Clinical Depression

FCMS Conference 2016

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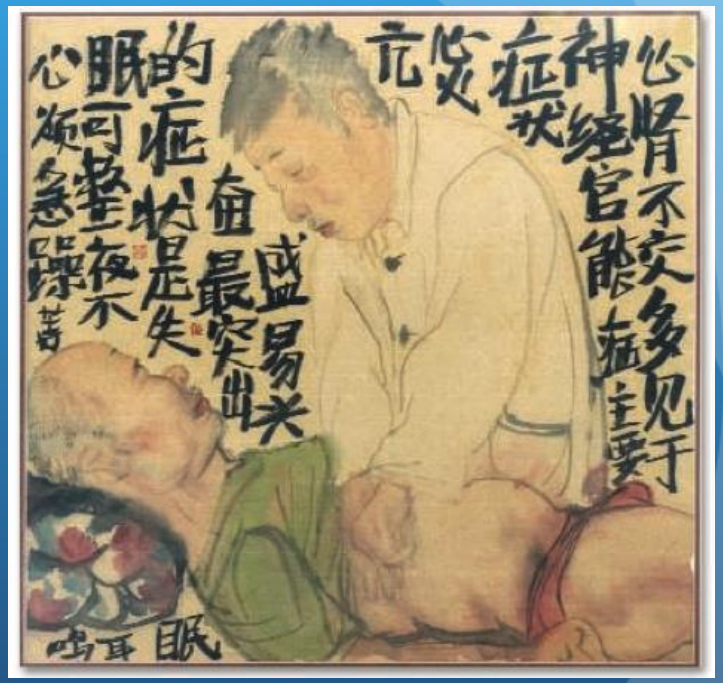
Faculty/Presenter Disclosure

- **Faculty:** Kenneth Fung

- **Relationships with commercial interests:**
  - **none**

Learning Objectives

1. Discuss the basic symptoms and prevalence of depression
2. Consider cultural factors affecting the assessment and formulation of depression
3. Develop an integrated plan for treatment



Epidemiology of Depression

- Prevalence:
  - Lifetime: 4.4 – 18%
  - Lifetime prevalence in Canada: 11%
  - 2% with depression commit suicide
    - 50% in contact with GP 1 month prior
- 2:1 - F:M

DEPRESSION, A HIDDEN BURDEN

Let's recognize and deal with it

World Health Organization

What do I need to know?

At least 350 million people live with depression, and it is the leading cause of disability worldwide. It affects not only the person with depression, but their loved ones too. Yet, many of us are in denial. Depression remains hidden – not treated or talked about.

Depression often starts at a young age and affects women more commonly than men. 1 or 2 mothers out of 10 have depression after childbirth. Depression also limits a mother's capacity to care for her child, and can seriously affect the child's growth and development.

Almost 1 million people take their own lives each year.
For every person who commits suicide, there are 20 or more who make an attempt.

SYMPTOMS OF DEPRESSION ARE PERSISTENT SADNESS, LOW ENERGY AND DIFFICULTY IN FUNCTIONING NORMALLY

Depressive Disorders

- > 2 weeks:
  - Depressed mood
  - Decreased interest

  - Weight Loss or Gain / Appetite Changes
  - Insomnia or Hypersomnia
  - Psychomotor Agitation or Retardation
  - Fatigue or Loss of energy
  - Feelings of Worthlessness / Guilt
  - Decreased concentration or Indecisiveness
  - Recurrent thoughts of death / Suicide

Persistent Depressive Mood Disorder

- Depressed mood most days >2 years
- While depressed, more than 2 of:
  - Poor appetite or overeating
  - Insomnia or hypersomnia
  - Low energy or fatigue
  - Low self-esteem
  - Poor concentration or difficulty making decisions
  - Feelings of hopelessness
- Not without symptoms > 2 months at a time
- MDD may be continuously present

Other psychiatric symptoms to check

- Mania
- Anxiety
- Psychosis
- Substance

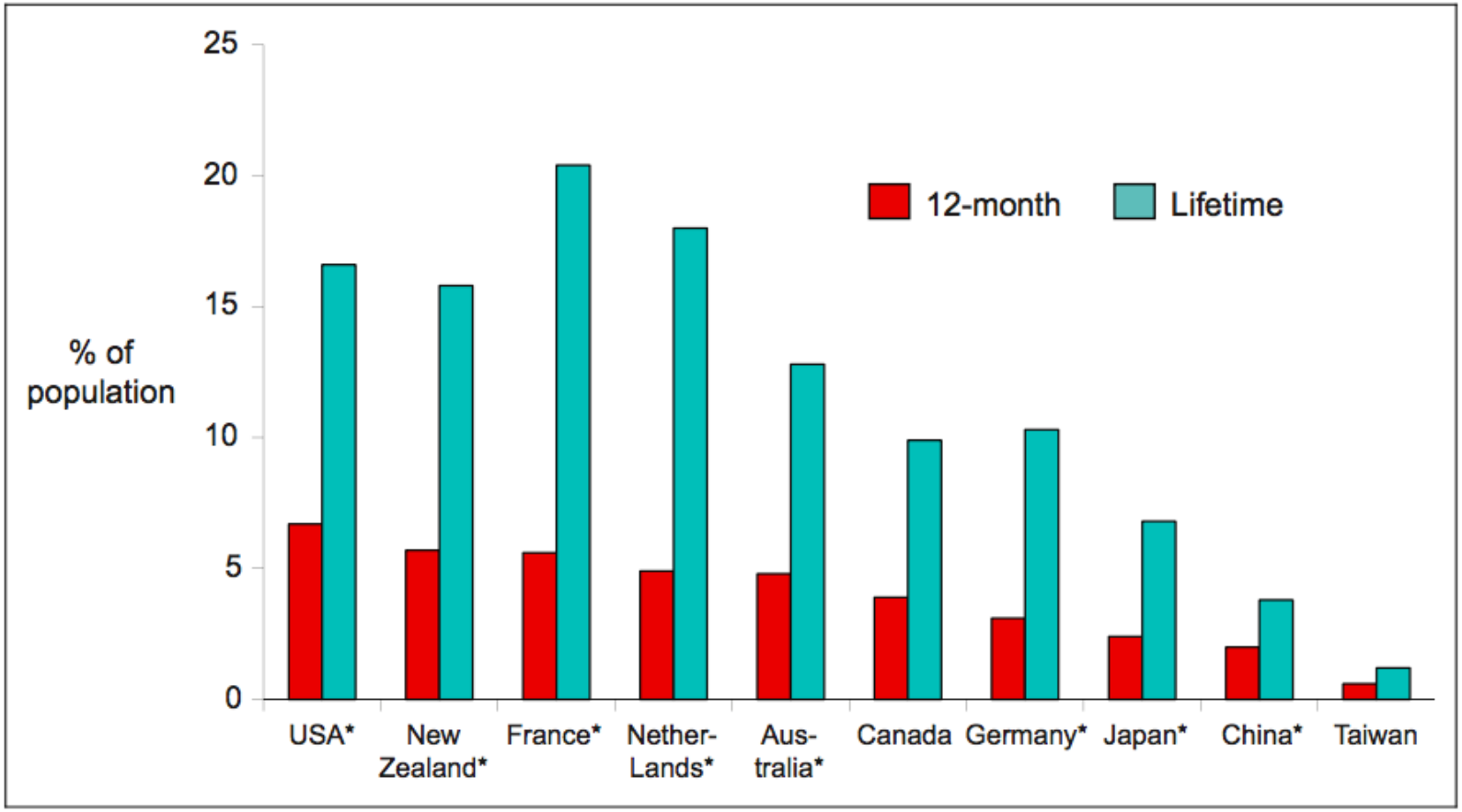


Figure 1. Prevalence of major depressive disorder by world region. *WMH, World Health Organization's World Mental Health Surveys, Canada, CCHS[113]; Taiwan Psychiatric Morbidity Survey.[114]

	Unweighted n	Weighted Percentage/ Mean	SE	Lifetime Prevalence of Any Disorder %	SE	12-Month Prevalence of Any Disorder %	SE
Gender							
Men	998	47.45	1.12%	17.18	2.39%	8.44	1.36%
Women	1097	52.55	1.12%	17.43	1.68%	9.87	1.15%
Age	2095	41.33	0.88				
Ethnic origins							
Chinese	600	28.69	2.66%	18.00	2.34%	10.00	1.73%
Filipino	508	21.59	2.32%	16.74	1.40%	8.99	1.26%
Vietnamese	520	12.93	2.09%	13.95	2.40%	6.69	1.38%
Other Asians	467	36.79	2.34%	18.29	2.81%	9.55	1.56%
Nativity status							
US-born	454	23.06	3.20%	24.62	3.22%	13.22	1.96%
Foreign-born	1639	76.94	3.20%	15.16	1.55%	8.00	0.79%
English-language proficiency							
Excellent/good	1292	66.19	2.33%	17.24	1.64%	8.82	0.91%
Fair/poor	797	33.81	2.33%	17.47	2.14%	9.85	1.04%
Years in the United States							
US-born	454	23.07	3.21%	24.62	3.22%	13.22	1.96%
0–5	302	14.17	1.98%	12.59	3.02%	5.90	1.50%
6–10	300	12.06	1.06%	15.69	2.89%	9.30	2.74%
11–20	532	26.46	1.70%	14.97	1.55%	9.12	1.09%
≥21	504	24.25	1.24%	16.62	2.17%	7.38	1.37%
Age at time of immigration, y							
US-born	454	23.07	3.21%	24.62	3.22%	13.22	1.96%
≤12	237	12.72	1.43%	25.32	4.43%	15.03	3.31%
13–17	130	5.08	0.56%	15.87	3.89%	9.30	2.95%
18–34	886	41.64	2.31%	12.76	1.66%	6.16	1.00%
≥35	385	17.49	1.84%	13.29	2.68%	6.90	1.55%
Generational status							
First	1639	76.94	3.20%	15.16	1.55%	8.00	0.79%
Second	272	13.68	1.85%	23.97	4.18%	13.92	2.64%

F: D/A/S
M: S

M: D/A

F: D/S

Takechui et al, 2007

Lower rates in Chinese?

- Cultural protective factors
  - Stronger social support
  - Tolerance/Forbearance
  - Different belief systems, e.g. fate
- Stigma
- Diagnostic Issues
  - Somatization
  - Neurasthenia

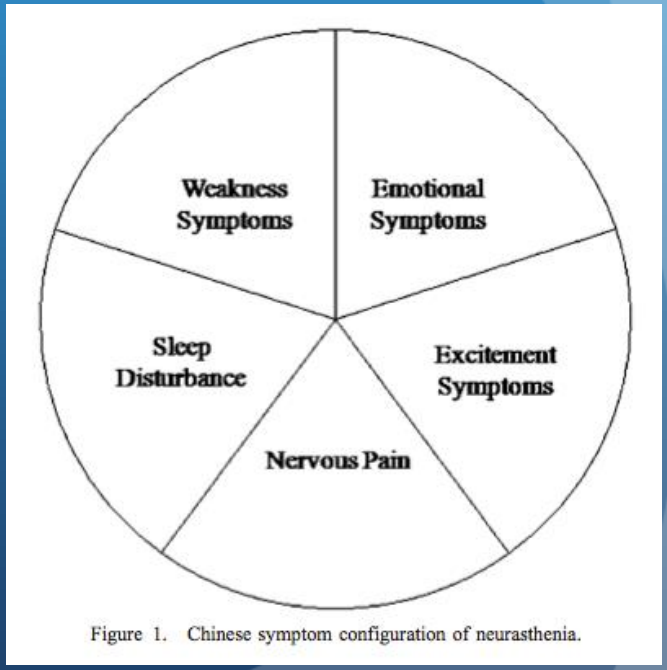


Figure 1. Chinese symptom configuration of neurasthenia.

Lee and Kleinman, 2007

Detection and management of depression in adult primary care patients in Hong Kong: a cross-sectional survey conducted by a primary care practice-based research network

Weng Yee Chin[1*], Kit TY Chan[1], Cindy LK Lam[1], Samuel YS Wong[2], Daniel YT Fong[3], Yvonne YC Lo[4], Tai Pong Lam[1] and Billy CF Chiu[5]

Abstract

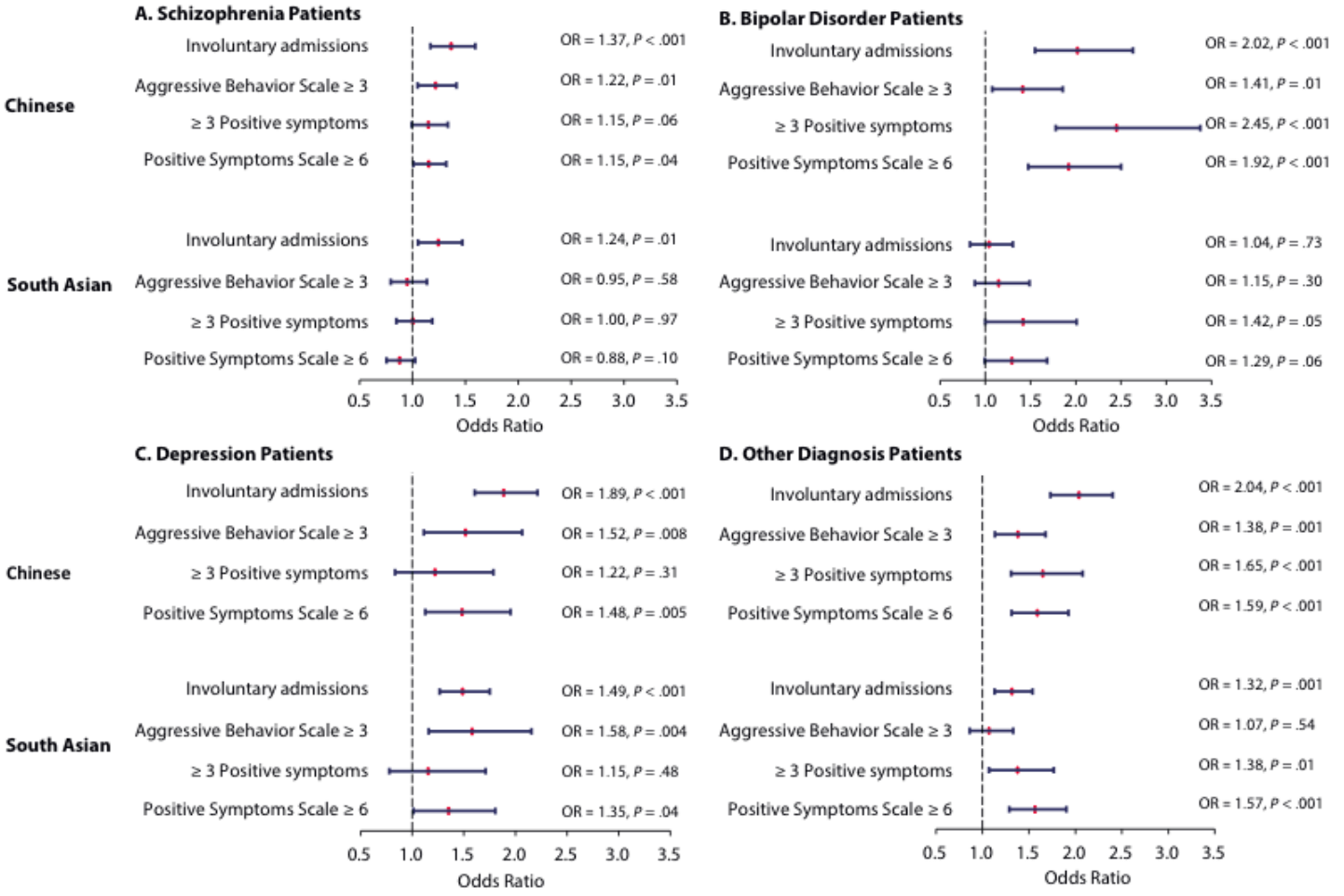
Background: This study aimed to examine the prevalence, risk factors, detection rates and management of primary care depression in Hong Kong.

Methods: A cross-sectional survey containing the PHQ-9 instrument was conducted on waiting room patients of 59 primary care doctors. Doctors blinded to the PHQ-9 scores reported whether they thought their patients had depression and their management.

Results: 10,179 patients completed the survey (response rate 81%). The prevalence of PHQ-9 positive screening was 10.7% (95% CI: 9.7%-11.7%). Using multivariate analysis, risk factors for being PHQ-9 positive included: being female; aged ≤34 years; being unmarried; unemployed, a student or a homemaker; having a monthly household income < HKD$30,000 (USD$3,800); being a current smoker; having no regular exercise; consulted a doctor or Chinese medical practitioner within the last month; having ≥ two co-morbidities; having a family history of mental illness; and having a past history of depression or other mental illness. Overall, [redacted] of patients who screened PHQ-9 positive received a diagnosis of depression by the doctor. Predictors for receiving a diagnosis of depression included: having

Non-Chinese diagnosed more than Chinese patients twice as much Chin et al, 2014

Figure 2. Ethnic Differences in Involuntary Admission and Illness Severity Among 133,588 Adult Mental Health Inpatients by Diagnosis (2006–2014)[a]



[a]The reference group was the general population with the specific diagnosis. Odds ratios (95% CIs [denoted by error bars]) were derived from logistic regression models adjusted for age (19 to 105 years), sex, income quintiles, education, immigration status, marital status, and urban/rural residence. Diagnosis-specific sample sizes are as follows: schizophrenia (Chinese, n = 934; South Asian, n = 750; general population, n = 26,134), bipolar disorder (Chinese, n = 287; South Asian, n = 341; general population, n = 19,214), depression (Chinese, n = 658; South Asian, n = 637; general population, n = 36,437), and other diagnosis (Chinese, n = 703; South Asian, n = 724; general population, n = 46,769). *P* values compare the Chinese and South Asian groups to the general population within each diagnostic category.

Chiu et al, 2016

PHQ-9

- Little interest or pleasure in doing things
  做任何事都覺得沉悶或者根本不想做任何事
- Feeling down, depressed, or hopeless
  情緒低落、抑鬱或絕望
- Trouble falling or staying asleep, or sleeping too much
  難於入睡;半夜會醒或相反地睡覺時間過多
- Feeling tired or having little energy
  覺得疲倦或活力不足
- Poor appetite or overeating
  胃口極差或進食過量
- Feeling bad about yourself — or that you are a failure or have let yourself or your family down
  不喜歡自己——覺得自己做得不好、對自己失望或有負家人期望
- Trouble concentrating on things, such as reading the newspaper or watching television
  難於集中精神做事,例如看報紙或看電視
- Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
  其他人反映你行動或說話遲緩;或者相反地,你比平常活動更多——坐立不安、停不下來
- Thoughts that you would be better off dead or of hurting yourself in some way
  想到自己最好去死或者自殘

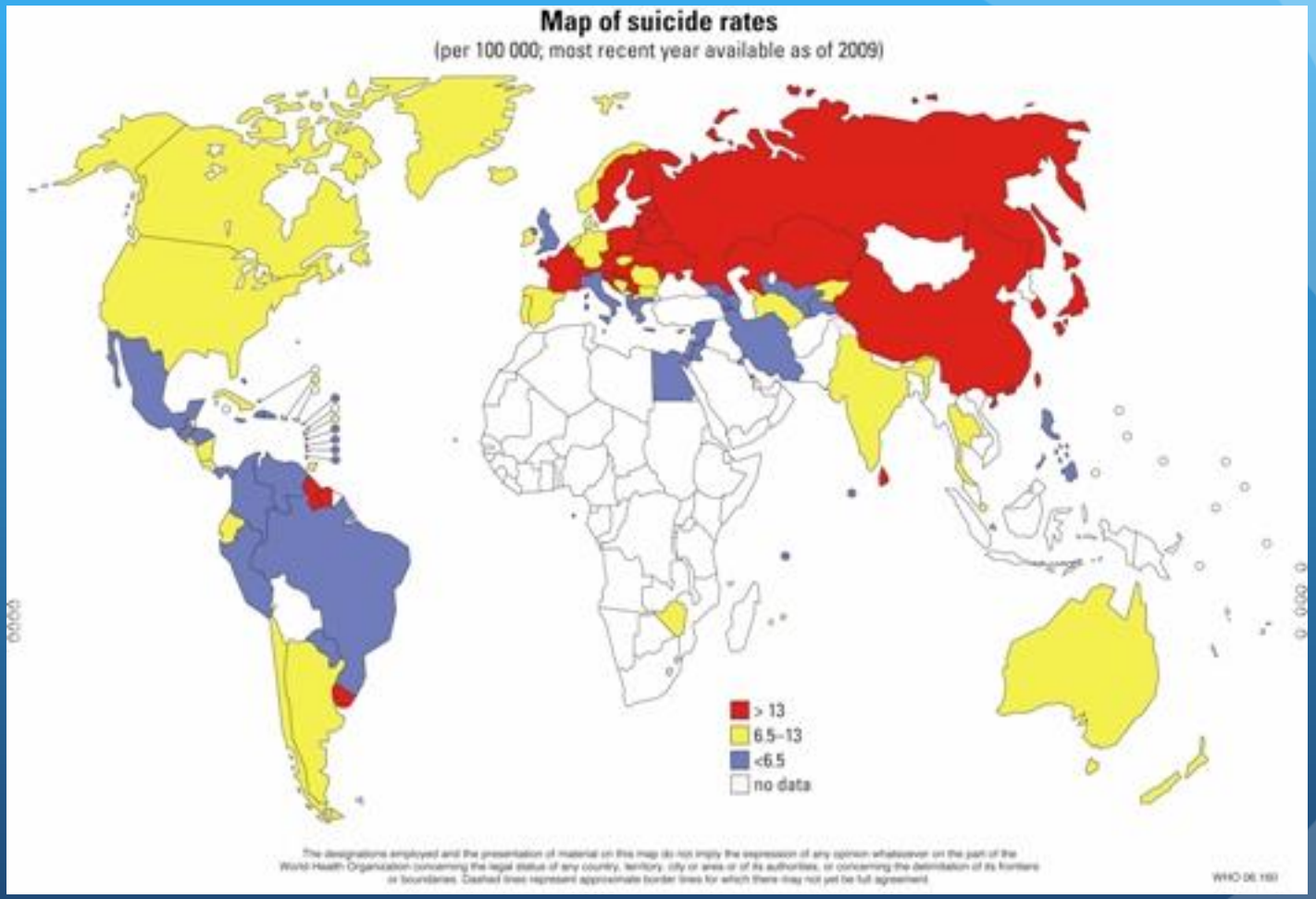
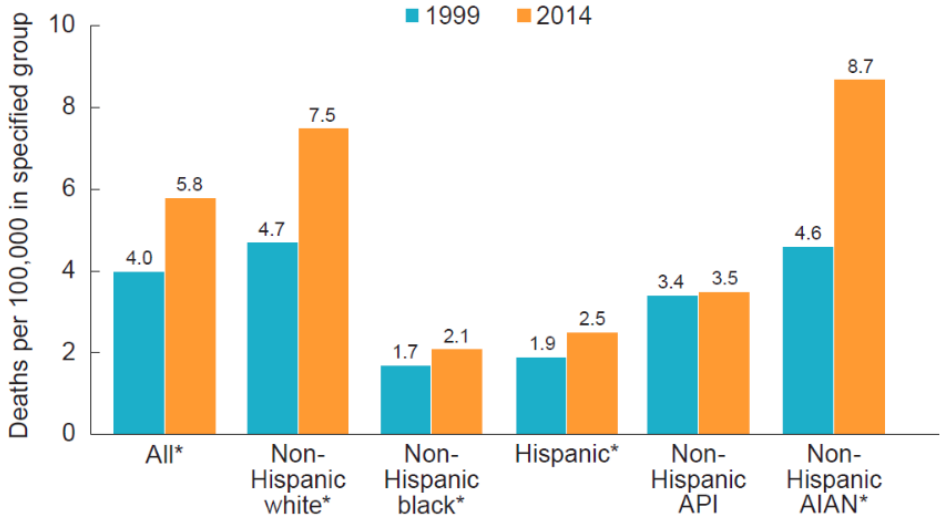
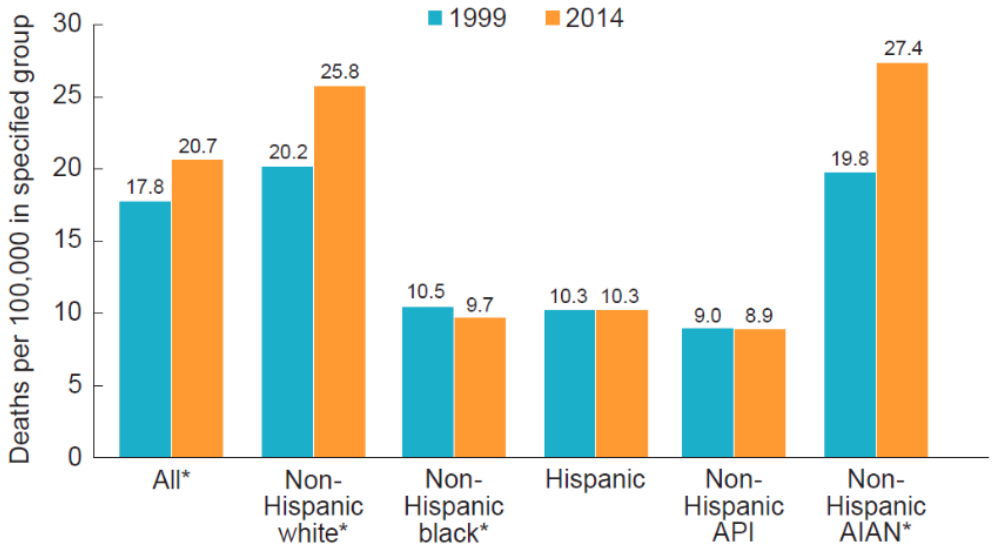

Map of suicide rates
(per 100 000; most recent year available as of 2009)
> 13
6.5–13
<6.5
no data
The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dashed lines represent approximate border lines for which there may not yet be full agreement.
WHO 06.169

Figure 1. Age-adjusted suicide rates for females, by race and Hispanic origin: United States, 1999 and 2014



* Difference in rates between 1999 and 2014 was significant ($p < 0.05$).
NOTES: Suicide is identified with ICD-10 codes U03, X60–X84, and Y87.0. Death rates for non-Hispanic American Indian or Alaska Native (AIAN), non-Hispanic Asian or Pacific Islander (API), and Hispanic persons may be underestimated and should be interpreted with caution; see Data source and methods.
SOURCE: CDC/NCHS, National Vital Statistics System mortality data, 1999 and 2014, available from: CDC WONDER online database.

Figure 2. Age-adjusted suicide rates for males, by race and Hispanic origin: United States, 1999 and 2014



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SOURCE: CDC/NCHS, National Vital Statistics System mortality data, 1999 and 2014, available from: CDC WONDER online database.

SADPERSONS

S: Male sex
A: Older age
D: Depression
P: Previous attempt
E: Ethanol abuse
R: Rational thinking loss
S: Social supports lacking
O: Organized plan
N: No spouse
S: Sickness

Asian American Suicides

- Life-time prevalence: SI – 8.8% and SA – 2.5%
- US-born AA women: SI - 15.9% > gen popl'n (13.5%)

- Risk Factors
  - Mental Illness
    - depressive & anxiety disorders
  - Social Factors
    - Family conflict, being a burden, discrimination
  - Chronic Medical Conditions
    - men

- Protective Factors
  - Ethnic Identification
  - Family cohesion and support

Hijioka and Wong, 2012
Cheng, 2010

A Clinical Approach to Screen for Suicide

Opening probes

- Do you ever feel that life is not worth living?
- Do you ever feel that you would be better off dead?

Specific questions

- Have you ever thought about hurting or harming yourself?
- Have you ever tried to hurt or harm yourself?
- Do you have any plans in hurting or harming yourself?

Soliciting protective factors

- What keeps you away from hurting yourself?
- Who can be a source of support for you?

Engaging the client to get help

- It seems like that it has been a difficult time for you. This is an important issue for us to address…
- I would like to connect you with a professional who can help you…

Fung and Lo, 2012

Treatment Considerations

- Holistic understanding of depression
- Type and nature of depression
- Course and severity of depression

Type and Nature of Depression

- Mania -> need mood stabilizers coverage
  - Monotherapy: lithium, lamotrigine, quetiapine
  - Combination: lithium/divalproex + SSRI, olanzapine + SSRI, lithium + divalproex, lithium/divalproex + bupropion
- Anxiety -> dose adjustment; anxiolytics
- Psychosis -> antidepressant + antipsychotics
- Substance -> address substance use

Outline for Cultural Formulation

I. Cultural identity: Ethnicity, Language, Involvement with culture of origin and host culture

II. Explanatory Model: Cultural explanations of the illness; Help seeking experiences and plans

III. Cultural factors in the psychosocial environment: Stressors and supports

IV. Cultural elements of the clinician-patient relationship

V. Overall Cultural Assessment

Severity

TABLE 1

PHQ-9 Scores and Proposed Treatment Actions

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
1 to 4	None	None
5 to 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 to 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 to 19	Moderately Severe	Immediate initiation of pharmacotherapy and/or psychotherapy
20 to 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

PHQ-9 Optimal Cut-offs

- Hong Kong - GP Clinics - 9
- China – College Students - 11
- Singapore – Primary Care - 6

Table 3. Summary Recommendations for Antidepressants.

Antidepressant (Brand Name(s))	Mechanism	Dose Range
First line (Level I Evidence)		
Agomelatine[a] (Valdoxan)	MT_1 and MT_2 agonist; 5-HT_2 antagonist	25-50 mg
Bupropion (Wellbutrin)[b]	NDRI	150-300 mg
Citalopram (Celexa, Cipramil)	SSRI	20-40 mg
Desvenlafaxine (Pristiq)	SNRI	50-100 mg
Duloxetine (Cymbalta)	SNRI	60 mg
Escitalopram (Cipralex, Lexapro)	SSRI	10-20 mg
Fluoxetine (Prozac)	SSRI	20-60 mg
Fluvoxamine (Luvox)	SSRI	100-300 mg
Mianserin[a] (Tolvon)	α_2-Adrenergic agonist; 5-HT_2 antagonist	60-120 mg
Milnacipran[a] (Ixel)	SNRI	100 mg
Mirtazapine (Remeron)[c]	α_2-Adrenergic agonist; 5-HT_2 antagonist	15-45 mg
Paroxetine (Paxil)[d]	SSRI	20-50 mg 25-62.5 mg for CR version
Sertraline (Zoloft)	SSRI	50-200 mg
Venlafaxine (Effexor)[e]	SNRI	75-225 mg
Vortioxetine (Brintellix, Trintellix)[f]	Serotonin reuptake inhibitor; 5-HT_{1A} agonist; 5-HT_{1B} partial agonist; 5-HT_{1D}, 5-HT_{3A}, and 5-HT_7 antagonist	10-20 mg
Second line (Level I Evidence)		
Amitriptyline, clomipramine, and others	TCA	Various
Levomilnacipran (Fetzima)[f]	SNRI	40-120 mg
Moclobemide (Manerix)	Reversible inhibitor of MAO-A	300-600 mg
Quetiapine (Seroquel)[e]	Atypical antipsychotic	150-300 mg
Selegiline transdermal[a] (Emsam)	Irreversible MAO-B inhibitor	6-12 mg daily transdermal
Trazodone (Desyrel)	Serotonin reuptake inhibitor; 5-HT_2 antagonist	150-300 mg
Vilazodone (Viibryd)[f]	Serotonin reuptake inhibitor; 5-HT_{1A} partial agonist	20-40 mg (titrate from 10 mg)
Third line (Level I Evidence)		
Phenelzine (Nardil)	Irreversible MAO inhibitor	45-90 mg
Tranylcypromine (Parnate)		20-60 mg
Reboxetine[a] (Edronax)	Noradrenaline reuptake inhibitor	8-10 mg

5-HT, 5-hydroxytryptamine (serotonin); MAO, monoamine oxidase; MT, melatonin; NDRI, noradrenaline and dopamine reuptake inhibitor; SNRI, serotonin and noradrenaline reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant.

[a]Not available in Canada.

[b]Available as sustained-release (SR) and extended-release (XL) versions.

[c]Available as rapid-dissolving (RD) version.

[d]Available as controlled-release (CR) version

[e]Available as extended-release (XR) version.

[f]Newly approved since the 2009 Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines.

Table 2. Summary of Neurostimulation Treatment Recommendations for Major Depressive Disorder.

Neurostimulation	Overall Recommendation	Acute Efficacy	Maintenance Efficacy	Safety and Tolerability
rTMS	First line (for patients who have failed at least 1 antidepressant)	Level 1	Level 3	Level 1
ECT	Second line First line in some clinical situations (see Table 5)	Level 1	Level 1	Level 1
tDCS	Third line	Level 2	Level 3	Level 2
VNS	Third line	Level 3	Level 2	Level 2
DBS	Investigational	Level 3	Level 3	Level 3
MST	Investigational	Level 3	Not known	Level 3

DBS, deep brain stimulation; ECT, electroconvulsive therapy; MST, magnetic seizure therapy; rTMS, repetitive transcranial magnetic stimulation; tDCS, transcranial direct current stimulation; VNS, vagus nerve stimulation.

Table 2. Summary of Recommendations for Physical and Meditative Treatments.

Intervention	Indication	Recommendation	Evidence	Monotherapy or Adjunctive Therapy
Exercise	Mild to moderate MDD	First line	Level 1	Monotherapy
	Moderate to severe MDD	Second line	Level 1	Adjunctive
Light therapy	Seasonal (winter) MDD	First line	Level 1	Monotherapy
	Mild to moderate nonseasonal MDD	Second line	Level 2	Monotherapy and adjunctive
Yoga	Mild to moderate MDD	Second line	Level 2	Adjunctive
Acupuncture	Mild to moderate MDD	Third line	Level 2	Adjunctive
Sleep deprivation	Moderate to severe MDD	Third line	Level 2	Adjunctive

MDD, major depressive disorder.

Table 4
Standardized coefficients (beta) from multiple regression of perceived causative categories, perceived access, age, education, and acculturation on ATSPPHS

	Chinese				
	A Hong Kong	B China	C Taiwan	D Korean	E Vietnamese
Stress	0.262**	0.032	0.162	0.151	0.020
Western physiological	−0.060	0.134	0.018	0.109	0.084
Non-Western physiological	−0.065	−0.053	−0.153	−0.057	−0.175
Supernatural	−0.268**	−0.063	−0.194*	−0.128	−0.056
Access	0.090	0.283**	0.208**	0.220**	0.278**
Age	−0.016	−0.049	0.023	0.056	0.013
Education	0.093	0.056	0.061	0.079	0.074
VIAH	0.000	−0.082	0.031	−0.093	0.074
VIAM	0.071	−0.059	0.176*	0.193*	−0.002

* $p < 0.05$; ** $p < 0.01$

Fung and Wong, 2007

	Hong Kong Chinese (n=86)	Mainland Chinese (n=91)	Taiwan Chinese (n=86)	Korean (n=97)	Vietnamese (n=98)
Becoming more active physically	**20.9%**	**18.7%**	**19.8%**	**28.9%**	**28.6%**
Dealt with people with similar problems	9.3%	7.7%	9.3%	9.3%	7.1%
Getting out and about more	2.3%	2.2%	4.7%		4.1%
Talking with other people	10.5%	**18.7%**	**16.3%**	11.3%	2.0%
Attending courses on relaxation	8.1%	6.6%	9.3%		**16.3%**
Cutting out alcohol altogether					1.0%
Treatment from a traditional healer	2.3%	2.2%	1.2%		1.0%
Psychotherapy or counseling	**23.3%**	**26.4%**	**16.3%**	**24.7%**	7.1%
Taking a holiday	**14.0%**	12.1%	15.1%	**22.7%**	6.1%
Admitted to psychiatric hospital		1.1%	1.2%	1.0%	**8.2%**
Admitted to a psychiatric ward of a general hospital					1.0%
Acupuncture					1.0%
Special diet or avoiding certain foods					3.1%
Taking vitamins and minerals					2.0%
Taking psychiatric medicines	4.7%	1.1%	1.2%		4.1%
Taking some sleeping pills					1.0%
Taking pain relievers					2.0%
Other	4.7%	4.4%	5.8%	3.1%	4.1%

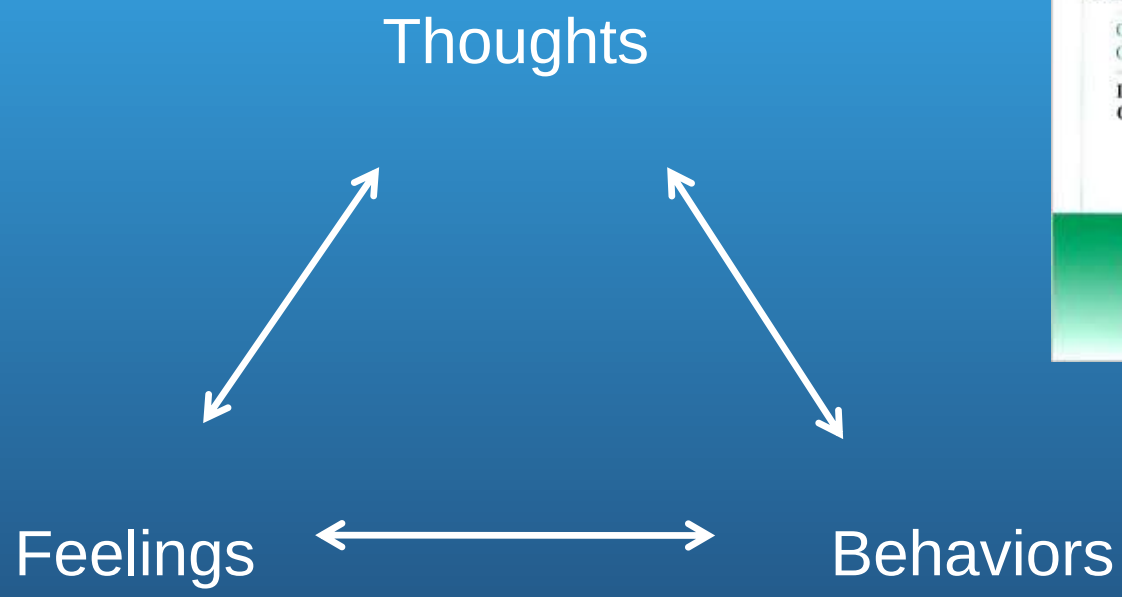
Table 13: Depression Vignette - the intervention considered to be the most helpful*

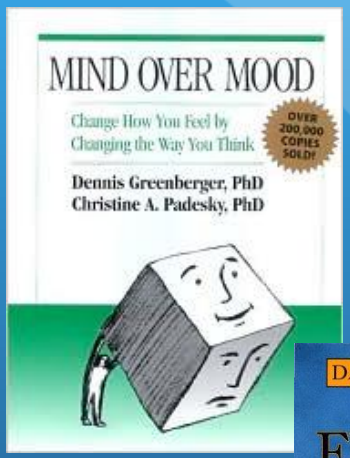
* some respondents chose more than one intervention as the "most helpful intervention"
** the three most popular choices of each group are bolded

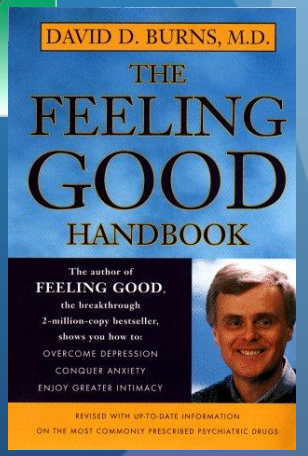
Table 5. Recommendations for Psychological Treatments for Acute and Maintenance Treatment of Major Depressive Disorder.

	Acute Treatment	Maintenance Treatment (Relapse Prevention)
Cognitive-behavioural therapy (CBT)	First line (Level 1)	First line (Level 1)
Interpersonal therapy (IPT)	First line (Level 1)	Second line (Level 2)
Behavioural activation (BA)	First line (Level 1)	Second line (Level 2)
Mindfulness-based cognitive therapy (MBCT)	Second line (Level 2)	First line (Level 1)
Cognitive-behavioural analysis system of psychotherapy (CBASP)	Second line (Level 2)	Second line (Level 2)
Problem-solving therapy (PST)	Second line (Level 2)	Insufficient evidence
Short-term psychodynamic psychotherapy (STPP)	Second line (Level 2)	Insufficient evidence
Telephone-delivered CBT and IPT	Second line (Level 2)	Insufficient evidence
Internet- and computer-assisted therapy	Second line (Level 2)	Insufficient evidence
Long-term psychodynamic psychotherapy (PDT)	Third line (Level 3)	Third line (Level 3)
Acceptance and commitment therapy (ACT)	Third line (Level 3)	Insufficient evidence
Videoconferenced psychotherapy	Third line (Level 3)	Insufficient evidence
Motivational interviewing (MI)	Third line (Level 4)	Insufficient evidence

Cognitive Behavioral Therapy







CBT & Chinese

Cultural compatibility:

- More directive therapist
- Clear structure in therapy
- Spirit of self-improvement, and akin to conventional learning esp in structured groups
- Rational
- Beliefs in positive thoughts, Ah-Q (阿Q)

Challenges:

- Accessing automatic thoughts may be difficult
- Homework can be a problem
- Collectivism: values and interdependent self
- Beliefs of Fate, Bad Luck, Yuen Fan, etc.
- Dismissing CBT as just Ah-Q (阿Q)

CBT in Hong Kong Chinese

TABLE 2. Effect sizes of the C-BDI, COPE, DAS, negative emotions, and positive emotions when comparing the post-test scores of the experimental and control groups

	Cohen's *d*
C-BDI	0.76
COPE	0.57
DAS	0.88
Positive emotions	0.13
Negative emotions	0.59

C-BDI, Chinese version of the Beck Depression Inventory; DAS, Dysfunctional Attitude Scale.

TABLE 4. Predictors of the C-BDI for the experimental group

Predictors	β	*SE*	*t*	*P*
COPE	−0.13	0.53	−0.11	0.91
DAS	0.25	0.14	2.457	0.01**
Positive emotions	−0.11	0.07	−0.918	0.364
Negative emotions	0.26	0.04	1.95	0.07

**$P<0.01$.

C-BDI, Chinese version of the Beck Depression Inventory; DAS, Dysfunctional Attitude Scale.

Wong, 2008

How should we feel?

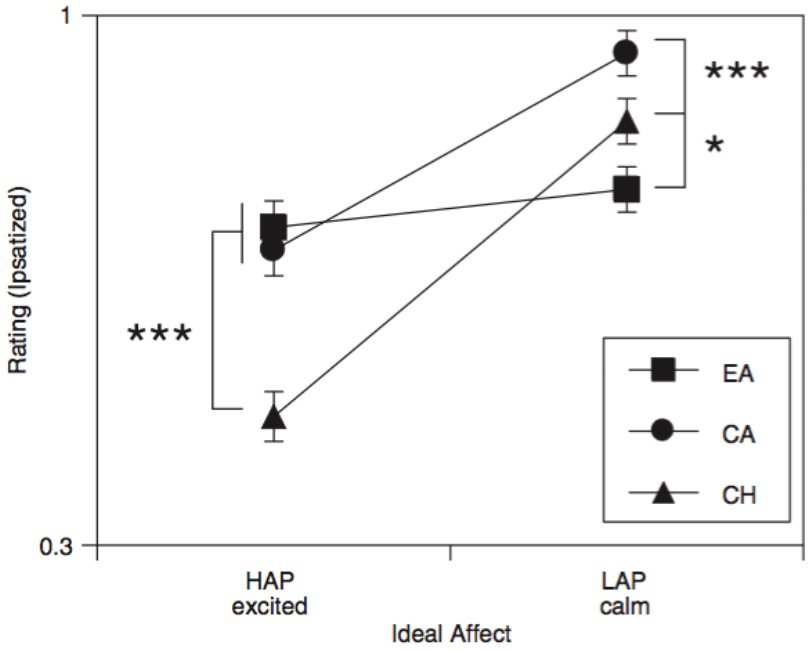


Fig. 2. Cultural differences in ideal affect (ipsatized mean and standard error). EA = European Americans; CA = Chinese Americans; CH = Hong Kong Chinese; HAP = high-arousal positive states; LAP = low-arousal positive states. *$p < .05$, ***$p < .001$. This figure was adapted from Figure 3 "Cultural Variation in Affect Valuation," by J.L Tsai, B.K. Knutson, and H.H. Fung, 2006, *Journal of Personality and Social Psychology, 90*, p. 300. Copyright 2006 by American Psychological Association. Adapted with permission.

Tsai J, 2007

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transcultural psychiatry

Article

Acceptance and Commitment Therapy: Western adoption of Buddhist tenets?

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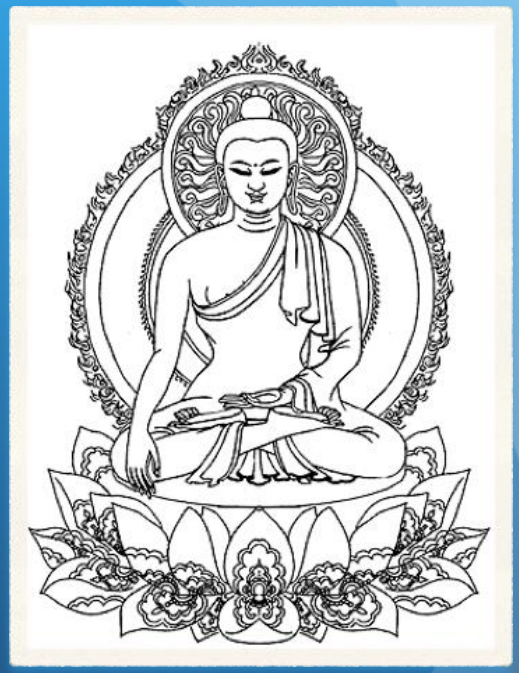
Abstract

Acceptance and Commitment Therapy (ACT) is a psychological intervention that has wide clinical applications with emerging empirical support. It is based on Functional Contextualism and is derived as a clinical application of the Relational Frame Theory, a behavioral account of the development of human thought and cognition. The six core ACT therapeutic processes include: Acceptance, Defusion, Present Moment, Self-as-Context, Values, and Committed Action. In addition to its explicit use of the concept of mindfulness, the therapeutic techniques of ACT implicitly incorporate other aspects of Buddhism. This article describes the basic principles and processes of ACT, explores the similarities and differences between ACT processes and some of the common tenets in Buddhism such as the Four Noble Truths and No-Self, and reports on the experience of running a pilot intervention ACT group for the Cambodian community in Toronto in partnership with the community's Buddhist Holy Monk. Based on this preliminary exploration in theory and the reflections of the group experience, ACT appears to be consistent with some of the core tenets of Buddhism in the approach towards alleviating suffering, with notable differences in scope reflecting their different aims and objectives. Further development of integrative therapies that can incorporate psychological and spiritual as well as diverse cultural perspectives may help the continued advancement and evolution of more effective psychotherapies that can benefit diverse populations.



Fung 2014

Dominance of Conceptualized Past and Future

Contact with Present Moment

Lack of Values Clarity; Dominance of Unworkable Rule-Governed Behaviors

Values

Experiential Avoidance

Acceptance

Psychological Inflexibility Flexibility

Inaction, Impulsivity, Avoidance

Committed Action

Cognitive Fusion

Defusion

Self-as-Context

Attachment to Conceptualized Self

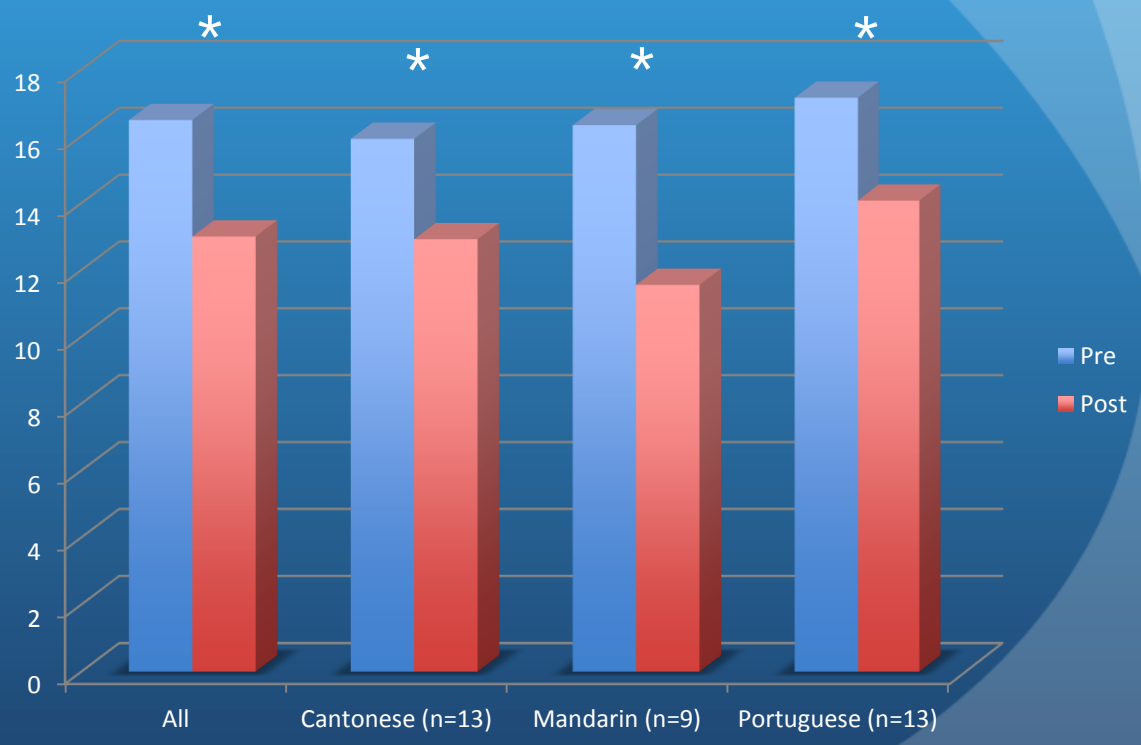
OPEN

CENTRED

ENGAGED

Integrated Behavioral Group Therapy

- 12 sessions
- Integration of:
  - CBT
  - ACT
  - Mindfulness



Focus	Dates 2013	Topic	Speaker	Skills Emphasized
(I) Holistic & Integrated Mental Health	Jan 24	Introduction to holistic & integrated mental health Relaxation	ND, RN	Deep breathing; self-awareness
	Jan 31	Self Care & Lifestyle I (Nursing Perspective)	RN	Mindfulness
	Feb 7	Self Care & Lifestyle II (Holistic Health Perspective)	ND	Mindfulness, music, food, senses
(II) Internal Resilience	Feb 14	Emotions	MHC	Centering
	Feb 21	Thoughts I	MHC	Centering, Basic CBT
	Feb 28	Thoughts II	MHC	Basic CBT
(III) External Resilience	Mar 7	Relationships & Communication	PW	Communications, Coping with Stigma
	Mar 14	Stress Management I	TCM	Tai-Chi
	Mar 21	Stress Management II	MHC	Coping & Resources
(IV) Consolidation & Graduation	Mar 28	Consolidation & Graduation Ceremony	MHC	Emotional Self-Regulation & Problem Solving in Daily Living

Journey to Healing Psycho-education Group