition, stress or depression, participants have a rationale for trying new behaviours to manage fatigue. As each symptom or problem is discussed, the multiple possible causes are identified and a set of management techniques suggested. This allows participants to choose techniques that fit within their cultural belief system. For example, participants who have never exercised or who work at physically demanding jobs may not accept the idea of exercising to help control their disease. However, if exercise is linked to dancing, for instance, it becomes fun and more easily adopted.

Social Persuasion

In each community, family and community relations are very important. These social supports are incorporated in the program by having family members and friends attend and assist participants in their new self-management activities. Another form of persuasion comes from peer leaders encouraging participants to do more than they are doing now. For example, if participants are walking fewer than three times a week, the leader might suggest walking one more time each week or a little farther each time. These examples not only help to guide the participants, but also support them as they begin making lifestyle changes.

Findings from diverse lines of research reveal that perceived self-efficacy affects every phase of health behaviour change: whether people even consider changing their health behaviours, how much they benefit from treatment programs, how well they maintain the changes they have achieved, and their vulnerability to relapse.^{3,4,5}

As discussed throughout this article, evidence exists that self-efficacy is a key factor that mediates the effects of psychosocial programs (such as the CDSMP) on the health status of individuals, including those with chronic health conditions.^{6,7} The structure and activities of the CDSM program is designed with this knowledge in mind, and with the recognition that people’s ability to manage their health depends not only on their relevant skills, but most importantly on their confidence in their abilities to carry out those skills. ❏

footnotes

- 1 Bandura, A. (1977). “Self-efficacy: Toward a unifying theory of behavior change.” *Psychological review*, 84(2), 191-215.
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- 3 Schwarzer, R. (1992). “Self-efficacy in the adoption and maintenance of health behavior: Theoretical approaches and a new model.” In R. Schwarzer (Ed.), *Self-efficacy: Thought, control and action*. (pp. 217-243). Washington: Hemisphere.
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- 6 O’Leary, A. (1985). “Self-efficacy and health.” *Behavioral Research and Theory*, 23(4), 437-451.
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Mind vs. Matter

Perception and Recovery

Life is not easy and it can demand our complete attention, but the ability to navigate life's daily difficulties relies on perceptions; perceptions dictate action. Humans have the distinct ability to endure hardships for the sake of future reward in a way other members of the animal kingdom do not. This allows us to design bridges, plan surprise parties, and tie our shoelaces. Perceptions are powerful, and the power of human perception is unprecedented. Our perceptions have allowed us to reshape the world through science, literature, and art, allowing us to successfully execute what we imagine. Imagining how a building will look is not enough; we must also be able to perceive how best to construct it.

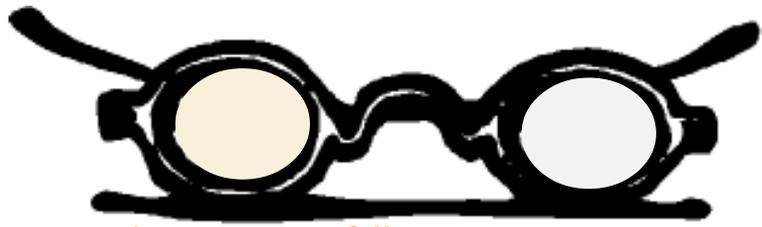
Perception also has a means of acting on our health in a way that is not completely understood by science, but we can gain some insights by describing two phenomena: the placebo effect, and the relationship between perception and endurance.

The *placebo* effect enables an illness treatment that would otherwise have no medical value whatsoever to affect recovery or alleviation of symptoms. If a patient is given a treatment with no medical value and believes that it will work, it sometimes will. This belief can be supplied by cultural beliefs, personal beliefs, religion, or even through trust in the person who administers this treatment. It is so remarkable a phenomenon that research studies evaluating the efficacy of different treatments must go

through elaborate controls to ensure that positive results are not in fact the same improvements that could have been noted had subjects been given an inert placebo treatment rather than an active treatment.

Perception also enables people to endure discomfort to a greater extent if they are led to believe that this discomfort is temporary. Breznitz¹ investigated this phenomenon by asking subjects to keep their hands in ice-cold water, a painful prospect. The experimenter told one group that the test would last four minutes, but did not give the information about a time limit to the other group, even though the test was to last four minutes for both. It turned out that participants in the second group were 50% less likely to keep their hands in the water for the full four minutes than the group that had been told the test would last four minutes. The group who had been told about the timeframe were better able to withstand the discomfort, since they saw a limit to it.

This effect was first noted during the Second World War, when flight crews on missions over Germany were noted to be suffering from stress-related illnesses. Almost daily they would fly into danger and suffer terrible casualties; their morale was understandably low. A team of psychologists was then consulted, and the problem of stress-related illnesses was reduced through their advice. It was their opinion that crew members could perceive no end to their ordeal and this was feeding their stress; so the psychologists suggested changing this



The success of illness management strategies for mental illness can be said to hinge on perception, in the sense that their success requires the belief that one will in fact succeed.

perception by specifying a definite limit to the number of missions each crew member had to fly. Each crew member was then informed that their tour of duty would end after forty missions. The incidence of illness declined.

In both cases, illness-related phenomena (pain, stress-related illness) were shown to be influenced by psychological processes, and in both of these cases, the primary active agent could be loosely defined as hope.

The success of illness management strategies for mental illness can be said to hinge on perception, in the sense that their success requires the belief that one will in fact succeed. Success also hinges on a vision of the self having an active role in recovery. Exercising perceptual power in this fashion can put mind over matter. The only problem is, of course, perception itself.

With the onset of mental illness, the world no longer seems the same as it did before illness. This can undermine mental health consumers' ability to interact with the world and achieve goals, large or small. If, for example, someone who is depressed perceives a grumpy cashier's manner as personal

dislike, this can further fuel symptoms of depression; by contrast, someone without depression is better able to excuse and/or ignore the cashier's manner.

Hope for recovery is hard when faced with long-term illness. Upon diagnosis, consumers are often told that their illnesses are likely to be life-long, and therefore they must struggle with a sense of very-real-yet-invisible boundaries. This concept of internal barriers is such an abstract and implacable concept that often consumers can feel defeated by it. Therefore, people with mental illness cannot perceive any eventual improvement, or generate the motivational energy necessary to embark on a strategy for managing the illness.

It is in human nature to hope. One can be persuaded to hope by any number of means, either by oneself or through friends, family, observation or caregivers. One psychologist, Nicholas Humphrey, claims that this hope can come from three different means of persuasion: *personal experience* (observing something yourself), *rational argument* (relying on logical argument), and *external authority* (the influence of a respected authority figure).²

Coralie McCormick

Coralie is Employment Database Administrator and Insurance Project Research Assistant at CMHA BC Division

footnotes

¹ Breznitz, S. (1999). "The effect of hope on pain tolerance." *Social Research*, 66, 629-652.

² Humphrey, N. (2000). *How to solve the mind-body problem*. Charlottesville: Imprint Academic.

Everything that is done in the world is done by hope.

—Dr. Martin Luther King Jr.

Any one or combination of these factors can enhance (not guarantee) the success of an illness management strategy. Perhaps observing the recovery of someone with a similar diagnosis on a documentary can aid someone in envisioning recovery. Perhaps a therapist or psy-

chiatrist can fuel this hope by describing the likelihood of success of a treatment regimen. Believing in the logic of a well-researched illness management strategy can also work.

Building belief takes work and maintaining that belief in spite of inevitable setbacks can

be crucial to learning to live with illness. Successfully changing perceptions — changing the way you look at yourself and the world — can be pivotal to the success of illness management and recovery. ■

Self-Management and Addictions

Lisa Dive
PhD (candidate)

Lisa is Marketing Assistant for the Kaiser Foundation, a BC addictions charity

An increasing body of literature supports treating addiction as a chronic relapsing disease, a move which is paralleled by similar shifts in our understanding of several mental disorders. Self-management is recognized as providing an appropriate framework for the treatment of a wide range of chronic illnesses. It encourages individuals to take responsibility for their own recovery and to utilize available resources effectively to achieve healthier lives.

There are many parallels between addictions and conditions where self-management approaches have been effective, such as adult onset diabetes, asthma and hypertension:¹

- multiple factors contribute to the onset of the disorder: genetic, biological, behavioural and environmental
- behavioural choices play a part in both the onset and severity of the disorder, regardless of whether a biological or genetic predisposition exists
- rates of successful treatment are similar across all disorders (as with other chronic diseases, the success of addictions treatments is measured in terms of improvement rather than complete recovery)
- rates of compliance with pharmacological or behavioural treatment regimes are comparable across all disorders
- factors such as low socio-economic status, comorbid psychiatric conditions, and lack of family or social supports are most commonly associated with lack of treatment compliance and relapse after treatment for all disorders.

In treating a chronic disease, supporting the person's self-management ability is an important factor, and involves a number of aspects. The person must be informed about their condition, and they must learn strategies for improving their health and avoiding a relapse. Often there is a treatment regime that must be followed, and the patient must understand the importance of maintaining it. These principles can be applied to addictions, to various mental disorders, and to other chronic diseases.

For instance, an asthma sufferer must take daily preventative medications, exercise regularly, ensure they always have emergency inhalers with them, and avoid aggravating situations (such as dusty environments or a park in springtime). Similarly, a recovering addict must comply with a treatment regime, such as regular counselling, daily methadone doses, or nicotine patches. Improving other areas of their lives, for instance, spending time

with family and exercising regularly, are also valuable in the course of recovery. Like the person with asthma, and like an individual with diabetes who must avoid sugary foods, recovering addicts may also need to avoid potential aggravating situations, such as friends they used with or situations that may make them want to use again. In each of these examples, self-management allows individuals with a chronic relapsing condition to take an active role in their recovery.

Applying self-management principles to problem substance use has the added benefit that it fits with a harm reduction approach. This philosophy recognizes the value of achieving improved overall health, reduced use, a stabilized living situation, an improved employment situation, and other gains that work towards the individual's stabilization and reintegration into society.

Self-management allows and encourages individuals to participate in setting their own goals and determining the type of intervention that is likely to be helpful for them. A variety of goals are supported under this approach, which is an advantage since the same goals may not be appropriate for everyone. For instance, one problem drinker may adopt strategies to limit their use to within-moderate drinking guidelines, while another may find that abstinence is their preferred goal.

The question of competence or capability is an important consideration when applying self-management principles to addictions treatment. An addicted individual's competence varies over time; it is not constant. There are a range of factors that can constrain the choices available to an individual at a given time.² Examples of such constraining factors include:

- poverty
- past or present abuse
- lack of a supportive home environment
- undesirable peer or social influences
- unemployment
- physical or psychological cravings
- psychiatric problems

The more such factors are present, the more difficult (although not impossible) it may be for the individual to make healthier choices.

When an individual's ability to choose is constrained by circumstances such as these, self-management can be more challenging. If there are too many constraints limiting the choices

footnotes

1 McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). "Drug dependence: A chronic medical illness." *Journal of the American Medical Association*, 284, 1689-1695.

2 Committee on Addictions of the Group for the Advancement of Psychiatry. (2002). "Responsibility and choice in addiction." *Psychiatric Services*, 53(6), 707-713.

3 Apodaca, T.R. & Miller, W.R. (2003). "A meta-analysis of the effectiveness of bibliotherapy for alcohol problems." *Journal of Clinical Psychology*, 59(3), 289-304.

available to the individual, a great deal of support will be required. In some situations, for example, when a person is overdosing, they may be incapable of any action and require professional intervention. However, if all interventions are informed by a self-management approach, they can work with the aim of supporting the person into a more empowered position and improving their ability to make healthy choices.

There is evidence that specific self-management techniques are valid and effective in addressing the problem of addictions. A recent study found that providing people with self-help materials in a written format was as effective as more intensive counselling in reducing at-risk and harmful drinking among problem drinkers who self-referred, as opposed to those who were re-

ferred to treatment by others.³

While this particular intervention is only one among many self-management techniques, this finding reinforces the idea that self-management approaches, in general, may be a cost-effective way of addressing substance use problems. While extensive research has not yet been undertaken into the effectiveness of such techniques for addictions of varying type and severity, it appears a promising route to pursue. After all, many people with substance use problems have been successfully self-managing to a more healthy state. Nevertheless, there is a need for both the development of a range of self-management tools for addictions and for broad evaluations of their efficacy. ■

Caring for Self and Others

Consumer Board and Committee Participation

Consumer representation and participation on boards and committees has been an important step in improving the mental health system. A research study aimed at understanding consumers' experiences on boards and committees highlighted important issues in relation to self-care and participation. The study included consumers who were active members of boards and committees in the mental health field in British Columbia for at least a one-year period. The consumers became involved with boards and committees due to a desire to make the

mental health system better for other consumers. One person said, "If I can help one person to keep from experiencing what I experience, it makes it all worth it." Overall, board and committee membership posed a number of challenges and benefits in relation to self-care.

Consumers stated the main reason they were asked to participate on boards and committees was to use their first-hand knowledge of the mental health system to inform policy and practice. Consequently, in meetings they would sometimes share personal experienc-

es, which could be painful and distressing. The consumers were strongly attached to their views of the mental health system but these views were not always recognized or validated by other committee members. Consultation did not mean agreement, which was stressful given the personal investment of the consumers.

The majority of consumers interviewed reported a high degree of stress and frustration due to relationships with other board members and the board process in general. One consumer said, "It takes a lot of energy, a lot of analytical sort of energy to be doing board work, and a lot of political sort of things ... It's really an unusual kind of stress." Some consumers reported feeling burned out, that they were mentally and emotionally exhausted because they were spread too thin due to a shortage of consumers who were willing to participate on boards and committees. At times, they felt disempowered, isolated, and responsible for speaking on behalf of all consumers. This responsibility increased the pressure they felt to perform: "I just think it feels

more uncomfortable when you're a consumer because you feel the weight of all these people who need help, who need assistance like that. I don't want to act as some kind of interpreter."

Sometimes consumers were intimidated given the power differential they experienced with non-consumers on their board or committee. "It's not only not equal, it's slanted and it's threatening and very ominous at one end, and that's the end the consumers are playing at." Differences in power often translated into differences in recognition and status. Furthermore, membership on boards and committees sometimes placed the consumer in a conflict of interest in relation to his or her own mental health care. They were sometimes in the position of receiving services from the agency of which they were a board member, forcing them to make alternative arrangements for their mental health care.

Despite a number of challenges posed to self-care, the consumers stated board and committee membership also brought numerous benefits.

Deborah MacNamara

Deborah is a counsellor at Kwantlen University College and assists students with career, academic, and personal issues. She is currently completing a doctorate in Interdisciplinary Studies at the University of British Columbia



The Challenge to Manage

Nan Dickie

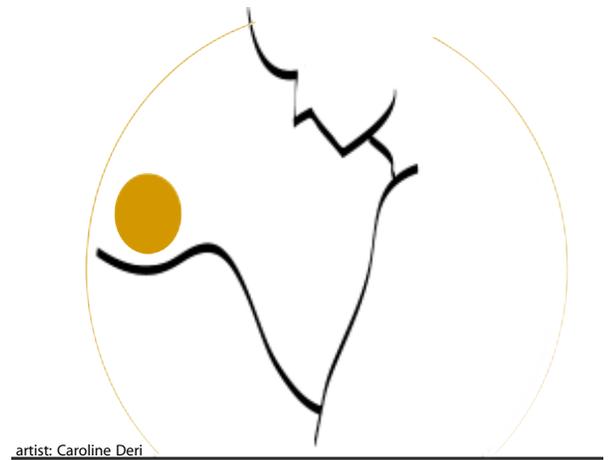
Nan is author of *A Map for the journey: Living meaningfully with recurring depression*. You may purchase her book by emailing her at nan-dickie@shaw.ca. Nan is offering a course "Not Just the Blues: Managing Major Depression" through North Shore Continuing Education on Thursday, November 13, 2003. Phone (604) 903-3333; Course number: HE 79-1.

As a person with a 40-year history of recurring depression (unipolar mood disorder), I am encouraged by the new language and strategies that have recently entered the realm of treatment for people with mental illness.

For many years, the term *self-help* has been used to describe various ways by which people with mental illnesses can best contend with the symptoms of mental illness. Numerous self-help books (of varying applicability) line bookstore shelves; a growing number of useful self-help groups exist.

Today, we talk about illness self-management. This term challenges one to be even more responsible for his or her life. Self-help, though a proactive term, seems to imply coping with, dealing with, or living with an illness. Self-management, on the other hand, as used today, goes one step further; it requires that people with mental illnesses be responsible, not simply to help themselves, but to:

- learn everything they can about their illness, its usual and abnormal symptoms, and the wide range of traditional and alternative treatments



artist: Caroline Deri

- with this knowledge, devise a personalized, comprehensive and well-thought-out action plan for their entire life of repeating mood cycles
- when possible, employ applicable self-management strategies and/or self-help strategies
- find the necessary outside resources (personal and professional) to truly manage the illness throughout their lives, and use these resources effectively and optimally.

Caring for Self and Others (cont'd from prev. page)

Through their board or committee, consumers often learned of mental health services and resources that could benefit them directly. They also developed friendships, felt empowered, experienced greater self-esteem and confidence, which all served to enhance one's self-care. One consumer said participating on boards and committees, "changed my attitude, my whole self concept, this board...I was always ashamed of my disease, very ashamed and kind of paranoid, almost to the point of hysteria ... of people finding out that I was a mental patient."

Good self-care according to consumers meant finding a balance between taking care of themselves and their responsibilities as board and committee members. Having a strong support network of friends and family helped them cope with the stress and pressure. In order to survive mentally and emotionally, some of the con-

sumers changed the expectations they had of themselves in relation to their board and committee work. One person said, "certainly since I've started, my definition of what could be accomplished has changed you know, I feel that I had to really change my expectations to survive ... because, or else I would have just exploded with frustration I think."

Like any job, board and committee membership requires attention to self-care and managing one's stress and workload. The irony of board and committee membership is that in the process of trying to take care of other consumers and make a difference, consumers face increased challenges to their own self-care. Given the importance of consumer participation on boards and committees there is merit for consumers and non-consumers to consider how to better support participants with these challenges. ■

Everyone can, and sometimes ought to, be challenged beyond their present capabilities. That is a requisite for growth. When people with mental illness accept the term self-management, chances are that they will strive, and sometimes — hopefully often — succeed in going beyond what they had previously been able to do, and perhaps even beyond what was thought to be possible.

Self-management strategies must not be onerous or complex, for if they are, one may well face failure, something people with mental illnesses are too familiar with already. Nor should self-management be assumed to necessarily ease symptoms of an episode, or hasten recovery from it. Wise self-management strategies may do so, but there is no guarantee. However, when one employs self-management strategies on an ongoing basis, one may discover, over time, that the quality of life during all phases of a cycle may be enhanced.

For self-management to work, strategies must be realistic, and customized for each person, as no two people experience episodes in exactly the same way, with identical symptoms, nor to the same degree of severity.

Often the most one can do on the descent into an episode, and during an episode, is to employ self-help techniques which have worked in the past, as well as some they may have learned about since their last episode. For instance, during a particularly dreadful episode of depression, a person's self-help may be limited by the grip of the symptoms, to ensuring personal safety and eating

properly. This being the case, it is best to establish, implement, reinforce, and if necessary, revise self-management strategies during remission (that is, good mental health), and during the long road to recovery when one regains self-confidence, a self-concept beyond the illness, and a sense of hope and optimism.

A question facing a person with mental illness is: what strategies beyond those of self-help can I employ to manage my episodes, and the rest of my life with the mental illness? Here are a few suggestions:

Make Informed Decisions About Treatment

- Discuss all medications with your doctor or psychiatrist, and perhaps as well, your pharmacist. What are the intended effects and likely side-effects of a medication, or combination of medications? You may choose to examine alternatives to conventional medications
- What other treatments are available other than medication? What types of therapy are available? Would it be wise for you to pursue one of them?

Educate Yourself

- Find out the causes of your illness: exactly what is happening in your body when you enter and recover from an epi-

sode? Might there be a genetic component to your illness?

- Seek out courses or workshops offered on coping with and managing mental illness
- Determine aspects of your illness that are different than those of other people and seek ways of dealing with them. Consider joining a self-help group, a safe environment in which to explore a wide range of mental health and illness issues

Plan for the Future

- Make wise career or education choices, taking into account that you may have episodes of your mental illness for your whole working life
- Plan strategies for managing future episodes, based on what works best for you now
- Tell supporters (family, friends, colleagues) how they may contribute to your illness management program during each phase of your mood cycle

By implementing and practicing illness self-management strategies during every phase of our mood cycles, we who have mood disorders (or other mental illnesses) can lead productive, challenging and meaningful lives. ■

Limitations and Complexities of my Self-Management



I recently learned that my mental disorder (unipolar depression) will be a life-long battle. It was hard to hear, after seven years on medications and still in my mid-20s, that the reason the weaning-off process never seemed to work well for me was because I probably needed to be on meds for life. Of course, over the course of these past seven years — and the relapses and setbacks and successes along the way — I have learned a whole host of techniques and skills, and pursued various alternatives that help keep me well: from relationships with doctors, to going through counseling, to making lifestyle changes and nurturing social supports. These skills and processes for participating in my own recovery are what academics and others now call self-management. I call it ‘taking care of myself.’

Still, I sometimes feel the whole concept of self-management isn’t great for self-blaming perfectionists like me. I know it isn’t trying to suggest I can ‘fix’ my condition myself, but I do know a lot of things that can help. And that help can feel awfully powerful sometimes. But there are a few barriers that I, and many others I imagine, inevitably come across:

- 1 Although taking some control away from this beast of a disorder inside me has been very therapeutic, not everything about my condition is within my direct control (if it were, it’s probably a sign of a transient depressed mood, not the illness of depression). So I can be maintaining a healthy lifestyle, and taking my meds faithfully and I can still crash and not prevent it. This happened recently, and it can be really hard to cope with because I feel I have failed somehow. I start to think, “well, self-management has helped prevent relapse before, why not this time? is there something I could have done? forgot to do?” After all, using self-management principles, I’ve been able to cut down my setbacks to twice a year; when I ignore those principles, I can easily have symptoms return half a dozen times a year. So self-management can be powerful medicine, but it’s not a cure-all; it has its limitations. And that’s hard to remember sometimes because it has been so helpful to me.

Sarah Hamid-Balma

Sarah is Visions’
Production Editor and
Public Education and
Communications
Coordinator at CMHA
BC Division

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EMAIL: CM@feinet.com
FAX: 414-359-1978

2 The principles of self-management are often the hardest things to bring myself to do when I'm even slightly low. When I'm depressed, I feel like brooding, oversleeping and eating all the wrong foods — even though I know better! But I'm not alone here. Think about it: most North Americans *know* that exercising or eating lots of fruits and vegetables is good for you, but plenty of folks still sit on the couch eating potato chips. My point is that *knowing* is one thing; *doing* is quite another. There are a lot of health-promotion principles, mental illness self-management included, that make sense, sound good, feel good, and we know them intellectually to be true. But it takes something else altogether to make them resonate emotionally — and that's where true behavioural change and motivation come from. As a counselor of mine once told me, "The trip from the head to the heart is the longest seventeen inches in the world." Long indeed.

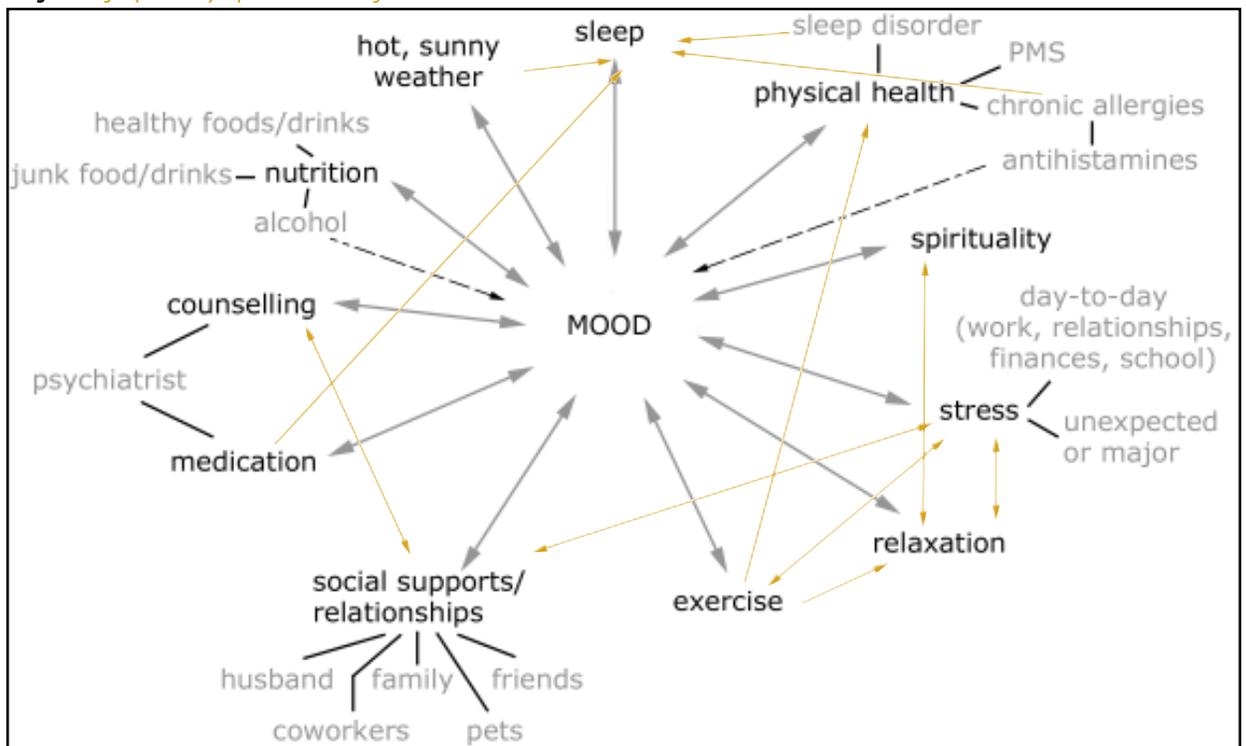
3 Having any co-occurring conditions can make self-management that much more difficult. So imagine what happens in these two common scenarios for me:

a I have a disabling sleep disorder that is unrelated to my depressive illness. As a result of the sleep disorder that leaves me unrefreshed upon waking, I have a tendency to feel sleepy and lethargic a lot. That sleepy feeling I carry with me all day is frustrating and often depressing. It even feels like depression, which it isn't, which, in turn, makes it harder to fight off any real symptoms of depression that do ever return.

b I have chronic allergies to a whole slew of environmental allergens, and although I get two weekly allergy shots, symptoms are still a real bother. However, I can't take antihistamines to relieve them, because they always interact with my antidepressants and trigger a depressive episode. The ear-nose-throat congestion that goes unrelieved then bothers me during my sleep making my sleep disorder worse (see a above!) and the cycle continues. The figure below should further shed light on the complexities of self-management in my world.

Anyway, you probably get the idea. Self-management doesn't happen in a vacuum. You can control only certain variables and have to take the rest as they come. ■

▼ figure 1 a glimpse into my depression self-management world



Everyone can draw a map like this, whether you have a mental illness or not. The difference is one of degree. The consequences of each arrow require that I pay much more attention to these interrelationships, only a few of which I've shown here.

My Brother's Nightmare

Coming to Terms with and Learning to Manage Hallucinations

People who cannot distinguish reality from illusion may be worse off than those who are terminally ill. We often hear of the mind's great power to overcome a physical ailment, even one that's considered incurable. But what if the ailment is part of the mind itself? Unlike those who suffer from diseases such as cancer or AIDS or those who are physically challenged, people who suffer from hallucinatory and delusional symptoms of schizophrenia have no idea where the problem is, since the mind itself is playing tricks on them. What mental anguish do these people feel as they go through this continuous nightmare? How can family and friends help, if at all?

My brother was a normal teenager, bright, conscientious, and academically brilliant. Five years ago, a few months after we arrived as high school students from Hong Kong, my brother became very sensitive towards 'noise.' One day we were on the bus on the way home from school; he turned to me and said, "Did you hear what other people around us are mumbling about?" Not only was he staring at the person he believed was talking about him, he also started responding to what he heard by mumbling to himself. He earnestly told me that people were following him around all day and were mocking and ridiculing him. Initially, I thought it was some kind of a joke and replied like most people would: "What do you mean? I have

been with you all day and have not seen or heard the people you are talking about."

"Of course you wouldn't notice. They're after me. They belong to a group that's targeting me only," he said.

Though he let the conversation drop, over the next few months such conversations would occur again and again. As time went on, he became more and more obsessed with the voices in his head. He was always ready to give me detailed, seemingly-logical answers whenever I questioned what he saw or heard. With my limited knowledge of psychological illnesses, one day I had a talk with him and told him how I thought we could approach the problem. We started out by doing some research on the internet together. Everything we read seemed to point in the direction of schizophrenia. I was still hoping that I would be wrong. However, after we consulted with a psychologist, my brother was tentatively diagnosed with schizophrenia.

A few weeks after seeing the psychologist in Burnaby, one day my brother sobbed desperately at school that he wanted to kill himself. Not knowing what to do, we went to an instructor we knew for help. He suggested we go to Vancouver General Hospital immediately. By the time we arrived at VGH, he was getting desperate about the voices in his head, "I hear a lot of voices all around me. People are mocking and jeering at me non-stop.

I can't take it any more. I feel like ..." After some eight hours of examination by doctors and psychiatrists at the hospital, my brother was hospitalized in the mental health ward for the next few weeks.

During his stay in the hospital, he was put on different medications and dosages every two weeks as the doctor was trying to find out what worked best for him. Each medication brought on different side-effects: dry mouth and fatigue, for example. But regardless of what medicine he took, side-effects inevitably came with it, although some less severe than others. On the medication with the least side-effects, my brother looked happier and more relaxed, and heard no voices. I went to see him after school every day. However, when I took him out of the ward for a walk, the voices would come back to haunt him, especially in crowded areas. After a month or so, he was released from the hospital.

As the days passed, he became increasingly more upset and worried about how he could continue with his life, especially with school, when he found out that the medication could only reduce hallucinatory symptoms, but could never be able to eliminate them all. In addition to my brother's difficulty in accepting this fact, our parents, who live in Hong Kong, were also stunned to learn of his mental illness and of its incurable condition.

Months after he was released from the hospital, a

friend introduced my brother to a woman in her 60s who'd been suffering from schizophrenia for the last 20 years. She had it so bad that she couldn't hold down a job, left her family, and was homeless for many years living on skid row. When my brother spoke to her, even though she was still on medication, her life had normalized. He spoke to her at length in a restaurant on Commercial Street. Asking very few questions, he was listening to her most of the time learning from her experience. Inspired after listening to how she survived the illness, he told me that he wanted to overcome this illness with as much courage as she.

For a few months, he did demonstrate courage in fighting this illness. Whenever the voices started to cram into his head, he would first ask me whether I heard those voices as well. If not, he would try to convince himself that the noises were not real. But, when the voices got too unmanageable, he would learn to tell me about them instead of mumbling to himself. For a while, it did appear that he was on top of things.

With more confidence in living with unreal voices, his illness became more stable — or so it seemed to us. However, his increased confidence also prompted him to skip dosages. I didn't know until the university counsellor sent him to the hospital again. He fightingly said, "I heard a lot of noises around me again. A lot. Non-stop. I've forgotten to take medication a few times in the last

M.C.Wong

M.C. is a 3rd year international psychology major at Simon Fraser University and volunteer in the Chinese mental health promotion program at CMHA Vancouver/Burnaby branch

two weeks. I didn't mean to do that. I just forgot. You can't understand. I can't focus in class after taking the medicine." Every time he skipped his medication, he had to start with a new medication plan that doubled his original dosage. He was also forced to go back to the ward again for the next couple of weeks. He said he deeply regretted what he had done.

Being re-hospitalized must have taught him to be more vigilant in taking his medication. Rather than being apathetic and frustrated, he was more zealous than ever in fighting the hallucinations. Not only was he willing to go out alone, he also improved his strategy in dealing with the voices. Whenever he heard too many voices, he would try to go to a quiet place

to empty his mind. He also tried to convince himself that those voices were unreal. But if he felt he was losing self-control, he would try to reach me, friends or even our parents to distract himself from the voices. Sometimes, he would bring a CD player along with him wherever he went, so when disturbed by voices, he would just put on his headphones and try to ignore them. Though small, these pro-active techniques did help my brother cope with the symptoms.

The voices would appear and disappear like waves rising and subsiding. A couple of years ago, when another wave of symptoms came crashing in, he made a difficult decision to quit school and return to Hong Kong. Under the care of a psy-

chiatrist there, he is now in his last year of university. The waves still come and go, but he finds the symptoms more manageable living at home.

Though I couldn't, and perhaps never will, understand the mental hell he has gone through and is going through, there are a few things I have found effective in helping him cope. First, telling him what is exactly happening in reality can help him make a distinction between what is real and what is not. This is crucial in helping him actively fight the voices. For my brother, and I suspect for most people in a similar situation, accepting the illness seems to be the most challenging task, because a passive attitude would lead him to be completely dependent on the

medication and reduce any effort in dealing with the illness. But once he accepts his condition, he will learn to deal with the symptoms actively. Second, family support is another big resource in dealing with schizophrenia, especially at the beginning of treatment. His confusion, as well as the negative side-effects of the medication, can easily lead to passivity. Family support gives him the strength for positive thoughts.

In a phone conversation with him last week, my brother now seems to be living a fairly normal life. He knows that this is a challenging and difficult journey, but he tells me that he won't allow the voices to interfere with his life. "The more noise I hear, the more I am going to fight it," he added. ■

Self-Management of Psychosis and Schizophrenia

Dana **T**o some it might sound like an oxymoron, but many believe it possible that people with schizophrenia can manage this illness in a way that will enable them to lead fulfilling lives. I present three accounts in favour of this approach. One is by Canadian Robert Chapman, who recovered from this illness and now speaks to others about his journey to recovery. Another presents excerpts from UK's Rethink Project. And the last one is my personal look at this issue as someone who has been hospitalized and recovered from psychosis.

Robert Chapman's Approach

Robert's Chapman account of his fight with schizophrenia is one of determination to conquer delusional beliefs by replacing them by others that are based on reality. At first, Chapman became angry at the illness, a turning point on a slow path to recovery. He says that "there ought not be a race in trying to recover."¹ Although it is an illness that is usually branded on people as a terminal one, he did not want to accept that fate, and by applying 'method to his madness,' developed ways of controlling it. What started Chapman down this path was when someone told him that his ideas were part of an internal process related to his disease, rather than something external. This allowed him to develop his method for testing out his often-delusional ideas against reality.

Chapman's three-step strategy worked as follows:

"The first step was to recognize the delusional scenarios. Evidence for delusional ideas were found to contain doubt. Second, I developed counter-arguments and explored alternative interpretations [for my delusional interpretation]. The third step was to replace the delusion with reality, truth and rationality."

He developed the method over the course of several years. After that, he went public with his findings, to share this journey with others on TV, in newspapers, conferences and in books he has written. Unfortunately at present, his books are hard to obtain in libraries or bookstores since they are out of print. However, his website, www.nas.net/~chapmanr, describes the approach in more detail.

Rethink: Self-Management Project for Schizophrenia

When considering self-management, we shouldn't just focus on eliminating the negative impacts that the illness has on our lives. The organization known as Rethink, based in the UK, conducted a study that asked people with schizophrenia their views on self-management.² And as the study showed, a focus on the *positives* of the illness experience is also an important aspect of self-management. For instance, one person interviewed in the study noted the positives of "having a feeling for sounds of words and seeing puns in what people say — loving music and

Dana is a Master's Student in Political Science at Simon Fraser University and Branch/ Public Communications Support at CMHA BC Division

footnotes

¹ Chapman, R.K. (1997). "Eliminating paranoid delusions and telepathy-like ideas in schizophrenia: A personal account." In C.T. Mowbray, et al. (Eds.), *Consumers as providers in psychiatric rehabilitation*. (pp. 201-208). Columbia: International Association of Psychosocial Rehabilitation Services.

² Martyn, D. *The experiences and views of self-management of people with a schizophrenia diagnosis*. London: Self-Management Project. www.rethink.org/recovery/self-management

feeling at one with nature and the universe — being strongly affected by beauty in a positive way”; another felt that he was “a much better person for having suffered... and ...many facets of my personality have developed as a result.”

The Self-Management Project finds that self-management is an individual journey, but one with common themes such as:

- acceptance of experiences
- struggling against societal stigma
- journeying through different understandings of illness-related experiences, including the psychiatric, social and spiritual
- over a period of time, developing hard-won coping strategies
- having to choose between fitting into ‘normal’ society and redefining what ‘normal’ is and giving value to difference

The self-management strategies in this approach and in the one discussed above involve more than medication. They also involve communication with the person about the illness experience, as well as developing ways of evaluating and countering unhelpful ideas, such as delusions, paranoia or negative ideas about oneself.

My Personal Experience

From my personal experience of psychosis, I found that the turning point in my hospitalization came at a time when I was thinking that I could not trust anybody, that everybody wanted me dead, and that there was no other escape other than suicide. Gradually, I started remembering my childhood and the times when I was loved and when I trusted people. I then made a decision to trust someone that I knew and felt good about.

And that’s how I started climbing up the ladder from the pit of delusions and hallucinations. Another turning point was when I was finally provided information about schizophrenia: the first diagnosis my doctors gave me. I asked them repeatedly for it, but for some reason they were reluctant to give it to me until almost the end, when they deemed I was ‘ready.’ Once I held this information in my hands and was able to read academic text — just like I used to for my classes at university — I realized that all the delusions of grandeur, paranoias and hallucinations I experienced had also been shared by many others before me. I also realized that I was not as special as I thought I was, in the grand scheme of things, and that I would be able to lead the normal life I wished.

After that, I had to relearn how to look at people and to walk the streets in the same way as other people do. It was hard because I was still fighting my delusions and was ashamed of what had happened to me. But slowly, within weeks, my rational thinking and determination brought me out of my previous frame of mind. My sense of humour helped too, in tackling the embarrassment of returning to places where my psychosis happened. For that quality, and for all of the strengths that enabled my recovery, I am very grateful to my upbringing, and to my wonderful family, friends and therapists.

Before I came back to SFU, where I was studying at the time, I flew back home to recuperate for the summer, and got excellent care at the Centre for the Treatment of Psychosis, where I received help from a psychiatrist, psychologist and cognitive therapist.

I think all of these things have been an important part of my recovery and my ability to self-manage, and I would recommend them to anyone. ■

Valuable Advice



Lately, to my elderly and blind mother, I have been reading aloud *The right words at the right time* by Marlo Thomas. Famous and well-known persons such as fighter Mohammed Ali, TV host Katie Couric, and writer Tom Wolfe, offer up stories. They tell of moments, for them, when something someone said motivated them to move ahead and achieve success.

As a mental health consumer, I too recall valuable advice, accepted from mentors, that helped me to cope with life. Four special comments played a vital role when direction was much needed. Coming at crucial points during my psychological growing pains, they gave pause for reflection. In turn, they enabled a greater degree of integrity and balance to take place.

My late father’s wisdom fostered in my heart and soul the ability to carry on and endure my mood swings. Often, in the early years of my illness, he would join me in my basement suite in the family home. During those evenings, we’d listen to inspiring songs like *Pick yourself up*, *High hopes* and *The impossible dream*. But one thing he said, touched me deeply. Concerning my extreme highs and lows, he remarked “Nothing is ever as good as you hope or as bad as you fear.”

Like dad, my brother is fiercely loyal and, in his busy schedule, has always found quality time to spend with me. One day over lunch, I shared my little pearl that “there are no answers.” He looked me in the eye and, smiling, said “Jim, there are no questions!” A light lit up in my head. It wasn’t necessary to ask the ‘who, what, why, where and when’ of the mystery of life. Just live spontaneously in the moment and, as the Beatles sing, *Let it be*.

Dropping out of law school when I had my breakdown, my intellectual drive was channeled into serious works of philosophy and psychology. I became full of ideas and theories that had no relevance to my day-to-day functioning in the world.

One day I was expounding to my mother. She sat quietly and patiently, listening. When I came up for air, she poetically said “let the muddy waters settle.” It dawned on me that I needed to stop reading so deeply and clear my mind, allowing the kernels to separate from the chaff.

The last insight I’d like to discuss came from the Merv Griffin Show on television. One of the guests was an actress, then appearing on a popular sitcom. She preached that everyone in the world must meditate as the end was near. Merv asked his other guest, singer-songwriter Roger Miller, if he had anything to say. Roger simply said “I’m gonna plant in the spring.” ■

Jim Gifford

Jim is the editor of *In A Nutshell*, a publication of the Mental Patients Association

On the Morning Tides

Hope in Self-Management of Mental Illness

Scott Whyte

Scott worked for the RCMP, where he served as a constable for 23 years. In BC, he was stationed in Quesnel, Fraser Lake, Alert Bay, Fort St. John, 100 Mile House, Prince Rupert, and on the PV Pearkes, a patrol vessel working on BC's West Coast. He retired to Prince George, where he now works as Education and Projects Coordinator for CMHA Prince George branch

It seems like a long time ago and so far away. I am speaking of my near breakdown and diagnosis of bipolar disorder, or manic depression. I say *near* breakdown, because successfully breaking anything nowadays usually would spell its end. We may live in a fast-paced world of disposable goods, but I am one good that won't easily be tossed.

Not so many years ago in the history of psychiatric treatment, our role as being a part of 'the team' would have been scoffed at and universally resisted. In more recent times, success stories are validating today's growing evolution toward psychosocial rehabilitation practices, where consumers are being drawn into active participation, becoming an integral part of our own treatment plans. There are still some of the 'old time thinkers' in positions of authority, but thankfully there is a new wave of belief, knowledge and hope arriving on each morn-

ing's tide. I believe that with each flooding tide comes natural erosion for a positive change. I recognize milestones regularly within my own recovery and there can be no doubt that I am self-managing my illness.

I needed to know my illness and get reacquainted with myself on very intimate terms. I had to identify triggers, learn to recognize and monitor how I felt every day. This led me to an understanding that my triggers were all related to stress. Extreme stress had been a very dangerous element in my life. I am stuck with a mental illness, but I can do something positive with my stress. I began to research stress management. What did I find out? Don't let anyone tell you that you can resolve stress with one pill, or that you will be freed by laughter; it's more complicated than that. While researching, I was also impressed by the apparent influence that stress seems to have over many different men-

tal disorders. Effectively managing stress hinges upon a healthy lifestyle makeover.

I have since discovered that by effectively managing my own stress, the effects of my illness have diminished significantly. I will be honest and admit that self-management is plenty of work and it is time-consuming. It has involved my complete commitment to the following life changes:

Medical Compliance

Like anyone else initially caught up in the psychiatric soup, I had to experiment with new medications. I remember that these were the bad times, and I endured many setbacks before finding the right mix, at least the one that is working for now. After all that work, it only makes sense for me now to stick with the program. I have had to accept that I will be taking pills until the day that I die. Maybe then, I'll be afforded the time for a break from routine!

Regular Exercise

Stress pumps us up with very powerful agents, giving us the abilities to fight and/or run for our lives. These stress hormones are produced with the intention that they be used, so to do nothing with them will leave them in our systems for too long, where they will become unhealthy and eventually toxic. I now vigorously exercise two to three times a week so that I can burn off these chemicals in a socially acceptable manner — because fighting or running away is usually inappropriate these days. My re-

wards have been fairly simple, too. I end up feeling pretty good afterwards, both physically and emotionally.

Regular Relaxation

I have found that deep muscle relaxation, visualizations, and meditation allow me to attain a relaxed state very quickly and, most importantly, on demand. Learning to relax was essential for me. I have become skilled at taking the '10-minute vacation.'

Healthy Diet

Eating good food has made a real difference for me as well.

Problem-Solving Skills

There is a moment in time between any stimulus and our reaction to it. We can learn to recognize that moment and use it to our advantage. We can change our interactions with the things that are bothering us. Now that's enviable control!

Strong, Individualized Support Networks

The people in my network are those who I can trust and confide in completely. They know me when I am well and outwardly recognize changes in me that might be signaling early trouble.

In my old life, I was ill prepared for the toll that stress takes. I have since learned how to harness that stress and in turn, self-manage my illness. I am once again happy and gainfully employed. I am now able to reach out and offer help to others seeking change; either before or after their own near breakdowns. ■



Self-Control and Bipolar Mood Disorder

We have diagnosed you with bipolar mood disorder...’ so began the doctor’s first words to me upon our second meeting. His words were both a revelation and a double-fisted punch in the face.

On the one hand, the discovery of this illness means it partly explains why I had ‘progressed’ through so many jobs. On the other hand, it was initially a shock to my identity.

While I won’t go into embarrassing details, it appears to me that my erratic behaviour and poor judgement led to some job losses. The good news is that after several years of struggle, I have been correctly diagnosed and can now take steps to deal with the illness.

Bipolar illness or manic-depressive illness is a disorder in which an individual experiences extreme mood swings. The individual can be happy or experience elevated moods, and also experience low and depressive states. It is estimated that one to two per cent of the population suffers from some form of bipolar disorder.¹

The most extreme cases of elation and increased activity are described by the term *mania*. Some symptoms of mania are:

- euphoric or elevated mood
- increased energy
- decreased need for sleep
- irritability
- lack of inhibitions
- accelerated thinking, usually accompanied by lack of judgement
- grandiose thoughts²

While we cannot be in complete control of how we behave, I believe we can be in better control of our emotions. Some ways that help me maintain self-control are:

- Reducing stressors that trigger symptoms. Stressors can be any number of variables that can trigger an incident: coffee, the amount of work that has to be done daily, time limits, and so forth.
- Taking medicine regularly and in the correct dosage. Many relapses occur because the person stops taking the medicine! When I first starting taking lithium, I was tempted not to

God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference. — Reinhold Niebuhr



take it because of that first phase of feeling ‘flar’ or drugged out. However, after a month on lithium, I found that my normal emotions returned and the robotic mood subsided.

■ Recognize the symptoms and take appropriate action. Have an emergency plan ready to implement when you are becoming ill. Since I have been diagnosed with bipolar disorder, I have read several books and numerous pamphlets on this subject. I speak to doctors, nurses and social workers as well as friends and family, in order to get their sense of my mood. I also monitor my own mood. For instance, I sometimes experience a mixed mood where I feel irritable and snappish to people, almost to the point of

rage. Knowing this, when I speak to someone in person, I try to look them in the eye and speak calmly. I try to see a human being rather than a target for my rage. Mostly, this action succeeds, for the rage is only a temporary feeling. Also, I speak to the doctor about getting my medication adjusted.

- Another way to maintain self-control that’s worked for me is to listen to motivational tapes, such as the ones by Og Mandino, Anthony Robbins and Steven Covey. The latter in his tape, *The power of the seven habits*, notes that an effective person is proactive and takes responsibility for their life. One is not a product of their genetic makeup, even though it may be a powerful influence.

In summary, there can be a number of ways to manage bipolar disorder. Drug therapy, counseling and mood disorder support groups are only some of the ways to combat this illness, but bipolar illness can be effectively managed using the kinds of strategies that have worked for me. ■

footnotes

- ¹ DePaulo, J. R. (2002). *Understanding depression*. Baltimore: Johns Hopkins School of Medicine.
- ² Bartha, C., Kitchen, K., Parker, C. & Thomson, C. (2001). *Depression and bipolar disorder: Family psychoeducational group manual*. Toronto: Centre for Addiction and Mental Health.

Erika

Erika is in her early forties, from the Lower Mainland, and has recently been diagnosed with bipolar disorder

My Path to Wellness

From Psychotic Depression to Recovery



Debbie Sesula
BA, RTC

Debbie is President of
the White Rock/South
Surrey branch of the
Canadian Mental Health
Association

Part 1: Enslaved by Mental Illness

The year is 1988. I was just your average university student struggling through, determined to get my Bachelor of Arts (BA) degree. Being in my last year, I had high hopes for the future and nothing was going to get in the way. Or so I thought.

Life was about to change drastically. I began to find it almost impossible to face another day. The inner pain was getting worse. I felt so inadequate, unworthy and unwanted. It was all so overwhelming. I barely attended classes, I was doing lousy on my exams, and I didn't even bother doing my oral presentations. I was totally unable to express how I felt; all I could do was cry and withdraw. I felt so alone. That aloneness was the most painful - that gap between me and the rest of the world. The fear of being alone like this forever was agonizing. I was trapped. It was all so hopeless. Exhaustion overtook me, as it took every ounce of strength I had just to do the simplest things like taking a shower or brushing my teeth. Nobody knew the torment that was going on inside of me; outwardly, I appeared perfectly normal. I didn't care anymore and I certainly didn't feel like living. I became more and more withdrawn. If I wasn't crying, I was tossing and turning, trying to sleep. I was on edge and everything irritated me. There was so much turmoil inside that I thought I would go crazy. My mind was dying and I wanted to die with it. Despite the turmoil I was experiencing, I did graduate and received my BA degree in Psychology.

After a series of unsuccessful suicide attempts, I was hospitalized a number of times. The turmoil continued. The suicidal thoughts didn't end. The depression and anxiety just kept getting worse and worse. I then went into a psychotic depression. Psychosis basically means disconnecting from reality. I suffered from hallucinations, which is seeing or hearing things that aren't really there, and I suffered from delusions which is believing in

things that are not true. I lived in a haze of medications and nothing was helping. I was obsessed with taking my life. As a last resort, they gave me shock treatment.

I was not ready to face the outside world. I was terrified. I had lost my entire identity. There was no me; I didn't exist, but I must have existed to suffer so. This confused, disoriented state of depression mixed with psychosis went on and on.

I was quite heavily medicated, but the psychotic states did finally come to an end. Actually, the craziness of psychosis was easier to handle than the hell of depression because I wasn't connected to reality — and reality hurt.

Reality continued to hurt for seven years as the depression lingered on. There were periods of relief every so often. It wasn't non-stop torment anymore.

Part 2: Freedom Through Self-Management

Gradually, I started to think and feel in a more rational way. Maybe life did have some possibilities; maybe there was hope after all. I felt ready to get going in life and to fight to get over any obstacles that got in my way. It started feeling like the war was coming to an end. Life was worth living after all.

How did I ever get to this state of thinking that life was now worth living? It's hard for me to say what really helped. One thing I do know: time was the most important healer. I know, that's what people always say, "Oh, you'll be fine, just give it time." But that is so true; it was vital that I was allowed time. Then there were the countless talks, the encouraging words, people reaching out to me, being firmly challenged, a lot of hard work on my behalf. Most important was that people didn't give up and they continued to believe in me even though I didn't.

Therapy, support groups, psychiatric outpatient programs, clubhouse activity and medication also played an important role in my recovery. During the crises, having respite in a residential facility known as CRESST (Community Residential Emergency Short Stay and Treatment) helped me to feel safe and taken care of. Having supported subsidized housing was what kept me connected and what took away the worry about having a decent roof over my head. Taking part in an employment training program was a major turning point for me in that I was able to learn new skills, utilize skills I already had and take the risks needed to enter back into the workforce.

Another major turning point for me was going into private, one-to-one counseling. I was willing to put forth the effort no matter how much it cost. Throughout my seven years with the public mental health system, I made very minimal progress. I remember being told that I would be mentally ill forever, that I would never be able to work and that I would be on medication for life. Not so! Throughout my two years of intensive counseling, I progressed in leaps and bounds. I learned that I had a purpose, that I had needs like everyone else and had the right to meet those needs, that I could be in control of my life despite

having a mental illness, that I was responsible for my behaviour. I also learned to empower myself instead of giving my power away. I worked hard at recovering and my efforts paid off. One cannot put a monetary value on that. I had a counsellor who would not give up on me and continued to believe in me.

Later, I went on to pursue my Reality Therapy Certification, because I wanted to give to others what was given to me. Two more major leaps occurred in my life. First, I switched from supported subsidized housing to regular subsidized housing through BC Housing, in which one's rent is based on 30% of their income. Second, since 2001, I have been working part-time and am off of disability benefits. I still struggle with psychiatric symptoms but nothing like before. Now I know what to do to nip things in the bud. How do I maintain my recovery? For me, it's all about self-management and balance. Self-man-

agement for me is about being aware of what I need to stay mentally healthy, such as knowing when to say 'no', putting aside one day a week as a 'me' day to spend as I wish, knowing when to ask for help, challenging my mind by learning something new each year, not taking life so seriously, having two cats and doing things I love such as traveling. Balance for me is about eating healthily, exercising regularly, getting adequate sleep, decreasing stress, having positive and supportive people in my life, consciously choosing positive thinking, meeting my needs every day, laughing and carpe diem (latin for 'seize the day!').

The mind really is so fragile and complex. No one is exempt from a broken mind. It can happen to anyone. But there can be healing and recovery. It is just so refreshing to remember where I was and to think where I am today. ❧



Depression Screening and Education DAY

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More than 50 sites will be set up around BC to help you learn more about the signs and types of depression, how treatable it is, and the range of supports in your community that can help you or a loved one. You can also fill out a short quiz on depression symptoms and meet with a clinician to discuss the results. The event is free, confidential and anonymous.

Presented by **BC Partners for Mental Health and Addictions Information**
EMPOWERMENT THROUGH INFORMATION

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Mood Disorders Association of BC
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Helping Myself to Help Myself

Tips for Self-Management of Eating Disorder Symptoms

Tannis Hugill
MA, RCC, RDT, ADTR

Tannis is a registered clinical counsellor and registered dance and drama therapist, with a private practice in Vancouver. She is also an artist-in-residence for the Vancouver School Board, where she uses dance and drama to teach healthy body image

I am a therapist who works with people dealing with disordered eating. A major part of my work with clients is to help them discover ways to manage what seems like a flood of urges to binge, compulsions to purge and fears of getting uncontrollably fat. People suffering from disordered eating often feel out of control, as if their symptoms have taken over their minds, their bodies and their spirits. Part of the difficulty is that sometimes the symptoms are felt to be an enemy, and sometimes a friend. There can be a lot of ambivalence towards giving in to the symptoms, and this contributes to the struggle.

It is important to view eating disorder behaviours, whatever they may be, as simply that: behaviours, or actions that have become a habitual way of dealing with the painful feelings and experiences of life. They are patterns that have become coping tools, serving a protective function. They are also actions that create a cycle of destruction and pain on their own. Those that seek treatment discover this and wish to find a way into true health, peace and loving self-care. In some way, eating disorder symptoms are an effort to do just that, but were developed when the individual just didn't know any better.

Viewing symptoms in this way can lessen the shame and guilt bound up with the symptoms' patterns. Instead, they can be seen as signals, alerting us to a need that is not being met. Unmet needs cause difficult feelings. When these are

numbed out by symptoms, the needs and feelings remain unconscious. One feels continually unsatisfied, empty, hungry — without knowing why.

Through the strengths of creativity and body awareness, one can gain a friendly relationship to the experience of the self in one's body. This is vital: our bodies are our homes, where all of our memories and emotions live. They can be creative resources, through which the world is experienced — in pleasure as well as pain. One

can practice taking a few deep breaths, and scan the body for information, noticing areas of comfort and discomfort, while being attentive to the feelings, images, thoughts, memories, and associations that are connected with these. When there is a thought or impulse to enact a symptom, one can take a moment to slow the reaction down, to discover what is going on underneath and get some clues as to what is needed. Even if, after a while, the symptom is used, the cycle has

been interrupted. This is a victory that proves other choices can be made.

Often, symptoms mask a need to be soothed, and to feel safe. One can create lists of activities that are pleasurable, calming, and easy to do. For some it may be writing in a journal or talking to a friend. For others it might be going for a walk, cleaning the closet, renting a video, petting the cat, taking a bath or having a shower.

Meditative activities that quiet the body and the mind, such as a daily sitting or walking meditation may be helpful to lower long-felt anxiety which makes all other emotions harder to tolerate.

Maintaining a daily journal of symptom triggers can be useful. List the time, place, activity, people and feelings connected with the triggers on one side — and the chosen, helpful activity used on the other. This serves as a record of what works to manage the symptoms and teaches that the symptoms are not in control.

Recovering from disordered eating is a process of learning that takes time. There are many rewards. Through the process, true self-knowledge can be gained — based on a connection to one's deep strengths, and trust that eating disorder symptoms are not necessary for survival. When one no longer feels impaired by the wounds underlying the complex of eating disorders, life becomes an unfolding story in which love and acceptance of self can be known, and shared with freedom — at last. ■

our bodies are our homes, where all of our memories and emotions live. They can be creative resources, through which the world is experienced — in pleasure as well as pain.



Practical Mindfulness

Tending the Mind and Spirit to Mend the Mood

I'm sitting cross-legged on my pale green comforter, staring at the TV. Someone, a woman, with too much lipstick and stark, penciled-in eyebrows squeaks about the greatest buy shoppers could ever hope for on the Shopping Channel.

I notice a familiar feeling sinking into my chest, dawning into a heaviness in my arms, trailing into my legs. What I fear and respect most begins to show its edges: depression.

I have learned, thank God, that this doesn't mean I must spiral out of control, and descend under its darkness. I have learned if I gently invite these demons in for tea, the power they threaten to hold over me dissolves.

I have learned this through the art of mindfulness.

Mindfulness is loving all the details of our lives.

—Pema Chodron, author and teacher, *When things fall apart*¹

A nanny 'minds' a baby. With tenderness and care, she attends to the needs of a wee, bright being. So, too, does the practice of mindfulness. At its most basic, mindfulness is observing what is happening in the present moment.

Practical mindfulness, what I use to travel through the emotional storms of my mood disorder, involves something more: a purposeful, 'unconditional friendliness' and awareness towards the inner goings-on of my mind, the subtle shifts in my emotions and body — ideally, just as microscopic changes from normal mood into depression begin.

Under this warm light of watching, unspoken, almost unbelievable, transformations start to take place.

Mindfulness... teaches how to make simple yet radical shift(s) in our relationship to our thoughts, feelings and bodily sensations that contribute to depressive relapse.

—Jon Kabot-Zinn

Often associated with *Insight* or *Vipassana* meditation, a tradition dating back two and a half thousand years, this awareness of mood, mind and matter is easily practiced, with or without the Buddhism that is at its roots.

"Mindfulness [in relation to preventing depression]," explains Jon Kabat-Zinn, PhD, founding director of Mindfulness Based Cognitive Therapy (MBCT), "is based on the meditative

view that change and health come about through acceptance of whatever is happening, no matter how painful, frightening or undesirable." "Acceptance," he notes, "does not mean resignation, but actively coming to terms with things as they are and learning creative ways of working with one's situation."

I am still sitting, knees aching, back sore, on the bed. I have been slumped here for over three hours. Self-reproach, for reasons unknown, begins to surface. My thoughts slow and become menacing. I am wary but watchful.

I inhale; focus on the rise and fall of my tummy and chest, trying to be aware, without judgement, of the whirl of mean-spirited feelings and thoughts within. This is not easy.

People, in general, often find it difficult to be self-loving. This is a massive understatement when fighting depression. Self-acceptance, at this point, I can barely remember, let alone practice.

Gradually, as you remain open and mindful... you begin to feel well in your own skin. From this comes release and a profound ease.

—Sogyal Rinpoche, teacher

Managing a mood disorder requires us to know what our 'fingerprint' of warning signs looks like. Because mindfulness asks us to note even the slightest change in mood, it offers a straightforward tool to do so.

I shuffle towards the kitchen: dirty plates piled high, coffee stains, bits of dried spinach shellac the tiles. A relentless "I'm so stupid... *#%!... I'm such a loser... I'm so stupid... *#%!... I'm such a loser..." a familiar loop of potentially crippling remarks.

I observe the thoughts and feelings and the throngs that follow them, as they dart and pinch the corners of my mind.

I try to do what I've been taught; see them just as they are: simply thoughts and feelings. Not facts about who I am or edicts of what I'm worth.

But they seem so real. Feel utterly convincing. I hear myself scream inside. I inhale, slowly, again. They are simply thoughts and feelings passing through me. Nasty, mean, horrible ones, but just thoughts and feelings. Not the truth. Not me.

I can make them real by believing the story they tell me or by wrestling them into momentary submission. Either way, I lose my centre and therefore lose myself. And I become vulnerable to the onslaught of a full depressive episode. I practice seeing these demons and basement dwellers with child-like curiosity.

"Look at that," I think, "isn't that interesting: Self-Hate? Hmm. And Jealousy, huh? Interesting." They are characters pitching camp from time to time inside my head.

Victoria Maxwell
BFA, BPP*

*BFA: Bachelor of Fine Arts
BPP: Bi-Polar Princess

Victoria is a mental health educator, consultant, actor and writer. Her one-woman show, *Crazy for Life*, and her *Creating Optimism: Reducing Depression in the Workplace* program is presented to audiences and corporations across BC and Canada

You can contact the author at victoriamaxwell@telus.net

Bipolar Self-Management Program Review

Self-management programs are based on a comprehensive knowledge about one's condition, its treatment and medication, and based on developing ways to get and keep well in the long run in the face of life's everyday challenges. They are an attempt to counter philosophies such as that of Elizabeth Miller's psychiatrist who told her upon discharge from the hospital: "You will not know when you are ill; only I will be able to tell you that. You won't know what you are feeling; only I will know."

Dana

This article reviews the work of several authors who realized the value of a consum-

er-driven approach to recovery, starting with an approach developed by Miller herself. This approach stems from the premise that people should gain control over their illness by managing it responsibly.

Elizabeth Miller

There are four crucial components to Miller's approach. First of all, the person needs information and a peer support network. Secondly, the individual needs to learn to recognize the warning signs and triggers of the illness, both generic and individual in character, then needs to develop a plan for the onset of symptoms in coopera-

tion with health professionals. Finally, there is the task of maintaining good mental health overall through monitoring of one's mood swings and symptoms, getting feedback from friends and relatives, having a healthy diet and exercise regime, as well as maintaining proper sleep patterns. As Miller says, "Not everyone wants to take responsibility for their illness, but just about everyone benefits from more information." Willpower and perseverance help people learn more and apply the knowledge for their own benefit. For more, see www.primhe.org/downloads/journal/vol_001and2/miller.pdf

Manic Depression Fellowship

The Self-Management program of the Manic Depression Fellowship (in the UK) is a six-week program of three-hour sessions led by people with bipolar disorder. In the first two weeks, participants learn to recognize the nature of their illness and what impact it has on their lives. Half way through the course, the sessions centre on learning about triggers and warning signs by keeping a mood diary. Other topics addressed at this stage include self-medication, building support networks, and making action plans. The last two weeks

Practical Mindfulness (cont'd from prev. page)

By fostering this 'witness' perspective, I start to see a way out. Mindfulness has the extraordinary ability to shift distortion into discernment. Thoughts and feelings, which normally send me into tailspins, now rest in neutrality. I gain objectivity leading to new, more adaptive choices and healthier self-talk.

Mindfulness offers a precious split second between feelings and reactions. In this flash of time, reactions can be habitual, or new responses can occur. Feelings of inadequacy and anxiety do not magically evaporate. But they cease to intensify as quickly and fade more rapidly.

It takes practice to stay awake to these emotions, to refuse to flee, fight or freeze. I have learned this skill over time — years to be exact. Mindfulness is cultivated, not innate.

Practicing this art daily, even when things are going well, increases clarity and compassion and well-being unfolds.

Mindfulness is not a substitute for medication and intelligent cognitive therapy. It is however, one of my most potent power tools to maintain recovery and prevent relapse.

In repeated studies, MBCT "substantially reduce(s) the risk of relapse in those who had three or more previous episodes of depression (from 66% to 37%)."²

I'm at the sink. I step back in my mind, start rinsing the sticky bowls and allow thoughts of self-hate and self-deprecation float in and move about as they wish — noticing these disorderly characters jostling for attention. Literally.

I just watch, with as much patience, as much kindness, as I

can muster — which at this point, isn't a lot. I swish the soapy dishcloth over the lip of a travel mug, and the cruel thoughts and mean-spirited emotions begin, ever so slightly, to soften.

A therapist I worked with taught me to mentally catalogue my thinking patterns, and note the most common themes. Anxiety and self-loathing? Despair and disdain? Then, like a teacher with an unruly class take role call.

"Ah yes...Despair ... oh, and Audacity and Arrogance. Hmm... isn't that interesting. Haven't seen these scalawags in a while." And so the watching goes.

Because practical mindfulness at its best is without judgment and full of loving-kindness, it teaches me to embrace my humanness — awkwardness and all — to welcome home my quirks, my warts, my diamond-like beauty: the masterful beauty and warts we all have, and we all try to hide.

This arms-wide-open position allows me to hold all my aspects: those I hate, and those I love. Even when I refuse to be kind to myself, and demand that I berate myself and whip myself into perfection, this too I can watch. With perhaps less warmth, but still I can watch. And slowly, just as dark turns to dawn, more light creeps in, despite myself. ■

related resources

- Chodron, P. (2002). *The places that scare you*. Boston: Shambhala Publications.
- Williams, M. (2002). *Mindfulness-based cognitive therapy and the prevention of relapse in depression*. Online at www.rcpsych.ac.uk/college/sig/spirit/publications/williams.pdf

footnotes

¹ Chodron, P. (1997). *When things fall apart*. Boston: Shambhala Publications.

² Segal Z., Teasdale J., & Williams M. (2002). *Mindfulness-based cognitive therapy for depression*. Guilford Press.

address developing a lifestyle that promotes good mental health. This involves developing personal awareness and maintaining a daily routine — just to name a few of the topics discussed. Active participation in the sessions is encouraged, and the program is accompanied by exercises that are done on an individual or group basis. Positive outcomes achieved with this approach include reduction of participants' negative attitudes towards the past, as well as reduction of suicidal thoughts and difficulty with concentration. Participants in the program also tend to feel more in control of their illness as well as more involved in the treatment offered to them by their clinicians. For more, see www.mdf.org.uk/services/smt.html

Wellness Recovery Action Plan

Mary Copeland's book *Living without depression and manic depression*³ is a practical workbook that shows that it is possible to live with this disorder through information, acceptance and conscious change. By gaining confidence in one's knowledge of the disorder, and about what treatments and medications work best, the individual is able to prepare not only for a relapse situation, but also for long-term management of the illness within the person's social networks. The workbook offers practical examples of questions to ask the doctor and things to know about conditions that might look like bipolar disorder. It also deals with issues such as the value of receiving and giving peer support, the advantages of developing a lifestyle that enhances wellness, coming to terms with the past, and getting the most out of counseling. Numerous charts offer suggestions of how to track one's moods, how to change nega-

tive thoughts into positive ones, or what actions to take to avert a relapse.

Copeland's concept of WRAP (Wellness Recovery Action Plan) provides a simple system for monitoring and managing emotional and psychiatric symptoms, as well as avoiding unhealthy habits or

behaviour patterns. In order to arrest symptoms and hasten remission and recovery, people both learn and share personal strategies for dealing with each level of relapse. For more, see www.mentalhealthrecovery.com

All of the programs listed have a common underlying message:

that it is possible to break away from the inevitability of the illness, take charge of the course of life, and to work on getting oneself out of the trenches and back into the social networks that are so valuable for the people who live with this illness. ■

footnotes

- 1 Miller, E. (1999). "Self-management in manic depression." *Journal of Primary Care Mental Health*, 2.
- 2 Harris, A. (2000). "Self-managing manic depression." *Mental Health Care*, 31(8), 274-5.
- 3 Copeland, M.E. (1994). *Living without depression and manic Depression*. Oakland, CA: New Harbinger Publications.

Hearing Voices that are not Real

Advice for Consumers and Those who Want to Help



Hearing voices that are not real can be a distressing experience, both for the person that hears voices and for those who want to help. Understanding the experience of hearing voices has been stifled by the traditional psychiatric approach, but thankfully there are resources now available to those who hear voices and those who want to help — resources that are the result of new approaches to the task of understanding and managing voices that are distressing.

The conventional psychiatric response to voices (otherwise known as auditory hallucinations) once sought to deny, suppress and ignore voices. It was believed that only people with schizophrenia heard voices. It was believed that voices made no sense, could not be understood, and therefore that there was nothing that could be done about them if they did not respond to medication. Furthermore, it was believed that talking about voices could only make them worse. Engagement of the voices was emphatically discouraged, on the theory that to engage the voices was a kind of buying in to the hearer's delusional fantasies. The result of this approach was to further isolate the significant minority of voice-hearers who do not respond to medication or those who find medication intolerable.

For those who hear voices, one thing is clear: that voices can have a great deal of control over the person who hears them. Also, voices do make sense in that they often reflect issues that a person has in their life — and the voices can have a lot of power. As a result of this increased awareness, new approaches to coping with voices help the voice-hearer take control and gain understanding and power over the voices and their disruptive effects.

Contrary to the belief that only people with schizophrenia hear voices is the acceptance that hearing voices is a relatively common experience, and under certain conditions of duress (such as sensory deprivation, lack of sleep, or with drug use) anyone can have the experience of hearing voices. Have you ever heard your name spoken, only to turn your head and discover that no one is there? It is a starting point to understanding the experience of hearing voices and of being able to help.

Patricia Deegan has a PhD in clinical psychology and has heard voices most of her life. With the National Empowerment Center (NEC), a US-based consumer-run organization, she has developed the *Hearing voices that are distressing* curriculum for mental health professionals, a component of which replicates the experience of hearing voices in a simple but effective way. Participants wear headphones and listen to an audiotape that runs as they undertake a series of tasks, including social interaction and cognitive tests. The result is a dramatic experience of what it must be like to try to function as the voices are active.

Another resource, *Understanding voices: A guide for family or friends*, provides written guidelines for those who want to help but may be unsure of what to do. The full guide, which includes

Cynthia Row

Cynthia lives in Vancouver and has a background in freelance writing and broadcasting. She is also Editorial Assistant for *Visions*

I recently participated in the Hearing voices training. I must confess, I was disturbed by the sudden realization that I have been treating schizophrenia for four years, yet I've never known what it really was. I may have had the knowledge, but not the wisdom or true empathy until now.

— Jim Willow, MD, Psychiatric Resident, PsychHealth Centre (Winnipeg, Manitoba)

a useful guide of dos and don'ts for caregivers can be found online at www.nsfscot.org.uk/text/fifetext.htm

While *Hearing voices* training and other resources are useful tools for caregivers, a significant amount of progress has been made in developing coping strategies directly for those who hear voices. Advances have been made especially by European researchers in the field of cognitive-behavioural therapy, and by networks of people who hear voices themselves.

This work has resulted in a number of potentially helpful strategies for people who hear voices that are distressing. In general, these approaches to managing voices involve the awareness of, tracking, and engagement of the voices in a way that improves one's control over them. Suggestions that individuals can try, with the support of their treatment team, include:

- **Accept** that the voices belong to you, and are not an external force that can read your mind or steal your thoughts. In the process of developing your own point of view and taking responsibility for yourself, an important and difficult first step is to take ownership of the voices.
- **Get to know** the voices by keeping a diary, so that you can know when the voices come on and what might trigger them.
- **Make a contract** with the voices, perhaps allotting a specific time when you will listen to them. In this approach, the voice-hearer exerts some control over the voices and lessens their impact.

- **Tell** demanding voices that you want control of your own life; realize that despite what the voices are saying, they are a part of you, so you are in charge, and no harm will come to you when you don't listen to them.
- **Engage in** non-stressful, distracting activity such as gardening, listening to music etc., when the voices come on.
- **Experiment** with ways of diminishing the voices, for example, by 'shadowing' the voices, that is by whispering the content of the voices under your breath, or by humming when the voices come on.
- **Avoid unhelpful strategies**, such as
 - passive activities (e.g., watching TV)
 - arguing with the voices
 - self-medication
 - social isolation
- **Make use of resources** that suggest strategies and networks that connect voice-hearers.

Hopefully, the advice and resources in this article go some way toward achieving their aim, that is, to make the lives of those who hear voices easier and better understood. ❧

related resources

- **Understanding voices (fact sheet)** – This site features a fact sheet developed by UK cognitive psychologist David Kingdon, based on his research in this area. The fact sheet was one of the sources for the strategies described in this article: www.schizophrenia.co.uk/background/Understanding_Voices/understanding_voices.html
- **Hearing voices (fact sheet)** – A helpful resource on dealing with voices, developed by the UK's Mental Health Foundation: www.mentalhealth.org.uk/page.cfm?pagecode=PMAMHV
- **Hearing voices that are distressing (curriculum program)** – The curriculum and tapes can be ordered through the NEC Store link on the NEC website at www.power2U.org. This website is also an excellent source of information for consumers and professionals.
- **Accepting voices (book)** – Marius Romme and Sandra Escher have published coping strategies after years of listening to the experiences of voice-hearers. Their book is called *Accepting Voices* (1993) and can be ordered from MIND Publications, Granta House, 15-19 Broadway House, London, E5 England (ISBN #18874690138). Online ordering at www.mind.org.uk/osb/showitem.cfm/Category/104
- **Making sense of voices (book)** – Romme and Escher have also published a recent title (2000) called *Making Sense of Voices: A guide for mental health professionals working with voice-hearers*, which would also be helpful for voice-hearers themselves. Online ordering at www.mind.org.uk/osb/itemdetails.cfm/ID/138 or via mail at the MIND address listed above

Checking Things Out A Tool for the Consumer

Punkaj Bhushan

Punkaj is on the Board of Directors for the BC Schizophrenia Society. He has made many presentations relating his experiences with schizophrenia and his methods of managing the illness. He has a wife and two children and lives in Surrey.

Medications, while extremely valuable in treating mental illness, often still leave a number of symptoms of psychosis still present. Medications are also in the control of the treating physician. But what is in our control as mental health consumers?

People with schizophrenia still have problems with their interpretations of events, such as conversations or another person's body language. Recent research suggests the frontal lobe functions in a person with schizophrenia are impaired. The frontal lobe is involved with the

complex work of reading and interpreting body language.

I have found an invaluable tool to keep my thoughts on an even keel so that I can continue to work at a job and to keep my relationships healthy. I call this process, 'checking things out.' What I do is, when I come home from work, I relate all my experiences during the day, to my wife, Anoo, and she comments on my version of what happened: my interpretations. This time allows us to share and have quality time. She also relates her day and what

Evidence-Based Treatments for Alcohol Problems

Brief Interventions

Problems involving alcohol are common, and take on a variety of forms. Numerous interventions for alcohol problems have been devised over the years, and the evidence supporting different treatments varies. Since 1980, Miller and colleagues have published a series of increasingly rigorous, systematic reviews of the alcohol treatment literature.

In their latest review,¹ a total of 381 studies were identified, representing 99 different treatment modalities and involving over 75,000 clients. A number of the findings are provocative. For example, the majority of treatments for alcohol problems have little or no evidence of effectiveness. More troubling, the treatments with the strongest evidence are the ones that are least available in practice, and the most commonly available forms of treatment are those with the least scientific support. In the authors' words:

The negative correlation between scientific evidence and treatment-as-usual remains striking, and could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of efficacy.

But there is also good news. Specifically, a number of treatments have repeatedly been found effective, presenting a range of evidence-based options that benefit clients. The most effective therapies include motivational enhancement, bibliotherapy (reading- or workbook-based interventions), and other forms of brief intervention. In general, brief interventions place considerable emphasis on self-directed change, with minimal input from professionals.

Thus far, the evidence supporting brief interventions for



Julian M. Somers
MSc, PhD, RPsych

Julian is a full-time member in the Department of Psychiatry at the University of British Columbia. His research interests include telehealth and collaborative care, as well as innovations in the education and development of health professionals. Dr. Somers has also conducted research in the areas of addictions, motivation for change, and child and adolescent mental health.

You can contact the author at jsomers@interchange.ubc.ca

alcohol problems is considerably stronger than the evidence for all other forms of treatment to date. Brief interventions have been used effectively for several target groups including youth, hazardous drinkers, dependent problem-drinkers, and clients who have not responded to other forms of treatment.

The effectiveness of brief interventions is good news for several reasons. First, there is growing recognition that many problems with alcohol do not involve severe dependence. Many people who would not be considered alcoholics will nevertheless experience adverse impacts due to drinking. Brief interventions can be employed effectively with a broad range of clients, including high-risk drinkers. Second, brief interventions can be used in the context of a *stepped care* approach. Rather than providing intensive treatment for all clients, stepped care approaches proceed gradually, beginning with less intensive forms of treatment, increasing the intensity only as needed. If the client responds to the less intensive step, then no additional resources are required. This ties in with a third benefit of ▶

Checking things out (cont'd)

happened, more to share than anything else.

Often times, Anoo will disagree with my version and interpretation of what happened and what the intentions of colleagues at work were. This allows me to put those interpretations in a holding pattern, and I will say, "Ok, maybe my beliefs are wrong and I do not have to get worked up about so and so..."

It is not that I totally dismiss my beliefs, but I place enough of a question mark behind them

to keep my mind in symbiosis and not veering along the path towards psychosis. This method really works like a charm. I believe without it, I would probably be unable to work or help my wife in raising our family.

It seems to me that most people have varying success with medications: sometimes, they control most of the symptoms of schizophrenia and sometimes they do not. But for most people, proper medications — found through trial and error — lifestyle adjust-

ments and the method of checking things out will control the illness.

Unfortunately, people often do not want to relate their innermost thoughts because of shame and embarrassment that the thoughts would be unacceptable to another human being. People sometimes do not even reveal their thoughts to their doctor or psychiatrist. This keeps people in a pattern of distorted thinking and keeps them out of touch with the reality that is generally accepted

by the rest of the world. Even when you religiously take medication, you must develop the habit of checking things out so that you continue to get better.

I strongly feel many people remain closed and isolated because they don't get it in habit of checking things out. This is a way towards recovery and stability. Try it out and develop it into your own tool. If you don't have a significant other, try it with a family member or good friend. ■

Stepped Care

Moving Beyond the Vision to the Evidence

John F. Anderson, MD

John is an Adjunct Professor (appt. pending) with the Department of Psychiatry, Faculty of Medicine at the University of British Columbia. Dr. Anderson can be reached by phone about this article at (250) 952-2301 or by email at John.Anderson@gems3.gov.bc.ca

Background

Shared Care and Stepped Care

In 1997, a Canadian Psychiatric Association (CPA) and College of Family Physicians of Canada (CFPC) combined task force released a joint discussion paper entitled *Shared mental health care in Canada*.¹ The first author is Dr. Nick Kates, a psychiatrist who has pioneered a *shared care* approach between the departments of psychiatry

and family medicine at McMaster University. The CPA/CFPC shared care paper emphasizes the importance of collaborative care between psychiatrists and family physicians.

The concept of collaborative or shared care has evolved to include the idea of *stepped care*, i.e., that the level of intensity of care should be matched to the complexity of the condition. Depending on complexity, and on other factors, the

most appropriate (and cost-effective) level of care may range from brief, non-intensive interventions that can be initiated by the family physician, to interventions requiring the coordinated, ongoing efforts of a range of professionals in addition to the family physician. As will be discussed later, many of these interventions are consistent with the principles of self-management. The concepts of shared care and stepped care are also integral to the Chronic Disease Prevention and Management approach, described elsewhere in this edition of *Visions*.

Stepped Care and Managing Mental Health Problems

For many persons with mental health problems, the family physician's office is the first point of contact with the mental health system and, for many of these, the only contact. The high rate of contact between family physicians and people with mental health problems can be viewed as a window of opportunity for family physicians to provide interventions known to benefit those seeking assistance and care.

In order to meet the needs of as many people with mental health problems as possible, a stepped care approach to primary mental health care should include:

- entry-level prevention and treatment interventions, such as brief interventions (described below)
- strategies to meet the needs of those who don't respond to initial interventions (enhanced treatment)

- aftercare strategies for those patients who require longer term follow-up and supervision

Entry-Level Interventions

Entry-level prevention and treatment interventions share some of the following characteristics:

- minimally intrusive
- easy to implement
- relevant to a broad range of mental health problems
- likely to be effective for most people
- likely to generate a population health benefit; that is, it may benefit groups of people, rather than just individuals
- cost-effective

There is evidence in the medical literature that suggests that the delivery of these interventions by family physicians can be effective. Many of these options, such as those known as brief interventions, are consistent with self-management principles and are aimed at helping people build skills or motivation to remain healthy or deal with symptoms outside of the office setting. Some of the relevant findings include studies showing that:

- the impact of family physician brief interventions on both smoking cessation and reductions in alcohol consumption can be substantial^{2,3}
- a brief school-based intervention for children can produce durable reductions in anxiety problems: a recent Australian study found evidence of success in a child and family-focused group

Evidence-based Treatments for Alcohol Problems (cont'd from prev. page)

brief interventions: cost-effectiveness. Brief interventions present a rare opportunity in the current context of health reform: they are both more effective than typical treatment and they are considerably less expensive. A fourth benefit relates to the fact that many people with alcohol problems will drop out of treatment. Brief interventions allow providers to make a positive impact in one or two sessions, stimulating changes and increasing the likelihood that the client will return for additional treatment if necessary.

So if brief interventions are cost-effective, useful with a broad range of alcohol problems and have abundant empirical support, then why aren't they offered in practice? And what types of reforms might help ensure that the most effective alcohol treatments are routinely available to people who need them? In many areas of health care, coverage by health care plans is reserved for treatments that reflect evidence-based practice. This is only now becoming true with respect to treatment of alcohol problems.

Many jurisdictions are currently working to better integrate the treatment of alcohol problems with other relevant health services, including mental health and primary health care. These reforms have the effect of broadening the base of practitioners who encounter alcohol problems and can provide care. For many health professionals, brief interventions will be appealing — first because they work, and second because they can be introduced through an existing treatment relationship and do not necessarily require referral to a specialist. Clients and family members can also facilitate change by inquiring about treatment alternatives and the probability of success associated with different options.

Brief interventions are not a cure-all. However, they represent a currently-neglected component of treatment for alcohol problems, and warrant much greater attention by all parties concerned with the welfare of problem drinkers. They also deserve consideration as the first step in a menu of evidence-based alternatives from which problem drinkers may benefit. ■

footnote

¹ Hester, R.K. & Miller, W.R. (2003). *Handbook of alcoholism treatment approaches: Effective alternatives*. 3rd ed. Boston: Allyn & Bacon. (p. 41).

intervention for preventing anxiety problems in at-risk children through a range of strategies, for instance, by the young people developing problem-solving skills for social situations.⁴ The intervention could be extended to other settings including family physician offices.

Currently, the Cochrane Collaboration — an organization dedicated to understanding which interventions are evidence-based, or proven effective through rigorous studies — is systematically reviewing all studies examining brief psychological treatments for depression.⁵ Depending upon the results of this review, the implementation of brief psychotherapeutic interventions — such as manual-based self-management interventions based on the principles of cognitive behavioural therapy (CBT) — could have a profound impact on the large number of people receiving treatment for depression from family physicians. The *Depression Self-Care Guide* — see page 5 in this issue of *Visions* — is an example of such a manual-based self-management intervention, also known as bibliotherapy.

Enhanced Treatment

A stepped care approach also includes a strategy for targeting enhanced treatment to those patients who do not respond to the initial simpler intervention(s). These approaches also include self-management-related interventions, such as psychoeducation. Some of the relevant findings include:

- a recent study that reported on a multifaceted program targeting depressed individuals whose depressive symptoms persisted six to eight weeks after initiation of antidepressant medication by their primary care physi-

cians.⁶ Patients in the intervention group received enhanced education as well as increased visits by a psychiatrist working in collaboration with the primary care physician. The enhanced treatment improved adherence to antidepressants, patient satisfaction with care, and depressive outcomes compared with usual care.

- a review showing that a sequential or stepped approach to the treatment of bulimia may be as effective as standard cognitive-behavioural treatment (CBT) and can considerably reduce the amount of therapist contact required. In one study, patients who received a self-care manual followed, if necessary, by a brief version of CBT achieved similar outcomes to those who received standard CBT.⁷

More research is required to understand the needs of those who don't respond to initial interventions. In some areas, such as problem drinking, additional research is needed to identify target groups most likely to benefit from brief interventions⁸ as well as to identify individuals not responding to treatment.⁹ In other areas, such as eating disorders, more effective treatments are required for those who fail to respond to self-help and other brief, cost-effective therapies.¹⁰

Follow-up or Aftercare

Finally, stepped care defines a role for family physicians in the delivery of aftercare for patients who require follow-up of a mental health problem, such as for people who have attempted suicide. The authors of a recent review¹¹ note the frequency of suicide attempts seen in general practice, and conclude that family physicians have a crucial role in prevent-

ing suicide through aftercare and ongoing monitoring of patients who have made attempts. Research cited above⁶ also indicates the importance of the family physician in the ongoing management of depression, including the role of the family physician in supporting the development of self-management skills.

Conclusion

Attention to evidence, some of which is outlined above, should assist in removing the obstacles that interfere with making evidence-based interventions — including those based on self-management principles — available to people with mental illness. The same evidence should also provide an impetus to the necessary collaboration among health professionals as they help people manage their conditions. ❧

footnotes

- 1 Kates, N., Craven, M., Bishop, J., et al. (1997). *Shared mental health care in Canada*. Ottawa: Canadian Psychiatric Association.
- 2 Silagy, C. & Ketteridge, S. (1999). "Physician advice for smoking cessation (Cochrane Review)." *The Cochrane Library*, 4. Oxford: Update Software.
- 3 Kahan, M., Wilson, L. & Becker L. (1995). "Effectiveness of physician-based interventions with problem drinkers: A review." *Canadian Medical Association Journal*, 152(6), 851-859.
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- 7 Treasure, J., Schmidt, U., Troop, N., et al. (1996). "Sequential treatment for bulimia nervosa incorporating a self-care manual." *British Journal of Psychiatry*, 168(1), 94-8.
- 8 Drummond, D.C. (1997). "Alcohol interventions: Do the best things come in small packages?" *Addiction*, 92(4), 375-9.
- 9 Breslin, F.C., Sobell, M.B. & Sobell, L.C. (1998). "Problem drinkers: Evaluation of a stepped care approach." *Journal of Substance Abuse*, 10(3), 217-32.
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Building Mental Health Literacy

The Mental Illness First Aid Course

Jonathan Oldman

Jonathan Oldman is the Executive Director of CMHA Vancouver/Burnaby branch

For more information about the timelines and details of the proposal, please contact Jonathan at (604) 872-4902.

People in our communities who experience some form of mental illness are often misunderstood. For many, an interaction at the corner store, with a building manager or police officer is accompanied by a sense of being different, and with difficulty in being understood. This is not because people are naturally unkind; it is simply that they have not known or loved someone with a mental illness and therefore have never learned how to recognize and then support someone who may need an unfamiliar type of help.

According to research, poor mental illness *literacy* leads “to delays in recognition and help-seeking, hinders public acceptance of evidence-based mental health care, and causes people with mental disorders to be denied effective self-help and appropriate support from others in the community.”¹

The Vancouver/Burnaby branch of CMHA is developing a mental illness ‘first aid’ course, designed to address the issue of stigma, communication and support when people with a mental illness interact with other community members. By utilizing the skills and talents of contracted mental health professionals and consumers already involved in the mental health community, the project seeks to help improve the mental illness literacy of the general public, and particularly key community groups, services and organizations that are identified as having a regular and critical contact with individuals with a mental illness. The project is designed to replace introductory mental illness community workshops that were presented by the branch only in response to proactive requests.

Program Goals

- 1 To reduce stigma regarding mental illness
- 2 To promote recognition of mental illness
- 3 To improve the communication and helping skills of people and institutions interacting with individuals with mental illness
- 4 To increase awareness and information regarding mental illness services
- 5 To increase acceptance of and support and participation in a holistic, recovery-based approach to mental illness

Target Groups

The focus of the program is to identify and directly approach key target groups of workers, professionals and businesses that interact on a regular basis with individuals with a mental illness. Some key groups that the program could address include public service workers (such as parks staff), and social service personnel (such as income assistance staff). These groups regularly come into contact with people who have mental illness, and could benefit from training about how to recognize mental illness, how to be supportive, or how to connect people with the services they need.

Format and Content

The course is designed to be presented in a one-day interactive workshop format, or in a three-part day format. The workshops will be presented by a mental health professional, assisted by a consumer. The mental health professional will have a para-medical or clinical designation, including experience with those who have a severe or persistent mental illness. The consumer presenters are to have experience with the recovery model, to be actively contributing to their own wellness, have knowledge of community resources and strong presentations skills. If some of these are lacking, the person will need to have aptitude and willingness to acquire the skills through training.

The course will be presented in three main sections: a) what is mental illness?, b) communication and helping skills, and c) resources:

What is mental illness? We will look at exploring the myths and realities of mental illness, and the recognition and reduction of stigma. Participants will learn the symptoms of various mental illness diagnoses and groups, including dual diagnosis, and also be introduced to some of the risk factors and characteristics of mental illness.

Communication and helping skills will address the communication challenges particular to mental illness, discuss strategies for effective communication with individuals suffering from mental illness, and teach basic helping skills, including giving effective feedback and support. The difference between helping and rescuing will be a focus, as well as the issue of how to set and maintain boundaries.

Resources involves teaching participants how to identify and access the appropriate resources and teaching *community mapping*, that is, knowing the local resources.

We are also working with a project steering group to examine ways in which we can realistically provide follow-up support to workshop participants, whether that be one-to-one advice about how to handle situations, or organizational advocacy regarding further training or policy development. The project is currently under development and pilot workshops are expected to take place in early 2004. The project is generously funded by the Vancouver Coastal Health Authority, the United Way of the Lower Mainland, and Janssen Ortho Pharmaceuticals. ■

Footnote

- 1 Jorm, A.F. (2000). “Mental health literacy: Public knowledge and beliefs about mental disorders.” *British Journal of Psychiatry*, 177, 396-401. Quoted in Kitchener, B.A. & Jorm, A.F. (2002). “Mental health first aid training for the public: Evaluation of effects on knowledge, attitudes and helping behavior.” *BMC Psychiatry*, 2(10). This project proposal is based upon the project Kitchener and Jorm evaluated, as well as CMHA’s own experiences in Vancouver. Kitchener and Jorm’s article is available at www.biomedcentral.com/1471-244X/2/10

'Don't Trust Anyone Over 30'

Youth Net Facilitates Mental Health Literacy by Youth for Youth

Don't trust anyone over 30' is a phrase coined long ago by youth who had a hard time believing anyone over that magical age would understand their dreams or fears. It's a mantra that Youth Net Vancouver (YNV) has taken to heart. The original Youth Net Ottawa model was created in 1995 after researchers found youth were experiencing high levels of stress, and were more likely to turn to their peers than to access clinicians or specialists.¹ At a time when suicide is the second-leading cause of death among young people, Youth Net's model of peer-led discussions — focusing on mental health and mental illness — seemed to make a whole lot of sense.

Since its launch in June 2002, YNV has facilitated over 90 discussion groups with youth in Vancouver, going into schools, community centres, shelters — anywhere there are youth. Our diverse team of trained youth facilitators (aged 18-29) leads discussion groups for younger youth (13-21) and gets them talking about what stresses them out, and the different ways they cope in their day-to-day lives. Our goal is to work towards de-stigmatizing mental illness, while providing a safe context for thinking about different strategies that will work for them in maintaining good mental health and well-being. In keeping with the peer support model, no one over 30 is present during the discussion groups without consent, and confidentiality is assured.²

To ensure that individuals participating have support if they are in crisis, YNV has drawn together professionals trained in dealing with young people into a *clinical safety net*. They are professionals who are on call during the discussion groups should a youth identify him or herself as being in crisis. In addition to the safety net, our resource manual (given to everyone in the groups) is a compilation of resources in Vancouver, evaluated by our facilitators for their suitability for youth. Not only do we want to make it easier for youth to talk about what stresses they're dealing with, we also want to support them in accessing the resources they need.

Knowing that sometimes talking can only go so far, YNV advocates for youth to take action around issues impacting on their mental health. In partnership with the Self-Help Resource Association's youth initiative, Kinex, youth are provided with organizational support and access to resources (and some seed money) to start a group, whether it's to organize a queer youth conference, start a hip hop dance class or a sports group — the possibilities are endless — but the main goal is taking action and building peer support networks, both of which are important components of mental health.

Youth Net has a transformative effect on the young people who participate. When I think about transformation, I think of it beginning with the 'aha!' moment of realization when a piece of the puzzle falls

into place that allows change to happen, or at least helps make more sense of the situation. I think about all the seemingly little 'aha!' moments that have taken place for youth who have participated in YNV discussion groups, because there

connect with youth, transforming their lived experiences into teaching tools to help guide open and honest discussions of what good mental health is all about for folks under 30.

To me, the Youth Net discussion groups make a lot of

Amanda Walker

Amanda Walker is Program Coordinator at Youth Net Vancouver



artist: Annie Wilkinson

was a space to talk openly and freely about mental health, mental illness and coping strategies. I think about the youth who reaches out through his or her depression, because they finally feel supported and okay with the idea of asking for help. I think about a youth living with a mental illness who hears one of their peers say for the first time, 'yeah, I have a mental illness too,' breaking their bubble of isolation. I think about youth who are challenged to rethink their assumptions and perceptions of mental illness. And I think about YNV facilitators who are able to con-

sense ... it's not rocket science. It's all based on the simple principle that youth talking with their peers in a safe and supportive environment can truly be a transformative experience, one 'aha!' moment at a time. ■

bookings

To book a YNV discussion group or to find out more about becoming involved with YNV, call Amanda or Sabrina at (604) 732-8353 or check out the website at www.youthnetvancouver.org

footnotes

- 1 Research carried out by the Canadian Psychiatric Association.
- 2 Facilitators are aware of their duty to report any suspected/disclosed abuse, self-injurious behaviour or intentions of violence against others.

Visioning Recovery in a Day Program

Schizophrenia Rehabilitation Day Program

When individuals encounter their first episode of psychosis or face a diagnosis of schizophrenia, they often ask, “will I ever get better?” They will have also experienced difficulties with school or work, conflict and isolation from their family and friends, disruption or loss of activities and interests, or loss of housing. Despite these difficulties and losses, they can begin navigating their way towards recovery by having their experiences acknowledged and their goals and needs recognized and respected.

Otto Lim, RSW

Otto is a clinical social worker with the Early Psychosis Intervention Program/Schizophrenia Rehabilitation day Program at UBC Hospital, Vancouver Coastal Health Authority

Since its inception in 1987, the Schizophrenia Rehabilitation Day Program (SRDP) at UBC Hospital, has gradually evolved from the original form of a weekly question-and-answer group, with a physician and nurse, to the current model of a full-time five-day-a-week program, complete with a multidisciplinary team of occupational therapists, nurses, a psychiatrist, and a social worker.

The mission of SRDP is the rehabilitation of clients with schizophrenia or psychosis. With psychosocial rehabilitation, the goal is to promote recovery, to empower individuals with skills to increase self-worth and a sense of control over their lives. In more concrete terms, recovery ultimately means to move forward with one's life by maintaining health and avoiding hospitalization in order to succeed with meaningful activity and relationships, to reclaim the self from illness. This often means returning back to school or work, volunteering or engaging in a social life. Numerous studies have shown that psychosocial rehabilitation, along with medications, can lead to better outcomes such as improved rate of recovery, decreased severity of symptoms, decreased relapse rates and fewer hospitalizations, reduced suffering of the individual and family, and better quality of life.

Recovery from illness, as the saying goes, is a process rather than an event. It requires motivation and patience to accomplish short-term goals that will ultimately lead to larger successes. Psychosocial rehabilitation is more than a treatment model but also a philosophy that is client-centred — that is, it focuses on the individual and his or her strengths rather than deficits — and helps the individual deal with specific environments or settings that may be important to them like home, family, social networks and community. The approach also encompasses the key element of maintaining hope.

Psychosocial rehabilitation within the SRDP focuses on group-based skills training to enable the individual to self-manage their illness. In particular, skills training focuses on three areas: social/living skills, stress management and relapse prevention. Social and living skills include problem solving, goal-setting, assertiveness and communication techniques to assist in overcoming social and daily barriers. Also falling within the sphere of social and living skills is the need to develop routine and structure for the person. Stress management involves the use of simple relaxation

techniques such as breathing exercises, progressive muscle relaxation, and visualization to manage stress and anxiety. Relapse prevention includes education about the illness such as medication and side-effect information, symptom recognition, warning signs and crisis planning. Cognitive-behavioural therapy is used to help people understand and manage the links between their symptoms and their thoughts, feelings and behaviours. Recently, SRDP has developed two new modules to address the concerns and/or goals of clients: weight management and dating.

The practice of psychosocial skills training is achieved through the use of modelling, role-playing, social reinforcement (e.g. peer, therapist and video feedback), goal-setting, and problem-solving. Homework is assigned to incorporate the skills and strategies learned from the groups. Vocational rehabilitation is also used to identify individual goals and to assess aptitudes, interests and barriers to employment or school. Drug and alcohol counselling and interventions may also be offered. In addition, support and education for family members and significant others are also critical elements of recovery to strengthen the support network for the individual.

Informal feedback given by clients who have engaged in psychosocial rehabilitation in the SRDP have indicated that they found medication, goal-setting, social and physical activities, stress management, and peer support as useful elements in attaining self-management of their illness.

Currently, the SRDP is conducting an ongoing outcome study to review the effects of psychosocial rehabilitation offered within the program. The preliminary results show that after one year of graduating from the program, the majority of clients:

- are involved in productive activity (e.g. work, school, volunteering, vocational training)
- participate in social activity at least once per week and maintain regular social contacts
- report minimal or no symptoms
- experience no hospitalizations
- take medications and see their mental health follow-up appointments regularly
- report moderate to very good satisfaction of life

In sum, psychosocial rehabilitation enables the individual to become the expert in developing skills and making the decisions that help them manage their illness, accomplish their goals and move towards recovery. ■

For any questions about the Early Psychosis Intervention program, please contact Miriam Cohen RN, BSN, Coordinator, Early Psychosis Intervention Program, Vancouver Coastal Health Authority; Phone (604) 822-9732; Email mcohen@vanhosp.bc.ca

For information and/or referral to the Schizophrenia Rehabilitation Day Program (SRDP), please contact Otto Lim, RSW, Schizophrenia Rehabilitation Day Program, Vancouver Coastal Health Authority; Phone (604) 822-7022; Email olim@vanhosp.bc.ca

Early Psychosis Intervention

Group Therapy



“It’s not what we as professionals bring into the room that’s important, but what each individual takes back out with them, having shared and gained from others in the room whose experiences may parallel their own,” said Walter Lidster, an Early Psychosis Intervention Program Group Therapist

Lidster’s comment is directed to a group program that is an essential component of the Early Psychosis Intervention (EPI) program in the Fraser South area.

Early psychosis is the early stage of any psychotic condition that affects the mind, such as schizophrenia or bipolar disorder. About three per cent of all people will experience a psychotic episode in their life, and often the first episode occurs in young people between the ages of 13 to 30 years old.

“Despite limited research on early psychosis and recovery, there is emerging evidence that the opportunity to meet in a group setting with others who have walked in the same shoes supports early recovery and aids in decreasing the impact of the stigma of mental illness,” Lidster says.

Recognizing the unique course that each individual and their family encounter when experiencing the first episode of psychosis, a range of group programs have been developed including client programs, a family support group, psycho-educational sessions, and a sibling group. One client group targets clients under the age of

19, some of whom are in the recovery stage while others are still acute. The sessions begin with a meal prepared with the youth, followed by discussion on stress management, cognition, relapse prevention, alcohol and drug use and communication.

“Many youth don’t have a lot of insight into their illness and we help them to reconnect,” Lidster says, “We teach strategies for recovery, for managing psychosis and re-learning skills like how to become social and make friends again.”

Having a range of youth, both acute and in recovery, is a very effective strategy. “We stress that you will get better and seeing is believing,” he says, pointing to the tremendous impact those in recovery have on the others.

The other client group focuses on young adults from 19 to 30 years old, working with the many developmental milestones and processes which occur during this life stage. In a safe, non-judgemental environment utilizing a cognitive therapy approach, clients develop a personal understanding of psychosis and their own coping strategies.

At the same time as they need to provide support, EPI families emotionally impacted by their own grief and loss issues may need a forum themselves. To answer this need a monthly support group for families is offered in partnership with the Canadian Mental Health Association and the BC Schizophrenia Society.

“Engaging the family as therapeutic partners has emerged as an integral component to the success of the EPI Program,” Lidster says. “Family involvement appears to reduce the vulnerability of the client and aids in maximizing potential recovery while preventing relapse.”

In addition, psychoeducational sessions are offered four to five times a year to help parents and caregivers learn about psychosis and how best to help their loved one through recovery.

A sibling group has evolved from the family sessions with an apparent need for an opportunity away from parental ears for brothers and sisters to express their fears, their anger at the illness, and the many times the guilt they feel for what they may have done to cause their

sibling to suffer, Lidster says. Group programs are at the earliest stage of development in Fraser North. “We have integrated EPI with the family support groups that already exist here, and will be tailoring client programs to meet the needs of the clients in Fraser North.”

For more information call Walter Lidster: (604) 538-4284 Fraser South, (604) 469-5153 Fraser North. ■

Marie Nightingale

Marie is Communications Consultant with the Fraser Health Authority

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WORLD MENTAL HEALTH DAY™ 2003
OCTOBER 10, 2003



2003 Theme:
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Survey of Chronic Disease Management in BC

Focus on Self-Management of Mental Illness within Primary Care

The classic model of chronic disease management within primary care was fairly simple, and is the model of care with which most people are familiar. The job of the doctor was to diagnose and treat, and the job of the patient was to follow orders; in theory anyway, the person would recover and be on his or her way. For years, this was the model that was used in the treatment of chronic illnesses, whether it be mental illness or diabetes or a heart condition.

Mykle Ludvigsen

Mykle is Public Education and Communications Support at CMHA BC Division

Today, however, medical service providers are beginning to understand that while this model may still be relatively effective for treating acute illnesses, it is not terribly effective for chronic illnesses. They are also coming to the realization that, given the pivotal role of the family physician in managing mental illness, a new way of doing things is especially important in this area.

In response, BC's Ministry of Health Services is implementing an approach to chronic disease management (CDM), based on a chronic care model developed in the United States by the Robert Wood Johnson Foundation, known as the *Expanded Chronic Care Model* (see figure 1 below).

- The core components of the model include:
- **decision support** – or clinical guidelines for health professionals reflecting the best available evidence regarding the management of each chronic condition
 - **clinical information systems** – or databases that allow health professionals and managers to track expected performance and health outcomes
 - **delivery system design** – the planning and implementation of a service delivery model that allows for a team approach to providing the continuous and coordinated care that is so necessary for managing ongoing health conditions
 - **self-management support** – providing resources and strategies, such as information and tools, that allow health professionals to build their clients' ability to manage their own health care both within and outside of the health delivery setting

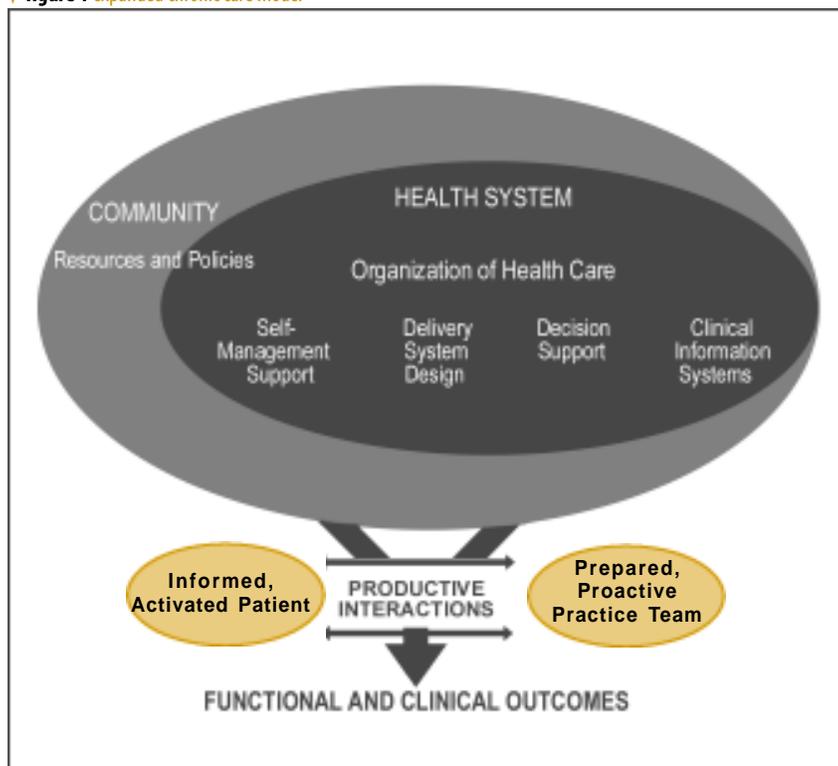
Overall, the model reflects the reality that people with ongoing health conditions need a range of evidence-based resources (i.e., interventions that have been proven effective), and that the health care delivery system needs to be organized in a way that allows individuals to access these easily, initially and over time. It also reflects the need to support individuals in their ability to play a key role in managing their own health, for instance by being an active partner in making treatment decisions, and by building the skills that enable them to manage symptoms and stay healthy in their day-to-day lives. The ideal scenario envisioned in the model is of an “informed, activated patient” working productively with a “prepared, proactive practice team” to produce better health outcomes.

It is important to note that the Expanded Chronic Care Model being used in BC differs from the original Chronic Care Model, most significantly in that it includes prevention and health promotion components. This reflects the view that the essential first step in management of chronic disease is to prevent it in the first place — or at least delay its onset.

While the Chronic Disease Prevention and Management initiative is led by the Ministry of Health Services, implementation is taking place within the health regions. The description below provides a snapshot of the activities taking place within each health authority, focusing on what each is doing with respect to the model generally, as well on what each is doing specifically with respect to supporting self-management in the area of mental illnesses such as depression and anxiety, within primary care settings.

Before focusing on the health authority activities, however, a brief description of other relevant provincial activities is neces-

▼ figure 1 expanded chronic care model



sary context for understanding what's happening throughout the province. Other centrally coordinated activities that will support the move to chronic disease management of depression and anxiety in the health authorities include development of physician guidelines for managing depression, development of a business case outlining the arguments for adopting a new model for managing both depression and anxiety, snapshots describing care throughout the province, and the development of a patient registry to meet the information needs required by the CDM approach. Other relevant self-management-specific resources — such as the anxiety and depression self-management toolkits, the mental health toolkit and addictions tool, all part of the BC Partners for Mental Health and Addictions Information project — are also in the process of being released, and will be described elsewhere in this edition of *Visions*, and in future issues.

Vancouver Coastal Health Authority

The Vancouver Coastal Health Authority has focused much effort on integrating the chronic disease management approach into their existing primary care delivery system, and has included this as a key factor in their re-organization. In a March report, the health authority stated that it is indeed an important strategy in reducing pressure on the acute care system.¹ Vancouver Coastal plans on implementing a diabetes chronic disease self-management plan before moving onto other areas including congestive heart failure and depression.

“We do not want to take on too much,” says Alex Berland, Primary Care Leader. “We want to take an incremental approach — do a good job with this first wave of projects and then expand from there.” He adds that the authority will be posting a manager position for the chronic disease management program shortly. While he acknowledges that the health authority is behind where it would like to be and that there is a definite lack of resources, Berland notes that there is considerable interest in the program within the health authority.

“There is lots of activity going on around the edges,” he says pointing out that if a group of people within the clinical care community came forward to spearhead the program and stated their desire to move ahead on it, it would help move things along. While the initial roll-out of the program in the Vancouver Coastal Health Authority does not envision depression or anxiety disorders among the initial illnesses to be managed by CDM, it will be monitored as a secondary problem with the initial diabetes and heart disease programs. According to Berland, a focus on depression and anxiety would be the next logical step.

Vancouver Island Health Authority

The Vancouver Island Health Authority is planning on having chronic disease self-management at the foundation of their delivery system beginning with a group of family physicians working together on diabetes, congestive heart failure, and major depressive disorder, sharing responsibility for chronic care with a larger interdisciplinary team including nurses, specialists and community-based services and resources.

“We're absolutely convinced that chronic disease management will work well,” says Sylvia Robinson, Manager of Chronic Disease Initiatives. Currently in the initial phases of implementation, the health authority has recently signed on 30 family

physicians to take part in the program, as well as a few dedicated CDM nurses, and prominent psychiatrist Dr. Rivien Weirnerman. “We have been thrilled with the response [from doctors],” she says. “More people applied than we were able to accept.”

The health authority is currently completing some baseline documentation of patients within the program and will begin the full roll-out starting September 2003. According to Robinson, the aim is to learn as they go along with the new system, and ascertain what works and what doesn't. She points out that it is critical in the current initial phase of the project to ensure that there is excellent information systems support within the organization, for all health care professionals working on an individual file. From there, these professionals can work as a team to provide crucial support to the patient. For example, physicians may make follow-up calls to patients to see how they are doing and to remind them of upcoming appointments.

Decision support will also be a key function of these teams, ensuring that patients have access to information from both physicians and clinicians. For self-management in depression, there will be key support available for the individual from the local mental health team, community-based peer support and community agencies. Robinson stresses that it is important to start building relationships and linkages with these critical supports that sometimes are not always included. She points out the need to strategize around the different characteristics in each community — for example language or culture — that impact on the successful management of depression or any other chronic disease. While some of the issues are the same regardless of the disease, Robinson says, some of them are very different, and there needs to be a specific strategy to deal with these differences.

While the funding for this project (made possible by the Health Transition Fund) runs out March 31, 2006, part of the conditions of the initial grant will help to ensure that the program could continue after the 2006 cut-off. Robinson is confident that it will continue post-2006. “We want to see what works in Victoria and how to spread that throughout the island, and then throughout BC.”

Fraser Health Authority

The Fraser Health Authority is currently working with the University of Victoria's Chronic Disease Self-Management Program (described in two separate *Visions* articles on pages 9-10 and 39-40) to develop a region-specific, self-management plan. The initial plans have focused on congestive heart failure and diabetes, but the health authority is planning on developing chronic disease management strategies in other areas including depression. The health authority is using these test areas of diabetes and congestive heart failure to develop best practices models for self-management in other chronic disease areas. A shared care model for depression is being explored, with links to primary care.

“If there was a critical mass we would do it,” says Frank Fung, Health Services Director for the Fraser Health Authority, Fraser East. He points out that while Fraser Health certainly pays attention to depression as a critical secondary issue, major depressive disorder issues are currently being handled in a community context, within the mental health centres.

The CDM model that is being implemented in the Fraser Health Authority is similar to the one being introduced in the

footnote

- 1 (March, 2003). *BC chronic disease management update*, p. 12. Online at www.healthservices.gov.bc.ca/cdm/research/updatesmar03.pdf

Vancouver Island Health Authority. Doctors and other team members will work together closely to remind people of appointments, and provide some encouragement to ensure medications and other remedies are being taken, as well as ensuring a significant level of public education in the community, working closely with the provincial government and other agencies to provide that goal.

Northern Health Authority

The Northern Health Authority has plans to implement the University of Victoria's Chronic Disease Self-Management Program in various communities. According to Elizabeth Tovey, Regional Director of Mental Health and Addictions, the Northern Health Authority is initially working at building skills for the chronic disease management staff to deal with depression issues when they arise for people, with chronic disease management programs as secondary issues. "Mental health and addictions services are so needed in the North, and [individuals] requiring medical treatment [for issues ranging] from diabetes through [to] Hepatitis C, as example[s], [often have] risk factors closely associated with mental health and addictions."

The Northern Health Authority is putting together a com-

munity response unit which can address any questions from primary care providers. Tovey adds, "We still see each service providing a 'specialty' but [they] will also learn to better identify co-occurring disorders."

Interior Health Authority

While somewhat behind other health authorities in its plans for initiating the CDM model, Interior Health has recently begun to identify key strategies for implementing a CDM model within the Interior Health Mental Health Plan. Over the six-month period between October 31, 2003 and March 31, 2004, Interior Health will be reviewing where they can begin developing CDM strategies, and how to work closely in partnership with the Ministry of Health Services. Meetings were recently held with senior managers from throughout the health authority and with the Ministry of Health Services to get an understanding of the program.

According to Kim Marshall, Mental Health Manager for Interior Health, "What we would like to see is where the Ministry is going with this and how do we implement this, and how do we partner with public health and other agencies." ■

BC Clinical Guidelines for the Diagnosis and Management of Depression

Raymond W. Lam
MD, FRCPC

Raymond is Professor and Head, Division of Clinical Neuroscience, Department of Psychiatry, University of BC, and head of the Mood Disorders Centre at UBC Hospital. Dr. Lam is chairing the Work Group on Depression Guidelines for BC

For more information on the guidelines, visit the BC Ministry of Health Services website at www.healthservices.gov.bc.ca/msp/protoguides/gps/index.html

As a key part of the overall *Depression Strategy for BC*, clinical guidelines are being developed to help physicians manage the treatment of people with depression.

What are clinical guidelines? They are "systematically-developed statements about specific clinical problems, intended to assist practitioners and patients in making decisions about appropriate health care."¹ Clinical guidelines are a series of evidence-based recommendations for good clinical care. They can help physicians to standardize their care, provide accessible knowledge about available treatment options, facilitate learning of basic principles, encourage disease detec-

tion, and promote quality improvement and clinical practice research.

Clinical guidelines are not recipes to be used for every patient, nor are they endless lists of every possible treatment, or textbooks. They are not meant to restrict choice of treatment, and they should not be regarded as standards of care because specific clinical situations may override the guidelines. Instead, they should be considered a framework to enable the physician to provide the best quality of care for individuals with depression.

Clinical guidelines are necessary for depression because the detection rate by physicians is still low, outcomes for patients

are not optimal, there has been an explosion of new knowledge about treatments (both medication and psychotherapy), and there is still considerable variability in the treatments offered.

How are clinical guidelines developed? Clinical guidelines follow the principles of evidence-based medicine. Evidence-based means that treatments are selected based on the scientific weight of evidence to support their use. Proven effective treatments are recommended first, before unproven treatments. The clinical research evidence is rated both on quality and quantity. The 'gold standard' of evidence in medicine is the *double-blind randomized controlled trial*, where

patients are randomly assigned to an active treatment or to a *placebo* or inactive treatment. *Double-blind* means that neither the patient nor the physician knows which treatment is used until after the study is completed, in order to avoid bias in assessing the results. Placebo treatment is necessary because there is a spontaneous improvement rate in conditions like depression — for example 40% to 60% of people who take a placebo pill (i.e., like a sugar pill) in a clinical trial feel substantially better in six to eight weeks. That doesn't mean the depression is all in their heads; rather, the simple act of participating in a research study — being diagnosed, receiving

treatment, talking to the doctor, finding out about the illness, going regularly to the clinic — can help people with depression feel better.

Randomized controlled studies don't tell the whole story, however. Often, the studies do not include the 'typical' patient being treated with depression, so the results may not be applicable to everyone. That's why clinical guidelines also use expert opinions to evaluate the evidence and to come up with clinical recommendations that make sense to physicians.

The development of BC depression guidelines is under the direction of the Guidelines and Protocols Committee, a joint effort between the BC Medical Association and the Ministry of Health/Medical Services Commission. A work group was appointed, which includes psychiatrists, family physicians, a psychologist, and representatives from consumer associations and the Ministry of Health. The work group started with a detailed map — the clinical guidelines developed by the Canadian Psychiatric Association and the Canadian Network for Mood and Anxiety Treatments in 2001² — and adapted them for use by family physicians. A preliminary summary was published as a theme issue on Depression in Primary Care [Family Practice]³ in the *BC Medical Journal* last year. The draft guidelines are now being sent out widely for external review, with an anticipated release in the autumn of 2003.

However, mailing out written guidelines to busy physicians is not likely to change the way they practice. That's why we need to pay attention on how to get physicians to start using the recommendations. Education is one way to promote the use of guidelines, but, sadly, education alone has not been shown to influence phy-

sician behaviour. Other methods, which include additional support for physicians such as practice aids, electronic reminders, educational materials, small group tutorials, practice management sessions, and resource directories may have better results.

Another means for promoting clinical guidelines is to make sure that patients are also educated about them. In the BC depression guidelines, self-management is emphasized, including ways that the physician can promote and encourage self-management. An important aspect of self-management is learning about the options available for treatment. To support this, we plan to develop a "Patient Guide to the Guidelines." This guide will help patients and families understand what to expect in their treatment, what kinds of information they should expect from their physician or caregiver, and what questions they should be asking about their clinical care. Having patients as active partners in treatment will provide another incentive for physicians to learn and apply the guidelines.

In summary, clinical guidelines are one tool to help busy physicians organize their management of common clinical problems like depression. We hope that these depression guidelines, as part of an overall *Depression Strategy*, will help improve recognition and treatment, relieve the burden of suffering experienced by people with depression, and reduce the economic burden that accompanies depression. ■

footnotes

- 1 Davis, D.A & Taylor-Vaisey, A. (1997). "Translating guidelines into practice: A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines." *Canadian Medical Association Journal*, 157, 408-16.
- 2 Canadian Psychiatric Association & Canadian Network for Mood and Anxiety Treatments. (2001). "Clinical guidelines for the treatment of depressive disorders." *Canadian Journal of Psychiatry*, 46(Suppl 1), S1-S92. Available online at www.canmat.org
- 3 To, A., Oetter, H. & Lam, R.W. (2002). "Treatment of depression in primary care: Parts 1 and 2." *BC Medical Journal*, 44, 471-482. Available online at www.bcma.org/public/bc_medical_journal/BCMJ/november_2002/default.asp

Chronic Disease Self-Management Program Effective Over the Long Haul

People with chronic diseases need all the support they can get, and now there's a provincial program that's just for them. The Chronic Disease Self-Management program teaches people practical self-mastery skills that enable them to effectively manage their health conditions for a lifetime. First piloted by Stanford University in California, the Chronic Disease Self-Management program (CDSM) is now taught in several countries around the world.

Patrick McGowan, MSW, PhD, and BC's CDSM program coordinator, first travelled to Stanford in 1986 for a closer look and promptly brought the program home. Delivering it first through the BC Arthritis Society, McGowan has since helped train people to deliver the program in various health organizations all over Canada. In BC, more than 20 cities, including aboriginal communities have benefited.

"One of the most important aspects of the course is how people interact with and learn from each other," says McGowan. "The way the course is taught is important. It brings about high levels of self-efficacy: a person's perception of how they can handle a task in the future."

The free CDSM program is held for one-hour each week over a six-week period, generally lead by two trainers with chronic diseases. Participants learn to create *action plans* (setting reasonable goals for managing illness), then to report what transpired at the following meeting. If they had difficulties carrying out their goals, the group will try to help problem-solve. Participants also learn about the symptom cycle, the roundabout circle of symptoms and associated emotions that can prevent people from moving forward (see figure 1, right). Caregivers of those with chronic diseases are also encouraged to take the program — and they participate like everyone else.

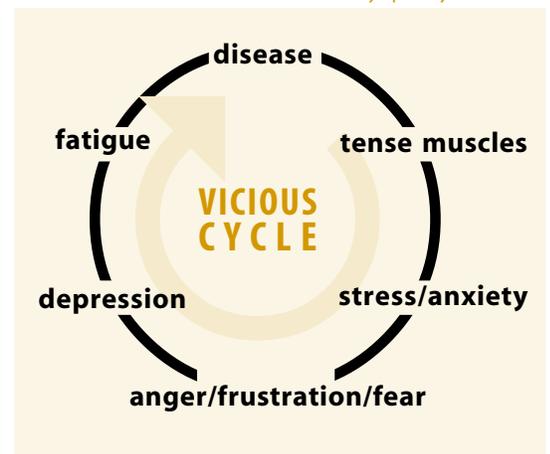
Anne Riddick knows too well the challenge of dealing with chronic disease. Currently

Kathy Smith

Kathy, consumer and proprietor of Smith Secretarial and Design in Victoria, is a freelance writer who specializes in writing about mental health issues

The CDSM headquarters is the Ladner office, satellite office for the UVIC Centre on Aging. For more information, contact Dr. McGowan at Phone (604) 940-3574; Email mcgowan@dccnet.com

▼ figure 1
the symptom cycle



living in Vancouver, she suffered from an early age with arthritis and over the years has also had to deal with osteoporosis, Crohn's disease, fibromyalgia and more. But it wasn't until she was 45 that she first found the program, and has championed its cause ever since.

"When you're first diagnosed with a chronic disease, you go through some grieving for your health. It's like losing your best friend," she says. "Then each time you're diagnosed with another chronic condition, you go through the process again. The program can help you recognize what's happening and help you get through these stages faster."

Riddick says learning to manage depression and fatigue is very important. "We talk about dealing with depression, often a side-effect of chronic disease," she says. "For me, if my symptoms are pain in my body, I can deal with that quite well, but when it reaches above a certain level and I can't do things, I get depressed. Having learned about the symptom cycle, I now understand feeling depressed is usually transitory," she says. And she's quick to point out: "Sometimes you just have to let yourself feel depressed, but if it lasts for more than 2 weeks, you should seek professional help."

Riddick, also a program leader, knows that to live successfully with chronic disease, you have to get proactive and learn all you can about your condition. "You need to find tools — and

education is the key," she says. "Everyone can make their lives better; they just need to know how."

Another program participant, Joan Jacobson from Vernon, is living a much brighter life now. A long-time sufferer of depression, she wasn't sure if she'd ever find everything she needed to cope. Vigilant about managing her condition, Jacobson had always adhered to proper diet and exercise, but eight years ago, she found that wasn't enough anymore.

"I thought I wasn't trying hard enough," she says. "I thought there was a key somewhere and that I just needed to work harder." Then after the birth of her second child, she was prescribed an antidepressant, but was not told of the side-effects. She struggled for the next few years to find the right medication and get on the road to recovery.

While looking to start a support group, she found the CDSM program. "It was nice to meet others who were functioning despite their conditions. They were very inspirational." Now a program leader, Jacobson says, "I found a lot of things that helped me could also help anyone with a chronic disease."

It's clear this program is indeed proving successful for people with chronic health conditions. In April of 2003, it was announced the government would make the program available to every health region in BC over the next three years. A 1-800 information line is slated to begin operation this fall. ■



Turning Over a New LEAF

A Self-Management Program for Adults with Panic Disorder

Sarah Newth, PhD

Sarah is the Provincial Liaison for the Anxiety Disorders Association of BC (ADABC). She is a cognitive-behavioural therapist, provides consultation to other mental health professionals and has published articles in the area of anxiety, stress and coping

In 2002, the Anxiety Disorders Association of BC (ADABC) launched the LEAF program (Living Effectively with Fear and Anxiety). The LEAF program is the first self-management program of its kind to be offered in British Columbia, and is aimed at individuals suffering from mild to moderate levels of panic disorder. During the 14-week program, participants receive training in skills that allow them to effectively manage the symptoms of their anxiety disorder, regardless of whether or not they are currently taking medications.

The LEAF program is an evidence-based self-management program. People suffering from mental health problems

have a right to access evidence-based programs, in other words, interventions where evidence from well-conducted research shows that people are helped to lower their level of symptoms and to live more fulfilling and healthy lives. Unfortunately, despite the evidence that they work, such programs are not widely available in BC for people suffering from anxiety disorders.

LEAF is currently available in four pilot communities: Delta, Surrey, Kamloops and Kelowna. While this is a beginning, there is significant unmet need, considering that over 400,000 people in the province suffer from an anxiety disorder. Anxiety disorders are the most common mental health prob-

lem, with approximately one in four adults experiencing significant problems with anxiety at some point in their lifetime.

LEAF is based on a cognitive-behavioural program for panic disorder that has been shown to work for approximately eight out of every ten people who complete the program. Many people who complete a self-management program such as LEAF are able to use their new self-management strategies to prevent or minimize panic attacks — some even end up completely panic free! Anyone who has been living with unmanaged panic disorder can tell you that this is an incredible outcome that inspires hope for the future and a renewed joy for living.

In the LEAF program, each participant attends a two-hour session once a week for 14 weeks. The weekly sessions are held in small groups of six to ten people who all have mild to moderate levels of panic disorder. A unique and powerful aspect of the program are the LEAF leaders, who run each group in pairs. LEAF leaders have personally overcome their own problems with panic and anxiety by using the same cognitive-behavioural skills they teach the participants. Leaders also receive training and weekly supervision from ADABC experts. As a result, they have strong skills combined with high levels of empathy and understanding.

Participants report that they trust their leaders and feel

Anxiety
Disorders
Association
of British Columbia
www.anxietybc.com

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Addictions Information**
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 **Mheccu** Mental Health Evaluation &
Community Consultation Unit
mheccu.ubc.ca

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Funding provided by the
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**BRITISH
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www.healthservices.gov.bc.ca/mhd

Update: Summer 2003

The Mental Health and Addictions Information Plan for Mental Health Literacy is a groundbreaking public information initiative driven by the seven provincial mental health and addictions agencies listed to the left, working together in a collective known as the BC Partners for Mental Health and Addictions Information. The project is funded by the Ministry of Health Services, under the direction of Dr. Gulzar Cheema, Minister of State for Mental Health. Over the next three years, the project will create a permanent communications infrastructure, including a website and a series of practical toolkits developed to help individuals living with (or at risk for) mental health or substance use problems to manage their health conditions on a day-to-day basis. Combined, the groups have more than 100 years of service to British Columbians and regional branch networks or linkages throughout the province.

The BC Partners project will release four new tools this fall, designed to help people with mental health issues, including concurrent mental health and substance use problems. The resources include toolkits for depression, anxiety disorders, a generic mental illness toolkit, as well as a tool for managing addictions. All of the tools will build on *The Primer*, a resource that provides basic information fact sheets about a range of topics having to do with mental health, mental disorders, substance use problems and addictions. The Primer was released during Mental Health Week 2003 and is available on all the BC Partners member websites.

The *Mental Illness Toolkit* outlines core self-management issues that are generic to any diagnosis or to concurrent diagnoses. The core issues that are addressed include:

- learning the basics of the illness and treatment alternatives
- how to play an active role in finding an approach that works
- how to manage one's health on a day-to-day basis (including managing stress, identifying illness triggers, and developing effective coping strategies to avoid relapse)
- how to access needed community resources

In addition to dealing with core self-management issues, the depression and anxiety disorders tools deal with diagnosis-specific issues having to do with managing each illness. The *Depression Toolkit* focuses on dealing with negative thinking, increasing activity and problem solving. The *Anxiety Disorders Toolkit* deals specifically with managing bodily symptoms, healthy thinking patterns, building strengths and decreasing avoidance. Each of the toolkits also features a self-test and information about how to access diagnosis-specific resources in the community.

Each of the tools is evidence-based, meaning that it is based on self-management principles that have been shown to be effective through sound methodological studies conducted over time.

For the year ahead, BC Partners activities will focus on disseminating the toolkits to the mental health community, and on piloting and evaluating the materials to make sure that the resources meet the needs of people with mental illness and/or addictions. Over the next year, the Partners will also be developing some new resources, including a toolkit for family members and other caregivers, a mental health promotion toolkit, and a mental health toolkit for the workplace.

is the LEAF program for me?

For a detailed description of all anxiety disorders and a self-test, please see the ADABC website at www.anxietybc.com. Print out the self-test and take it to your physician or mental health professional. If you have mild to moderate levels of panic disorder, the LEAF program might be suitable for you

For more information about the LEAF program contact ADABC: Phone (604) 681-3400; Web www.anxietybc.com; Mail #119 - 4438 West 10th Avenue Vancouver, BC V6R 4R8

Funding for the LEAF program is provided in part by the Ministry of Health Services via the BC Partners for Mental Health and Addictions Information plan. The LEAF program is led by Dr. Lynn Miller, a past president of ADABC and a counseling psychologist who specializes in anxiety disorders in children and youth

inspired by the powerful example of what life can be like when panic disorder is better managed and under control. Recent participants stated the leaders “did a wonderful job of making us all feel comfortable” and were “wonderful, compassionate instructors...who could relate to us as they went through similar experiences.”

Each LEAF group is held at a convenient location in participants’ home communities (e.g., mental health centres, community centres, schools, etc). The groups are deliberately held in neutral safe locations that are within commuting distance and easily accessible via public transit. ADABC plans to expand the LEAF program to additional communities throughout British Columbia — especially the more rural and remote areas of BC where mental health services are particularly sparse.

All LEAF participants are evaluated prior to beginning the program and after completing the program — an important feature of evidence-based programs. Without these evaluations, we would not know for sure if the program is actually helping. Pilot data indicates that most LEAF participants experience significant reductions in their symptoms of panic, anxiety and depression. They also report significant drops in their avoidance behaviours and an increased ability to do things they hadn’t been able to do before like going to public places, driving, taking public transportation, doing things alone, or trying new things. Some participants have even been able to return to work during the program with the support of the leaders and other LEAF participants. Many LEAF participants also tell us their self-esteem and confidence has significantly improved. Recent LEAF graduates stated, “this program taught me more than I ever dreamed,” “I

am conquering my fears,” and “I can now do things I couldn’t do before.”

It is the cognitive-behavioural skills taught and practiced in the LEAF program that allow participants to overcome panic disorder and get their lives back. Participants get the opportunity to review and practice these skills in session with supportive feedback from the LEAF leaders and the rest of the group. Participants then have the opportunity to practice these skills during the week. Leaders help plan weekly homework assignments in a way that sets up participants for success. Developing goals that are realistic and attainable increases motivation to do even more. Leaders also give feedback about weekly progress and help participants troubleshoot any difficulties that may arise.

The cognitive-behavioural skills taught in the LEAF program cover the following five basic areas:

Education

First, participants are provided with basic educational information about the nature of panic disorder, panic attacks and anxiety symptoms. For example, many LEAF participants are surprised to learn that rapid heart beats or difficulty breathing are normal symptoms of anxiety that are not dangerous. They also learn that most adults experience symptoms of anxiety from time to time.

Managing Symptoms

Second, participants are taught controlled breathing and muscle relaxation in order to manage the bodily sensations of anxiety and panic (e.g., rapid heart beats, difficulty breathing, feeling dizzy, feelings of disconnect from reality, muscle tension, etc).

Healthy Thinking

Third, participants are taught

how to examine their thoughts and beliefs in order to identify any misconceptions that maintain the cycles of repeated panic attacks. For example, LEAF participants learn that we cannot die or go crazy from a panic attack. This is good news for all of us given that one in three adults will experience a panic attack in any given year, especially during times of high stress.

Overcoming Avoidance

Fourth, participants learn to gradually overcome the avoidance behaviours that can be a significant part of living with an anxiety disorder. For example, someone who can’t ride the bus might start by riding the bus to the next stop with a loved one. Over the course of the LEAF program they might work up to riding multiple stops with a loved one and eventually to riding alone. This well-controlled gradual exposure to feared experiences is very successful in helping people get their lives back and do things they had been unable to do prior to the LEAF program.

Maintaining Gains and Relapse Prevention

Fifth, and finally, participants are taught how to maintain their gains and how to manage or prevent any relapse of their symptoms. This set of skills includes setting up ongoing goals for the participants to work on after the program has finished. Participants also learn that it is normal to experience episodes of anxiety and an occasional panic attack from time to time, especially when coping with stress. As a result of the program, they now have the skills to cope with any future waxing or waning of symptoms.

Many LEAF participants tell us that they were initially very nervous and uncomfortable about attending a program offered in

a group setting. However most LEAF participants feel immense relief after meeting other people who are also suffering from panic disorder. They realize they are not alone and many look forward to seeing each other each week. By the end of the program, most LEAF participants tell us the support they receive from others during the program is invaluable and helped them make progress. One recent LEAF graduate told us “I had a real feeling of belonging to a welcoming group of individuals.” Another LEAF graduate stated, “I met some wonderful people...we laughed and cheered with each success, and there were many successes ... I leave here with new friends, new understanding and a new future.” It’s no wonder that people are excited about the LEAF program.

In the future, ADABC would like to adapt the LEAF program for use with youth who are experiencing similar problems with panic and anxiety. Ideally, additional LEAF programs would also be made available throughout the province for other types of anxiety disorders. As mentioned, there are very few evidence-based resources for anxiety disorders in BC other than medications. This is unfair and must change given that anxiety disorders are the most common type of mental health problem. If you would like to see evidence-based programs for anxiety disorders offered in your home community, please express your concerns to the local health authority. For additional information about how to increase resources for anxiety disorders in BC, please contact ADABC. ■

profile

LEAF Participant Story



From all appearances, Nadia had a normal life. At 41, she was in a stable career with a Vancouver advertising agency, happily married with 2 children, and had a house outside of the city, complete with mortgage to pay and mouths to feed. Like most who are eventually diagnosed with a mental disorder, she did not fit the profile of someone whom society would normally perceive as being in a risk group for a mental illness. While Nadia had a family history of some mental illness — her mother lived with depression — prior to her first panic attack in the summer of 2002, she didn't notice any signs of her illness.

"There wasn't necessarily one trigger," she explains. "I had been feeling quite anxious over the last couple years, and under a lot of stress and then one morning I was in the office by myself and I got all worked up about all the stuff going on. I thought I was going insane and thought I was completely breaking down."

Over the next few months, Nadia continued to have panic attacks, each time hiding them and not telling anyone in the fear that she was, indeed, going insane. "I would be running late for work," she explains, "and I would start to have what I call my catastrophic thoughts and think 'what if I lose my job?', 'how am I going to pay my mortgage? My family is going to be out on the street.'" These types of thoughts would continue, but Nadia continued to hide them from her friends and family, afraid she was 'losing it' and was going to end up committed — a thought which encouraged more catastrophic thoughts about losing her home and her job.

Eventually Nadia summoned the courage to see her family doctor. After a short 10-minute visit, he prescribed her clonazepam, a benzodiazepine commonly used to treat anxiety disorders. Benzodiazepines act as a sedative and muscle relaxant. They work by slowing down the central nervous system, and can be addictive if used over an extended period of time. They are, however, effective over the short term.

But Nadia felt uncomfortable taking a drug. "I felt I was just resorting to taking it," she says, adding that she thought it was just masking what was causing the panic attacks in the first place. She does, however, acknowledge that the drug did indeed help with her symptoms. It was at this point that she decided to tell her husband that she was suffering from an anxiety disorder.

"It was a thorough conversation," she said, recounting the discussion. "I was very ashamed. I was embarrassed about feeling this way. I didn't understand what was going on and I wasn't told by my own GP about the drug that I was taking. My husband didn't want to hear about [the illness], and he was very scared."

Under treatment, but unhappy, she started seeing ads for the LEAF program, both in her community paper and on her community television station. Nadia wanted to be able to feel 'cured' but also wanted to be off the drugs that her doctor had prescribed. Nadia was also, however, extremely anxious about calling about the program. But eventually she worked up the courage to pick up the phone and enrolled in the program.

"I was very anxious to go to my first meeting. My fear was that it would not work." Nadia went into the first meeting expecting something far different than she ended up participating in. "It sounded like work. They had you doing these exercises and I guess I was looking for answers as to what was wrong with me. I thought they were going to have some magic bullet. After the first meeting, I knew I was going to have to look inside myself."

"They had seven or eight other people in the room along with two leaders who had gone through this themselves. Right away, everyone understood what it meant to have [this illness]. There was this support and you were able to say 'I feel this way' and they wouldn't be judging me for it. I began to understand what was

causing the attacks. It was like a light bulb went off inside in my head as to why things were happening the way that they were. I started to understand what was causing the attacks, and you really start to understand the anatomy of it."

Nadia learned some basic relaxation and coping mechanisms, and she personally found the breathing techniques among the most useful. Interestingly, in this type of therapy, participants are slowly exposed to situations that might trigger an attack and are forced to cope with it by controlling the response. In Nadia's case, this included the all-too-familiar commuting nightmare, which made her fear she'd be late, triggering the catastrophic thoughts that had emotionally paralyzed her earlier. But this time she got through it. "I was taught how to be in control of my thoughts and my body — now I was late and there were no catastrophic thoughts!" she says.

A criticism often made of these types of programs is that they are not effective when push comes to shove and the real stress is applied. Nadia says that is simply untrue, at least in her case. Prior to starting in the LEAF program, Nadia was terrified of medical procedures in general. "God, it's going to happen to me," she recalls thinking to herself whenever someone had to go in and have a procedure, and then the catastrophic thoughts would begin. Shortly after the end of the LEAF program her stepfather was hospitalized and her father-in-law died. These were two large, traumatic events for both her and her family and Nadia managed to cope through unimaginable pressure. "I used my strategies to cope and used my calming thoughts and it worked. I was able to get through it."

After the program, Nadia was able to almost completely eliminate her use of clonazepam. "Prior to the program, I was taking about a ½ pill every day. Since the program I've only had to take the ½ a pill once on a very stressful day, and even then, as I was swallowing it, I was thinking I could have probably done without it."

Nadia says she's learned to recognize the body reactions that tell her an attack could be coming on. Knowing what to look for is crucial. In her case, she says she often gets hot and sweats a lot, and that's when she knows that she has to begin using her strategies to calm down. These include using her breathing techniques and her repetition of various phrases to help prevent the catastrophic thoughts from coming on. Since leaving the program, Nadia has not had another panic attack and says she feels essentially 'cured,' while understanding that this is something she will have to live with for the rest of her life.

"Now that the support group is over, I have revealed what has happened to me to others. I'm not ashamed about it. Now that I understand it, I can reveal it. I know that I'm not going crazy, and that I'm not going to be committed." She goes on to say, "I feel in control of it, and I don't want anyone to think that I'm not in control, so I can tell them."

"I reveal it to people and they tell me that their sister had it, or their brother had it or that sometimes they feel that way, too." She says she has no hesitation in recommending this program to anyone having difficulty with an anxiety disorder. She says that since the program she has been setting aside more time for herself and doing things for herself that she was not doing before. She says she is having people over for dinner and enjoying her life again. As she has become more educated about this illness, so has her husband, so the support that she had in the support group now exists at home.

But she demurs. "You know, I don't really feel a huge need to talk about it, because I just feel so much better. Calling that number was probably one of the hardest things I've ever had to do in my life," she says in retrospect, "but it was probably one of the best things I've ever done." ■

Mykle Ludvigsen

At this point, future funding of central coordination of the BRIDGES program (including facilitator training) has not been assured. However, the program may still continue to be available in your community. Contact the BC Schizophrenia Society toll-free at 1-888-888-0029 for more information.

Getting From Where We Are to Where We Want To Be

Debbie Sesula
BA, RTC

Debbie Sesula is the Program Coordinator of the BRIDGES Education and Support Program with BC Schizophrenia Society

BRIDGES stands for Building Recovery of Individual Dreams and Goals through Education and Support. The mission of BRIDGES is to empower people with mental illness to take an active and informed role in their treatment and to recover a new sense of purpose in life. BRIDGES is built on the philosophy of recovery, a philosophy that one can live an active and full life even while experiencing psychiatric symptoms.

BRIDGES consists of a 15-week educational course that is taught by people with a mental illness and is attended by people with a mental illness. The curriculum covers key topics such as the basic facts about psychiatric diagnosis and medications, identification of needs, obtaining mental health resources and dimensions of recovery from mental illness. Each class is two-and-a-half hours in length and consists of a classroom format including discussions, class activities and question and answer periods. Learning from each other empowers one with the tools to build their own bridge to recovery.

I have struggled to build my own bridge to recovery for seven years, and becoming involved with BRIDGES was the beginning of my climb out of the grasp of mental illness to a whole new world of recovery and self-management. Instead of letting mental illness control me, I learned to control it. I learned to accept my limitations and to cope when the going got rough, and that despite my illness, that I have a lot to contribute and the skills to match. And despite setbacks, I have what it takes to get back up again. I learned that with BRIDGES, I am not alone.

I have seen first-hand the many changed lives because of BRIDGES. I listened to the excitement in the voice of one gentleman, who for the first time in his life, was able to find employment and keep a job. I heard from a young woman who had been depressed and suicidal, and no longer wants to end her life.

I listened to the amazement in one lady's voice as she shared that she couldn't even go out for coffee for many years, but has since dealt with her fears and now goes out for coffee quite regularly. I heard from one young gentleman who wouldn't go anywhere or do anything without his mother, and who now does things for himself and believes in himself. I listened to the inspiration in the voice of one lady who really

wanted to go back to school and has since found the courage to do so. I have seen people who could hardly say their own name make it all the way through the course and go on to become a BRIDGES teacher. This is what BRIDGES does for me — I am so rewarded by observing the many changed lives. BRIDGES helps individuals get from where they are to where they want to be.

Since the introduction of BRIDGES in BC, responses from teachers, students, service providers and family members has been very enthusiastic: teachers say the course is fun to teach, students say they are learning things they wanted to know for a long time, service providers and family members tell of the impact BRIDGES is having on their clients and family members.

BRIDGES is open, free of charge, to any person with a mental illness. A referral for BRIDGES is not required. To learn more about BRIDGES and to find out if BRIDGES exists in your community, please contact the BC Schizophrenia Society at 1-888-888-0029.

The Impact of the Program

Based on a 2001 survey,¹ the impact of taking the BRIDGES course for participants is as follows:

- has given me the tools for my recovery (99%)
- has helped me in my own personal recovery (90%)
- has given me information about resources I didn't know about before (78%)
- has decreased my need for hospitalization (76%)
- has decreased my need for other crisis services (74%)
- has increased my socialization (65%)
- has helped me to be as independent as I can be (64%)
- has led to new friendships with other students (63%)
- has decreased my use of mental health services (61%)
- has increased my support network (57%)
- has led to my involvement in advocacy (42%)
- has since led to my obtaining a volunteer position (36%)
- has since led to my obtaining employment (25%)
- has led to my becoming a BRIDGES teacher (10%)

The most important curriculum gains for participants included:

- an understanding of mental illness (21%)
- knowledge and information (19%)
- insight (16%)
- knowing others like me (14%)
- increased self-esteem (6%)
- knowledge of resources (6%) ■

footnote

¹ In 2001, a survey was conducted of past BRIDGES students. Out of 235 BRIDGES graduates from 1996-2001 that were contacted, seventy-two individuals participated in the survey; 72% of the participants were female and 28% were male

profile: bill maycock

Bill Maycock had some traumatic blows to his life which left him crippled in a depressed psychotic state. He lived his life in a medication haze with no purpose or direction. He heard about BRIDGES and decided to attend, not once, not twice, but three times. He says, "The first time I slept through most of it, the second time I started to feel hopeful, and the third time I was beginning to feel worthwhile again."

Previous to BRIDGES, Bill had been seriously thinking of ending his life. What a transformation — not only did Bill graduate from BRIDGES three times, but he went on to become a BRIDGES teacher. He surprised himself at what he was capable of doing. He says, "The BRIDGES' claim is true that it helps one get from where they are to where they want to be."

profile

My BRIDGES Diary



Tracy May

Class 1: Introduction — First class is over. It seems like a bit of a blur. So many new faces, and a new experience. Everyone seemed perfectly normal: no obviously disturbed behaviour or visible medication side-effects. The instructors are upbeat and sympathetic but task-oriented so we got through the material within the allotted time. We did some 'let's get acquainted' stuff. It is nice to know we can pass if we are uncomfortable. Talked, too, about the emotional stages of recovery and made a commitment to attend the course. So far, so good.

Class 2: Thought disorders: Schizophrenia — We started the class with a one-word feelings check. What is it about one word that is so hard to understand? Today's class dealt with schizophrenia and some of the myths and realities. Interesting. Rather glad I deal with mood and anxiety disorders; the medications for schizophrenia (I gather) aren't pleasant. The instructors told their stories today and it was interesting, mainly because they both seem . . . normal!

Class 3: Mood disorders and suicide prevention — Today's class was an emotional one as it dealt with suicide and so many of us had attempted it or had seriously considered killing ourselves. We worked on a suicide support system and I realized that although I have many friends, I have virtually no one to whom I could turn. I just do not discuss my condition. Have to be perfect, have to be normal. We also discussed mood disorders. It strikes me how people get into trouble when they don't get enough sleep. I've always needed a lot of sleep and done better when I achieve that. Could it have been that simple?

Class 4: Anxiety disorders, personality disorders — I told my story today, as the topic was anxiety disorders, and hey, that's me! I actually was pretty anxious doing it, but I felt very accepted and not judged at all. The class is starting to bond somewhat, which is nice. People are being honest about what they have, do, have done, and so on. Some people have really been through the wringer and it seems to take a lot of time for people to get help and then get their lives in order. I feel that I am learning both about my illness and about myself.

Class 5: Recovery from mental illness and chemical dependency — This is *my* class. What a package! I feel very, very lucky that my addiction ended when I got and used Prozac appropriately. How many drunks are really mentally ill? How much of mental illness is the result of using? Which came first, the chicken or the egg? There were four of us in the class who are dual disordered. Four out of 13: almost one in three. Really, this type of class could be a course in itself.

Class 5: Building support, crisis planning — It strikes me that I do not talk much about my illness, except in class. I feel very sad that I have no one, really, to talk to, to understand. Perhaps it is more that I don't reveal myself and that I'm afraid of being judged. Lots of planning in this class, forms to fill out. I can see how this is necessary but would anyone in crisis remember to carry it along? I guess that you have to share your information about your crisis warning signs with family, doctor etc.

Class 7: Biology and the environment — This is a little drier than some classes; I guess that is why we were colouring in areas of the brain. Wow! Interesting though, the research, theories, statistics. Makes me feel less flawed, less responsible.

Class 8: Medications and how to talk to your doctor — I am amazed at how many antidepressants I tried before Prozac. And none of them worked. I'm thinking that I lean more to the anxiety disorder and the depression is secondary. The antipsychotics don't sound as uninvasive as do the antidepressants. They sound difficult, so many side-effects. I feel lucky to have Prozac, my little friend.

Class 9: Mental health services and psychotherapy — What's available? What's not available? What are the kinds of therapy and how do they work? Not a fan of therapy, at least not for me. It never did a thing in terms of stopping the anxiety

or depression. Just Prozac did. However, chatted with the instructor about this and my experience is far from universal so, I will be tolerant. And a lot of people with mental illness have maladaptive behaviour that they need to change. I guess that I could stop rescuing people! Am I just being a perfectionist...no, no, it's not me, it's a disease.

Class 10: Rehabilitation services — I did like the 'hospital thinking' vs. 'recovery thinking'. TAKE RESPONSIBILITY FOR YOURSELF! Some of the financial details were very interesting. So many people with mental illness are so poor. How, then, do you get better with the constant financial stress, poor housing, food etc.?

Class 11: Tools for recovery: Wellness, problem-solving — This stuff is important especially in the light of the poverty issue. Discussed diet, exercise, sleep, stress reduction and problem-solving. Very practical, very logical. This is useful stuff. I really enjoyed the problem-solving — breaking a problem down into parts and then tackling it, leaving emotion and feelings to one side. I was already doing some of it. Good for me!

Class 12: Tools for recovery: Communication skills — This was a rather fun class. Role-playing and practicing assertiveness and reflective response. A lot of stuff to use and it will take practice. Maybe I should make a cheat sheet and carry it with me!

Class 13: Healthy spirituality — A thinking/feeling/considering class. What are virtues, what is religion and so on? Also, identifying unhealthy religious practice. I got thinking a lot today and feel more connected to God. Amazing enough to me, considering that my first obsession was religion. Hallelujah!

Class 14: Advocacy — How to change the system. Not on my agenda right now. A trifle dull.

Class 15: Certification and celebration — Evaluation forms, certificates and then a lunch with the class, paid for by BRIDGES!

Three months later...

When I look back at the BRIDGES education course, I am struck by the following things:

- that the course was completely free of charge
- the genuine feeling of "we're all in this together, so, let's learn and help together"
- that it was a safe place to be
- that the instructors were consumers, but make no mistake, they were in control
- that recovery happens. ☑

profile: barbara moreau

When Barbara Moreau first entered the room, she appeared very sullen and withdrawn. After three classes she began to open up, sharing with us the ongoing depression she continually struggles with. Finding others who could relate brought a sparkle of hope to her eyes. She pushed herself 100% throughout the course and did all the extra readings. She took pride in what she was learning and shared her many 'aha!' moments.

Barbara no longer appears sullen and withdrawn, but animated and approachable. Her involvement with BRIDGES has decreased her need for crisis services and has increased her self-esteem and confidence immensely. But Barbara didn't stop there: she went on to become a BRIDGES teacher, determined to be a "shining star" to others. And a star she has become as her peers see where she was in her life and where she is now. She feels good about giving back to her peers the message of hope she was given. She says, "I want to help erase the stigma that exists with mental illness and teaching BRIDGES is one way of achieving that."

The Bottom Line

Untreated Depression and Anxiety Disorders in the Workplace

Conference ■ October 30, 2003 ■ Hyatt Regency Vancouver

Reasons to Attend:

- 1** Because in today's competitive work environment, many employees are reluctant to admit to having difficulty keeping good mental health in the workplace.
- 2** Because companies are losing their most creative and productive employees to depression and anxiety disorders.
- 3** Because mental illness is the fastest growing cause of workplace disability.
- 4** Because a mentally healthy workplace is the best insurance policy against long-term disability.
- 5** Because the CMHA Bottom Line Conference is designed to help small and large businesses, organizations, unions, and benefit providers reduce the impact of depression and anxiety disorders in the workplace.
- 6** Because the bottom line costs are staggering.



The Canadian Mental Health Association's BC Division is proud to host the Bottom Line Conference. Working together closely with industry and labour, together we can lessen the impact of depression and anxiety disorders on workers and on the bottom line.

www.cmha-bc.org/bottomline



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Articles

- **The clinical and cost-effectiveness of self-help treatments for anxiety and depressive disorders in primary care: A systematic review.** Bower, P., Richards, D. & K. Lovell. (2001). *British Journal of General Practice*.
- **Reclaiming your power during medication appointments with your psychiatrist: A guide to becoming an active partner in decision-making about treatments.** Deegan, P. (1999). *National Empowerment Center Newsletter*. Available at www.power2u.org/selfhlep/reclaim.html
- **Evidence-based practices for services to families of people with psychiatric disorders.** Dixon, L. et al. (2001). *Psychiatric Services*, 52(7), 901-910. Also available at www.mentalhealthpractices.org/pdf_files/dixon.pdf
- **Implementing dual diagnosis services for clients with severe mental illness.** Drake, R. et al. (2001). *Psychiatric Services*, 52(4), 469-476. mentalhealthpractices.org/pdf_files/drake1.pdf
- **How persons recovering and clinicians can promote self-managed care.** Fisher, D. (1999). *National Empowerment Center Newsletter*. www.power2u.org/recovery/selfmanaged_care.html
- **Psychotherapy for bulimia nervosa and bingeing.** Hay, P. & Bacaltchuk, J. (2002). *Cochrane Database of Systematic Review*.
- **How I perceive and manage my illness.** Leete, E. (1989). *Schizophrenia Bulletin*, 15(2), 197-200.
- **Self-management education: Context, definition, outcomes and mechanisms.** Lorig, K. & Holman, H. (2000). First Chronic Disease Self-Management Conference, Australia. www.chronicdisease.health.gov.au/pdfs/lorig.pdf
- **Behaviour therapy for obsessive-compulsive disorder: A decade of progress.** Marks, J. (1997). *Canadian Journal of Psychiatry*, 52, 1021-1027.
- **Illness management and recovery: A review of the research.** Mueser, K. et al. (2002). *Psychiatric Services*, 54(10), 1272-1284. www.mentalhealthpractices.org/pdf_files/mueser.pdf
- **Self-administered treatment in stepped-care models of depression treatment.** Scoggin, F. et al. (2003). *Journal of Clinical Psychology*, 59(3), 341-349.
- **Implementing evidence-based practices in routine mental health service settings.** Torrey, W. et al. (2001). *Psychiatric Services*, 52(2), 179-182. www.mentalhealthpractices.org/pdf_files/torrey.pdf
- **Stepped care treatment for eating disorders.** Wilson, G., Vitousek, K. & Loeb, K. (2000). *Journal of Consulting & Clinical Psychology*, 68(4), 564-572.

Websites

- **Evidence-Based Practices project**, based at Dartmouth University. Project information on illness management, family education and concurrent disorders approaches. www.mentalhealthpractices.org/index.html
- **Human Behaviour and Health Research Unit**, of Flinders

University, Australia. Self-management literature review and project links. som.flinders.edu.au/FUSA/CCTU/

- **Australian Shared Care Initiative**, includes self-management guidelines for GPs, nurses and allied professionals. www.racgp.org.au/folder.asp?id=299
- **Wellness & Recovery Action Plan model (WRAP)**, founded by Mary E. Copeland. www.mentalhealthrecovery.com
- **The STEADY project**, a self-management approach for young people with bipolar illness. www.steady.org.uk
- **The Improving Chronic Illness Care initiative**, of the Robert Wood Johnson Foundation. Basis of the BC-based chronic disease management model. www.improvingchroniccare.org
- **Stanford Patient Education Research Center**. Info on CDSMP model. patienteducation.stanford.edu/programs/
- **Comorbidity of Mental Illness and Substance Abuse Project of the Primary Mental Health Care**, Australian Resource Centre. som.flinders.edu.au/FUSA/PARC/comorbidhome.html
- **Changeways**, out of Vancouver, BC. Develops evidence-based treatment protocols and training programs for professionals in the mental health field. www.changeways.com
- **Expert Consensus Guidelines**, includes patient/family versions of clinical guidelines. www.psychguides.com
- **Panic Centre**, includes cognitive-behavioural strategies for panic disorder. www.paniccenter.net. Also see www.anxieties.com/index.php?nic=panic

Recovery/Self-Management Guides or Books

- *Self-care depression program: Patient guide.* R. Paterson & D. Bilsker (MHECCU, 2002). Online at www.mheccu.ubc.ca
- *A guide to recovery.* Organization for Bipolar Affective Disorders Society (OBAD, 2002). Online at www.obad.ca
- *Getting out of it: How to cut down or quit cannabis.* H. Mentha (Inner East Community Health Service [Australia], 2001). Online at www.aa2.org/tools/mar/mari.htm
- *Personal assistance in community existence: Recovery at your own PACE.* L. Ahern & D. Fisher (National Empowerment Center, 1999). Online at www.power2u.org/pace_manual.pdf
- *Storm breaking: An anthology of experiences through mental illness and into recovery.* E. Macnaughton (Ed.) (CMHA BC Division, 2002) Online at www.cmha-bc.org
- *A map for the journey: Living meaningfully with recurring depression.* N. Dickie (PublishAmerica, 2001)
- *Riding the roller coaster: Living with mood disorders.* M. Bergen (Northstone, 1999)
- *Feeling good: The new mood therapy.* D. Burns (Avon, 1999)
- *Your depression map: Find the source of your depression and chart your own recovery.* R. Paterson (New Harbinger, 2002)
- *Getting better bit(e) by bit(e): A survival kit for sufferers of bulimia nervosa and binge eating disorders.* U. Schmidt & J. Treasure. (Psychology Press, 1997)
- More self-management books at www.wiltshire.nhs.uk/awp/swindonpsychology/Self-Help.htm

This list is meant as a guide only and not meant to be exhaustive. While we have attempted to include helpful references, inclusion in this resource list does not necessarily reflect complete content endorsement by CMHA BC Division

BC's Only Online Searchable Inventory of Employment Services



www.cmha-bc.org/inventory

5000 services and growing...

Check out a free, comprehensive employment services database for BC, particularly those specializing in supports for mental illness. This searchable database includes detailed information about accessing a wide variety of employment-related programs. Search by community, health region, client base, service type or combinations thereof. There are currently **530 agencies** listed and over **90 categories of services** such as negotiating accommodations, accessing subsidized volunteer opportunities, as well as subsidized educational opportunities.

Why am I receiving Visions?

As part of the new BC Partners for Mental Health and Addictions Information (see page 41 of this issue of *Visions* for more information on this initiative), members of provincial mental health and addictions agencies other than CMHA, whose members already receive *Visions*, will now receive a complimentary copy of this quarterly, award-winning journal. Neither your name nor your mailing information was shared as it was sent by the organization of which you are already a member. If you would NOT like to continue receiving your free copy of *Visions* in the future, please let your member organization know.



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HEALTH ASSOCIATION
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CMHA BC Division
1200 - 1111 Melville Street
Vancouver, BC V6E 3V6

