BC PSYCHOLOGIST

SPRING 2006

APRIL IS CANCER AWARENESS MONTH!

Tom Gilligan, Ed.D R.Psych.

In the spirit of National Cancer Awareness Month, I wrote this piece with the hope of increasing awareness of the emotional distress that may occur after a caner diagnosis, and how that distress may be alleviated by psychological treatment.

For twenty two years I have worked as a psychotherapist with people who have cancer. During that time I have noticed both a growing professional and public awareness of the psychological consequences of this illness, as well as an increased understanding of empirically based effective ways of responding to those consequences, including education, and group and individual psychotherapy. It is not my intention to provide a comprehensive summary or critique of these changes but to merely highlight my own experience and biased view of what I think is important and to do so within the context of my own story and professional development in helping people with cancer and their families.

When I was child living in post-war England, I became aware of cancer through the illness and death of my grandfather. Medical treatment and support were limited at that time and his illness was difficult and prolonged. The dormant memories of that childhood experience were awakened many years later, when I carried out a doctoral research project that brought me into contact with a small group of extraordinary cancer patients. These individuals were extraordinary because they had transformed the fear and loss brought on by their illness into a process of personal growth and meaning. Each story was unique but at the same time there were easily recognized commonalities. Immediately following the diagnosis, each person described feeling alone, numbed and somehow dissociated from their normal sense of self and the lives that they had been living. In most cases the moment of diagnosis was vividly etched in their memories and they could recount minute details of time and place associated with that moment. Many of them described a recurrence of those intense feelings whenever they were getting chemotherapy or even driving past the place of treatment. Initially I had understood those feelings and descriptions within the context of a psychological healing process that had reconnected them to their emotional experience and deepened their relationships with others. At the time, the intense descriptions of emotional distress following diagnosis and recurrence were understood as being a normal response to extraordinary events and without clinical significance. It was only later that I realized the possible clinical significance of those intense descriptions as symptoms of a stress disorder.

In 1983 I began to work with Dr. Alastair Cunningham in The Cancer Coping Skills Training Program at The Princess Margaret Hospital in Toronto. Dr. Cunningham had been trained as a research hematologist before becoming a psychologist. At that time other people such as Carl Simonton and Lawrence Le Shan were providing group support programs for people with cancer. What made Dr. Cunningham's program unique was that he structured his support groups within the context of a scientific research project with measurable outcomes. The program was based on an underlying philosophy that healing involved many levels beyond the physical and that helping people become better integrated at psychological, social and spiritual levels may not only alleviate distress but also, in some cases, affect the disease - radical notions indeed given the time and place. He was also an early advocate for psychological support for the spouse or primary support person, recognizing that the stress associated with this role often placed the support person at risk for later physical illness.

In 1993 I returned to Vancouver and for nine years maintained a private practice, in which I provided individual psychotherapy and co-facilitated cancer support groups with Ms. Moyra White. Moyra and Claude Dosdall were the founding members of Hope House. Both Moyra and Claude had been diagnosed with cancer and through their own experience had realized that there was a need for emotional support for people with cancer that was not being provided by the current medical and social services in Vancouver. Drawing from their own experience and with the help of community funding, they established Hope House, a non-profit agency founded in 1980 with the objective of providing support groups and services for people with cancer and their families. During the period that I worked at Hope House I wondered why it seemed to be so helpful for people to talk with others who had also been diagnosed with cancer. I wondered why cancer, as a medical condition, seemed to be associated with so much fear and why that fear seemed to go unrecognized and unalleviated. I thought that perhaps we had placed too much confidence in the ability of medical science to cure rather than care for people with illness. Despite the resources devoted to finding a cure for cancer, many forms of cancer remain difficult to treat with confidence, often leaving both patient and physician with limited options in knowing how to respond in a hopeful and meaningful way. I wondered if a disease based approach to health and ill health tended to treat aspects of a person's experience rather than the whole person. One consequence of this bias for people with cancer, is that the emotional effects of cancer are seen as irrelevant in terms of treatment focus. For people with cancer this response may create a sense of alienation and separation from their own experience and relationships with others. People came into the groups at

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PRESIDENT'S COLUMN

Wolfgang Linden, Ph.D., R.Psych.

Dear Colleagues,

As we're moving into Spring, we are also planning to come a little more out of our shells and increase BCPA's visibility via the most extensive CE curriculum to date, and plans for advocacy. In hindsight, I am very happy that we acted out our plan of inviting local MLAs for breakfast. 16 of you had volunteered to do so although I have not yet heard back from everybody who was actually successful in taking their MLAs out. Please do share what you learned to help us with our advocacy efforts. What I have heard was uniformly positive, and we anticipate that these personal connections will help us do better lobbying. Thanks to the office staff for compiling a handy info package. I think it is fair to say that the breakfast participants did not have an onerous task in preparing for the breakfast as we had excellent preparation materials and handouts ready for all of them. I am just a little sore that my own riding representative (our Premier) did not respond to my invitation.

It was good to see that so many of you were willing to participate, and this reflects a basic willingness to not just have your Association do something for you, but it reflects a growing number of members who do something for their own association. Along these lines, my plan in the short run is to reactivate and possibly breathe more life into our committee structure so that the workload can be better shared and new ideas can be brought in.

Just a few weeks ago, CPA held one of its regular Board meetings in Victoria and we gladly accepted their invitation to co-host a social get-together for Island psychologists at no expense to us. Cathy Bond, a board member, and Shona Boisvert represented us and reported back that the whole affair was most pleasant and well attended. We always feel a bit guilty that we can not readily offer services to colleagues outside of the Lower Mainland, and this was a welcome break.

We also believe that with our smoothly running office, an exceptional layout for CE activities over the next 6-8 months, and a sound financial situation, we are attractive to new members and we will be seeking ways to increase membership.

So, as the increasing outside temperature and longer daylight hours make us feel more energetic, I invite you to think of sharing some of that gained energy with your professional organization. See you at one of the many upcoming CE events!

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Hope House often in a state of intense fear, believing that they had only a specific time to live and feeling powerless to do anything to change the absolute certainty of that prognosis. Frequently, the fearful belief was based upon a mistaken understanding of the meaning of statistical probabilities connected with their particular cancer, an understanding that can be stated with some mathematical degree of probability for large numbers but cannot be stated with the same degree of certainty for any one individual within the group. Unfortunately this distinction had never been clarified and seemed to relieve some of the fear once it was made.

Cancer brings change. It can change the way a person lives in the world. It can change personal identity and ways of relating to others. It can change the ways that a person thinks and feels. Cancer is more than just a physical disease. Cancer is an illness that can affect every part of a persons experience including the emotional, mental, social and spiritual dimensions of being. Sometimes the experience of having cancer may create a deeper awareness of life but often, particularly in the initial moments following diagnosis or learning of a recurrence, it more frequently brings an emotional suffering that is not fully recognized or understood by others. Cancer, perhaps more than any other illness, can leave an individual feeling powerless to change a fearful situation in which they feel alienated and isolated from others. The individual with a cardiac disease is encouraged to believe that they can positively influence his or her physical health through exercise, diet and stress reduction. However, the current forms of cancer treatment (chemotherapy, radiation therapy and surgery) leave the cancer patient with a basic lack of control in contributing toward a positive outcome.

The research literature on stress notes that loss of control and feeling isolated are the two most significant factors in creating and maintaining psychological stress. The work of the early pioneers in the psychological treatment of cancer patients has now evolved into a significant and growing awareness of the need for effective empirically validated intervention strategies that will help people with cancer cope with the emotional aspects of their illness, enhance the effectiveness of other treatment modalities and prolong their living. Research is now showing that providing a safe and supportive environment, where individuals with cancer can share their experience with others and learn how to cope more effectively with stress can change the quality of their experience and may ultimately prolong their living.

During the past five years a growing body of literature and research, centered on two main themes, has emerged to validate the need for psychological treatment being made available to people who have been diagnosed with cancer. The first concerns the prevalence of PTSD arising from a diagnosis of cancer. The second concerns the physiological effects of stress on immune system functioning and response to medical treatment.

DSM IV (1994) now includes being diagnosed with a life threatening illness as a traumatic event that can precipitate the development of a diagnosable and treatable condition. In 1999, Smith, Redd, Peyser & Voul published a review of the research in Psycho-Oncology, entitled "Post- Traumatic Stress Disorder In Cancer." The review analyzed nine published studies across a wide range of client populations and cancer types and noted that evidence of full-blown PTSD was found for adults and parents, and for children in all but one instance. The authors concluded that a PTSD symptom assessment provides valuable clinical information concerning the post-treatment adjustment of cancer survivors and their immediate families. Additional comments noted that this particular finding does not mean that people with cancer, for the most part, suffer from major anxiety or stress disorders, but for some people the stress is capable of precipitating symptoms that meet the criteria of a diagnosable condition. For others, and perhaps the majority, the stress levels may not result in psychopathology but they are significant in terms of their impact on the immune system and response to medical treatment.

Dr. Barbara Anderson is the lead researcher at the Ohio State University's Stress and Immunity Breast Cancer Project, a nine year ongoing longitudinal study funded by N.I.M.H. The results are showing that women who reported high levels of personal stress scored lower than less stressed women on three biological markers of immune system functioning. These results hold up even after taking into account other factors that can influence immunity in breast cancer patients, including the patient's age, disease severity and length of time since surgery. The project has a treatment component which includes training in relaxation, stress reduction and coping strategies. The results of these psychological treatments are that psychological interventions have reliable biological effects and may play an important role, not just in improving quality of life, but also improving the health of breast cancer patients. In addition, women who received psychological treatment were able to tolerate higher levels of chemotherapy treatments with less nausea and treatment refusal than the control group. The encouraging results emerging out of this well funded and ongoing project are consistent with a meta-analysis of 293 independent studies carried out by Psychologists Susanne Segerstrom of The University of Kentucky and Gregory Miller of UBC, reported in the APA press release of July 4, 2004. This analysis covered studies reported in peer-reviewed scientific journals between 1960 and 2001 involving some 19000 individuals. The results confirmed that stress alters immune system functioning. In conclusion the authors expressed the hope that future studies would examine the influence of behavior, such as optimism and coping, on the stress-immune system relationship.

When psychologists suggest that stress levels and immune system functioning are correlated and that individuals can positively influence this relationship and the course of their illness by changing personal behaviors, critics of this approach claim that it suggests people have somehow caused their own cancer. This is like criticizing the advice given to a man that he should come in out of the rain when he discovers that he has a cold, on the grounds that such advice is guilt inducing because it suggests that he caused his cold by going into the rain in the first place; the advice to step out of the rain is simply practical advice intended to optimize the conditions to relieve his cold symptoms and does not imply that rain causes colds.

Over time, I have learned to help people cope with the emotional distress of cancer. I have had many teachers but the most

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significant and influential have been the people who have been able to share with me their personal experience of cancer. What I have learned is that, for some people a diagnosis of cancer or a recurrence of the illness can create levels of stress that are both psychologically and physically harmful and often go unrecognized and untreated. When the stress symptoms are present they are frequently taken as normal responses and ignored. Alternatively, the distress is avoided because the treatment response is not known or understood. However, I now believe that this situation is slowly changing. With empirical validation of the psychological factors associated with a cancer diagnosis, research funding and treatment resources are being made available. In keeping with these changes, The American Psychological Association Practice Directorate, using the term "Mind-Body Health", initiated a public education campaign in 2005 to emphasize the connection between mental and physical processes and the significance of that connection to physical health, "[a]nd not just to convince consumers that there is a connection - we find that's already established - but to position psychologists, with their unique skills as the best and most logical providers of these mental health services, whether alone or in collaboration with other health professionals" (Kersting 2005). For those who have an interest in this area and are not already familiar with the book, I would strongly recommend "Psychosocial Interventions for Cancer," found in the the 2001 APA publication and written by Eds Andrew Baum and Barbara L. Anderson.

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APA STATE LEADERSHIP CONVENTION 2006 REPORTS

Mike Foreman, Ph.D., R.Psych.
BCPA Federal Advocacy Coordinator Representative

For the second occasion, I had opportunity to participate with other representatives from BCPA in attending APA's Practice Organization State Leadership Convention in Washington, DC March 3-6. Fellow BCPA reps in attendance were: Trish Crawford, Disaster Response Network (DRN), Catherine Bond, Public Education Coordinator (PEC), Jennifer Newman, Business of Practice Network (BOPN) and Shona Boisvert, BCPA Director of Administration. This is a marvelous example of political involvement and activism promoting the recognition of psychology's contribution to Health Care, and the growing emphasis of behavioural health. This convention brings in representatives of various interests from every US state Association plus Puerto Rico and Guam, as well as six Canadian provinces of which BC is one. Focus for the US participants is the mobilization of 'grassroots' resources to address legislation that will affect access to mental health services. The meeting culminates in a "trip to the Hill" in which representatives from the state associations will visit their respective Congressperson and Senator in the Capitol (sic) building to lobby on issues of current concern.

From the Canadian perspective, it is an excellent opportunity to meet with representatives from other jurisdictions and discuss common issues reflected in efforts to improve recognition and access to psychological services, and to bring some focus to our own issues. There were a variety of speakers representing Government, the insurance industry, and health care providers. One particularly entertaining speaker, Dr. Ian Morrison, a researcher and "futurist" for a major insurance company (and onetime UBC student), emphasized the significance of behavioural health care in view of the accelerating epidemic of obesity in North America and the impact of various associated disorders on the economy. Dr. Morrison also noted the risk (more humourously than I can here) of a "Pimp my Ride" approach to health care reform in which appearance may be given emphasis over reliable performance.

There was also an interesting presentation from the APA's legal department on managing the risk of liabilities for Associations with particular emphasis on Listserves as "the greatest point of liability." Issues reflect the potential for defamation of others in public statements, anti-trust (competition) regulations as in the fixing of fees, copyright infringement with wholesale reproductions of material without permission, and 'political discussion' that I'm not entirely clear on. We will be receiving the materials for more detailed review. Suffice it to say that the presentation recapitulated our own recent concerns regarding the need to monitor and respond to issues on the Listserve as a process of collective responsibility. (The advice is to have rules for the use of the Listserve, and a mechanism to respond to potential problems at the earliest opportunity.)

We also met with representatives of the other Canadian associations attending - Alberta, Manitoba, Ontario, and Nova Scotia to discuss recent advocacy efforts (for those of you paying attention and wondering, Quebec is the sixth but did not attend this year). All reflect interest in common pursuits regarding multidisciplinary health care initiatives, involvement in the Disaster Response Network, and the building recognition and success of the Healthy Workplace Awards. (The first National award was presented at the SLC this year). Here in BC we have participated in the above and, with 'Psychology Month' in February, sought to arrange meetings between BCPA member representatives and their local MLA to outline the contributions of psychology to health care. Incidentally, with respect to the Healthy Workplace, CRHSPP is working on arranging a workshop with follow-up for psychologists interested in the role of "workplace health advisor" - if you are interested please contact BCPA so that we can coordinate with CRHSPP - more information will follow.

Overall, it was informative and energizing to see the effects that 'grassroots' involvement can have in developing recognition of the value and benefits that psychology can bring to Health Care. There are currently various issues before us in Canada and BC reflecting on health care reform and the prospective role for psychology. We need you to get involved.

Trish Crawford, Ph.D., R.Psych.
BCPA Disaster Response Network Representative

The current Coordinator of our Disaster Response Network, Dr. Nicole Aubé, was unable to attend the meetings for the leaders of DRN's across Canada and the US, and so I had the privilege of standing in for her. As many of you know, the BCPA DRN is currently participating in the planning and training of clinicians in BC to respond to provincial disasters by providing psychosocial support in the community. The workshop on April 21/22 in Vancouver, entitled "Psychosocial Response in Disaster: What is our role?," will be the first of many workshops providing that training. The US DRN obtain their training through the American Red Cross but the Canadian Red Cross has not positioned itself to provide that training, so each province is developing their own model at this point in time.

The DRN gatherings at the APA Leadership meetings were an opportunity to network with other psychologists from nearby States and Provinces (Alberta and Washington State) and to learn from the recent experiences of responders to Hurricane Katrina and Rita. For example, psychologists from the Psychological Association of Alberta (PAA) have worked out an Agreement of Understanding with the Alberta branch of the Canadian Red Cross to provide a few pro bono sessions to individuals and families affected by a disaster. Referrals to these psychologists would be made by the Red Cross. This is an entirely different model than the one used by APA and the American Red Cross, where psychologists are deployed to disasters to provide whatever help is needed and are specifically asked NOT to provide counseling and therapy.

Other highlights of the DRN meetings included a focus on providing appropriate multicultural education and knowledge for those psychologists who are providing Disaster Mental Health

Assistance. As they said, "the importance of strengthening one's abilities to work with people of diverse backgrounds was a lesson that responders learned in offering psychological support to the citizens of Louisiana and Mississippi following Hurricane Katrina." The BCPA CE committee is currently in the planning stage of providing a workshop on multicultural issues and psychological services in BC, both for DRN providers and psychologists in general.

Catherine Bond, Ph.D., R.Psych.
Public Education Coordinator Representative

This was my second year attending the State Leadership Conference in Washington, D.C. Once again I left the conference feeling inspired about psychology and the impact we can have on people's lives. There were some very moving presentations by recipients from the Healthy Workplace Awards Program who felt honored at the recognition they received for the innovations they had made in making their workplaces creative, interesting places to work. Some highlights included a company that offers "lunch together" four times per week as a forum for promoting teamwork and cross departmental communication and another that offers comprehensive health and wellness programs for employees. There were other psychologists who spoke about their work in Public Office and the changes that they are making on a state level. There was a particularly poignant presentation given by a Congresswoman who made the decision to enter politics after being in therapy with a school psychologist whom she felt validated her experience and difficulties in such a way that she felt empowered to enter public life to share her perspective. She was there to thank our profession.

The theme of the conference was health and behaviour. There was an excellent keynote address by Ian Morrison, a consultant and futurist specializing in long term forecasting and planning, on the alarming rise of obesity in the U.S. and Canada and the impact on health care planning. Psychology was seen as having the potential to play an important role in chronic care management, compliance and in shifting the emphasis towards individuals taking personal responsibility for their own health.

The theme of this year's public education initiative is Stress and Mind/Body Health. APA has kits available for Psychologists who want to give public information sessions on the interface between stress and mind/body health.

On a more informal basis the conference afforded the opportunity to meet with and talk to psychologists across Canada and throughout the States. It was particularly interesting to talk with psychologists from Loisianna about life after Katrina and how the struggles continue for people in the New Orleans area.

HIGHLIGHTS FROM APA COUNCIL OF REPRESENTATIVES MEETING

Trish Crawford, Ph.D., R.Psych.

There are approximately 100 psychologists in BCPA who are also APA members. Those psychologists - if they are paying attention to APA election processes - may vote (in mid-April every 3 years) for a BC psychologist to represent them on the APA Council, the 160 (give or take) member ruling body of APA. I was fortunate to be elected in the first election in BC in 2003, to begin my 3 year term in 2004. Being on Council has been an amazing experience - an inside look at the politics of psychology and governance in APA. The Council meets twice a year and votes on the 100 million dollar budget and on "official" policy of APA.

Each State, 6 Provinces, the Territories and the 55 (now 56) Divisions have a delegate that is elected to Council. Some of the business conducted at Council is fairly routine and mundane (approving certain aspects of the budget and non controversial policy) but at times the debate on the floor of Council can become very heated, with fierce debate. Some examples of more controversial issues would be a) what constitutes Evidence Based Practice in Psychology, b) how to formally address racism and anti-Semitism, and c) whether the Task Force on the Psychological Ethics and National Security makes a strong enough statement.

An example of a less controversial, but still very important policy issue that was addressed, was a Resolution Recommending the Immediate Retirement of American Indian Mascots, Symbols, Images, and Personalities by Schools, Colleges, Universities, Athletic Teams and Organizations. This was based on the research of a social psychologist who (not surprisingly) found that the use of these mascots had a negative impact on the self-esteem of youth.

One of the most surprising and interesting aspects of Council is the degree to which Caucuses influence the process on Council. At last count there were about 12 different Caucuses. These meet before, during and after Council meetings, 7:30 to 8:30am for some and 9:30 to 10:30pm for others. It is in the Caucus meetings that coalitions form to push for policy, budget items and candidates for various positions which they endorse. The Caucuses are the Caucus of State/Provincial and Territorial Representatives, Child and Adolescent Caucuses, Rural Health Interest, Education and Training, Public Interest, Health Care/Health Science, Coalition for Academic, Scientific and Applied-Research, Association of Practicing Psychologists, Scientific/Practitioner Caucus, Women's Caucus, and the Caucus for the Optimal Utilization of New Talent. To say the least, it is a very busy time at Council meetings. As the BCPA delegate I have been lobbying for APA to have its annual convention in Vancouver, and at this point, they are waiting for Vancouver to have larger conference facilities (for twelve to fourteen thousand psychologists). I was also very active in having the policy changed to provide more financial support to Council delegates, so that finances were not a barrier to participating at Council. If any APA/BCPA members have any questions or concerns about APA Council matters, please contact me at drtrish@telus.net.

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SMOKING: IMPACT AND PSYCHOLOGICAL CONTRIBUTIONS TO TREATMENT

David Aboussafy, Ph.D., R.Psych.

Each year, smoking kills over 45,000 Canadians, primarily through heart disease, lung disease and cancer. Smoking kills at least one in two smokers who continue to smoke (American Thoracic Society), and also kills non-smokers who are exposed to significant amounts of second hand smoke. The link between tobacco use and the incidence of a previously rare but deadly form of cancer, lung cancer, was made more than fifty years ago. Unfortunately, lung cancer now kills more women in B.C. than breast cancer, and more men than prostate cancer. Furthermore, unlike other cancers, we know what causes lung cancer. The main cause of lung cancer is known and is something that is entirely preventable. The primary cause of lung cancer is inhaled tobacco smoke. Lung cancer has a very high mortality rate and its incidence among different groups increased in direct proportion to the past increases in the smoking rate (for example, the increase in the incidence of lung cancer among women paralleled the increase in the smoking rate among women twenty years before).

As if this wasn't bad enough, smoking also greatly increases the risk of other cancers such those of the mouth and throat, and is the primary cause of other fatal lung disease such as emphysema. Smoking also plays a significant role in the number one killer of Canadians, heart disease. Smoking contributes to hardening of the arteries and vasoconstriction and thereby greatly increases the risk of heart attack or sudden cardiac death. Fortunately, for smokers with heart disease, becoming smoke free significantly lowers this risk of heart attack almost immediately. In addition, smoking delays wound healing and significantly increases the risk of complications during surgery.

Given all this, why do people smoke? People smoke for many reasons. First and foremost are reasons associated with the neurochemistry and addictiveness of nicotine. 'Drug-liking' studies in both mice and humans have shown that nicotine rates as highly as amphetamines or cocaine. Nicotinic acetylcholine receptors are found throughout the central nervous system. Recent research has shown that once someone has become tobacco dependent, these receptor sites change to facilitate the impact of nicotine. This may be one reason that it is so easy for smokers who have become smoke free to relapse even if they have been smoke free for years. In brief, for people who are tobacco dependent, ingesting nicotine is very pleasurable and has both stimulating and sedating effects. In short, because of the neurochemical properties of nicotine, smoking is experienced as tremendously and immediately rewarding for the tobacco dependent person.

The way nicotine is delivered through inhaled smoke also contributes to its reinforcing properties. When inhaled, nicotine reaches the brain in about seven seconds. A smoker who smokes a pack a day may have as many as 300 discrete inhalations, each of which causes a big spike in brain nicotine seven seconds after the puff is taken. Behaviorally, this immediately and strongly reinforces the behaviour of lighting up and inhaling. The behaviour quickly becomes overlearned or automatic as it is done many, many times. Furthermore, other external factors also tend to positively reinforce the smoking behaviour as smoking is associated with pleasant event (e.g, work breaks, socializing, etc.).

For many smokers, smoking also becomes an important stress management tool. Many smokers habitually light up when under emotional stress. The smoking rate is also especially high among people living with severe persistent mental illness. Smoking also may have an important social component; it may have first begun with peers and may be maintained partly via rewarding contact with "smoking buddies." About 85% of smokers start smoking before age 16. Studies have shown that it takes as little as a couple of weeks of daily smoking to become addicted. Many smokers even describe tobacco use almost as a "friend," something that began during adolescence and is part of their adult identity, and which has given them reliable hits of nicotine no matter what else has been going on in their lives.

To effectively help smokers become smoke free, all of the important neurochemical, behavioural, psychological and social factors that contribute to tobacco use must be effectively dealt with. Unfortunately, most single attempts to quit do not result in long term smoking cessation. This reality often has the effect of strongly discouraging smokers from subsequent quit attempts. Most smokers relapse to smoking within two weeks of quitting, and it takes an average of 5 to 7 serious quit attempts before they are smoke free for good (which is a relapse patterns similar to that of other addictions). However, smoking cessation counseling programs have been found to triple the long term effectiveness of smoking cessation quit attempts (US Public Health Service, 2002). Here, psychologists can play a very important role in developing and implementing treatment programs and in supporting their clients as they become smoke free. Psychologists, as experts in behaviour change, also have particular skills, such as in motivational interviewing and in assessing readiness for change, that help clients make the decision to attempt to become smoke free.

Once someone has become tobacco dependent, in simple terms, their brain has gotten used to functioning with nicotine. When they then try to become smoke free they must survive a period of irritability, concentration difficulties, and negative mood symptoms as their brains learn to function without nicotine. For many smokers, this is the most distressing part of quitting. For them, knowing what to expect and preparing for these effects are of paramount importance. Fortunately, nicotine withdrawal, although usually very unpleasant, is not life threatening; unlike withdrawal from other substances (e.g., alcohol, cocaine, narcotics, benzodiazepines, etc.). Furthermore, useful tools such as nicotine replacement therapies and strategies such as gradually cutting down can reduce the impact of nicotine withdrawal after the quit date. In addition, the strong cravings for nicotine during this period are not constant but tend to last at most 5-10 minutes at a time.

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Psychoeducational interventions such as the development of action plans to deal with cravings (e.g., a personalized list of 4-5 activities to do until the craving passes), can be very helpful in helping smokers through the rough first few days. The good news is that if smokers can get past this early difficult phase of the first few weeks after quitting they will find the going much easier, as their brains begin to function well nicotine free. Effective smoking cessation programs include preparation and both short and long term action plans to stay smoke free. A main theme in effective programs is that quitting is a process and to keep trying, learning from past slips, and not to give up. Effective manualized smoking cessation programs, such as the ones I have developed, involve components such as helping the participants:

- Understand nicotine addiction and the psychological, behavioural and social factors involved in smoking (why it is difficult to quit and what can help)
- Learn from past quit attempts and developing their own quit plans
- Learn how nicotine replacement therapies and other cessation tools work
- Get ready to quit step-by-step; for example, cutting down and practicing smoke free behaviour to see what works best before their quit date
- Develop action plans for managing cravings and withdrawal symptoms in the first few weeks after becoming smoke free
- Learn stress management techniques and develop long term plans to stay smoke free
- Learn about relapse prevention and relapse management

This program, like other effective programs, takes a highly interactive approach, whereby the clients take an active role in planning their preparation and quitdate plans. To both reach the maximum number of smokers and to provide an opportunity for peer support this program has been offered in a group setting. An independent evaluation of this program by the Center for Clinical Epidemiology and Evaluation and VGH concluded that "the results are clearly impressive and the challenge from a public health perspective is to make the program more widely available."

Dr. Aboussafy has a clinical and health psychology assessment and treatment practice based in New Westminster and Coquitlam, B.C. Dr. Aboussafy has over ten years of clinical and research experience in treating nicotine addiction and is a past Chair of the Health section of CPA. He is a co-author of a recent Health Canada Best Practice Review in Tobacco Control and has developed, ran and evaluated stop smoking programs funded by the BC Ministry of Health, Vancouver Coastal Health, and Health Canada. He also trains health professionals in smoking cessation counselling across B.C. and internationally. Currently, Dr. Aboussafy runs the Stop Smoking Before Surgery program for patients on the pre-surgical waiting list in the Vancouver Health Authority, which has been partially funded by the BC Cancer Agency. Dr. Aboussafy also runs a fee-for-service smoking cessation group program in Coquitlam, B.C. (for information see www.denisboyd.com/david-aboussafy.html). For more information, Dr. Aboussafy can be reached at: 604.671.9318 or at daboussafy@shaw.ca .

PROFILES IN PSYCHOLOGY

Interview with Dr. Pat Fisher, Ph.D., R. Psych.

By: Shona Boisvert, Director of Administration

I reached Dr. Fisher on the phone from her new office in New York City. She was generous enough to give me a full hour out of her busy day and was extremely gracious, well spoken and an absolute pleasure to speak with. Here's a look at our conversation:

***Q**. You've had a remarkable and fascinating career, Dr. Fisher. I'm interested to hear about your transition from working with survivors of sexual abuse at Maple Ridge Mental Health Centre to working with sex offenders through BC Forensic Services. Can you describe that experience and share some reflections about what you learned from working with such different clients, and any challenges you may have faced from that transition?*

A. Where it all started [for me] was in the early 80s at the Maple Ridge Mental Health Centre as an unpaid practicum student. What I was seeing coming in the door were primarily women and some male clients who had been victims of childhood sexual abuse, physical abuse and trauma and of course a lot of adult traumatic experiences. And at that point, there wasn't much attention being paid to [theses issues], and I realized that this seemed like an enormously important thing. I did my Ph.D. research dissertation around treatment protocols and differential diagnosis around women clients at the mental health centre who had significant childhood and adult trauma histories - that is where I started at an academic and clinical level and things have just followed from there.

Initially the work I was doing in private practice and at the Mental Health Centre was with people who had experienced significant trauma, childhood physical abuse, sexual abuse, etc. Over time, I also encountered a number of people in my private practice who had experienced other kinds of trauma, including folks from Central America and South Africa for example, who had been subjected to State-sponsored violence and torture. Interestingly enough I also treated folks who had been perpetrators in those countries. There was a lot of experience with people who had experienced all kinds of terrible, terrible things, and what's always so striking is the amazing resilience and possibility that people still carry.

After a number of years of working with people who had been victims of sexual abuse and trauma, Bruce [Etches, M.A., R.Psych.], a very good friend of mine, who for a number of years had been asking, suggested that I join him over at Stave Lake. Bruce had started the sexual offender treatment program at the Stave Lake Correctional Centre, which was the provincial corrections centre specifically for the treatment of sex offenders on sentence. For many years I said no, and then eventually felt I needed to understand that side of the equation too. I started part time at three days a week, while maintaining my private practice, and became A.T.S.A. certified to offer specialized treatment in that area. I was at Stave, with Bruce and Susan Turnbull, P.h.D., R.Psych., for 4 years. I learned an immense amount and certainly came to better understand both sides of the spectrum.

***Q**. Were there any specific challenges personally or professionally during that transition?*

A. I think when you are intimately familiar with the impact of

offending and trauma on the people who are victimized, it's an interesting challenge to sit and be present with someone who has been an offender. I think that if you are going to have any kind of therapeutic impact or effect with somebody, you need to be present, you need to be engaged with them and that needs to be authentic and appropriate. One has to put all of that other knowledge in the background because you need to be there with that person. And of course few offenders set off in life thinking "I'm going to grow up in life and become an offender." They all come with their own histories and their own stories. I think it's possibly more about understanding just how much pain there is on all sides of the equation, and how we can be present with that, and how we can help move folks forward on both sides of that continuum.

***Q**. Let's talk more about your research on trauma. Following your work at Stave Lake Correctional Centre, you went into private practice, providing clinical supervision at Simon Fraser University, and then to a contracted position with Riverview Hospital. There you implemented training, treatment and assessment programs to address the issues of abuse histories in the chronically mentally ill, including institutional abuse.*

A. What was interesting about that was that the Ombudsman had done a very wide-ranging assessment of Riverview two years prior to my engagement there and came up with a number of concerns which they wanted Riverview to address. One of those concerns was that the sexual and physical abuse of patients, historically and currently, had not been addressed at any point. The ombudsman was concerned that this issue be looked at and appropriately addressed. Almost two years after the initial report, they came back and assessed how Riverview had progressed with things, and that was one of the elements that had not, at that point, been addressed. So, I was approached by the head of the psychology department at Riverview and asked if I would consider taking that one on, and I did.

The first stage was doing a comprehensive assessment of the patients' histories - primarily the patients were people who were diagnosed with schizophrenia. We used what were fairly good protocols at that point to do a wide assessment of childhood history - parenting, neglect, physical abuse experience, sexual abuse experience - and then taking a look at their adult experience (again, of physical and sexual abuse). We had a great many participants and we trained the nurses and members of the Social Workers Department to administer the structured interviews. Then it was a matter of collating all of that data. The results were very compelling and, in hindsight, pretty much what we would have expected; a substancial proportion of the patients had significant trauma histories (childhood neglect, multiple parenting, etc.), and there was a correlation of the severity of their childhood experience, the age of onset of their first psychotic break, and the chronicity and severity of their illness. It's not a big surprise when you think about it.

At that point there was very little work done with patients diagnosed with schizophrenia in the hospitals. Most of the work in mental hospitals had been done with people with Borderline Personality Diagnoses. We ended up partnering with Vancouver Mental Health, most notably with Liz Choquette, a Nurse specialist and their specialist for trauma in chronic patients. Liz and I did a lot of work together compiling resources from her side of things and trying to bridge that over into Riverview. Those were the days when people were moving out into the community at much greater rates, and so we were really trying to get the resources out to them. I also started and supported a training program specifically around trauma at Riverview, and that was delivered subsequently by the Justice Institute to Riverview Staff.

***Q**. Tell us about your company, Fisher and Associates, of which you are President. What is your mandate, what populations do you serve and from what experiences and insights did it develop?*

A. It started with the trauma work with victims, and then working with offenders, and with all kinds of people on either side of the equation. And then what I started to see more and more of in my private practice were colleagues and folks who worked on the front lines with offenders and with victims. These clients were experiencing what we now call secondary trauma/vicarious trauma/compassion fatigue. It seemed to me that the next step in all of this was to start paying attention to our own, the folks who work with this because it was really clear at that point that this was having some significant and quite devastating impacts on people and on their lives. At that point, which would have been the mid-90s, I started an active research program for [corrections staff] with BC Community Corrections, as well as in Washington State with the specialized incarceration program they have down there for people who are on indeterminate sentences (the worst of the worst). I was particularly interested in the corrections end of things and those who were dealing with the sex offender files, the family violence files and the spousal violence files. Out of that work came the model that is central to all of the work we've done since then: the Complex Stress Model. We were really interested in workplaces where you were dealing with workers exposed to traumatic stressors, both direct trauma (primary trauma), as well as secondary trauma. That's the one arm of it. The other arm of stressors that people were facing, and this was ramping up hugely at that point, were all of the systemic work place stressors. The 90s was when we were facing all of the huge cuts and downsizing. People were working so much harder, the fear factor was higher, the resources were diminishing and the systemic pressures in the workplace were getting very significant and severe. When we were finding people who were being exposed to both the systemic workplace stressors as well as the traumatic workplace stressors, it appeared that those individuals were going to be experiencing much higher rates of negative outcome. That is fundamental to the work I've been doing ever since then: looking at workplace stressors, but particularly with those people who are also subjected to traumatic stressors, because there is a very different mechanism of action between those two types.

When we are talking about systemic stressors, it's largely cognition first. It's how you're thinking about it that's going to lead to your experience and outcome. Whereas when we're talking about traumatic experiences, that's much more physiology first and it's only further down the line that we start getting into the cognitive pieces. When you have both of these targeting in on somebody, it can be a much more demanding and negative situation. As it turns out, there's a wide array of risk and resilience factors associated with both systemic stressors and traumatic stressors. So the research protocol continued looking at all of the risk and resilience factors and seeing what profiles were associated with what kinds of outcomes, and the range of outcomes. Our work was developing programs specifically addressing these issues. The first one we

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developed was for corrections people. That was the first book ["The Road Back to Wellness: Stress, Burnout and Trauma in Correction" (2001)], in which there were three sections. The first section was a backgrounder to how all this stuff works: systemic and traumatic stressors and the very specific stressors that folks in corrections face, looking at symptoms, outcomes, etc. All of this was based very much on the research existing at that point, as well as our own research. The second part was a self-assessment protocol where people could profile themselves for all of these risk and resilience factors and take a look at their self care in their personal life and professional life, and then a set of symptom screens. The third part was: What are we going to do about it? That's where we were looking at ways of addressing this both personally and professionally.

We started piloting the program in the late 90s in corrections and we had terrific response with it. At this point most correctional jurisdictions in Canada have rolled out the programs or taken on significant components of it. The next things that happened was that it became apparent out in the field was that while we can do all we want with the staff (we were looking at everybody from Assistant Deputy Minister level all the way through to folks who were doing clerical support work), the management style inside these organizations was also a significant player. And so the second component was developing a manager training program, and the book that went with that, to assist managers and do a risk needs assessment and profile of the group that they were supervising, and from there being able to move forward to targeted kinds of strategies that would address the issues. We also introduced them to the notions of primary, secondary and tertiary levels of intervention. We also did a bit of a managment-101, because most managers were never trained to be managers. They're just in there and struggling and it's rarely a bad person situation. It's usually people doing the best they can with inadequate training and skills.

What followed next was a request from police, so we went back and did a parallel version of both programs, but for law inforcement. The last step was in the area of human services (particularly social services and child protection), health care folks and emergency services people.

When we look now at the groups that we've worked with, it's been everything from corrections, both institutional and community across the country, RCMP, and Department of National Defence. In BC, we worked with MCFD, MEIA, and a number of child protection agencies across the country, as well as with the emergency services, health care and continuing long-term care sectors.

The other interesting part in all of this has been the research based versions of the workplace wellness program roll-out. We do a train-the-trainer for clients so that they can roll-out [the program on their own]. They also have the option of doing the research version and, in that condition, all of that data from the self-assessment profiles comes back to us, of course all under the appropriate CPA and APA approved research conditions. What I'm working with right now is a data-deck of over 2500 folks, including repeated measures. Our efficacy data is looking very good and we've now got comparisons across different occupational sectors. I've also got 6 academic papers as well as a new book in preparation right now. We've also had graduate students work with our data.

The other really interesting part is that we started getting specialized requests for programming when specific things would come up like, for example, when a client dies - particularly in child protection and social services. What we did is design specialized one-day programs, and made them accessible so they can be ported over with very minor modifications, if any, to other sectors. We've now got a whole array of specialized one-day programs.

We also do consulting work in situations where it gets very sticky. For example, back in 2002 in Ontario there was a big public service strike. What that mean in the corrections world was that all of a sudden it was managers who were running all the jails, and of course they didn't have enough managers so they had to recruit managers from a bunch of other departments. So some poor soul would be in forestry taking care of payroll and the next thing they knew, they were in a jail doing strip searches. Not only that, but they were inside, and most of them couldn't come outside. They were away from their families. They were there 24/7 for months on end (the strike went on for over eight months). At month 4.5, I got a call from the Deputy Minister asking for help. I went to Ontario and luckily they had all the senior managers at one command centre (they were sleeping there, working there around the clock, the whole bit). I was able to do a round-the-block assessment of what all the needs were, and then able to design protocols to help the folks inside during the transitioning as well as post-strike. Their EAP actually delivered the services that we designed and then we worked with them to do all the follow up and advocacy around that.

Now I'm down in New York where we've just incorporated a subsidiary of the Canadian company and am probably going to be spending most of my time here for the next couple of years. Of course I'm still very much engaged with [the Canadian component of the company]!

***Q**. You were recently part of an international delegation of psychologists that went to China through the People to People Ambassador Program. Can you tell us a bit about that?*

A. It was fascinating. We went to interact with psychologists and psychiatrists in the mental health arena to discuss and promote sharing of mental health knowledge between east and west. There were three cities we went to: first we were in Beijing, then Guiyang, which is in the Interior and the poorest state in China, and probably the most traditional, and then out to Shanghai. The difference between them was fascinating, but I think the central theme behind it was that I was so impressed with the quality and calibre of the people working in mental health there. We had discussions and meetings with people from their university medical schools, psychiatric training schools, as well as their actual psychiatric institutions and hospitals. I think when you have a population [like China's] and you are choosing your brightest and your best, those folks are just outstanding, and the level of commitment, the humanity - they were very impressive people. The way they are incorporating Western approaches and Western medicine was also really interesting because they have not let go of their traditional approaches. They are seeing the traditional medicine as being most helpful with chronic and ongoing problems, and the western approaches as being more applicable to acute situations. They were also at the early stages in terms of their understanding around traumatology and developmental trauma, and they were really, really interested in that area.

[The Chinese] are going through such a huge social shift right now. They are going from family structures where you have sets of grandparents, sets of parents and multiple children, to a place now where you've got all of the grandparents, and the parents and only one child that they are all vectoring in on. It's a tremendous upheaval in their primary social structure. [The mental health teams] were very concerned about the kind of impact that's having, psychologically and socially. One of the things they were finding was the pressure on these children to excel was huge. They kept asking us what we knew about video game addictions and internet addictions because one of the things they are seeing a lot of is that these kids are under so much pressure, and they are getting on the net and gaming and not stopping - and spending many, many hours a day doing that. They were starting to look at how this all fits together with the inversion of the social pyramid, and the tension going down singularly into these children.

***Q**. Wow, Pat, that's a lot to take in! Thank you for taking the time to share your professional experiences with our readers. It's truly been inspiring. As I final note, I wanted to ask you about your other interests in life. I understand that you have some incredible talents in the arts and that before becoming a psychologist, you earned your degree from Emily Carr and made some independent productions for National Film Board. Can you tell us about that?*

A. Interestingly, my daughter, my one and only, is just finishing her first year at Emily Carr--and she's really good.

***Q**. How do you find time for those ambitions, passions?*

A. That's what keeps me sane. It's the place where my heart is. One more important piece in all of this is that I think everybody's lives are fascinating and you could pick anybody and it would always be interesting.

Dr. Fisher is the President of her company, Fisher & Associates Solutions Inc., a national organization specializing in developing and providing organizations with resources, programs, consultation, and research addressing workplace stress, burnout and trauma in high risk occupations. Up until fall 2002 there was a particular emphasis in the areas of corrections and law enforcement. Over the past 3 years the fields of human services, health care, and the military and emergency services have also been added to the mandate.

In the kind words of her friend and colleague, Bruce Etches:

"Pat is ferociously intelligent, yet incredibly passionate, compassionate and generous to a fault. She is also committed to solid research grounding as part of her tremendous work."

Sample Publications:

Fisher, P.M., & Abrahamson, K. (2002). When working hurts: Stress, burnout & trauma in human, health and emergency services. Victoria, BC: Spectrum Press.

Fisher,P.M., & Abrahamson, K. (2002). The managers guide to stress, burnout & trauma in human, health and emergency services. Victoria, BC: Spectrum Press.

Fisher, P.M. (2002). The managers guide to stress, burnout and trauma in the law enforcement workplace. Victoria, BC: Spectrum Press

Fisher, P.M. (2001). The road back to wellness: Stress, burnout & trauma in law enforcement. Victoria, BC: Spectrum Press.

Fisher, P.M. (2001). The managers guide to stress, burnout and trauma in the corrections workplace. Victoria, BC: Spectrum Press

Fisher, P.M. (2000). The road back to wellness: Stress, burnout & trauma in corrections. Victoria, BC: Spectrum Press.

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Website: www.ce-for-psychologists.com

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Location: Vancouver, BC - UBC Campus
Website: www.psychologists.bc.ca

***April 21 (evening) & 22, 2006 Co-Sponsored**
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* Please visit http://www.psychologists.bc.ca/educ_events.html to download the registration form

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Western Canadian Solution Focused Conference
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Website: www.jackhirose.com

****April 28 & 29, 2006***
Disaster and Trauma: Preparing for the Unthinkable
Location: Victoria, B.C.
Website: www.ce-for-psychologists.com

****April 30, 2006 to May 4, 2006***
17th International Conference on the Reduction of Drug Related Harm
Location: Vancouver, BC
Website: http://www.harmreduction2006.ca

****May 4 - 6, 2006***
The Second National Biennial Conference on Late Adolescents and Adults with Fetal Alcohol Spectrum Disorder Treatment
Location: Vancouver, BC
Website: www.interprofessional.ubc.ca

****May 5, 2006***
The Aging Brain, the Rejuvenated Brain
Location: Burnaby, BC
Email: info@biocorp.com

Ψ Thursday, May 11 -13, 2006
PAA Annual Conference
The Heart and Soul of Change – What Works in Therapy: Practical Applications of 40 Years of Outcome Research with Dr. Scott D. Miller
Settling the Unsettled: Integrating Therapeutic Approaches to Depression and Anxiety Disorders with Dr. Jeffrey K. Zeig
Dialectical Behavior Therapy for Borderline Personality Disorder with Dr. Alex Chapman
Location: Edmonton, Alberta
Website: http://www.psychologistsassociation.ab.ca

Ψ May 11, 2006
Restoring our Connections: Ethnocultural influences on spirituality, identity and the human condition with Joseph E. Trimble, PhD
Location: Seattle, WA
Website: www.wapsych.org

****May 15, 2006***
Ethical, Competent, and Safe Practice wtih Chidlren and Youth with Dr. Pierre Ritchie
Location: Vancouver, BC
Website: www.bcchildrens.ca (visit "events" page under "professionals")

****May 15, 2006***
Making Sense of Adolescence with Dr. Gordon Neufeld, Ph.D.
Location: Vancouver, British Columbia
Website: www.jackhirose.com

Ψ May 16 & 17, 2006
Emotion-Focused Psychotherapy: The Transforming Power of Affect with Dr. Les Greenberg
Location: Saskatoon, Saskatchewan
Website: http://www.psychsocietysk.org/

****May 13, 2006***
Silent Men: Angry Women - Strategies For Working More Effectively With Couples with Dr. Fredric Rabinowitz & Dr. Holly Sweet
Location: Vancouver, BC - UBC Campus
Website: www.psychologists.bc.ca

****May 17 - 19, 2006***
Working With Violent and Aggressive Children & Youth with Dr. Gordon Neufeld, Ph.D.
Location: Vancouver, British Columbia
Website: www.jackhirose.com

****May 24 - 27, 2006***
Art & Science of Psychotherapy Conference
Location: Richmond, British Columbia
Website: www.jackhirose.com

****June 2, 2006***
Testifying in Court: The Expert Expert Witness with Dr. Stanley Brodsky
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Website: www.psychologists.bc.ca

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****June 22 & 23, 2006***
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Location: Vancouver, BC
Website: http://www3.telus.net/trauma/Conference2.html

****June 22, 2006***
Gaining Confidence with EMDR Skills (practice)
Location: Whistler, BC
Website: www.healthandemotionalwellnessseminars.com

****June 23, 2006***
Attachment Theory: Case Formulation and Treatment Planning
Location: Whistler, BC
Website: www.healthandemotionalwellnessseminars.com

****June 24, 2006***
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Website: www.bluecomet.ca/medmovies/

****July 7-9, 2006 and September 15-17, 2006***
EMDR Training Part One/ Level I and Part Two Level II
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Website: www.emdrtraining.com

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August 9-13, 2006
Dreaming the Future: Expanding our Consciousness through Gestalt Therapy
Location: Vancouver, BC
Website: www.aagt.org

****September 29, 2006***
Advances in the Treatment of Alcohol and Drug Addiction with Dr. Alan Marlatt
Location: Vancouver, BC - SFU Downtown Campus
Website: www.psychologists.bc.ca

****October 20 & 21, 2006***
Sexual Addiction: An Integrative Approach to Treatment
Location: Vancouver, BC
Website: www.wcppa.ca

****October 27 & 28, 2006***
Acceptance and Commitment Therapy with Dr. Steven Hayes
Location: Vancouver, BC - SFU Downtown Campus
Website: www.psychologists.bc.ca

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