

visions

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the language we use

to talk about mental health
and substance use

why is the language of addiction so tricky?

words that heal and harm

visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental health or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Substance Use Information and funded by BC Mental Health and Substance Use Services, an agency of the Provincial Health Services Authority.

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We appreciate Visions' balanced and explorative navigation of the complexities and potentials of disclosures and accommodations in the workplace. We'd like to highlight the unique and significant barriers that youth with disabilities face, as both employees and employers.

Youth with disabilities are disproportionately affected by mental health issues such as anxiety and depression. As they enter the workplace for the first time, they may require unique support and clarification of their rights and their employer's responsibilities. As part of our Legal Workshops for Youth in the Workplace, the Cerebral Palsy Association of BC started discussions around the legal barriers that youth with disabilities may encounter in the workplace. A significant concern lies in the uncertainty and variability of accommodations.

Employment lawyers highlighted the need for a collaborative accommodation process, acknowledging they may provide imperfect resolutions. Youth can approach accommodation with creativity, and offer strengths and skills that exceed their roles.

Employment lawyers also emphasized the importance of young people being familiar with their rights and their employer's responsibilities. The provision of safe spaces and legal expertise for youth to have discussions about joining the workforce for the first time can be pivotal in ensuring a safe and inclusive workplace. Youth who participate in Choices in Supports for Independent Living (CSIL) and hire their own caregivers also require insight and understanding of an employers' role and obligations.

We hope to empower youth with disabilities in the workforce. The legal series will take place again in Richmond beginning August 24 (bccerebralpalsy.com/programs/legal-resources/).

—Feri Dehdar, Executive Director, Cerebral Palsy Association of BC

editor's message

My kids first saw the word 'crazy' in a book when they were around four. We've since had interesting talks about the words 'crazy,' 'fat,' and 'drunk.' All loaded words, for sure. It might be easy to dismiss this Visions as one about political correctness; it's not. It's about exploring some of the ways prejudice and power are created, communicated and reinforced. How we talk about mental health and substance use matters. Being clear, precise, compassionate and person-centred matters. Language defines, frames, clarifies or clouds, includes or excludes. It also changes. When I first started in this field two decades ago, the phrases I heard most were "drug abuse/misuse," "[the] mentally ill" and "consumers/survivors." Yet I don't use (and only rarely see) those terms today.

Because language matters, it's a good time for us to point out that... <drumroll>... Visions has changed its name. You'll see we have changed the word 'addictions' to 'substance use' in our magazine's subtitle (and also in the name of the BC Partners group that puts out Visions). Why? Addiction is a tricky word to use (see page 8!) but it also represents a very small slice of the spectrum of behaviour we've always covered in Visions. So it's time our name finally caught up.

Three final notes. First: This doesn't happen often but you may notice we don't actually have any lived experiences from men or from cultural minorities in this issue. This is unfortunate but not deliberate. Please contact me at visions@heretohelp.bc.ca to get your story heard in a letter to the editor or a future article. Second: my clustering of articles into sections is more arbitrary than usual. Every Experience article suggests solutions and every Approaches article gives a unique experiential perspective. Third: I would like to thank Karen Ward, a drug-policy advocate and activist in Vancouver. She was one of the two guest editors we had for this issue, but she ended up unable to contribute an editorial. At our brainstorm meeting though, she was passionate about the links between language, power, identity, and justice. Case in point: she has remarked in the news that it's time we stop calling deaths from fentanyl the "overdose crisis." The "poisoning crisis" would better reflect that it's not something users have control over.¹ Thank you, Karen, for reminding us to think about the impacts of our word choices on real people. In the end, that's the only language test that matters.

A handwritten signature in black ink, appearing to read 'Sarah Hamid-Balma', written in a cursive style.

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division

Minding Our Language

HOW WORD CHOICE SHAPES RIGHTS, RESPONSIBILITIES AND POWER IN MENTAL HEALTH LAW AND CARE

Iva W. Cheung

Psychologist and linguist Steven Pinker coined the term “euphemism treadmill” to describe the process by which a word or phrase that’s been introduced to replace an offensive term eventually becomes offensive itself.¹ We can find a fascinating—and perturbing—wealth of examples of the euphemism treadmill by diving into the history of mental health legislation.



Iva is a certified professional editor who specializes in plain-language and accessibility editing. She has a master’s degree in publishing and is working towards a PhD in knowledge translation in mental health at Simon Fraser University, where she teaches a course on plain language and health literacy

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In the UK, the *Idiots Act* (1886) made the clinical distinction between “idiots,” “imbeciles” and “lunatics.” This act was repealed by the *Mental Deficiency Act* (1913), which further classified people as “feeble-minded persons” or “moral imbeciles.” In 1930, the *Mental Treatment Act* replaced “lunatic” with “person of unsound mind,” which was itself replaced by “person suffering from mental illness” when the *Mental Health Act* came into effect in 1959.²

In BC, the *Insane Asylums Act* (1873) was the province’s earliest mental health legislation. It allowed physicians to commit people to institutions by issuing a certificate that read, “Such certificate shall be a sufficient authority to any person to convey the lunatic to the said Asylum, and to the authorities of to detain him therein so long as he continues to be insane.”³

Terms like “lunatic” and “imbecile” were meant to have specific legal



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Not only do labels hold power, but the one doing the labelling also holds power. Ensuring that people have the opportunity for self-identification and self-determination is a first step towards redressing the power imbalance.

and clinical definitions, but over time they migrated into the realm of casual, everyday use, where they were weighed down with stigma and fashioned into insults. Lawmakers faced the challenge of having continually to find new (and neutral) ways to describe people who needed mental health services.

More recently, those who receive and deliver mental health care have debated whether “patients,” “consumers,” “clients,” “self-advocates,” “people with lived experience” or another label is most appropriate for people who live with mental illness. Each label can be

justified, but each also has weaknesses. “Consumers” confers agency and choice, but it also imposes a material, transactional flavour on the therapeutic relationship. “People with lived experience” acknowledges a person’s self-understanding and expertise, but it is also vague and redundant.

What sets these more recent discussions apart from more cringeworthy historical approaches (consider, for example, the 1961 *School for Mental Defectives Act*) is that we seem to have finally recognized the importance of calling people what they prefer to call themselves. Not only do labels hold power, but the one doing the labelling also holds power. Ensuring

that people have the opportunity for self-identification and self-determination is a first step towards redressing the power imbalance resulting from centuries of social, cultural and political marginalization of people with mental illness.

A power imbalance between health care providers and patients exists almost everywhere, but in the realm of mental health care, patients (or service users) are also at the mercy of the state’s considerable power. For instance, BC’s *Mental Health Act* gives doctors the authority to detain a person with a mental disorder in hospital and give them psychiatric treatment against their will. I won’t delve into the debate about involuntary hospitalization (certification) here, but in my research interviews with people who’ve been certified, even those who felt that they ultimately benefited from their hospital stay have said that it was more dehumanizing than it needed to be. I think the language a person encounters while they are in the hospital plays a huge role in the experience.

Involuntary patients have to navigate a world of medical jargon and legalese. Unnecessarily complex language—especially in the fields of medicine and law—tends to confuse and exclude, reinforcing the power imbalance between those who provide care and make the laws and those seeking help. One of the easiest ways to make someone feel small is to use a word they don’t understand.

My doctoral research at Simon Fraser University focuses on how certified involuntary patients under

One of the easiest ways to make someone feel small is to use a word they don't understand.

the *Mental Health Act* are informed about their rights. When they are admitted to the hospital, involuntary patients are supposed to be given a government-issued information sheet (Form 13) about their rights. Whether that form is effective in communicating those rights to people with lived experience of certification had never been tested; that became one of my first areas of study.

My interviews and usability tests found that many people were confused by the bureaucratic and legal language on the form; they came away with misconceptions about what they could and couldn't do as involuntary patients. But more important than the lack of clarity was how the language of the form made people feel. Some of my interviewees said that the unfriendly tone and wording (such as "you are a person with a mental disorder") made them feel powerless, defective and alone. Legal terms like *habeas corpus* were intimidating and, in some cases, may have discouraged patients from asking about or exercising their rights.

Using plain language—clear, everyday terms and a conversational style—to explain mental health rights to involuntary patients may help level the

playing field. Beyond being the ethical thing to do,⁴ ensuring that involuntary patients better understand their rights can have an important therapeutic effect. It can give them a sense of agency and self-determination, which may help engage them in their own recovery, however they want to define it.⁵

Plain language is only one part of the more general movement towards accessible and inclusive language—one that asks us to be mindful of whether the words or phrases we use without a second thought could in fact be stigmatizing towards particular minority groups, like people of colour, people with disabilities or people with mental illness.

This movement is not without critics, many of whom believe we've taken political correctness too far. For example, would you ask someone to stop saying "I have an insane amount of work to do" or "It was crazy fun"? One might argue that these sorts of descriptions are so widespread, so frequently used as generic intensifiers in non-offensive contexts, that policing this kind of usage is an overreaction. But when we use "insane" or "crazy" to describe something overwhelming, chaotic or irrational, aren't we reinforcing stereotypes about mental illness?

I try to ask people affected by mental illness what terminology they'd prefer, but because they are a diverse group, my questions sometimes lead to interesting tensions. For example, many people prefer "person first" language, which emphasizes the human and doesn't define them by the illness. Within this framework, someone is "a person

with schizophrenia" rather than "a schizophrenic." Others, such as those in the Mad Pride movement, have pushed back, embracing their differences by using "identity first" language, reclaiming labels like "mad" and "crazy"—much the same way that the LGBTQ2S+ movement has reclaimed the word "queer." As this comparison shows, words that are empowering to some may be hurtful to others.

Language will evolve as connotations change, and we may never find terms that work well for everyone at the same time, but we have to keep critically examining our word choices when we talk about mental illness. Our only hope of stopping the euphemism treadmill is to stop the stigma that powers it. ▾

related resource

See Iva's team's plain language materials around understanding a person's rights under BC's Mental Health Act at www.bcmentalhealthrights.ca

Why Is the Language of Addiction So Tricky?

Gaëlle Nicolussi Rossi and Dan Reist

“I don’t think we can underestimate the power of language” – Carol Bruess

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Language shapes our thoughts and actions. It has the power to include or leave out. The words we use to describe things, people and ideas also reflect our values and influence how we and others think and act. This powerful effect can be observed in all kinds of situations and conversations, including our discussions about addiction and psychoactive substances.

The language of addiction is tricky because words mean different things

Language is alive and constantly changing. A single word can take on quite different meanings over time and in different situations (think, for example, of words such as “server”

and “tweet,” both of whose meanings have evolved in the past few decades). Yet, when someone uses a word wrong, we often understand them without difficulty. This is because meaning has as much to do with context as it has with the words themselves.

When it comes to the language around addiction, we tend to use words in confusing ways. For example, the word “drug” can mean a medicine or an illegal substance, or it can refer specifically to a substance (legal or illegal) that changes the way we think or feel (i.e., a psychoactive substance). The English word “addiction” was originally a legal term, having to do

with the surrender of something to someone, by order of a judge. Over time, “addiction” became a metaphor to describe the notion of “surrendering oneself” to a particular pursuit or activity.¹

In an environment of multiple and changing meanings, the language of addiction has taken on a negative tone. Consider, for example, the word “risk.” We take risks all the time, hoping for positive rewards but knowing that the opposite might happen. In the language of addiction, however, risk has become equated exclusively with danger. Another example of negative language is the phrase “getting clean,” with the attendant implication that addiction is somehow “dirty.” In both cases, we focus our attention on the negative and rarely consider the functional benefits that people may be seeking when they engage in certain behaviours.

The language of addiction is tricky because language can be a weapon

The language around addiction is also tricky because it is embedded within particular value systems and reflects particular interests. When people call someone an addict, for example, they are not simply suggesting that the individual is devoted to a particular pastime or activity. The term implies that, whatever the devotion (or addiction) is, it is a negative one. In the current climate, the term also carries the suggestion that the addict’s actions are blameworthy. This is even more the case with language such as “drug abuse” and “drug abuser.” With these words, we tap into a deep, collective reservoir of emotionally charged language, in which there are “victims” and “perpetrators.”

When we label someone a victim, we imply that they are somehow damaged and powerless. When we call someone an abuser, we imply they are monstrous, or somehow less than human. While we may not mean to suggest these extremes, the language we use creates stigma that excludes or disempowers people from the community or the conversation and ultimately impacts how we treat the people we label and how they think of themselves.

In our everyday lives, we tend to use stigmatizing language more often to refer to people we dislike or do not know. Thus, people from marginalized populations “abuse drugs,” while our friends might “party too much.” It is difficult to have a nuanced discussion about addiction without first addressing our biased and selective use of language.

The language of addiction is tricky because we blend different constructs together

The ambiguity of the language of addiction is systemic and has deep

historical roots. Prior to the late 19th century, what we call addiction was most often seen as sin, the result of moral weakness. As the study and practice of medicine became increasingly influenced by science, a new construct formed. Drunkards and opium addicts could be regarded as sick, the result of factors about the drug and the person.

Our current use of addiction language tends to blend these two constructs of sin and sickness—a blending that has significant implications. If we focus on the individual choices people make, we tend to adopt moral language and emphasize responsibility and blame for the use of drugs. On the other hand, if we see people as subject to forces outside of themselves, we tend to regard them as sick and needing treatment.²

Without clearly articulating these constructs and their implications, we often blame people on the one hand and deny their agency on the other. People sometimes regard

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alcohol as the cause of a person's violent behaviour, thus mitigating the responsibility of the individual. At the same time, we often hear people describe the use of illegal drugs as a personal choice reflective of the innate criminal nature of the user—essentially placing all of the responsibility on the individual. Often, the language used depends on the situation and the relative position of the speaker and the people described.

The language of addiction is tricky because our relationship with psychoactive substances is complex

The human relationship with psychoactive substances—a relationship that goes back thousands of years—is complex. People have used (and continue to use) drugs for a variety of functional reasons. We have used drugs to feel good, to seek pleasure and to enhance social interactions. We have also used drugs to enhance our intellectual and physical performance, to explore new ideas and to deal with pain or cope with anxiety and other health-related conditions.

No use of psychoactive substances is risk-free, and generally, using drugs to deal with a chronic condition is more likely to lead to problems than occasional drug use.³ But our motivations to use drugs are not the only factors that matter. Our choices, and the patterns we develop, are ultimately influenced by the options available to us. While we need to take responsibility for our choices and actions, none of us is completely free to do what we want. At the same time, few of us are completely dependent on circumstances; we all have some agency. In other words, accountability is a matter of degree.

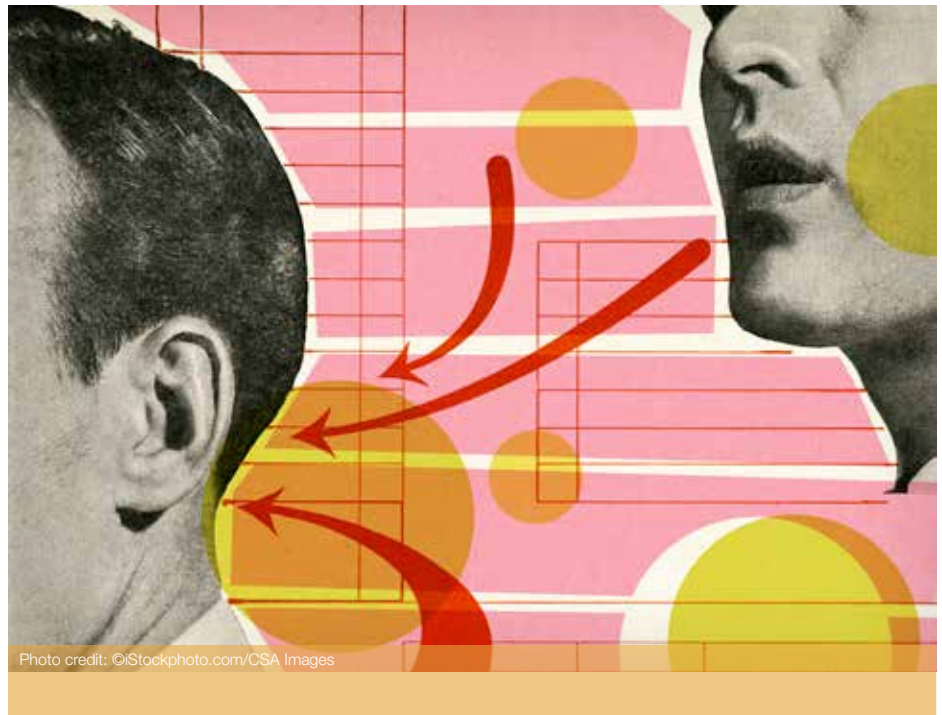


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In our everyday lives, we tend to use stigmatizing language more often to refer to people we dislike or do not know. Thus, people from marginalized populations “abuse drugs,” while our friends might “party too much.”

Yet our current language of addiction is overly simplistic—black and white in its options—and does not adequately reflect the complexity of addiction in our contemporary environment. We continue to use this simple language without clarifying context or making the distinctions necessary for balanced and meaningful conversations.

A final word

It is impossible to define what the best language is when it comes to addiction. However, we should recognize that our words matter. Our words influence our thoughts and

actions. They affect those we speak to and those we speak about. In using our words, are we building bridges or marking boundaries? If our goal is to connect and support, we must find the words to do that. We can't build connections with language that divides. ▾

With the New Cannabis Laws, Is Everyone Now an “Addict”?

Ashley

The language of mental illness and addiction can be almost as maddening and stigmatizing as the mental illness itself. I should know: I’ve struggled with mental illness for most of my life and I’ve been diagnosed with conditions with complex names that no one ever bothered to explain to me. And like many people, I’ve used cannabis before. I would never consider myself an addict, but I’ve been called everything from a “stoner” to an “addict” to a “liar.” Since when does using any kind of substance, legal or illegal, automatically make you a liar? It beats me, but the terms “addict” and “liar” often get lumped together by people who stigmatize substance use.



Ashley lives in Vancouver and volunteers in Vancouver’s Downtown Eastside. She is a certified JRNI life coach

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With the legalization of cannabis on the horizon, it’s time to think critically about the language we use when we talk about substance use and substance users. Arguably, whatever language we use ends up oversimplifying human experience. That’s why the words we choose are so important, and that’s why we have to think very carefully before we label people.

Labels *stick*. Once you have been labelled a “stoner” or an “addict,” it doesn’t seem to matter what you do or how you live your life: it’s almost impossible to change how people see you. But even more importantly, labels diminish people and their experiences. And if we diminish others, we end up diminishing our community and ourselves.

Labels *stick*. Once you have been labelled a “stoner” or an “addict,” it doesn’t seem to matter what you do or how you live your life: it’s almost impossible to change how people see you.

When I was growing up, I was generally against using substances. Although I drank alcohol occasionally, I was very aware of the dangers of substance overuse and I feared what would happen if I opened those floodgates and let myself try something that might be dangerous. Would I fall into the substance-use trap? Would I use it as an escape? As a way to cope? How far down that rabbit hole would I go?

Soon after I started college, I was diagnosed with major depressive disorder and complex post-traumatic stress disorder (C-PTSD). Nobody ever explained to me what that meant. I understood the *feeling* of depression, and I knew I had flashbacks and nightmares. But no one ever defined the terms of diagnosis for me. No one discussed with me how my brain *worked*. I was prescribed antidepressants and antipsychotics. My psychiatrist was very forceful and insisted that I trust him. When I brought up my concerns about the side effects I was experiencing, my concerns were dismissed. I was told, “You should stay on medication” or “They don’t work right away; you have to wait awhile.” Even after multiple appointments and multiple new side effects, my concerns were ignored. I was

simply prescribed more medications, one on top of another.

I was also not sure whether I should be treating the C-PTSD first or the depression. In the beginning, I focused on the depression, thinking that was the key, but with medication, my symptoms didn’t get better. If anything, they got worse. I was still not sleeping well. I developed anxiety and irritable bowel symptoms. I had panic attacks for the first time in my life.

I tried therapy, but after a few sessions, the therapist told me that clearly I wasn’t getting better because I didn’t want to get better. I was shocked. I didn’t know what to say. Wasn’t it obvious that I was in therapy because I *wanted* to get better? But she ended our sessions and said she couldn’t help me anymore.

I became desperate. I tried more medications, other types of therapy, different therapists. I tried naturopathic methods. I tried supplements. I allowed myself to drink more alcohol. Nothing helped.

I wanted to be able to work, to do my job like everyone else. But I’d go to work and stare at the screen while the prescription medications made

my brain feel like it was on fire. I wouldn’t sleep for days, and then when I finally did fall asleep, I would sleep through my morning alarm and be late for work. I couldn’t focus or even think straight, and I couldn’t meet deadlines, but the consistent refrain from my doctors was, “Stay on the medication.”

At work, I was repeatedly challenged by colleagues who thought I was lazy: “Why can’t you sit still?” “Why can’t you get to work on time?” “Why don’t you set another alarm clock?” “Why don’t you set the alarm farther away from your bed?” My desk was placed next to the manager’s office, and every time I was late, the time I arrived was noted down in my file. I had brought in a medical note from my doctor, but I guess the manager didn’t get the memo: eventually, when the stress became overwhelming, I broke down in her office. She told me that no one had ever mentioned a medical note.

For years, my physical and psychological symptoms worsened. My kidneys hurt and I wasn’t able to eat. I was constipated and nauseous. I was constantly getting sick—colds, viral infections—I was even hospitalized for illness. I spent thousands of dollars on therapy and prescription medications. Finally, someone suggested that I try weed (cannabis) for my C-PTSD. I wanted to try anything that might work. So I started smoking weed.

And then, people started to blame my ongoing health problems on the weed! Now I was late to work because I smoked weed. Now I couldn’t focus because I was an “addict.” Now I couldn’t meet deadlines because I was a “stoner.”

It took me a long time of come off the prescription medications—the withdrawal symptoms were horrible. I was told by my doctors that wasn't possible—that you can't get withdrawal when you come off pharmaceuticals. But I don't think that's true. There is a reason you wean people off those medications. Suddenly stopping a powerful medication is likely to have some effect on you. I tried to tell people that I was having trouble with withdrawal symptoms, but people just blamed the weed. To them, I was just a "dope-smoker," an "addict," and that was the source of my problems.

I began to expect the judgement from others. I was told I had "no drive," that I must not want to "help myself." It didn't even seem to matter whether I was actively using cannabis or not. Once, when I told my doctor that I hadn't smoked weed in over a year except for a single toke the previous summer, he told me that if I really wanted to get better, I wouldn't smoke weed at all—that if I did it again, I would get kicked out of the dialectical behaviour therapy program I was in at the time, and I'd be "forced" to go to rehab. Instead of focusing on what I was doing now, he focused on what I had done a year ago! I felt like he saw me as a criminal.

I found out later from one of the program coaches that what the doctor had told me about being kicked out of the program and forced into rehab was false. But at another appointment, the same doctor filled out a requisition for me to take a drug test. He didn't even tell me—he just added it to a requisition for other lab work. In fact, I only found out he

was having me take a drug test when the lab technician *asked* me why I was taking a drug test. I can only assume it was because the doctor still didn't believe I hadn't smoked weed in a year. Not only was I supposedly a "drug abuser," but I was apparently a liar, too!

I really wanted to prove that my health issues had nothing to do with the weed. It seemed like no matter what I did, no matter what medications or therapy I tried, if I didn't get any better, then my poor health was always blamed on the weed. Any efforts I made and any struggles I faced were going to be discredited as long as I smoked.

So I stopped completely. I wanted to be able to say, "No, I'm clean; smoking weed is not the issue"—even though I hate the word "clean." What does that word even *mean*? If I smoke weed, then am I somehow "dirty"? And if cannabis is legal for everyone to smoke, are we all now "addicts" and "stoners" if we smoke weed on our own time?

But I also know that whatever I do, it doesn't really matter. To some people, I will always be "lazy," an "addict," a "stoner"—someone who doesn't want to help herself get better—because labels *stick*.

How can we trust anyone—whether that person is a doctor, a therapist or a friend—who sees us so simplistically? How can we seek or accept help from anyone who uses that kind of diminishing language?

When we see people as individuals with unique experiences, then we are more likely to listen to their personal stories of suffering and come up with

supportive and helpful solutions. But when we label someone as an "addict," we stop listening. We think to ourselves, "Oh, you're just an addict. I know what to do with people like you."

The language we use and the labels we give each other have the power to shape how people think. We have a health system that is supposed to care for people. But if we really want to help people—whether we work in the health care field or not—we need to throw away the labels and look at the whole person: their pain, their struggles and their experiences. Only then can we find the right words to offer meaningful support. ▼

I'm Sorry, but What Did You Just Say?

TWO STATEMENTS THAT PROBABLY SHOULDN'T BE MADE

Kelsey Pekarek

There are a lot of things that mentally well people often don't understand about mental illness. One is what a mental health diagnosis really looks and feels like—that is, what it's like to be someone living with a mental illness. I don't usually talk much about what it's like, but sometimes, sharing is useful. Perhaps I can help someone understand why I have the quirks I do. Perhaps, by getting my thoughts out where I can see them, I can understand them better myself.

Kelsey lives in Delta with her husband and four kids, and their dog, Jet. When she's not driving her kids to activities, she can usually be found hiding in the kitchen with the doors closed



Kelsey Pekarek

Now, guess what?

I'm putting a thought out where I can see it.

Aren't you lucky?

One of the diagnoses I have is attention deficit/hyperactivity disorder (ADHD). There are two types of ADHD, hyperactive type and inat-

tentive type. To complicate life, the disorder can also present as a combination of both types. I have inattentive ADHD, which supposedly means that I have trouble paying attention, remembering things and ...

... what was I talking about?

Just kidding.

Okay, mostly kidding.

An ADHD diagnosis can be controversial. The Big Question is whether or not ADHD even exists. Once we get past that, some suggest that it's over-diagnosed, and others say that the disorder is missed in too many kids. Then there's the debate about medication: should I medicate, or shouldn't I? Now, I'm not qualified to say much about the medical aspects of the disorder or its treatment. However, having both experienced ADHD myself and seen it in others, I do feel that I can authoritatively say this:

It's incredibly annoying when people say, "I'm super ADHD today."

ADHD isn't a "today" or "right now" disorder; it's a neurological difference that doesn't go away. At any given moment, my symptoms might be better or worse than usual, but I always have ADHD. When people say that they're ADHD "right now," they are helping to perpetuate misunderstanding about the illness and about the real-life experiences of those who are directly impacted by the disorder.

I don't think that a statement like "I'm so ADHD" stems from anyone's desire to minimize the experiences of those who live with the disorder. It's more that people don't have a real understanding of what ADHD is, or of what living with ADHD is like. Now, because I'm terrible at transition paragraphs, here's a list of what I wish people could understand:

1. It's not that we're not paying attention. More precisely, it's not that we're purposely ignoring you. In fact, attention deficit is a bit of a

misnomer. We don't lack attention. We actually have so much attention to give that we can't help giving it to everything all at once. We really struggle to focus on one thing at a time. For example, anything eye-catching usually trumps anything important, so if there's a TV on behind your head, you might be out of luck. It's nothing personal.

2. We don't always display a lack of focus. Hyperfocus is a state of intense concentration. If there's something that we're interested in—maybe Lego, a certain topic of study or a sport—we have the ability to focus on it for hours. Lack of focus and hyperfocus may seem like contradictory behaviours, but there it is.
3. Hyperfocus can mean time-blindness. Some of us can get so caught up in a task or activity that we lose track of how much time is passing. We may end up being late to appointments, not meeting deadlines and panicking as we try to get caught up on our responsibilities. For example, I can stay up all night researching something interesting and not have any awareness of time until the sun rises.
4. Having ADHD isn't always negative. Those of us with ADHD may have traits that can make it challenging to function in the "normal" world, but our different wiring gives us a lot of advantages. We often come up with innovative and unorthodox solutions to problems, we're wildly passionate about our interests, we often have wicked senses of humour and,

frankly, we can be a lot of fun.

5. Be gentle with us. More often than not, we feel like we're letting people down. Have patience with us. We really are trying.

That's ADHD, but there are similar problems with a statement like "I spent an hour cleaning my house so it looked perfect for people to come over. I'm so OCD!"

I'm sorry, but what did you just say?

I'm one trait shy of an OCD diagnosis, so maybe I'm not "qualified" to talk about this. However, seeing OCD in the lives of people around me, on top of my personal experience, has left me sensitive. At the very least, "I'm so OCD" is a phrase that irks me. You cleaned for an hour before company came, and your house looks terrific. That's awesome! An hour of cleaning is a big accomplishment for a lot of people, and I bet your space looks and feels great.

However.

Comparing OCD with attention to detail or with keeping a clean house has an impact on how people view a very real, often very challenging disorder. It seems like "OCD" has become the socially accepted catch-all term for the minor annoyance of liking things a certain way, for example, or a way to excuse a quirky love of cleaning.

My OCD symptoms are not as significant as the symptoms of those who live with a more severe form of the disorder. I'm grateful that's the case; the traits I have are quite enough, thanks, and the idea of living with

A diagnosis is given because it is needed. It is not meant to excuse our behaviour but, rather, to frame it in a way that invites further investigation and understanding. When you use language that minimizes my experiences, it closes the door to further communication.

in my ability and want to work alongside me, or that expresses a desire to understand—language that empowers me—opens up opportunities for all of us to gain insight.

My diagnoses aren't something I take lightly. Please don't take them lightly, either. ▼

full-blown OCD is enough to make my stomach flip-flop. To give you an idea of what makes my stomach flip-flop, here's a list of things I'd love people to understand about OCD:

1. OCD is not always about cleaning. For me, OCD is a need for patterns and routines. Having everything in order is a crucial part of reducing my anxiety, and touching every knob on the washing machine relieves me of the worry that it will die a violent death mid-cycle.
2. OCD is not a way to laugh off being particular. OCD is an anxiety-fuelled, all-engulfing, life-controlling set of compulsions. While it's common to perceive people with OCD as needing to control certain aspects of their daily life, the truth is that the disorder is controlling them.
3. Please don't tell us we're not being logical. We know, in our hearts, that our compulsions aren't grounded in logic and that they don't actually affect the outcome. When people tell us that we're not being logical, they are not delivering a mind-

blowing piece of news. Rather than being helpful, statements like that make us less inclined to talk about what's going on.

4. We can't just stop. OCD isn't something we choose to take on. Likewise, it's not something we can choose to let go. When we are told to "just stop," it only reminds us that we can't. That can trigger feelings of guilt, embarrassment and failure. I want to stop. I don't want to be weird or annoying or ridiculous, but I can't stop—so I and people with bigger OCD challenges hide our symptoms. We count our steps silently, we avoid elevators so that no one sees us touch every button before we get to the one we can push and we do our laundry when no one is watching.

To sum it all up, a diagnosis is given because it is needed. It is not meant to excuse our behaviour but, rather, to frame it in a way that invites further investigation and understanding. When you use language that minimizes my experiences, it closes the door to further communication. On the other hand, using language that shows me that you have confidence

The Weight of Words

HOW MY LIFE WAS MEASURED BY LANGUAGE

Kylie Kranabetter

“Sticks and stones may break my bones but words will never hurt me.”



Kylie lives in Kelowna, BC, where she teaches yoga and mindfulness practices, always learning to embody her authentic self and unravel negative conditioning. She is a lover of the wild woods, community and expression, and she is passionate about helping other girls to cultivate self-love and embrace their uniqueness

Kylie Kranabetter

When I was growing up, I was told to repeat this mantra to myself anytime someone said something mean to me. I was taught the saying as a tool to use against bullies in the schoolyard. But I'd be surprised if it actually helps anyone who is feeling the real pain caused by corrosive language. The fact is that words can harm us profoundly and deeply, and the scars can last a long time. If we don't tend to those wounds, they can shape our internal dialogue in very negative ways.

When I was about 10, I noticed a shift in how people treated me and spoke to me. There was greater emphasis on exercise, eating habits and my appearance; it was increasingly important to be “pretty.” I began to experience the

same derogatory and demoralizing inner dialogues that my mom and many other people live with—words and phrases passed down from previous generations, perpetuating a pattern of unresolved abuse and neglect, words and phrases that criticized and scrutinized. *Try harder. Suck it up. You're fat. Get a life. Nobody cares. Go away.*

The environment I was raised in placed value on individualism, success and perfection. The message I received at home was to work hard, make lots of money, spend lots of money, maintain a perfect body and a perfect home. There was no focus on emotional support and connection, creativity or authenticity—even though my family



Photo credit: ©iStockphoto.com/Slava Olshevskaya

I had been taught to impress others, to please others, to be a good girl. I had learned that women are valued for being embodiments of the words “sexy,” “sweet,” “popular,” “easy-going,” “glamorous” and “pure,” all served with a smile.

members are sensitive and intelligent people! We were all trapped, focused on what others thought of us, on financial stability and outside appearances.

In addition to this, I was bombarded by images in the popular media that sexualized malnourished and under-aged girls as the feminine ideal. I was convinced that to be desirable, I had to be thin and young.

I now know that the ideal woman did not always look like this. Advertising from the 1930s through the 1950s shows women who are curvy and voluptuous—clearly women rather girls. In that period, it was the skinny girls who didn’t “measure up.”¹ Arguably, given the widespread frugality measures that affected many communities following the World Wars, a fuller body was desirable because it emphasized a woman’s contentment and wealth.

A focus on external appearance and a lack of connection to self or supportive community—both in the media and at home—were, I believe, primary factors in my developing a full-blown eating disorder by the age of 13. This took the reins of my life for over a decade. I became intensely insecure and dependent on others for validation and approval. It no longer mattered how I felt; all that mattered was how I looked. I found worth and belonging in the mirror, and from the words of my friends and boys. Words like “pretty,” “ugly,” “fat,” “skinny,” “cool” and “loser” determined who I had to be and who I could not be if I wanted to be accepted by my community and peers. Part of me retreated inside myself—but all my external efforts were focused on achieving the perfect body so I could be the best, most valued girl alive.

I imagine my life would’ve been very different if I heard words that

radiated love, respect and community—words that focused on the importance of my inner being and my natural beauty and value as a caring and compassionate person. I would love to have heard “It’s okay,” “You’re okay,” “I’m here for you,” “How can I support you?” or “What do you need to feel safe?”

Some of us are born into families that encourage us and demonstrate compassionate and respectful dialogue. Others come from environments in which the dialogue is harmful and toxic. I understand now that my family was not intentionally toxic; they were suffering in a state of survival themselves. But that meant that many of my needs were not met, and I experienced neglect and verbal harm. I was constantly criticized for all the things I wasn’t, rather than validated and loved for all the things I was.

I went from playing outside with my friends after school every day to being glued to the TV, doing exercises and counting my calories. With each year that passed, the eating disorder took a little bit more of my life. I became more withdrawn, depressed, hopeless and alone—under the weight of my own expectations and the words of others—of what I wasn’t, and what I was told I needed to be. I didn’t question the “rules” or the way things were. I had been taught to impress others, to please others, to be a good girl. I had learned that women are valued for being embodiments of the words “sexy,” “sweet,” “popular,” “easy-going,” “glamorous” and “pure,” all served with a smile.

But over time I realized that all of this came at a high price: I neglected

myself—not my external appearance but my whole human *being*.

By the time I was in my early 20s, the eating disorder had completely taken over my life. I left jobs, I lost friendships and my sense of self was completely destroyed. For days and months, I couldn't leave my room.

But following a particularly turbulent year, I started to seek out other options. My grandfather had long been interested in alternative healing therapies and, curious, I began reading books on mindfulness and spirituality. In 2013, I started practising yoga. Shortly after that, I began working towards my wholistic practitioners diploma. This opened a window into a world beyond my self-imposed isolation and self-judgement—a world that enchanted me.

Through yoga, school and my new jobs at a spa and a local, independent bookstore, I met a group of new friends and colleagues who lived seemingly free and wide open to experience, so authentic to themselves, unapologetic but at the same time respectful and kind. I also began to re-connect with old friends who were now on similar paths of exploration. At first, with my bulimic glasses on, I thought it was these people's external beauty that informed and created their internal beauty. I thought, "If I can just *look* like these people, then I will be okay."

I was not yet at a place where I could be transparent with my new friends about having an eating disorder, but eventually, I was able to share the truth. And I felt completely supported. These people celebrated life, they

celebrated different body shapes and they used each moment as an opportunity to use kind and loving words, with themselves and with others. They used words to create and reinforce the positive, the beautiful, the real.

What if we could harness the power of words to effect change? Imagine if we started using kinder words with ourselves. How would those words ripple through our lives? We are all to some extent products of our environment; we have all taken on beliefs, identities and perspectives that are not wholly our own. But while our culture and environment inevitably shape who we are, we have the power to shape our culture and environment as well. If we look closely, we can understand what needs to shift.

We are all, on some level, aware that things are weird, but there is something we can do about it. This is why things like mindfulness, yoga, art, music, spirituality and reconnecting with nature are getting more and more attention. By using these tools, we can increase our clarity, and we can begin to recondition ourselves for a life lived more authentically.

The best way to see the effect of our words is to look at our relationship with ourselves. How do we view ourselves? What do we perceive to be our limits? How are we worthy? What do we say to ourselves about our lives? Are we supportive or are we belittling and patronizing?

When we use language in a positive way, we can shift our internal conversation and recalibrate our sense of self. We can challenge the nagging voices that tell us we are not good enough,

not pretty enough, not skinny enough or not popular enough. We can choose to speak to ourselves as a loving parent or best friend. There is room for all bodies to be celebrated, and there is room for all people to be who they are. We must create that space for ourselves. Then, we can go from telling a story of victimhood ("I must be pleasing to others because others determine my value and worth") to taking inspired action in our lives ("I determine my own value and worth and that is pleasing to me").

I have been actively and consistently reworking my internal dialogue for the past year. I use my morning journal time to create a dialogue with myself that is uplifting, supportive, nurturing and inspiring. I talk to other people with words that remind them of or reinforce their goodness and beauty. I am doing art and spending time in nature to get back in touch with the real me. I am taking actions that show that I believe in myself and my ability to grow. I am using words that I feel are too scarce in our collective dialogue.

I have gone from being someone who hid from the world, chronically withdrawn and focused on my eating disorder, to being fully engaged, able to enjoy the highs and support myself through the lows, while working to create a more authentic life for myself. Words can be powerful weapons, but they can also be powerful tools. If we can learn to use them properly, we can all begin to experience a sense of internal peace and a greater sense of love for ourselves and of our purpose in the world. ▽

Words That Heal and Harm

MAKING WISE CHOICES WHEN WE TALK ABOUT MENTAL HEALTH

Suzanne Venuta

Several months ago, I was out on the water with my dragon boat team. Two of my team members, both of whom work as health service providers, were talking to each other about a patient who had arrived at the hospital in crisis the night before. Throughout their conversation, the two made disparaging remarks about the patient, her condition and the family member who had brought her in, suggesting that the episode was a cry for attention rather than a real health crisis.

Suzanne is a mental health educator, advocate and inspirational speaker. She writes two blogs on mental health (hopeandmentalhealth.blogspot.ca and suzy-livingsuccessfullywithdid.blogspot.ca) and a travel blog (suzyepicirishodyssey.com), and she was the recipient of the 2018 Coast Mental Health Courage to Come Back award. She lives in Comox, BC



Video credit: Coast Mental Health

Screenshot from Suzanne's "Courage to Come Back" award presentation video

We live in a small community; anyone on the team could have known the family these two were speaking about. As I listened to their conversation, all I could think was, "Wow, if anyone on this boat was considering reaching out for help about a mental health issue, this would certainly change their mind." I understand my teammates probably needed to let off some steam, but this was not the right time or place. Would they have made these sorts of

remarks about someone who had just had chemotherapy, or about someone who was the victim of a car accident? Not likely.

There were 20 people on the boat that day. I'll bet at least half of them knew someone who had a mental illness or had experienced a mental health challenge themselves. It was discouraging to see two health service providers so thoughtless when it came to the power of their words.

Words.

We use words thousands of times a day, often without even thinking about it. We use them to communicate what we want, how we are feeling, where we are going, what we are doing. Sometimes, we have lots to say. At other times, we may find it hard to find the right words to express ourselves in particular situations.

Words do not simply communicate information; they also have the power to help, heal and harm. We have all been taught from a young age to avoid hurting other people's feelings with our words. But how often do we really examine closely how the words we use affect others?

In my day-to-day life, I have been on the receiving end of words that both harm and heal, especially in the context of living with a mental illness.

I live with complex post-traumatic stress disorder, depression and dissociative identity disorder (DID). Living with a mental illness can be challenging. During the challenging times, I am especially aware of how people's words can help or harm.

Dissociative identity disorder develops in early childhood as a coping mechanism to deal with overwhelming or traumatic events. In my case, it was a response to severe abuse, neglect and abject poverty. Whenever my DID is triggered by a traumatic event, a second "identity" steps in and deals with whatever is going on. When the event is over, my "normal self" returns and carries on like nothing happened. I often have no conscious memory of the identity

You don't need to understand what's going on, but you need to know that I am suffering and terrified. If someone beside you on the sidewalk suddenly went into cardiac arrest, what would you do? Most likely you would stay with them until the paramedics arrived. You would tell them, "I'm here, you're not alone; help is on the way."

shift or I'm not even aware it has occurred until after the event.

When I am in crisis, others do not see me at my best. I have difficulty finding the words to express what I am really feeling; I'm in pain, and I feel lost, alone, scared and absolutely exhausted because I have been trying to hold it together for so long. I used to frequently have thoughts of self-harm and suicide. During those times, I worked hard to stay safe, avoiding harmful coping mechanisms (like alcohol) and focusing on living minute by minute. This kind of self-care is exhausting. Sometimes I needed to call on my family and community supports for help, and in the past, I've had to be hospitalized.

While in crisis, I have been told more than once that I was acting a certain way because I wanted attention. On one occasion, I was asked by a psychiatric nurse if I had tried praying. I just looked at her in disbelief. I had been seeking help and support, and her remark made me feel like I had done something wrong. It was as if she was saying that I wasn't trying hard enough, that I was flawed, that my illness was a direct result of my

connection (or lack of connection) with God—if I tried harder or prayed harder, I wouldn't be ill. I have been told, by practitioners and non-practitioners alike, that dissociative identity disorder does not exist, that it's a made-up illness—despite the fact that it is in the *Diagnostic and Statistical Manual of Mental Disorders* and there are researchers who study it and practitioners who encounter it.¹

Needless to say, none of these remarks helped me in any way, especially during difficult times, when I felt particularly vulnerable.

But I have also experienced words that helped me through these challenging periods—statements like "I can't imagine what you have been through or what you are going through right now, but I'm here for you and you are safe" or "You did the right thing, asking for help." Other helpful comments include "I am sorry you are experiencing this" and "If there is anything I can do, I'm here for you." These supportive, non-judgemental remarks open the door for conversation.

In times of crisis, no one can really "fix" things. Perhaps this leads to people

feeling frustrated; maybe that's where their negative words come from. But what I need in those times are words of kindness and compassion and, most of all, acceptance. You don't need to understand what's going on, but you need to know that I am suffering and terrified. If someone beside you on the sidewalk suddenly went into cardiac arrest, what would you do? Most likely you would stay with them until the paramedics arrived. You would tell them, "I'm here, you're not alone; help is on the way."

In addition to having lived experience of my own, I am also a parent of a child with mental health challenges, and I have heard hurtful words in that capacity as well. Once when my son was having a really hard time with depression, I took him to the emergency room. I overheard one nurse say to another, "Well, look who his mother is—another attention seeker."

This kind of remark is unacceptable—from anyone, but particularly from a health care provider. I was seeking help and supports for my son, who was spiralling down and finding it hard to carry on. He was no longer the happy-go-lucky, laughing, motivated, sharp-witted young man I knew and loved. We were reaching out for help—just like anyone else experiencing a health crisis—but no one said, "I'm here," "You're not alone" or "Help is on the way." No one opened the door for conversation. Instead, we were left to deal with this on our own.


It also would have been meaningful if someone came up to me and asked how I was doing through all of this. As a parent, I was undergoing my own stress. I was worried beyond belief.

I hadn't slept, and I was emotionally and physically exhausted. It would have been nice if someone had asked, "How are you doing? Have you been eating enough? Have you been drinking enough water?" This sort of genuine concern would not have solved the problem, of course, but such a connection would have buoyed my spirits and given me additional strength as I sought care for my son.

This is how powerful our words can be, even when we are not aware of their effect on others. We all need to pay more attention to how the

language we use has an impact on those around us, particularly when it comes to mental health issues and addiction. This includes me: I'm sure my words have also harmed or healed when I haven't been fully conscious of their power. I remind myself each day to be mindful and to choose my words with care. I also try to remember that sometimes things can't be "fixed," and when that is the case, the only way to support someone is with our words. It is in those times that our word choice matters most.


Choose wisely. ▾




IS THIS HOW YOU FEEL?

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Bad Personality? Poor Character?

COMING TO TERMS WITH BORDERLINE PERSONALITY DISORDER

Marja Bergen

When I received a diagnosis of borderline personality disorder (BPD), I did an Internet search to find out exactly what I was dealing with. What did BPD mean for my life?



Marja has lived with bipolar disorder for 50 years and was diagnosed with borderline personality disorder (BPD) three years ago. She founded Living Room, a peer support group, now part of Sanctuary Mental Health Ministry (www.sanctuaryministries.com). Author of six books, Marja writes weekly reflections to encourage those living with mental health challenges. See www.marjabergen.com

Marja Bergen

What I found alarmed me. Symptoms of borderline personality disorder include periods of intense anger, impulsive behaviour and difficulty with relationships. Needless to say, I was horrified. Is this how people see me now? I wondered. Am I now considered to have a bad personality? I had always thought of myself as “good” person—a kind person with a desire to help others!

My findings were very hard to cope with. Shame filled me like never before. Distraught, I asked myself, Am I really such a bad person? What’s happening to me?

I picked up the phone and called the crisis line. I started to tell the person on the other end of the line what I was feeling. But before long, I became so nauseous I had to interrupt the conversation in order to throw up. I couldn’t help myself. I didn’t even have a chance to properly end the call.

I hate the label “borderline personality disorder.” Those words are, I’m sure, a big part of why the illness is so stigmatized. Some misunderstand personality “disorder” to mean personality “flaw” and fail to see BPD as an illness. The word “borderline” also distresses me, suggesting that

I hate the label “borderline personality disorder.” Those words are, I’m sure, a big part of why the illness is so stigmatized.

the person with the disorder does not have a “valid” or complete personality. “Emotional dysfunction” would be a far better description. I could live with a label like that because the focus is in the right place—on emotions, the most dominant facet of the illness.

The current label also places emphasis on personality. I think that when people understand that BPD is a disorder involving the personality, many mistakenly conclude that someone with BPD is “bad,” that we have poor character. That’s one of the worst things I would ever want people to think about me. It’s terribly stigmatizing—not to mention just plain wrong.

Too often, people seem to think of personality and character as the same thing. But there is a difference. Put simply, personality is what we are on the outside—the qualities and traits we reveal to others; character is what we are on the inside—the beliefs or values that constitute our core being. Personality is easy to read. We judge people to be funny, extroverted, energetic, optimistic, confident, overly serious, lazy, negative, or shy. Character, on the other hand, reveals itself only in specific—and often uncommon—circumstances, and may include traits like honesty, virtue and kindness.¹

In other words, I might have the most beautiful character and be the

most loving person around and still develop BPD. Borderline personality disorder has absolutely nothing to do with my inner character. Yet no matter how much goodness there is within, the focus is on our emotional reactions and behaviours, and this is often how we are judged. Even well-educated individuals make the mistake of judging us solely on our reactions and behaviours rather than taking the time to see our inner character. How tragic that such a misunderstanding should harm people who are already suffering!

When I was diagnosed, I received minimal direction from my psychiatrist and ended up doing most of my own research about BPD online. I shared my diagnosis with a few friends, thinking they would be understanding. I had lived with mental illness all my life (I also have bipolar disorder), and I am a leader who has done much good work advocating on mental health issues. I had the respect of my community... or so I thought.

The change in attitude came from mainly one person, a friend who meant a lot to me, and I’m not exactly sure when it started. But the shift was profound. This individual started treating me differently. Kindness stopped. Smiles disappeared. I was hurt repeatedly through the person’s

words and actions and there was no apparent concern for my feelings. The pain dug as deep as a knife, yet the person never expressed remorse. At times I felt as if the person had forgotten I was a human being. But ultimately, I wanted healing and peace, so I offered forgiveness. My forgiveness was refused.

At the end of a year, I walked away from this abusive friendship, something I should have done much sooner. In the years that followed, I continued to suffer, plagued by traumatic memories of the psychological abuse. I spent thousands of dollars on therapy—therapy that is still ongoing. My mental health will probably always be affected.

There is more stigma associated with BPD than with any other mental illness.² Personally, I find this fact one of the most painful things about living with the disorder. I am an emotionally sensitive person, like most people with BPD, and I have strong reactions to emotionally charged situations and I sometimes have difficulty controlling the intensity of my responses. Being stigmatized, or dealing with stigma, is no small thing. At its most extreme, stigma can cause irrevocable damage. It can erode a person’s self-esteem and ruin a person’s opportunity to experience a fulfilling life.

Individuals living with BPD must continually face the stigma and shame of having this illness, and this takes a further toll on their mental health. Some studies suggest that suicide rates in people with BPD are 4-9% and that as many as 80% of people with BPD display suicidal behaviours.³ As someone with an insider’s perspec-



Photo credit: ©iStockphoto.com/FilippoBacchi

Convincing people to change the words they use can be a slow process. In the meantime, those of us who live with the ugly label of “borderline personality disorder” must also make a change: We need to forget what people think and remember what we know about ourselves.

tive, I can confirm that the shame and the stigma are due in large part to a few badly chosen words: borderline personality disorder.

Convincing people to change the words they use can be a slow process. In the meantime, those of us who live with the ugly label of “borderline personality disorder” must also make a change: We need to forget what people think and remember what we know about ourselves.

I’m glad that I believe in a God who pays no attention to man-made labels. The God I know sees those of us with BPD as people who might have

had rough lives, making us overly sensitive. He sees the hurt child that is deep within so many of us. In other words, he sees our true character. He is less concerned about our personality, because he knows that personality is not always a good reflection of character. He will always see us the way we truly are. ▼

related resource

Dialectical behaviour therapy (DBT) can offer effective treatment for those living with borderline personality disorder. For more information on DBT, contact the DBT Centre of Vancouver, at www.dbtvancouver.com.

Obsessive-Compulsive Disorder

MY GREATEST SUPER POWER

C

I can remember the day I had my first real obsessive-compulsive disorder (OCD) thought. As a young girl, I worried about my friends, family and school work, and I struggled with perfectionism, but this was the first time I became obsessed over one thought. I was sitting on the couch, watching TV with my dad while we were on vacation in Palm Desert, California, when I thought, *What if you didn't clean your hands enough? What if you still have pee on your leg?*



Leah was born in Vancouver and is 18 years old. She is a high-level competitive golfer and hopes to become professional. She enjoys weight lifting, baking and waterskiing. Leah has served on various panels and has taken part in educational seminars to speak about her experience with obsessive-compulsive disorder (OCD)

I got up and went to the bathroom and spent the next 20 minutes washing my legs with soap and water. Then I spent a long time washing my hands. But when I returned to the couch, the same thought came back. Within days, these sorts of thoughts had escalated and I went through a full container of hand soap. I knew something was wrong. I was scared; my parents were scared. We didn't know what was happening.

Meanie. That's the name I gave my obsessive thoughts, or what I think of as the monster in my head. I wish now

that I had picked a better name, but at 13 years old, I felt the name was a good one. Giving it a name was really important to me; it allowed me to classify it, to separate it from myself. It was a lot easier to have a conversation about (and with!) my monster once I could address it. I felt more powerful when I could say, "That's just Meanie talking," or "Go away, Meanie!"

When we returned home from vacation, after much convincing and many tears, I saw a psychologist. She diagnosed me with obsessive-

Usually when people say, “That’s so OCD,” they are describing OCD tendencies. Using the wrong description for a behaviour can minimize the experiences of someone genuinely struggling with OCD.

compulsive disorder. At the time, I did not know much about OCD except as a term that some people used to describe themselves or others when they were neurotic about cleanliness or organization. When I actually experienced the struggles of OCD, I realized there was much more to it than that.

There are many different types of OCD. I was diagnosed with contamination OCD. My biggest obsession was over the cleanliness of my hair and anything to do with the bathroom. I had beautiful, long blonde hair that gave me a lot of confidence, but my hair was a great target for Meanie. Eventually I became afraid of the toilet, certain walls of the house, laundry and particular parts of my body (especially the backs of my legs because they would touch the toilet when I went to the bathroom). I viewed all of these things as contaminated. I even viewed my parents as contaminated if I saw them touch something that I thought was unclean.

My brain felt constantly punched and slapped by these thoughts, which would then stick to my mind like Velcro. In fact, I sometimes felt like I had two brains—my common-sense brain and my OCD brain—and they would argue continuously with each

other. One thought in particular used to always stick: *What if your friends never want to hang out with you again because you are so gross?* This kind of thought was difficult to deal with because I valued my friendships. I felt as if I was contaminated. And the more I used that kind of language with myself, the more I felt it to be true.

After three months, my OCD thoughts and compulsions had left me completely debilitated. I couldn’t go to school, I wore shower caps to protect my hair, I held my arms up in the air to avoid touching something contaminated and I went to hair salons because I was too afraid to shower. I stopped eating and drinking because I didn’t want to use the bathroom. My rituals were so tiring that I didn’t want to face them anymore. My hands and forearms had begun to bleed from all the washing I was doing.

One of the things that helped me accept my disorder was learning exactly what was going on in my brain from a scientific perspective. Understanding more about hormones and other parts of my brain was fascinating, but more importantly, knowing this information took the power away from the disorder. It no longer felt like a huge, scary illness; it was simply a chemical problem that

needed some tweaking. You could say that I regained control over my OCD with education.

Another vital component to beating my OCD fears was exposure. Exposure is a process in which, gradually and incrementally over time, you face the thing that causes you fear or anxiety. If you are afraid of heights, for example, you might slowly work your way up to standing on a 10-metre-high diving board. In my cognitive-behavioural therapy sessions, my psychologist and I planned out a series of exposures. These included standing in the bathroom and not washing my hands, starting to take showers again (at first fully dressed because I was too scared to be naked as that meant more parts of my body could get contaminated), and then dancing with dirty underwear on my head. My most memorable exposure was when I worked myself up to hugging the toilet and rubbing my hair all over the porcelain.

Imagine facing your fears multiple times a day, every single day, for months. It was awful, but it was a vital step towards my regaining self-control. Essentially, I retrained my brain to turn off its OCD switch. I had the most success in exposure therapy when I imagined myself the way I aspired to be: OCD-free with my friends, my hair hanging down, dancing. I also constantly challenged my OCD thoughts by repeating to myself a series of personally helpful phrases: *What would my friend do? And So what? Even Maybe I did touch the toilet seat, but I don’t care and my family will still love me.* These phrases would usually shut my OCD brain up for a while, and they reminded me that I am in control of my thoughts.

At the time, I told only my closest friends that I had OCD. Some were helpful and some weren't. When I told my closest friend that I had OCD, for example, she laughed. I believe she laughed because she was uncomfortable, but it still hurt my feelings. Other friends would tell me to "Hurry up!" while I was in the middle of doing a compulsive action.

But to be fair, mental illness is difficult even for adults to understand—let alone 13-year-old girls. The most helpful friends were those who didn't rush me during my rituals, and when I seemed extremely afraid, they were the ones to tell me that I would be okay. I relied on them to tell me what "normal" looked like. I used to ask, "If you went to the bathroom and your hair touched the toilet, would you wash your hair?" Sometimes I would watch a friend who also had long hair, to see how she would act, how comfortable she was if her hair flipped around and touched everything. Sometimes I would try to imitate her.

It was a long journey, but after three years of intense therapy, thousands of hours of exposure and support from my psychologist, family, friends and school, I was finally able to control my OCD. Looking back, I know that one of the most important factors in my recovery was that I did share my struggles with family and friends. How would I ever have got the help I needed if I hadn't shared my experiences with those closest to me?

When I struggled during class, I would go up to my teacher and say, "My OCD is giving me a really hard time right now. Could I please go outside for a walk?" And she would

say, "Take as much time as you need." Perhaps she didn't fully understand my disorder, but she understood that I was anxious, and her words were compassionate. I think it also helped that I was able to articulate so clearly what I was experiencing, what was causing me stress and what I needed at that moment.

There are still moments when OCD thoughts return, but with the skills I have developed and the trust I have established with family, friends, teachers and medical practitioners, I am able to manage them. I am now able to channel that analytical brain of mine so that it benefits me rather than hindering me. I run the Mental Health Club at my school and give frequent presentations to students and teachers about the significance of mental health care and wellness. These opportunities have helped me combat stigma around mental health, while also giving me a great platform to talk openly about my struggles with OCD.

One of the things I emphasize in my presentations is the importance of the words we use. We need to use the right vocabulary for the situation.

For example, there is a big difference between having obsessive-compulsive *disorder* and displaying obsessive-compulsive *tendencies*. Obsessive-compulsive *disorder* is a debilitating mental illness that prevents an individual from living a full life. An obsessive-compulsive *tendency* is something a person might do to feel comfortable but doing it doesn't prevent them from having relationships or performing daily activities. Usually when people say, "That's so OCD," they are describing OCD tendencies. Using the

wrong description for a behaviour can minimize the experiences of someone genuinely struggling with OCD. At the same time, comparing a tendency to a disorder can ascribe an undeserved gravity to behaviours that, while they may seem odd, are completely harmless in a healthy individual.

As a young adult, I now consider OCD to be a gift. I have a brain that can analyze and interpret things on a level that not many others can, and I think that is pretty cool. I am fortunate to have supportive parents who always remind me how much they love me and how strong I am. We talk often about the fact that many successful and intelligent people have a mental illness; part of me likes to think that I may be a member of their elite club. My journey has been difficult, but the skills I have learned and the knowledge I have gained will support me in the years to come. ▼

Paying Attention to the Language We Use

A MOTHER'S PERSPECTIVE

Colleen Clark

In the fall of 2017, when she was 22 years old, my daughter found herself facing a mental health crisis. The impact of depression and anxiety on her life was hard enough; trying to find the right medication and managing the side effects had created more challenges.

Colleen is the mother of two young adults, and works as a consultant for the Institute of Families for Child and Youth Mental Health



Photo credit: monkeybusinessimages

From my experience working with the Institute of Families for Child and Youth Mental Health, I knew it was important to help my daughter prepare for a conversation with her doctor so that she could express how her mental health challenges were impacting her life and clearly ask for the help she needed. Because she wasn't feeling well, I knew that she likely would have difficulty finding the language to do so, and that her frustrations with the medication may keep her from getting her needs met.

I told her about the language filters used by the Institute of Families for Child and Youth Mental Health's FamilySmart™ program. These filters are tools that help us to describe our experiences. The filters can be used to help us explain how an experience with others impacts us, or they can be used to help us explain our own internal experience. Filters such as *looks like*, *sounds like* and *feels like* help us to express the reality of our experiences while avoiding blaming any one person or thing. *Looks like* is what

we see, *sounds like* is what we hear, *feels like* is how we feel as a result of what we have seen and heard. In other words, what we see and hear directly impacts how we feel.

The filters are also useful tools to help others hear and understand us better. The question “What does that *look like*, *sound like* and *feel like* for you?” can empower someone to communicate clearly, respectfully and kindly.

While preparing my daughter to meet with her doctor, I asked, “What are you going to tell the doctor?” She mumbled something about not having any energy and just not feeling herself. Knowing she was struggling to put her feelings into words, I re-phrased my question: “What’s it like to be *you* right now? What does it *look like* and *sound like* to be you?”

Her answer to that question provided a much clearer picture of her experience: “I sleep all the time. After I’ve slept for 12 hours, I need a three-hour nap in the afternoon [what her experience *looks like*]. I’m always telling my friends that I don’t want to go out with them, or that I’m calling in sick at work [what her experience *sounds like*].”

“That must be really hard,” I said. “What does it *feel like*?”

“I can’t focus on anything. And it *feels like* the medication is working for the anxiety but it’s still not working for the depression. I can’t take the side effects of the medication anymore.”

The filters enabled her to better explain her mental health challenges and the challenges with the medication. It also clarified for her what she needed from

the doctor. My next question helped her to clarify this even further: “What’s the most important thing you need your doctor to know right now?”

At that point, she realized that when I asked her what it felt like to be her, she had also identified what she needed from her doctor. “I want him to know that I am still not well and I want to try a different medication.” Focusing on the filters meant that the challenge of expressing herself became less overwhelming, and she was able to find the words to accurately describe her internal experiences and her needs. It opened up the opportunity to shift from a place of blame (“the medication you prescribed me is making me feel terrible and it’s done nothing to help my depression”) to a place of empowerment (“This is what I need you to know about me, and this is my ask of you”).

At her request, I accompanied my daughter to her medical appointment the next day, and because she was prepared, she was able to clearly ask for help: “The anxiety is better, but the depression isn’t. And I just can’t take the side effects of this medication anymore. Is there a different medication I can try?”

The doctor acknowledged her concerns and was curious enough to ask for more information to clarify things. “I’m wondering about the depression. Can you tell me more about it?”

Remembering how she had described it to me by using the filters, she told him what it *looked like* and *felt like* to her.

The doctor’s response was validating. He agreed to look at other medications. Then he picked up his cell phone to

open a medication research application. “Just give me a moment, please, so I can refresh my memory on what medication might be the next best one to try.”

We *felt* acknowledged and supported and we felt that my daughter’s needs mattered. Why? Because his words *sounded* like kindness and respect. Instead of using phrases like “Let’s give it longer to see if the side effects go away” or “You’ll probably feel better if you start seeing your friends again,” which would have felt dismissive, he used words that told my daughter that he believed her when she said the medication’s side effects were no longer tolerable and that she was still struggling with the depression. And he made it clear that he was going to help.

It *looked* like he was genuinely interested in what my daughter had to say because he leaned in to my daughter when talking with her. His body language showed he was listening. We heard and saw that he believed her and respected what she was saying because he excused himself from our conversation to look up the information he needed, rather than looking at his phone while talking to my daughter.

Just before leaving the examining room, the doctor turned and thanked me. During the appointment, I had shared some of our family history, and I had told him about the changes I had noticed in my daughter. He said, “Having you here is actually great because it really helps me understand what’s going on. You’re able to fill in some gaps.”

Like many parents, I had gone into the appointment thinking that I might

be seen as a hovering parent, or that my perspective may not be viewed as having any value. Instead, after what I *heard* and *saw*, I *felt* like our doctor saw me as having something of value to give. Rather than judging me negatively for attending the appointment with my daughter, he appreciated that I made the time to be there. He saw me as an asset in my daughter's recovery. He could just as easily not have acknowledged my presence and dismissed my perspective. Instead, he made eye contact with me and said he was grateful for my presence and contribution. I saw, heard and felt the acknowledgement and caring.

The language we use and the way we communicate, both verbally and non-verbally, sets the stage for how we experience each other. Using the FamilySmart™ filters to describe our experiences and perspectives helps us communicate clearly and respectfully, and it can be empowering. Choosing words that acknowledge the other person's experiences or thoughts promotes trust; choosing words that show curiosity and validation helps us withhold judgement.

For example, try the following:

- "What's it like being you right now?"
- "I'm curious about _____. Can you tell me more about that?"
- "I am wondering, of all of the things that you have described, what matters most to you?"
- "It sounds like you are having a hard time. How can I help?"

Practise using these filters and the phrases above in everyday life and see how your conversations change.

The more you do it, the more natural it will become! Always remember, too, that sometimes people need space to answer and time to choose the right words. It's important to be comfortable with silence; don't rush to fill it.

What we see and hear directly impacts how we feel, which determines to a large degree whether we have a good or bad experience. Our good experiences promote caring, connected relationships, which enable us to work well together. And I know—from my experience as a mother and my experience with the Institute of Families—that working well together is crucial to creating better mental health outcomes for young people. ▼

related resource

For more on the Family Smart™ programs and resources, and a helpful video on language, see www.familysmart.ca/programs/familysmart/

The organization also publishes a set of resources to help begin conversations about mental health and wellness. See www.familysmart.ca/files/FamilySmart-Unfolding-Conversations-2017.pdf

the right words in the right time and in the right place

How we present ourselves when we are under stress is very different from how we present ourselves when things are going well. No one is at their 100% best all the time. This is especially true for youth and young adults who may not be well, and for families who are in crisis.

Sometimes we all need a confidential, safe space to share our feelings and vent our frustrations. Having conversations in private with a friend or FamilySmart™ Parent in Residence or Youth in Residence, away from the youth, family member or service provider about whom you're speaking, may allow you to identify your needs and reframe your language. Having this time and space gives us the opportunity to choose words of empathy, kindness and respect.

Language and Access to Mental Health Support

CHALLENGING THOUGHTS FROM A PSYCHIATRIST

Chris Williams, MBChB, BSc, MMedSc, MD, FRCPsych

I am a psychiatrist.



Professor Williams is Emeritus Professor of Psychosocial Psychiatry, University of Glasgow, UK, Director of Five Areas Limited (www.fiveareas.com) and President of the British Association for Behavioural and Cognitive Psychotherapies. His main work is in the development and evaluation of CBT approaches, including the Living Life to the Full resilience course

Has that put you off already? Do you assume or know what I'm going to say? Or what I'm going to do or think? Or what I'm wearing and what my voice sounds like?

In my experience, the language we use to discuss mental health issues shapes how we see ourselves and our experiences. That's one of the underlying principles of a course called "Living Life to the Full" (LLTTF™), a cognitive-behavioural therapy (CBT) approach to living a resilient life, which I and colleagues have developed over the past 15 years and which is now being used across Canada by the Canadian Mental Health Association (CMHA). One of

the focuses of the approach is on the importance of language in our view of self and our personal well-being.

For example, we can label ourselves as "distressed," or we can think of ourselves as "mentally ill." Perhaps we "want help" or we think we "need a diagnosis." Maybe we "have a problem" or perhaps we "face a challenge." Do we have "symptoms" or do we have "personality traits"? Do we "want support" or do we "need treatment"?

Many discussions of mental health and well-being involve technical jargon and a terminology of diagnosis. In contrast to physical disease, the stigma

surrounding mental health issues often leads us to use a judgemental language when it comes to our own mental health and the mental health of others. This can also affect how we understand and access the health care system. Even my title of “psychiatrist” —and whether I “am” a psychiatrist or simply “work as” a psychiatrist—influences how people see me and the help I can offer.

When something goes wrong with our physical body, we often address the issue quickly. While it’s human to avoid things that seem difficult or scary, many physical health problems feel straightforward and relatively easy to deal with. For example, if you went on holiday and broke a leg, you would probably not think twice about getting hospital treatment, and you would probably tell friends and family all about it when you came home. Most people would—all the while complaining about the pain and the hassle, how we couldn’t find our insurance documents and how long the emergency-room wait was.

Yet when it comes to our mental health, we are often less likely to seek help. We know that over 50% of people facing marked distress at a level that a psychiatric diagnosis could be made never go near the health care system. That figure is fairly constant across many countries and continents.¹

Let’s say, for example, it wasn’t your leg that broke on holiday, but your ability to cope. Perhaps you experienced a panic attack for the first time or felt so depressed or scared that you ended the holiday early and returned home. Would you tell family and friends what had happened as

One of the hallmarks of any profession is a dedicated, complex and often technical language. Yet that same language can also potentially create barriers to accessible care.

freely as you might have shared news about a leg fracture? Perhaps not. That sort of reticence is often the result of the stigma that characterizes our own concerns and society’s views of mental illness and mental health supports.

One would hope that in these enlightened times it would be easier to have frank, open and supportive discussions about mental health and well-being. In some ways, it’s easier than it once was, but in spite of national and local anti-stigma campaigns, stigma still has the power to influence our perspectives—and it remains one of the primary reasons that people fail to access mental health services.²

In the UK, where I work, the Asylum Acts of the 19th century set the groundwork for establishing a number of mental asylums. Initially intended as places of safety (literally, places for people seeking asylum), they also had unintended effects. The large, imposing buildings were generally constructed at the end of impressive, often tree-lined drives with a 45-degree bend in the middle. Members of the wider community passing the entrance to the asylum wouldn’t be able to see up the drive to the building. When an individual was admitted to the asylum, he or she would, quite literally, go “round the bend,” away from the rest of society.

Such history plays a significant role in our perceptions today. Many people would, I suspect, experience more internal resistance to the idea of seeing a psychiatrist than to the idea of seeing a podiatrist. That internal resistance may be reinforced externally as well, in the form of negative comments from family and friends. Even when someone does decide to seek mental health care, there are other barriers to receiving treatment. Again, one of the foremost of these is language.

One of the hallmarks of any profession is a dedicated, complex and often technical language. Doctors, psychologists and therapists of all sorts often spend years learning that specialist language. Among other things, it helps them demonstrate their knowledge, training and experience—a knowledge and experience that can justify salaries and specialist roles. Yet that same language can also potentially create barriers to accessible care.

For example, practitioners of cognitive-behavioural therapy use the abbreviation “CBT” freely. Yet to others, “CBT” may mean “Chicago Board of Trade,” perhaps, or “computer-based training” or (for a computer programmer) “closed beta test.” Even if someone knows the term “cognitive-behavioural therapy,”

how many people today regularly use the word “cognitive” to discuss their own thinking? Instead, we talk about “worries,” or things being “on our mind.” “Cognition” and “CBT” have specific meanings in the context of mental health care.

Other terms widely used in the context of CBT reinforce this. Certain thoughts and beliefs are redefined as “negative automatic thoughts,” “schemas” or “dysfunctional assumptions.” Our worries may show “dichotomous reasoning” or “selective abstraction.”

Each term describes an element of the experience of people in distress. They are helpful in discussions about theoretical models of anxiety and depression and essential for research, diagnosis and effective communication amongst practitioners. But they are not part of most people’s everyday vocabulary, and they can represent a barrier in discussions between practitioners and non-practitioners, who may not have the same contextual understanding of the language. When practitioners use them to describe an individual’s personal experience, they may inadvertently discourage that individual from taking the opportunity to engage personally in his or her mental health care.

Not all health practitioners use exclusively specialist terminology. Most health workers know the importance of using more accessible language and adjust their communications as a result. So, when someone with low mood struggles to live life as they did before, they may not enjoy things as much as they used to, and they may sleep poorly and feel exhausted. Some

practitioners might use the specialist term “negative reinforcement” to describe the general reduction in activity levels that results from these sorts of circumstances. But other practitioners know that it’s far easier to discuss an individual’s experiences if they talk about how “it’s such a relief not to have to do things that seem such a struggle.”

Similarly, practitioners can identify a vicious cycle of reduced activity, or we also explain to the client that this describes a common human experience—in which the less you do, the worse you feel, and the worse you feel, the less you do—a situation that is familiar to many of us.

This way of working underlies the Living Life to the Full approach. The power of the CBT model is in its capacity to help people work out why they feel the way they do. This understanding is essential for enabling people to take control of their experiences and make changes to improve their quality of life.

Ensuring that CBT is a tool that everyone can use is central to how I like to think and work. I’m passionate about ensuring that the language we use in CBT is assessable to everyone. It’s hard enough to make changes in our lives when low mood or stress occurs, without having to spend significant time learning a lot of technical terms. Far better to focus our energies on the process of positive change. Using accessible, everyday language also has the benefit of normalizing common problems such as depression/low mood and anxiety/stress and other mental health problems; they are common human experiences that

can affect anyone. This normalization helps to reduce the stigma as well.

It has been a privilege working with CMHA on the LLTTF™ initiative. The organization shares that passion to ensure equal access to help and support for all. The organization also recognizes the power of language to engage people or to push people away. The LLTTF™ course encourages individuals to ask questions of themselves and others so they can experience those “a-ha” moments—moments of insight that help us recognize and understand what is going on inside or outside ourselves.

The Living Life to the Full approach also understands that people learn in different ways—through books and reading, by attending classes or by working online. Course materials are designed to be visually inviting, and they also use humour to keep users engaged. People can choose how they want to learn, working on change at their own pace with support from a coach.

In short, the Living Life program at CMHA aims to help people live life to the full. Who wouldn’t want that? ▼

related resource 

To learn more about Living Life to the Full courses or booklets available across Canada in English and French, and with adaptations for youth and older adults, see www.livinglifetothefull.ca.

Junkie, Addict or Person with a Substance Use Disorder?

LANGUAGE IN JOURNALISM

Andrea Woo

In the business of words, language matters. I recognized this as a child, when I would plow through books, stopping at beautifully crafted sentences to re-read them out of admiration. That a few words strung together could transport a reader and evoke the deepest of emotions has always stuck with me.

Andrea is a Vancouver-based journalist for The Globe and Mail, with a focus on mental health, addictions and drug policy



Photo credit: ©iStockphoto.com/baona

As an adult, I think about the power of language when I listen to politicians speak and read news stories on contentious issues such as race and inequality: How is a black criminal described compared to a white criminal? Is this immigrant “illegal” or “undocumented”? Now, in my job as a journalist who covers mental health, addiction and drug policy, I make decisions about language every day.

A debate currently playing out in the media and in the public is whether or

not to use the word “addict,” a word that I myself used in my reporting until a couple of years ago. Many people I spoke with in the context of my work called themselves addicts, and the term was fairly common in both reporting and conversation. (It still is.) I didn’t find addiction to be shameful and so, by extension, I didn’t find the term “addict” to be shameful or derogatory.

But in recent years, I began hearing calls for change, from people who use drugs and from activists and

academics. To call someone an addict, they pointed out, is to label that person by his or her illness rather than recognizing him or her as a person living with a medical condition. The term “addict” also endows the condition with a sense of permanency.

Careful word choice is not just about courtesy, or even perception. A report released in January 2018 by the Global Commission on Drug Policy noted that language can negatively affect health and health care by feeding into harmful prohibitionist policies, sometimes affecting clinical care directly.^{1,2}

As an example, the report cited a US study in which mental health clinicians were given identical case studies about people in court-ordered drug-treatment programs. People were referred to as either “a substance abuser” or “someone with a substance use disorder.” “The trained mental health professionals who read about an ‘abuser,’” the report stated, “were more likely to believe that the individual in question was personally culpable for their situation and that punitive measures should be taken.”

In other words, to call someone a “substance abuser” is so quietly powerful that it can make trained medical professionals believe that the person is somehow more responsible for his or her addiction than someone referred to as “a person with a substance use disorder.”

Destigmatizing our language won’t happen immediately. “Person with a substance use disorder,” for example, is a clunky phrase that doesn’t neatly fit into headlines. Visuals are just as important; broadcast news will require

some creativity to move away from the commonly used B-roll footage of stigma-reinforcing images such as discarded needles and people injecting on the streets.

With today’s resource-strapped newsrooms and few journalists with dedicated beats, it’s understandable that one might miss the ongoing dialogue about the need for evolving language. But I choose to believe that most journalists are thoughtful, compassionate people who always strive to do better and who try to be aware of trends that affect their work. We can’t be naïve about the power of strong reporting, and the power that our words have to sway public opinion and effect change.

In 2017, the American news organization Associated Press (AP) updated its style guide to recommend that journalists avoid words such as “alcoholic,” “addict,” “user” and “abuser” (unless they’re used as quotations or form part of the name of an organization).³ This is a notable change on the part of AP and will have a positive impact on how substance use issues are reported and, in turn, understood by the public.

Using effective language also requires reporting from a place of curiosity, compassion and understanding. A large part of what fuels stigma is fear of the unknown; we can dismantle that fear with education. According to the Canadian Mental Health Association, one in 5 Canadians will experience a mental health event in any given year. By age 40, about half the population will have experienced a mental health event in their life or be facing one currently.⁴ For those of us fortunate enough to never have experienced a

mental illness or addiction, reporting on and describing what the experience is like for others can foster compassion and understanding.

Over the years, I’ve been fortunate enough to meet many wonderful people who live with mental health and addiction issues, who were kind enough to spend time with me and answer every one of my many questions: What does it feel like to have a psychotic break? When you hallucinate, whose voices do you hear and how do those voices make you feel? What does depression feel like for you? Why did you start using this drug? How does this drug make you feel? What do you need to feel better?

With these personal accounts, I was able to humanize the subject of mental health and addiction by describing the symptoms of mental illness as one would describe the symptoms of a heart attack or a broken leg, writing about them in plain language. My discussions with people with lived experience were invaluable not only for the specific stories I was working on at the time, but because they have helped me better understand the complexities of substance use and mental illness and continue to inform my journalism—and, I hope, encourage the same sort of understanding and compassion in my readers.

If you see problematic language in a news story, contact that reporter and voice your concerns. And while these deeply personal issues can be difficult to share, I urge those who are comfortable talking about them to do so, as these voices and perspectives are crucial to advance the discourse and combat stigma. ▼



media coverage of mental illness

Rob Whitley, PhD

Rob is an associate professor in the Department of Psychiatry, McGill University, and a research scientist at the Douglas Hospital Research Centre

For the past decade, I have been leading a national study that looks at media coverage of mental illness. In this study, my colleagues and I at the Mental Health Commission of Canada have been working proactively with journalists, newsrooms and journalism students to improve the reporting of mental health issues.

We have travelled to journalism schools across Canada, giving educational seminars on mental health to the next generation of journalism students. The Mental Health Commission of Canada has also created a free online “mental health 101” course for journalists and journalism students. This course has been well used across the country. In 2014, our colleagues at the Canadian Journalism Forum on Violence and Trauma published *Mindset*, a short glossy booklet aimed at journalists and containing best-practice guidelines for reporting mental health issues. Over 5,000 copies have been distributed to newsrooms and journalists across the country.

What are some of the key messages that we are conveying to journalists in all these activities? First, we show how many of the stereotypes about people with a mental illness are inaccurate. For example, we note that most people with a mental illness make a good recovery when given the right services and supports. We also point out that people with mental illness are much more likely to be victims of crime than to be perpetrators.

Second, we emphasize that journalists should be especially careful in word choice when writing about

mental illness. For example, we note that it is better to say “a person with schizophrenia” rather than “a schizophrenic,” as the latter falsely conflates the individual with the illness. We also note that words such as “crazy” and “psycho” are stigmatizing and should be avoided.

Third, we emphasize that suicide is a specific mental health issue, requiring especially responsible journalism. We encourage journalists to tread carefully around suicides, reporting only on newsworthy incidents, and then using this as a chance to educate and inform readers about pertinent social issues, suicide prevention and helpful local resources.

What effects have our activities had on how mental illness is portrayed in the media? Our analysis of trends over time indicates that the Canadian media have significantly improved their coverage of mental health issues in recent years, using less stigmatizing language and providing much needed social context in the discussion of mental health issues.¹

Language has consequences. Journalists are increasingly realizing this, and many are now using their talents to educate and inform. This is a welcome development and may help reduce stigma and stereotypes about people with mental illness. This change may herald a climate of increased inclusion, understanding and empathy for people with mental illness.²

What's in a name change— a temporary relief from stigma?

Constantin Tranulis, MD, MSc

Ever since psychiatrist and professor Paul Eugen Bleuler introduced the term “schizophrenia” in 1908, both the diagnosis and the term itself have been subjects of controversy.



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The previous term, “dementia praecox,” was considered imprecise and pessimistic (because it implied inevitable deterioration). The new term referred to a “split” (*schizo*) between mental functions and was perceived to be a more optimistic diagnosis. Yet the “schizo” prefix has also resulted in ongoing confusion between the public and practitioners’ perception of schizophrenia and their views of other mental illnesses, such as dissociative disorder and multiple personality disorder.

People who live with schizophrenia experience high levels of stigma, a situation that has not improved in

recent decades. This article focuses on the relationship between the term “schizophrenia” and stigma.

In recent years, both psychiatrists and patients have proposed changing the name “schizophrenia” in response to claims that the term lacks precision and carries stigma. I am not convinced, however, that simply changing the name of the illness will automatically result in less stigma.

As we have seen in the shift from “dementia praecox” to “schizophrenia,” changing the name of an illness is not a new phenomenon—and it certainly isn’t limited to the English-

speaking world. In 2002, the psychiatric community in Japan changed the Japanese name of schizophrenia—from the derogatory term “mind-split-disease” (*seishinbunretsu-byo*) to “integration dysregulation syndrome” (*togo-shitcho-sho*).

Some early signs suggested that this move could potentially diminish stigma. For example, Japanese clinicians began to tell their patients their diagnosis more frequently, and Japanese university students would associate the diagnosis less often with criminality.¹ Yet those who advocate for keeping the name “schizophrenia” argue that stigma is about much more than the name of an illness; changing the name will only create confusion for clinicians and result in a lack of continuity in research.

Stigma can be understood as a problem of ignorance (a lack of education and knowledge), attitudes (a lack of tolerance, and negative emotional responses) and behaviours (discrimination). When we focus on what really matters for patients and family members, it might well be that actual discriminatory behaviours are the most important and damaging dimensions of stigma.

Will a name change (on the level of education and knowledge) significantly affect attitudes and behaviours? We undertook two studies in Montreal, Canada, to explore this question, and published the results of our findings in 2013.²

In the first study, 161 university students were presented with a vignette that described a young man suffering from symptoms of psychosis. Half the

participants were told the man had been diagnosed with schizophrenia; the other students were told he had “salience syndrome.” (A currently popular alternative to the term “schizophrenia,” “salience” more precisely articulates the neurocognitive deficits of schizophrenia.³) Among the two groups, we noted no differences in anticipated discrimination (such as whether the young man was more or less likely to have a girlfriend, for example, or to be invited out to dinner).

In the second study, we conducted in-depth interviews with 19 young persons who live with psychosis, focusing on their receiving a diagnosis of schizophrenia and the perceived acceptability of that diagnosis in the context of their lived experience. These participants were also presented with two vignettes, one of which used “schizophrenia” and the other “salience syndrome.” Eight out of 19 participants preferred the label “salience syndrome,” five preferred “schizophrenia,” two liked both labels and four participants rejected both labels (“I don’t want any of them”).

The capacity to conceal a diagnosis with a lesser known term was a popular reason for preferring the less common “salience syndrome.” As one

participant put it, “I would like to have another name that I could use when I will be back in society, so I could tell the truth, but they won’t really understand it. I don’t want to lie so I think I’ll just say I have the salience syndrome, yep, that’s it.”

Several participants talked about the concrete advantages of choosing one name or diagnosis over the other—for example, the greater likelihood of being able to return to school. In these cases, participants preferred “salience syndrome” because of the term’s novelty and obscurity, which were both seen as useful traits when it came to avoiding stigma.

Yet even if a new term took the place of “schizophrenia,” it might well be that the new name will also become stigmatized, providing the individual with, at best, only temporary relief from stigma. In the worst-case scenario, a new term will simply be a source of new confusion and misunderstanding.

While words are important, I think that what really matters for persons living with mental illness is their lived experiences of discrimination and the concrete actions taken to combat discrimination and stigma. ▼

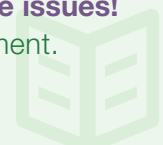
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Canadian Psychiatric Association

Media Guidelines for Reporting on Suicide: 2017 Update

www.cpa-apc.org/wp-content/uploads/Media-Guidelines-Suicide-Reporting-EN-2018.pdf

Information and guidance for anyone who reports on suicide.

HeretoHelp

Plainer language mental health information

www.heretohelp.bc.ca/plainer-language-series

HeretoHelp and BC Partners have six mental health booklets with audio designed for adults who are learning English or who would otherwise benefit from very basic, jargon-free language. The booklets are written in plain, clear language at a Grade 4 reading level to introduce mental health and mental illness.

Institute for Families

The Language We Use

www.youtube.com/watch?v=CFB52ddluSg

In this short video, individuals and family members share the impact of language in interactions with service providers and

others. For more on helpful conversations around mental health, the Institute of Families offers *Unfolding Conversations*, with more on what to say—and what not to say. You can download a copy at www.familysmart.ca/files/FamilySmart-Unfolding-Conversations-2017.pdf

Canadian Institute for Substance Use Research

Words, Values, And Canadians: A report on the dialogue at the national symposium on language

www.uvic.ca/research/centres/cisur/assets/docs/report-words-values-and-canadians.pdf


The Canadian Institute for Substance Use Research (formerly Centre for Addictions Research of BC) report on the language of substance use and shares recommendations.

BC Centre for Disease Control Harm Reduction Services

Language matters: Reduce stigma, combat overdose

<http://towardtheheart.com/reducing-stigma>

Quick tips for people who talk about substance use, including health care providers caring for patients who use substances. You'll also find a series of case studies to facilitate discussion about stigma and discrimination and at the bottom, a link to resources like *Respectful Language and Stigma*: regarding people who use substances report.

 This list is not comprehensive and does not necessarily imply endorsement of all the content available in these resources.

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