BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

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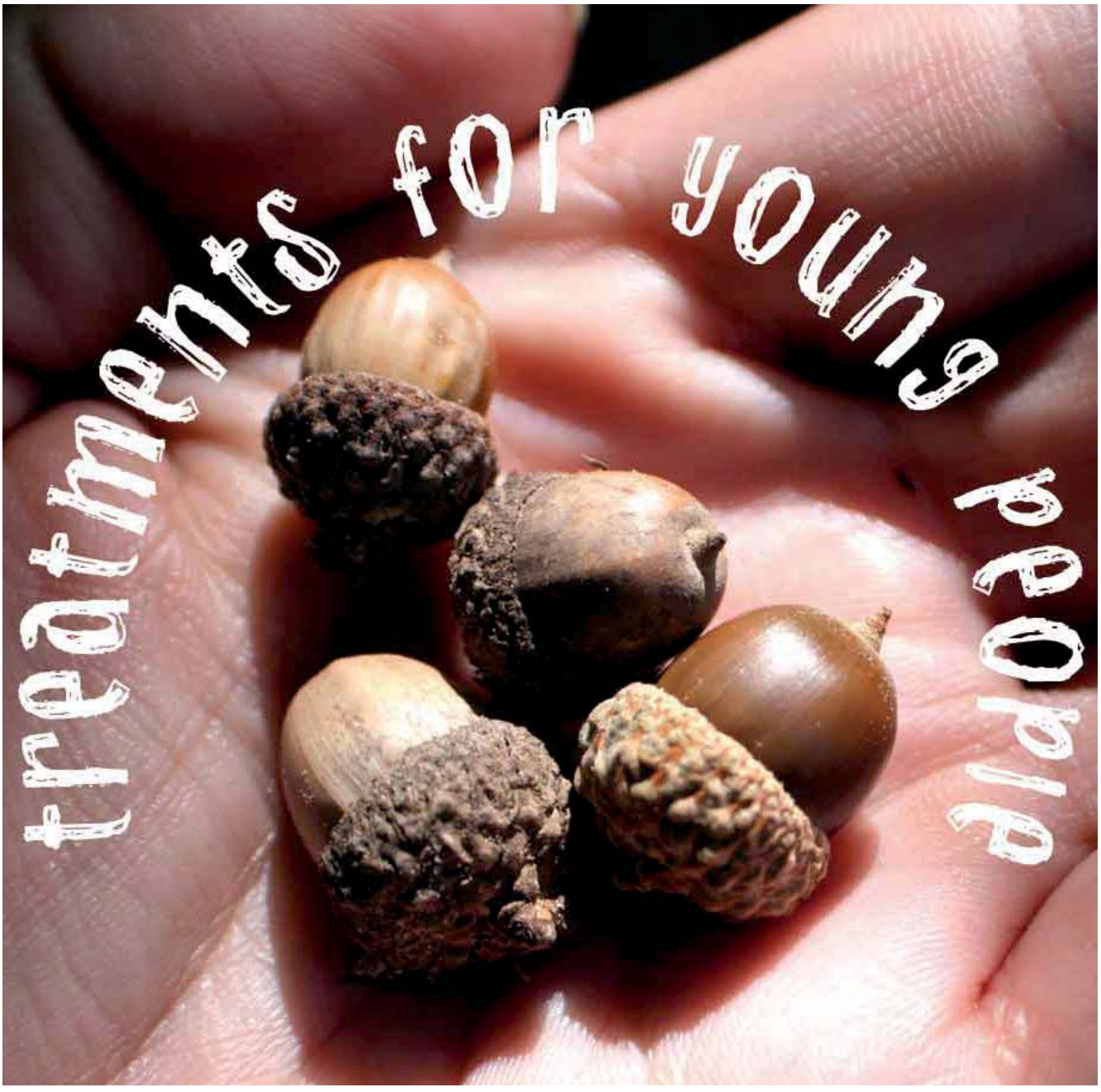

KIM MEIER & SHANTI HADIOETOMO

background

experiences & perspectives

alternatives & approaches

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society (formerly ANAD) and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

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

The BC Partners are grateful to the Provincial Health Services Authority for providing financial support for the production of Visions

regional programs

In this issue of *Visions*, and in the next one as well, the BC Partners for Mental Health and Addictions Information have chosen to focus on young people to the age of 25, in an effort to highlight not only the work being done by family members, teachers, counsellors, service providers, physicians and governments but also the experiences of youth affected by distress.

That said, it is difficult to find youth able or willing to write about their experience with distress or illness. (As an example, you'll note that we have no personal stories from youth struggling with addiction). It is interesting to see that for some the experience of distress and its treatment have taken hold in their lives and lead to change while for others the experience wasn't as positive or rewarding. Even so, creating space for young people to be creative and participate in expressing their needs and desires is a prevailing theme.

We often seem to think that types of treatments exist in silos—making families and youth choose between talk or drug therapy—when in reality, distress is likely multi-factorial: an intersection of psychological, social, biomedical, developmental and other factors. We often don't even consider young people expert enough in their own experience to be part of the treatment "team."

As always, there are issues remaining. We were unable to access stories and articles about how other frameworks such as gender, sexuality, class or economic biases prevalent in our society impact how our youth are conceptualized as distressed. This may be because there is increased urgency, in treating youth, to mitigate any long lasting impact that such serious distress can leave. Maybe it is because in order to think through distress in a different way means we have to evaluate our assumptions of what it means to be young in a society that both overvalues youth as a state of bodily perfection and undervalues youth as a state of experience. Does this have any impact on the numbers of youth in distress or does it merely change how that distress is viewed?

Barker's article reminds us that motivation and education, from whatever arena it is gained, must consistently be challenged and re-evaluated in order to provide the best in service to young people in distress and their families. As we see in the very personal accounts included in this issue, there is no one way to respond to youth distress. It is a good lesson to learn.

Christina Martens

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subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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Youth Treatments
For mental health and substance use

Shimi Kang, MD, FRCPC

Dr. Kang is Director of the Provincial Youth Mental Health and Substance Use Program at BC Children's Hospital. She is also a consulting psychiatrist to the BC Women's Reproductive Mental Health Program and a faculty member at UBC, where she researches mental health and addictions services and policy

I am excited to introduce this issue of *Visions*, with its focus on youth treatments for mental health and substance use problems. I commend the editors for their wisdom and vision in bringing such a timely and critical topic forward. And I think you will be happy, in reading about the well-established and innovative programs that exist for youth, to discover how far this field has come. Yet, some of the experiences and perspectives conveyed by our writers indicate that we still have a long journey ahead in creating an environment of care and support that is youth centred in every way.

Why we should care

Youth well-being is something that affects all of us in a myriad of ways. Recognizing the uniqueness of youth as a group and providing developmentally and culturally appropriate supports and treatments are key to our collective potential.

In my role as director of the Provincial Youth Mental Health and Substance Use Program at BC Children's Hospital, I come in daily contact with youth and their families. I am often dismayed to hear of the numerous failed attempts at finding youth-specific treatment, or of the pitfalls of applying adult management to younger individuals. All too often, such system issues leave the youth and family feeling frustrated and demoralized. At the same time, I am often thrilled to see the dedicated supports that many youth have. Whether a family member, school counsellor, coach, family doctor or probation officer, the network of individuals who are working hard for the well-being of youth is extensive and tends to self-select committed and compassionate people. This network of support is essential for youth, their families and the community as a whole.

The articles we have chosen represent a wide range of topics within the area of youth treatments. Some discuss programs or strategies that have stood the test of time; others are innovative and evolving daily. It is important to have both solid evidence behind our treatment, and to have strategies that meet the rapidly shifting, highly trendy life of youth. Programs must be built around evidence-based practices. However, this does not simply mean applying existing evidence. More importantly, new evidence must be created by programs through their own design and research. This is critical for youth treatments in mental health and addictions, as there is a real need for firm scientific literature on youth-specific treatments.

The younger years

An important question to ask is, why are youth-specific treatments needed and what are the critical components of such treatment? The answers lie within many layers that span the scope of the biological, psychological, social and spiritual continuum of the lives of youth. The younger years are a time of global change in all these areas. Puberty and the years pre- and post-puberty are when the human brain, mind and body undergo profound growth and change. These changes affect the individual completely ranging from the physiologic emergence of psychiatric symptoms, to issues of emotional regulation and self esteem. Youth also experience immense behavioural and social change. They are faced with numerous tasks, such as establishing coping mechanisms for stress and determining their own identity within their family, peer group and greater community. Youth must establish a fine balance between having the supports they need, yet moving forward in personal independence. It is no wonder that issues of stigma, privacy, stage of change, trauma vulnerability and recovery environment become pivotal for youth during these years. Perhaps it is a combination of such factors that lead to findings that youth ages 15 to 24 years are more likely to report suffering from mental illnesses and/or substance use disorders than any other age group.[1]

The impact of untreated mental illness or addictions on the developing brain, body and acquisition of important psychosocial skills can be profound, far reaching and often fatal. Comprehensive, integrated treatments of a high standard that involve family, peers, schools and other community links are critical. Care must be ongoing and along a continuum, providing entry at any stage of change and/or presentation of problem. Providers must be competent and comfortable within the culture of youth, including issues such as ethnicity, gender, sexual orientation and socioeconomic status. Treatments are best when developmentally appropriate and matched to the needs of the individual, yet flexible enough to serve changing needs by providing a diverse menu of choices.

'Treatment' can only occur if there is 'engagement.' Resistance to entering a treatment system, whether it is self-care, peer support or hospital based, is common. Approaches that are creative, minimally intrusive, strength based and that involve harm reduction may help with the challenges of engaging and retaining youth.

Progress is being made

In just the last few years, I have seen major progress in the area of youth mental health and addictions treatments in this province. Through the support of the Ministry of Health and the Provincial Health Services Authority, the first Provincial Youth Mental Health and Substance Use Program was established in 2003 and is rapidly expanding.[2] As part of the province's Child and Youth Mental Health Plan, a concurrent disorders experts group was established to assist in prioritizing goals for youth with concurrent disorders.[3] There has been focused training on Aboriginal cultural sensitivity, cognitive-behavioural therapy, dialectical behaviour therapy, interpersonal therapy, suicide prevention and early psychosis intervention. In addition, the Ministry of Health and the Ministry of Children and Family Development have supported tackling the problems of crystal methamphetamine use by youth, and BC is the first Canadian province to develop an integrated crystal meth strategy.[4]

I am truly inspired to see the direction we are heading as a community in recognizing the unique and diverse needs of youth. This is evident across the sectors of health, child protection, forensics and corrections, and education. Our collective hopes are for these efforts to reach every community, family and individual. We are all intricately connected to the well-being of the next generation. Today's youth are, after all, our future. i

footnotes

1. Currie, J.C. (2001). *Best Practice:Treatment and Rehabilitation for Youth with Substance Use Problems*. Ottawa, ON: Health Canada, Office of Canada's Drug Strategy.

2. Provincial Youth Mental Health and Substance Use Program, BC's Children's Hospital: contact program coordinator Linda Barker at lbarker@cw.bc.ca

3. Child and Youth Mental Health Plan's concurrent disorders experts table: contact Monica Armstrong at Monica.Armstrong@gov.bc.ca

4. Crystal Meth Secretariat: visit www.pssg.gov.bc.ca/crystalmeth

I love your "Visions Journal" magazine! I wanted to comment on a series of articles in the 2006 journals Vol.2 No. 7 & 8. On the topic of suicide, my church published an article indicating that most people attempt suicide because they want to manipulate and/or intimidate friends and loved ones. I challenged their theory because there is no one factor that can be used to define why a person attempts suicide. Personally I attempted suicide by hanging and survived—and the thought of manipulation never even crossed my mind. I was in so much emotional pain and lacked any coping skills that the only way I thought I would escape the pain was to kill myself.

My second thought is on Page 22 of No.8 on Panhandling. If the government and the welfare system was really doing their job and really supporting these mentally ill and homeless people, we wouldn't need panhandling or the food banks. Instead the government is closing down the mental institutions and dumping these people to fend for themselves on the streets. Some progress has been made in the welfare system that people without an address can collect a cheque because the credit unions in town are now giving bank accounts to these people without an address. I myself with a mental illness have had to utilize the Salvation Army among other places just to survive from month to month. These people who gripe about panhandlers need to learn how to say "NO" and not feel offended by it. Otherwise keep up the good work you guys. I look forward to the next issue. *—Anne Heese, Kamloops*

we want your feedback!

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

notes

Visions Survey Highlights

Our sincere thanks to the nearly 500 people with mental illness or addiction and their families and the 200 mental health and addictions service providers who provided valuable information during our evaluation of Visions late last year. Through surveys and interviews, evaluation consultants Shaffer Rootman & Associates found that Visions had a very satisfied core readership. Findings also indicated that the readership is relatively homogeneous and tends to be well-educated, female and between the ages of 45-64. The evaluation results suggest that personal experiences are engaging to both lay and professional readers and are an essential factor behind Visions' success. Visions was seen to be a credible provider of evidence-based mental health and addiction information. However, there was also broad support for developing new channels to bring this information to more diverse audiences.

Areas for short-term improvements include lowering literacy levels, reducing article lengths, and continuing to build a friendly and inviting look. Future work will build on Visions' strengths and examine ways to improve its reach, including exploring strategies for the potential repackaging of content for other audiences and dissemination media.

Treatment Options
for depression in young people

E. Jane Garland, MD, FRCP(C)

Jane is Clinical Head of the Mood and Anxiety Disorders Clinic and Clinical Professor of Psychiatry, both at the University of British Columbia

Depression affects as many as one in 10 teenagers at any time, with one in five developing major depression by the end of their teen years. Twice as many young women develop depression as do young men. Risk factors include genetic vulnerability, anxiety disorders, learning and attention problems, trauma and abuse, and family conflict.

When depressive symptoms are developing, it can be difficult for parents to figure out whether the problem is a clinical depression or simply a teen adjustment problem. Symptoms include ongoing sadness or irritable mood, loss of interest in usual activities, social withdrawal and physical symptoms such as sleep disturbance, changes in appetite, and loss of physical energy. There is a negative impact on concentration, energy and motivation, and school functioning.

By the time clinical depression is diagnosed, secondary problems of relationship conflicts have often developed. Parents and teachers become frustrated by school failure and erratic attendance, and friends may be turned off by the irritable, negative mood of the depressed teen. Hence, the teen's much-needed support system begins to crumble as a result of the depression.

Evaluation of depression requires a visit to the family physician to rule out physical causes of symptoms, and to facilitate diagnosis and treatment. Treatment resources in this province are provided through the local children's mental health teams of the Ministry of Children and Family Development. These teams provide psychiatric consultation and have children's mental health clinicians trained in the treatment of depression. Private psychiatrists, psychologists and trained counselling psychologists are also appropriate resources.

Treatment of depression must address the primary problems of physical and psychological symptoms, as well as the demoralizing effects on academic and social functioning. Basic treatment includes ensuring adequate diet, including essential (omega-3) fatty acids, physical exercise, a regular routine including sleep hygiene (conditions and practices that promote continuous and effective sleep), and a practical approach to school, such as a reduced schedule or modified curriculum goals while recovery is occurring. A support system must be put in place to nurture re-socialization and encourage exercise and pleasurable activities. In addition, underlying issues such as trauma, anxiety disorder or family conflict must be addressed.

The specific treatments for depression are psychotherapies and medications. However, during the past few years some disappointing research on antidepressant effectiveness has emerged. At present there is clear evidence for improvement with only one medication, fluoxetine (Prozac). There are unclear or negative results for at least five other antidepressants.[1] In addition, negative behavioural and emotional effects occur often enough that these medications now have warnings on the labels to watch for agitation, hostility and suicidal thinking in young people. It is not understood why medication responsiveness appears to be less consistent in young people than in adults.

It should be noted that if a medication is given, the teen is likely to improve more than half the time, but not any more so than with a placebo (sugar pill). This suggests considerable resilience in depressed adolescents. In fact, one community study found that half of the episodes of depression had spontaneously disappeared without specific treatment within two months.[2] However, there is a high recurrence rate of 50% to 75% within five years.

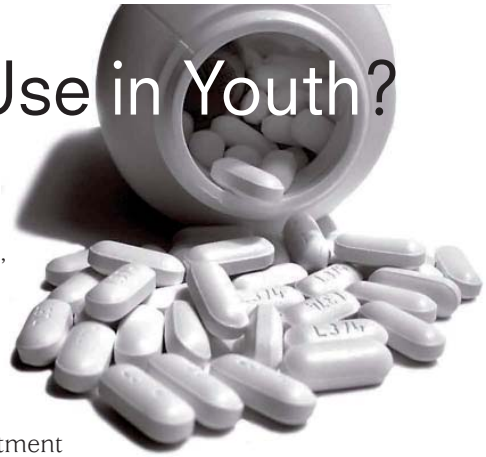
The cases of depression that do not remit in a couple of months tend to last for six months or more, which has a significant impact on psychosocial functioning. This can leave developmental 'scars' in the form of decreased self-confidence and low academic achievement. At present, medication is recommended for persistent and more severe depression, which has not responded to psychological interventions, and cases where there is also a significant anxiety disorder. Research has demonstrated that anxiety disorders do respond more clearly to medication than depression does.[1,3]

Psychological treatments in young people focus on changing negative thinking patterns and fostering healthy problem-solving and coping skills. Two main types are cognitive-behavioural therapy (CBT) and interpersonal therapy (IPT). At present, »

related resources Ministry of Children and Family Development, Child and Youth Mental Health at www.mcf.gov.bc.ca/mental_health, or check the blue pages of the phone book for your local office

Are Antidepressants Safe to Use in Youth?

Yes they are, but...



Suicide is a tragic outcome of clinical depression and is a highly emotional topic. So, it is not surprising that there has been so much emotion and confusion over recent reports that newer antidepressant medications like SSRIs (selective serotonin reuptake inhibitors),[1] thought to treat depression, might actually *cause* suicidal thoughts and behaviours in young people. Health Canada and the United States Food and Drug Administration (FDA) recently issued strong warnings to physicians that antidepressants may be associated with increased suicidal ideas or behaviours in youth (children and teenagers).[2]

Are SSRIs safe to use in youth? Like many mental health issues, this simple question is quite complicated—but it needs to be answered scientifically rather than emotionally. It is a complicated question because suicidal ideas are commonly experienced in depression, but can vary in intensity over time. Also, while suicidal ideas are common, suicidal behaviours (attempts or deaths by suicide) are thankfully rare compared to the number of people who are treated for depression. Therefore, whether a treatment causes or worsens suicidal ideas is difficult to separate from the effects of the underlying illness.

The Health Canada and FDA warnings were based on an analysis of the pediatric antidepressant clinical trials submitted to the FDA and drug regulatory agencies in other countries (not including Canada).[3] In these clinical trials, youth with depression agreed to be randomly assigned (like with a flip of a coin) to taking an antidepressant drug or a placebo (an inactive substance, like a sugar pill). Neither they nor the doctors knew which treatment they were taking. Depressive symptoms and side effects were measured weekly, and after eight to 12 weeks the effects of the drug were found by comparing patients taking the drug to those taking placebo.

In the 24 studies (involving a total of about 5000 youths), there were no deaths by suicide, and no individual study showed any increase in suicidal behaviour in those youths who were taking the antidepressant.[3] However, when all the studies were combined, there were *slightly* more suicidal behaviours in patients taking an antidepressant compared to those who took a placebo. The estimate was that for every 100 youths treated with a placebo, one might expect one to three of them to show suicidal behaviours in the first two months of treatment,

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treatment options | *continued from previous page*

mental health clinicians in this province are trained in CBT for depression and anxiety disorders, and more are being trained in IPT. As with medication, the response to CBT is greater in anxiety than in depression. Some of the principles of CBT are incorporated into a new self-help guide, *Dealing with Depression*.[4]

Depressed teens tend to gravitate toward other depressed teens, so supporting access to peers with a healthier outlook can be helpful. However, contact with depressed peers in the context of a therapist-facilitated group can help teens develop skills for coping with depression.

Treatment for depressed teens requires a mixed approach, including practical support, systematic treatment and careful monitoring. The high prevalence, serious impact and residual effects of depression indicate this is a condition that families and schools need to be very aware of. *Beyond the Blues*,[5] a video produced by the Knowledge Network in collaboration with the Ministry of Children and Family Development, also has an interactive website with helpful information for concerned family members.

Families and school communities can be part of the solution for young people suffering from depression. Relatives can make an effort to have more supportive and nonjudgemental contact, encourage exercise, provide tutoring and facilitate healthy social activities such as joining a community centre, church or ethnic community youth group.

footnotes

1. Cheung, A.H., Emslie, G.J. & Mayes, T.L. (2006). The use of antidepressants to treat depression in children and adolescents. *Canadian Medical Association Journal, 174*(2), 193-200.

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5. Palmer, M. (2004). *Beyond the Blues: Child and Youth Depression*. Burnaby, BC: Knowledge Network. Depression knowledge kit materials are accessed at www.knowledgenetwork.ca/takingcare/Video can be ordered from www.nfb.ca or by calling 1-800-267-7710.

summary recommendations

of the canadian psychiatric association for using antidepressants in youth

- All patients (whatever the age) beginning any treatment for depression should be watched closely for worsening of depression and suicidal thoughts
- For youth with uncomplicated depression of mild to moderate severity, psychological treatments should be used first
- Antidepressants can be used if the depression is moderate to severe, if there are other complicating medical or psychiatric conditions, or if psychological treatment is not helpful. Psychological treatment should be used along with the antidepressant treatment
- If treated with an antidepressant, patients and families should be educated about possible common and uncommon side effects, including anxiety, restlessness, and increased thoughts of suicide
- Fluoxetine (Prozac) is recommended as the first antidepressant, unless there are medical reasons not to use it

while for every 100 patients treated with an antidepressant, two to six youths would show suicidal behaviours.[3]

Unfortunately, clinical trials have limitations that make these results inconclusive. For example, patients participating in clinical trials may not reflect the "typical" patient with depression being treated in doctors' offices because there are so many strict rules for participation.[4] Combining results from so many studies is also a problem, because all the studies had different methods, medications, people, locations, and so on. Because of these problems, the accuracy of these results is questionable.

If antidepressants really do worsen suicidal behaviour, other types of studies should also show the same results as the combined clinical trials. "Observational" studies track large numbers of people who are prescribed antidepressants to see whether they made a suicide attempt or died by suicide.

Four large observational studies of depressed youth treated with antidepressants were reported, two in England and two in the United States. These studies each involved tens of thousands of youth treated or not treated with antidepressants, and none found evidence for increased suicide behaviours with antidepressant treatment.[5-8] In fact, one study showed that the risk for suicide attempt was highest in the week *before* starting an antidepressant, with the risk falling sharply in the weeks after starting a medication.[8]

In one of the English studies tracking three million patients, there were 15 youth who died by suicide—none of them had been treated with antidepressants.[5] Similarly, in a Danish study, drug testing was done on blood samples taken from almost 15,000 deaths by suicide over an eight-year period. In the unfortunate 52 youths who died by suicide, none had SSRI antidepressants in their blood at the time of death.[9] Many other studies have shown that in areas where more antidepressants are prescribed, the suicide rate is lower.[10-13]

These large observational studies confirm that antidepressants, in general, help to reduce suicide by treating the underlying depression. In contrast to the findings in the combined clinical trials, they provide evidence for the safety of antidepressants in youth. However, these studies cannot tell us if there are rare cases where individuals have a bad reaction to the medication.

So, are antidepressants really safe to use in youth? The answer is *"Yes, but…"* All drugs have side effects. Most of these side effects are mild and do not interfere with functioning, but there may be rare, unpredictable side effects that have serious consequences (such as allergic reactions to penicillin, gastrointestinal bleeding with aspirin, etc.). But, we need to remember that depression is a serious illness that severely disrupts lives and that, in extreme cases, can cause death by suicide. For depression, as for any other medical condition, you need to weigh the potential benefits of a medication with any small risk of serious side effects. Your doctor can help with that decision.

disclosure

Dr. Lam conducts research on new medication and non-medication treatments for depression. His research is funded by the Canadian Institutes of Health Research, other non-profit funding agencies, and pharmaceutical companies. He has also received speakers' and consulting fees from several companies, including ones that manufacture antidepressants.

related resources

Bender, K.J. (2006). Antidepressants: Youth suicide warnings increasingly questioned. *Psychiatric Times, (23)*4. www.psychiatrictimes.com/Depressive-Disorders/showArticle.jhtml?articleID=185303201

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antidepressants | *continued from previous page*

footnotes

1. *Author note*: Antidepressants work by altering certain neurotransmitters (chemical messengers that transmit signals between brain cells), such as serotonin and noradrenaline, in areas of the brain that regulate mood, sleep and appetite. Older medications like tricyclic antidepressants also affect many other neurotransmitters, which can lead to side effects. Newer medications like the SSRIs work selectively on neurotransmitters (e.g., only on serotonin), so they are generally safer and have fewer side effects than the older medications.

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4. *Author note*: Participants in depression trials are usually excluded if they have: a chronic (more than 6 months or a year) depression, a co-existing psychiatric diagnosis (such as an anxiety disorder, or ADHD), a co-existing personality disorder, a co-existing medical condition, co-existing substance use/abuse, active suicidal ideas, psychotic symptoms, any history of hypomania or mania, or if they are taking other medications for any other condition. Also, they must be willing and able to attend clinic visits at least once a week and spend two to three hours at each visit, and be willing to take a placebo. This means that patients participating in clinical trials often have only simple, mild depressions—which may explain why the placebo response is so high in many studies, since these depressions are more likely to resolve spontaneously.

5. Jick, H., Kaye, J.A. & Jick, S.S. (2004). Antidepressants and the risk of suicidal behaviors. *Journal of the American Medical Association, 292*(3):338-43.

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7. Valuck, R.J., Libby, A.M., Sills, M.R. et al. (2004). Antidepressant treatment and risk of suicide attempt by adolescents with major depressive disorder: A propensity-adjusted retrospective cohort study. *CNS Drugs, 18*(15): 1119-1132.

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AD/HD:
Treating young people

Kim Meier

Kim is an undergraduate student in cognitive science at Simon Fraser University. She is currently on a co-op term at Canadian Mental Health Association, BC Division

Just over 3%—or about 30,900—of BC's children and youth have been diagnosed with attention-deficit/hyperactivity disorder (AD/HD). This makes AD/HD the second most commonly diagnosed mental disorder among youth, second only to anxiety disorders.[1]

It was previously believed that a significantly higher number of boys are affected by AD/HD than girls. In recent years, however, it has become clear that the rate of AD/HD among girls is much closer to that of boys than was reported in the past. A 2006 Australian study offers some insight into why girls may be underdiagnosed: while problems with school and grades are common factors in boys who are receiving treatment for AD/HD, the most common factor for girls is the presence of depression—not a symptom typically associated with AD/HD.[2]

According to the *Diagnostic and Statistical Manual for Mental Disorders*,[3] diagnosis of AD/HD revolves around three types of symptoms: inattention, hyperactivity and impulsivity. Some of these symptoms must have been present before age seven.

Children affected by AD/HD often have trouble listening when people are speaking directly to them. They find it hard to follow instructions or stay organized. Easily distracted and forgetful, kids with AD/HD are often fidgety and restless. Unable to pay attention to detail, they may make careless mistakes in their homework assignments. They may also have trouble controlling impulses—causing them to interrupt others

it has become clear that the rate of AD/HD among girls is much closer to that of boys than was reported in the past

or blurt things out at inappropriate times. In order for an AD/HD diagnosis, symptoms must affect a child's ability to function in more than one setting—for example, both at home and at school.

AD/HD is typically treated with medication, behavioural therapy or a combination of both. Medications have shown to be the best treatment strategy for AD/HD, though when used in combination with behavioural techniques, kids may be able to take lower doses.[4]

Behaviour therapy works to change the way a child or teen acts and reacts. By looking at the situations that can make a child's symptoms worse, behavioural treatments teach new skills to children, their parents and even teachers and friends.

Each behaviour therapy plan is tailored to a child's unique needs. A typical plan involves techniques such as reinforcing positive behaviours, time outs and point reward systems. In addition, adults learn to create environments for children to help avoid situations that may set off symptoms—like quiet rooms free of distraction for studying.

Typically, AD/HD is treated with a type of medication known as a psychostimulant. Stimulants affect the body by improving communication between cells in the nervous system. In essence, they allow a person to feel more alert and more able to focus their attention. Stimulants commonly prescribed for the treatment of AD/HD include Adderall, Concerta, Dexedrine and Ritalin. About three-quarters of children who take stimulants find them effective.[5]

Generally, stimulants are effective for about three to six hours after a dose is taken. Children and teens will often need to take medication at school after the effects of the first dose wears off. Newer, longer-lasting medications allow kids to avoid midday doses—this helps to keep children from feeling self-conscious at school or in public places.

Although there are negative side effects to taking prescription drugs—loss of appetite, headaches, stomach aches and troubles sleeping, for example—many find the benefits of medication greatly outweigh the costs. Children with AD/HD who use stimulants often find it easier to concentrate. An improved attention span allows kids to follow directions, complete homework assignments and perform better in school. When more focused and less impulsive, children and teens find it easier to relate to their peers and get along with family members. Despite the benefits of medication, researchers say that nearly half of children with AD/HD who would benefit from prescription medication are not being treated.[6]

Unable to stay focused, children affected by the disorder, who do not receive treatment of some kind, can fall severely behind in school. Problems with concentration and impulsivity can continue into adulthood, following the adult with AD/HD through life, affecting employment and relationships. Children with untreated AD/HD are also at risk for criminal behaviour.[7] Youth can even go on to develop co-occurring disorders, including depression or substance use disorder. Appropriate treatment can reduce the risk of developing a substance use disorder by 50%.[8]

It's important to identify and treat a child with AD/HD. With the proper support and treatment, kids affected by the disorder go on to live healthy, normal lives.

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Anorexia
Treading a thin line

Claudia Tianne Chai

Claudia is a student at Simon Fraser University in Burnaby

Some people deeply miss their childhood or high school years. For me, the biggest wave of nostalgia arises when I think about the years I spent in hospitals and doctors' offices. While I would never wish an eating disorder upon anyone, I do hope everyone has a chance, at least once in their lifetime, to feel as cared about as I did through my eating disorder journey.

I don't remember much about my childhood before the time I began treatment. I was only nine years old when my family doctor sent me to the eating disorder treatment team at BC's Ministry of Children and Family Development. At that time I hated doctors, nurses and therapists and went kicking and screaming to every appointment. I didn't understand what the fuss was about—I didn't see anything wrong with my eating habits. But my mother, seeing how unhappy I was, took me out of treatment, against medical advice.

In the years that followed, with nobody to help me, my anorexia became more entrenched. I relapsed in the summer of grade nine and returned—reluctantly—to treatment through the Ministry. I still hated going to appointments, but this time my mother didn't back down. Now I am extremely thankful that I was forced to continue seeing specialists in the years that followed.

In grade 11 I was referred to the BC Children's Hospital (BCCH) eating disorders ward. With all its brightly coloured artwork and smiling suns on the walls, it made me feel safe and comfortable. For the first time in my life I felt at home. In the hospital there were people I could talk to and open myself up to without the fear of being judged or not taken seriously. In my own home I always had to be 'happy.' It felt as if I didn't have the right to be sad or angry, because there was always someone in the world who was worse off than me.

In the intensive day-treatment Capella Program, I was surrounded by other girls who knew what I was going through and by staff who did their best to understand. Through individual therapy, group therapy, meal time, cooking group and trips outside the hospital, the support I received was amazing. Ironically, unlike outside in the real world, while inside the hospital I never felt 'crazy.' I could express how I felt—good or bad—and it was accepted.

I remained in the day treatment and intensive outpatient programs at BCCH by choice even after I became medically stable. The truth is that by this time I had come to fear that I didn't know how to function without the consistency of weekly appointments. My therapist knew how hard it was for me to leave, so I was allowed to continue as an outpatient at BCCH until I turned 20.

When I reached the appointed age and walked out through those sliding doors for the last time, it was an emotional event. If you have spent more than half your life seeing therapists and doctors, when their services are removed it takes some adjustment. It has been a very difficult and lonely time. In these past two years since leaving BCCH, I have been trying to maintain a healthy lifestyle, but I have to tread carefully. There is a very thin line between sickness and health, and it's all too easy to be sucked into the other side. I've not had a major relapse since leaving the BCCH program, so some would say that I'm "recovered." But, though I no longer look like a skeleton, every day is still a struggle.

A common stereotype is that people with anorexia are looking for attention. In my case, I wanted nothing more than to disappear. Instead, the opposite ended up happening. I came across so many people who showed me they cared at a time when I really needed to feel cared for. I am touched by the number of people who left an impression on my heart. When I don't feel motivated enough to keep fighting for myself, I remember all the people who fought for me. I don't want to let them down. I wrote this goodbye card to my therapist:

related resources

BC Children's Hospital Capella Program: www.bcchildrens.ca/Services/ChildYouthMentalHlth/ProgramsAndServices/
Under Programs & Services, choose Eating Disorder Program

"I know that I need to stand alone now. Knowing that you believe I can makes it seem not so scary. I will honour all the work we've done by not letting this goodbye trip me up; by moving on and forward and living everything that life is. I hope I've made you proud."

I don't know why I got sick or why I still struggle with eating healthfully and maintaining my weight, but finding that answer is no longer my focus. I am content with who I am today. Rather than focusing on my past, I am trying to look to the future. I've already made the mistake of not seeing how much treatment meant to me until it was gone. I don't want to make that mistake again in any other part of my life. I want to enjoy life in the present. This time around, I want to truly be in the moment.

South Asian Youth
Addiction: a shared shame

Rob Rai

Rob is the Youth Diversity Liaison for the Surrey School District. He works with diverse youth who exhibit challenging behaviours, including gang-associated behaviours and circumstances involving weapons. Previously Rob worked with youth for 10 years on municipal, provincial and federal projects throughout BC

South Asian youths facing issues of addiction have more than the usual barriers between them and the treatment they require. The South Asian culture is a *shared-shame* based culture: that is, the shame of an individual often becomes the shame of the family or the extended family. This issue of collective shame prevents South Asian youth from accessing legitimate support for dealing with their addictions.

I have had the opportunity to work with at-risk South Asian youth throughout the Lower Mainland for the better part of 10 years; specifically, in the Downtown Eastside of Vancouver and in Surrey. For many years, I was the only street youth outreach worker of South Asian descent working with this growing population of street-active young people. The majority of the youths I have worked with have been male, although I have supported some females as well.

When I began to encounter street-active South Asian youths, I found they were different than the 'traditional' street youths I had previously worked with. South Asian youngsters do not always face issues of poverty, abuse or parental addiction at home, as do so many youth with addiction or mental health issues. Rather, these South Asian youths are often just bored and looking for something to do.

Cultural issues come into play as I assist these South Asian youths to seek support and treatment for their addictions. They are often unwilling to enter treatment for fear of their community finding out. This would bring shame to the youth and his or her family. Treatment for severe addictions can involve a long-term stay in a residential, psychiatric or detox facility; an extended absence would be difficult to explain to relatives, friends and the community at large. Parents of these addicted youth are also in a quandary. They desperately wish to support their child, but don't know how to tell others that their child is using illicit drugs. This would shatter the image of their 'perfect' family.

I know of instances where the parents found it easier to send their youngster to stay with immediate family in another city, or even in India, rather than send them into treatment. This 'solution'—of sending a child away, with a seemingly legitimate excuse—has been easier for parents to explain and have accepted, than explaining that their child is in a detox, treatment or recovery program. The parents also hope that extended stays away from the youth's immediate social circle may temporarily alter his or her pattern of substance use. But, it will not address the larger issue of their addiction.

Too often parents do not understand the issues behind their child's addiction and don't realize their child may require the support of medical professionals and trained alcohol and drug counsellors. Sending a child and his/her problems away ensures that the family name does not become blighted, but it does little to address the serious issue their child is facing.

We South Asians need to place a greater emphasis on support and recovery of our youths who are trying to manage their addictions, than we do on family image and reputation. Only when we disregard the fear of shame will we be able to support our youths in the manner they deserve.

these south asian youths are often just bored and looking for something to do

Did I need an attitude adjustment!

Shifting to youth concurrent disorders: A professional story

Linda J. Barker, MSW

Linda is Coordinator of the Provincial Youth Mental Health and Substance Use Program at BC Children's Hospital

Eight months ago I made a job change after working for 20 years as a psychiatric social worker in both adult and child psychiatry inpatient and outpatient settings. For the last 11 of these years I was based in an outpatient psychiatry department in a large urban children's hospital, running a crisis clinic. I made clinical decisions every day as part of my job and felt confident about my range of knowledge of childhood and adolescent psychiatric disorders. This article reflects some of the surprising discoveries I've made in my new job, and how my previous clinical beliefs about youth drug and alcohol use and mental health have been challenged.

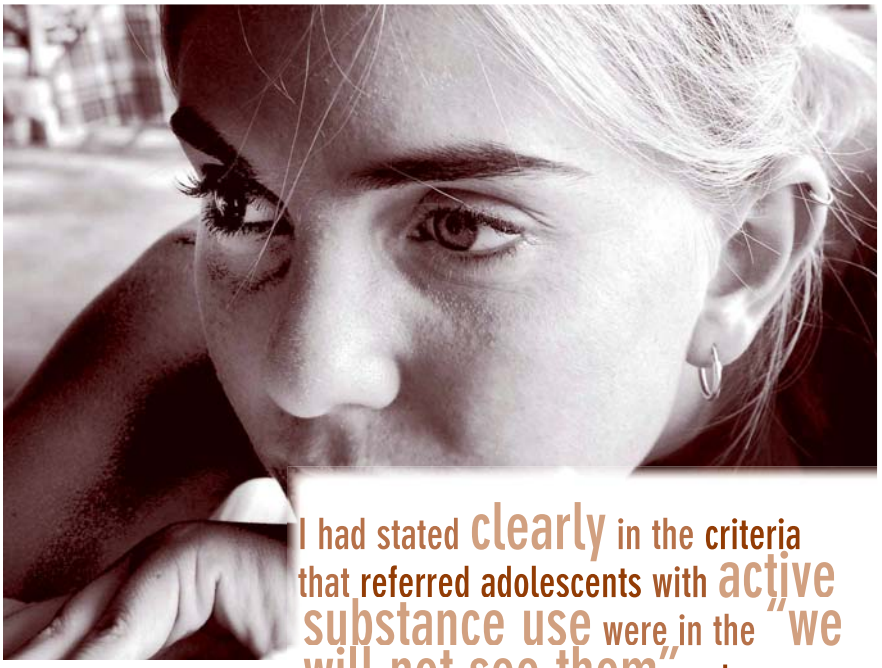
In my current position as coordinator of the Provincial Youth Mental Health and Substance Use Program at BC Children's Hospital, I have been developing, with my colleagues, a youth concurrent disorders program—that is, a program that serves youth who have both a mental illness and an addiction problem. The Provincial Health Services Authority recently granted ongoing funding to expand the program's clinical services, as it had been operating for the last two years with only one staff member.

One of my first tasks was to get myself up to speed on assessing substance use in youth. No problem! I thought. I would just learn the substance use assessment questions and tack them on to my mental health questions. I quickly became aware, however, that despite my years of experience, I didn't really know what a concurrent disorder was in the youth population. Did it mean the problem with drug use came first and then the mental health problem started? Or, was it the other way around? Did it matter which came first? Things were beginning to look more complicated than just adding a few questions. Moreover, I didn't know what I was supposed to do with the drug and alcohol information once I got it. I was firmly in the grips of the dreaded "I didn't know what I didn't know" feeling.

Eleven years ago I had been responsible for developing the referral criteria for the crisis clinic. With the blessings of my psychiatric colleagues, I had stated clearly in the criteria that referred adolescents with active substance use were in the "we will not see them" category.

When youth did come through my former "mental health only" door, I would ask them if they used any drugs, expecting a typical response like, "Yeah, I smoke a little pot and sorta get drunk on the weekends." I would then rapidly move on to ask more about their mental health problems; my comfort zone was only in doing a mental health/psychiatric assessment.

If they told me they were using a lot of drugs and/or alcohol daily, I'd begin to doubt that I could be very helpful. I would immediately start thinking about referring these youth on to addiction services and telling them to come back and see us when they had been "clean" for at least three months. Invariably, this would be the last time we saw them.



I had stated clearly in the criteria that referred adolescents with active substance use were in the "we will not see them" category

Why was this? Was this a service delivery issue? Was this a clinical issue? Had I inadvertently been giving the message that you could only get help from us for one problem, not two? Or that mental health problems and drug use problems were two separate issues and needed two kinds of specialists who weren't, most likely, going to speak to each other?

When I have attended conferences and workshops, they have been focused either on mental health or on addiction; I have attended just one conference with a specific concurrent disorders focus. It became clear to me that mental health and addictions clinicians spoke »

Amrik's Bout with Schizophrenia

Margaret Little

Margaret is a UBC graduate in Art History. She has also studied computer information systems and website design, and has worked for the BC government for 12 years. She enjoys aquafit, weight training, reading, writing and walking her dog

In 2003, at the age of 22, Amrik* had just graduated from a US university with a Computer Engineering degree. He was a normal, well-adjusted young graduate with no prior mental health problems. But after only three months at his first job, as a university Java program developer, he was unable to concentrate on his work or remember much of his programming skills.

"I had memory blackouts where I couldn't recall who I was and what I was doing," says Amrik. "This period in my life is a blur to me now. I knew something was wrong, but I didn't know what."

When Amrik came home from work one day, he was unusually tired. Suddenly, he had what he would later learn was an epileptic seizure. He had a memory blackout so he didn't know what happened at this time. During this seizure he bit his tongue. He was taken to the hospital by his parents, who, luckily, were present during this episode. At the hospital he was treated for the seizure by a general practitioner, but the GP referred him to a psychiatrist, whom Amrik saw the same day. The psychiatrist diagnosed him as schizophrenic because of his chaotic thought patterns. Amrik remembers telling the psychiatrist about a professor he'd had, who he thought was "out to get him."

"I truly believed this professor was plotting against me," he says. "The professor was out to get me because I was evil and would harm others." Now Amrik knows that he was living in another reality.

"I had suicidal thoughts during this period of time, but I didn't actively try to commit suicide," remembers Amrik. "When I was diagnosed as a schizophrenic, I don't remember being scared or surprised—just a blank." There is a hole in his memory around the onset of the illness.

The psychiatrist prescribed Amrik the antipsychotic drug Risperdal. With the medication his thoughts became more coherent and reasonable and he began to feel normal. The main side effect from Risperdal was drowsiness; luckily, the drowsiness only occurred in the morning before 9:00 a.m. During the daytime he was alert, with no side effects. He did not suffer from depression. Amrik continued with the medication for

** pseudonym*

attitude adjustment | *continued from page 13*

two different languages. There were also differences in assessment and treatment approaches, beliefs about change, and so on. It was also clear that we, though separate groups of health care professionals, were seeing the same clients.

Was the lack of a common language part of why it was hard to communicate with each other about our clients? Or was it deeper than that? Was there a level of discomfort with each other that was grounded in not wanting to feel exposed about what we didn't know about each other's area? And if we did discover that we were unfamiliar with something from the other's territory, then what? If I wanted to get more familiar with issues regarding youth drug and alcohol use, would I be welcomed as a colleague, or would I be treated as an "outsider"? If I felt this way, what must the clients feel like?

Posing these questions to myself made me come to terms with the fact that I was, in some ways, a product of the mental health/psychiatric system training. Even though I had been working in psychiatry for almost 20 years, I had no more than a basic introduction to substance abuse, its treatment or addiction medicine. I had never worked, or been offered an opportunity to work, alongside an addiction medicine physician or an addiction treatment clinician, so never gained a good understanding of how they worked, thought or conceptualized the issues facing their clients.

Service delivery to youth has traditionally been provided via referral to *either* mental health or addiction services, depending on who is doing the referring and what they thought the problem might be. The type of assessment and treatment these young people would receive depended on which "door" they went through. This system has not only led to fragmented service, but has also kept professionals separated from each other in terms of facilitating respectful understanding, acceptance and knowledge exchange.

As I move ahead in my new position, I hope to soften some of the professional barriers between youth mental health practitioners and addiction clinicians. I am now very aware of the clinical reality that if a substance problem exists in a youth, there is a good chance there is a mental health issue that needs to be explored in a comprehensive assessment. From a personal perspective, challenging my belief system about youth substance use has been a learning opportunity that I didn't often connect to myself. It is sometimes healthy to be just a little bit humbled.

three or four months, but was not able to continue his programming work at the university. It took several months for his mental condition to stabilize and his thoughts to completely return to normal.

Living in the United States with a mental illness had a downside, however. Amrik found his medications very costly, because he was not a US citizen. But since he had no US medical coverage, it cost him $800 to $1000 a month for his medication.

Fortunately, Amrik's mother and father were emotionally supportive. His parents understood, through talking to the psychiatrist, that Amrik's mental disorder was biochemical and was manageable with proper treatment. "But my diagnosis was kept very quiet in the family. Only my mother and father knew about it," Amrik says.

The family, after much discussion, decided to move to Canada where Amrik's medication would be cheaper. Amrik had dual citizenship from Canada and India, and had lived in Canada for nine years before the family moved to the US so he could attend college there. As a Canadian citizen, Amrik's prescription drugs would be covered under the Canadian health care system.

Here in Canada, Amrik was accepted to work on a master's degree in Computer Engineering.

Since schizophrenia is a life-long disease and there is no immediate cure for it, Amrik has to take his medication daily. Sometimes, he has mild relapses. To help cope with relapses, Amrik has been a patient at a psychiatric day centre. He is taking cognitive-behavioural therapy (CBT) and has found it to be useful. Although most often used in connection with mood and anxiety disorders, CBT can also help those with schizophrenia.

"The thought restructuring has really helped my thinking patterns, and I've become functional in my daily life using the pills and the cognitive therapy," says Amrik. He has CBT sessions once a week for one to two hours. CBT also helps him manage his school work and helps him set goals.

His CBT work is also supported by progressive muscle relaxation, deep breathing, relaxation, meditation and yoga. Exercise is recommended for day centre participants. Amrik goes to the gym and works on cardio and weight equipment to keep his fitness level up. He also likes sports, especially tennis.

This period in my life is a blur to me now. I knew something was wrong, but I didn't know what.

Amrik's life is reasonably fulfilling, but still not yet well rounded. He didn't have many hobbies during his student days, as he concentrated solely on his studies. He is now attempting to round out his life socially. He has a number of casual friends, but no close ones. He says he has good interaction with members in the day program and occasionally goes out with some of the male members to movies or similar activities.

Amrik is coping very well at present. He has one year left to complete for his master's degree. When asked what advice he would give to others who have a similar problem, he said they should try CBT and take medication. This helped him and should help others. He added that there is no cure for schizophrenia, but the disease can be managed with proper care.

And says Amrik, "Even if your schooling is interrupted by mental illness, with proper treatment, young adults can still fulfill their dreams and potential."

My Life

From one extremity to the other

How did 'it' happen?

Food, at times, has been my 'friend' and confidant (over-eating). Other times it has been my arch-enemy, out to ruin my life (anorexia). I don't think I've ever experienced normal eating on my own—only with my first hospital 'visit' back in grade eight.

I was physically, mentally and sexually abused as a young child. I numbed my pain away by binge eating. This led to weight gain and ridicule, which lead to more bingeing, weight gain and ridicule—a vicious cycle indeed.

When I was just shy of 12 years old, I got up to 150 pounds. The harassment was unbearable. So, after finding

Michelle Dean

Michelle describes herself as driven, kind and easygoing. She's coping well with her eating disorder, is working and will be attending college in the fall of 2006

a Weight Watchers book in my home, I told my mom I was going on a diet. My mom was completely against it, but I did it anyway.

The more weight I lost, the more people loved and accepted me. The compliments came one after another: "You're truly a beautiful girl under there!" or "Oh, wow, you're actually gorgeous now!" So guess what folks? I kept on with it. And things got progressively worse.

Over the next year, I lost 60 pounds. I'd corner my mother in the kitchen and lecture her on what she was putting in our bodies and how much it appalled me. Someone suggested to her that I might have an eating disorder and recommended that she get me a referral to BC Children's Hospital. In October 2001 I was assessed as having what was blatantly obvious—anorexia.

I started as an outpatient at BC Children's, but by Christmas I was an inpatient. But because I was forced to go into treatment, I chose not to get much out of it.

When I got out of the hospital, I hit a new all-time low. I needed to gain weight and picked up bad eating habits—figured I may as well enjoy myself. I ballooned up a good 90 pounds during grades nine and 10, reaching as high as 200 pounds.

Eventually the overweight got to me, however, and I began making "better choices" again. By the summer of 2004, I had lost about 30 pounds. That was the summer I met my current boyfriend, who had come out to the coast from Winnipeg; we had a mutual friend. I felt incredibly fat and disgusting standing next to him. I told myself that the next time I saw him I had to be size *x*—and thus began another battle with bingeing. I'd get to my desired weight, then would set myself a goal for the next time I saw him. Once again it was achieved—but it was never good enough. My boyfriend never put pressure on me to be thin. This was all self-induced.

Things continued to snowball. I wanted to see if I could get sick again. I had forgotten how physically and mentally agonizing anorexia is, and I welcomed it back into my life with open arms. I lost 45 to 50 pounds—excluding the healthy-start weight loss—by not eating, purging and exercising four to six hours a day.

So here I am, in the spring of 2006, back as a patient in BCCH's eating disorder program for youth. I've been on the inpatient ward for five weeks and on weekdays I am part of the day program.

In treatment: realizations . . .

This is my second shot at healing, and this time it was my own initiative. Every day was the same tedious routine, and when I looked into my future, I saw nothing for me. I just wanted to be dead and that petrified me. Also, contrary to many anorexics, who feel as though they're in complete control, I felt incredibly out of control. No matter how much I wanted to stop, I couldn't. My relationships were deteriorating—*I* didn't want to be alone with myself, let alone have other people around getting impacted by what I was or wasn't feeling. And, physically, I felt atrocious. I didn't have any energy, yet still gave 110% when it came to working out for hours on end. I'd look in the mirror and see a yellow, dark-eyed, bald-spotted, bruised-up person that was supposed to be me. I couldn't stomach it. I knew I was far from being healthy.

I'm confident when I say the program is working for me. Yeah, sure, I do go home on weekend passes and muck up here and there, but it's not intentional. The way I see it is, I worked hard to get where I am—it was my lifestyle for so long—that it will understandably be a long journey to get well. I'm not resisting the groups and other people like I did my first time around.

My days here in BCCH are structured. We eat three meals and three snacks, and attend various support groups. These include a nutrition group, in which we select our menus for the upcoming week and discuss diet myths and other facts to help us make wise eating choices. A few hours of schooling are also incorporated into each day, as the majority of us still need to complete our studies—I'd lost a lot of my grade 12 year.

DBT (dialectical behaviour therapy) is one of the more helpful groups. It helps us control our thoughts and not let them overpower us and run our lives. We typically start with a mindful exercise, in which we sit completely relaxed while listening to soothing music and become aware of our feelings. Most patients have trouble expressing feelings, and some are unable to distinguish between different emotions. This group helps us get an idea of what we're feeling and how to properly assert ourselves. »

My eating disorder is a way of shielding myself from the real world

What Works?

Family therapy for adolescents with anorexia nervosa

Ronald S. Manley, PhD, RPsych

Pat Roles, MSW, BCATR

Ron is Clinical Director of the Eating Disorders Program at BC Children's Hospital, and Clinical Assistant Professor in the Department of Psychiatry at UBC

Pat is Social Worker and a family therapist in the Eating Disorders Program at BC Children's Hospital, and is Clinical Coordinator in the BCCH Social Work department

Anorexia nervosa is a devastating illness that affects around 0.3% of young women (or about one in every 200 girls).[1] Boys are affected as well. Sufferers of this illness have a strong fear of becoming fat and may even believe they are fat when they are actually underweight. This distortion of body image is real for them. Individuals with anorexia nervosa try to keep a low body weight through restricting food, over-exercising or through purging food after eating (making themselves vomit, or using laxatives).

This illness most often develops during the early to mid teens, a time of life which brings great change. Changes include physical, social and emotional growth and development, shifts in peer relationships, emerging sexuality, greater independence from family, a move to high school or leaving school at graduation. Overwhelmed by these demands, some children with risk factors, such as low self-esteem, may develop an eating disorder as a way of attempting to cope with these pressures and changes. The illness is a way of communicating to others that something is not working for them in their life.

Treatment requires a team approach, which can include doctors, psychologists, social workers, nurses and nutritionists. Treatment approaches have changed greatly over the years. There used to be a reliance on behavioural approaches, such as a reward system where the individual earned privileges for weight gained. Now, efforts are directed more toward working on motivation to recover and self-responsibility for recovery.

Why family therapy?

These young people live in the context of their family. The family, therefore, can be an important resource in supporting the young person in their difficult process of gaining weight

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my life | *continued from previous page*

I've learned a lot about myself. My eating disorder is a way of shielding myself from the real world. The thought of finishing grade 12 and getting to a new point in life was horrifying and daunting. It still is. Part of me thought that if I was sick I wouldn't have to deal with things—I could just spend my days in treatment facilities or in my own world at home. But I've learned that's no longer what I want out of life. Life is too short. In two years I want to be able to travel to different parts of the world, and in five years I want to be finishing university, and in 10 years I want to be started on my chosen career path. I don't want to be asking myself in 10 years, what have I done with myself?, only to realize I haven't done or achieved anything because I've been sick.

A good state of mind and good health will enable me to hold down a job to make money so that my dreams can become reality. Previously, working out was a priority and every other eating disorder habit took precedence over my job, so I quit working. I want to be able to think clearly so I can do well in my university courses. Since I've been working on things, all my relationships have benefited.

I've been able to pinpoint some things that I've felt out of control with. For example, I can't control my long distance relationship and I can't control the fact that I'm going to have to face the real world in a month's time. But now I'm more willing to accept the fact that I just need to go with the flow of life. The thought of that, though still a bit frightening, is exhilarating.

So here I am today, writing a little blip of only a few of my struggles in the comfort of a treatment facility. It's been just over a month now and things are changing. I've realized I'm a great person with many wonderful assets to offer to people, the community and the world. Anorexia will only hinder my goals and passions. I will beat anorexia. And I assure you that I will achieve every goal I set for myself. This illness robs you of a quality life, the type of life I so desperately want to live.

and becoming psychologically healthy.

Family therapy is the process of a therapist meeting with a patient and family members to help the family work together to solve the problem, since anorexia affects the whole family. This may include counselling with parents alone.

Family therapy is *not* aimed at the family as the cause for an eating disorder. Parents often feel blamed and do much soul-searching about what they did or did not do that may have resulted in the eating disorder. Sometimes parents' fears overwhelm them, interfering with their ability to support their child effectively. It is important to enlist family members, in a non-blaming way, to work together with the treatment team so they can understand how to support their daughter or son through the process of recovery. Family members also need to look after themselves during this often lengthy recovery process.

Maudsley approach?

Research in the family therapy field has provided very encouraging results in answering the question: how can we best support an adolescent with anorexia nervosa in getting better? Some such early research took place at the Maudsley Hospital in London, England.[2,3,4]

Adolescents have been found to do better with family therapy than with individual therapy.[5] In the Maudsley approach, family members are supported to work directly with their daughter or son in encouraging them to eat, rather than being encouraged to "back off" from actively trying to get their child to eat. Control over eating is not returned solely to the adolescent until she/he has achieved a healthy weight. Only then does the therapy directly address issues less closely related to the eating behaviour itself.[2]

One review reported that, of patients who were assessed five years following treatment, three quarters were found to have a good outcome.[2]

The same review reports on another study that compared two types of family therapy: 1) involving the child in the family therapy, and 2) involving only the parents. The findings showed no difference in the outcome.[2] This result suggests that working with the parents alone is as important as involving the child in the process. It is essential that parents be able to work with one another and be consistent in their approach to their child, even if the parents are separated or divorced.

What's new in family therapy?

The family-based treatment for anorexia developed at the Maudsley Hospital has been developed into a manual for therapists.[2,3,6,7] This is important, because it means the treatment has been standardized and so allows researchers to study it more carefully. Standardization also means the therapy can be adopted in a variety of treatment centres, since the manual outlines how the treatment should proceed.[2]

More recently, a type of therapy called multiple-family day treatment has emerged as part of the Maudsley approach.[2,4] This type of family therapy is conducted with several families at one time, and views the family as an important resource in helping their adolescent to regain weight. Families meet together over several days, as opposed to the more traditional once-a-week family therapy approach. They hear about and share stories, discover more about their own resources and focus on solutions. These are experiences that empower families.[2,4] Improvements with this approach have been reported in a number of areas, such as gaining weight and binge eating and purging less. It is particularly noteworthy that the drop-out rate has been low. Both patients and parents have provided good feedback about this treatment.[2]

A proposal has recently been made to consider the multiple-family therapy situation as a "community of concern"[8] and to enhance this therapy with practices taken from narrative therapy. Narrative therapy[9] is an approach that helps people redefine their relationship to the problem through "re-storying" (the client constructs a new, empowering and preferred story about themselves and their life). An example of incorporating a narrative therapy strategy would be to expand the traditional family therapy format by having parents who have already gone through treatment be consultants to families who are in treatment.[8]

Where are we now?

At this time we can say more clearly, although not conclusively, that family therapy is the "treatment of choice" for children and younger adolescents with a short duration of anorexia.[2,3,7] While we also need to study other treatments for comparison with the results of family therapy,[3] it is clear that we need to welcome family members as part of the overall treatment team for youth with anorexia nervosa. For an illness that is so devastating to patients and their families, the favourable outcomes of this treatment approach are welcome news indeed.

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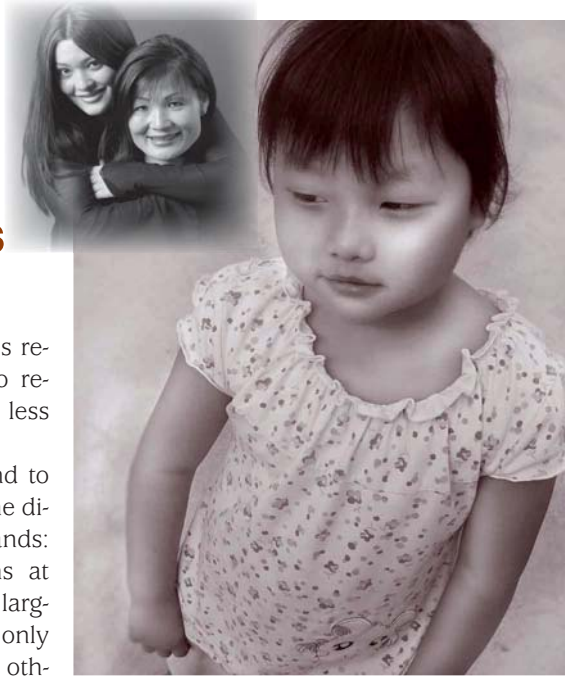
Between Two Cultures

Family therapy for Chinese Canadians



The process of immigration requires learning to live in a culture different from one's native culture. This process involves a large number of life changes and lowered well-being over a period of time. People often experience changes both individually and in their families—and family is very important in Chinese culture. Normal family conflicts and confusion are likely to be made worse. Issues such as cultural value differences and family structure changes are the major source of problems people in immigrant families may need help with.

Competing demands on Chinese youth

In North American culture, new family structures and practices have been emerging, and traditional values and assumptions have often been called into question. As a result, there aren't clear guidelines to help immigrant families as they experiment with different ways of relating and adapting to a new—and changing—social world.

During cultural transition, children often experience increased demands on them. Placed in a strange culture about which they had no choice, children are overwhelmed by the numerous obstacles confronting them. They are constantly reminded by their parents that the parents invest their future in their children. The children are expected to do well in an English-speaking school, even though they cannot speak English at the beginning.

When Chinese children enter the Canadian school system, they learn new social values that conflict with those of their parental culture. When the children become skillful in the English language, they also learn to accept and assimilate the culture and values that come with the English language. The children's assimilation into Western culture then makes them strangers in their own homes. Their newly learned assertiveness and freedom of choice and speech create increased conflict and physical and emotional distance between them and their parents. Should children disobey the parents—especially the father, who is the disciplinarian in the family—the parents will feel threatened and may demand more respect and deference from the children.

The children's rapid acculturation (i.e., shifting to the values of the new culture), however—including greater proficiency in the English language—can cause role reversal in the family. Because of their skill in English, the son or daughter may be asked to translate or speak for the family in situations and relationships outside the family. This status, newly acquired by children, may cause them to have less respect for their parents, who remain traditional, rigid and less educated in English.

Chinese youths thus tend to experience anguish due to the dilemma of competing demands: 1) cultural role expectations at home, and 2) survival in the larger society. This involves not only conflicting pressures from other people, but personal conflicts within the individual Chinese youth, who is oriented to both sets of norms.

Some suggestions for cultural sensitivity in family therapy

The wide acceptance of the family-centred approach to problem solving has generated many treatment theories and models. In working with Chinese Canadian families, Chinese cultural and family traditions must be considered. The following suggestions may be useful:

- ***Use of symbols.*** Symbols—words, objects, actions, gestures, images and sequences of interaction—can represent a client's way of communication , personal metaphors, culture and life stories in a familiar and comfortable manner. Instead of asking Chinese clients to directly express themselves in feelings or comments, symbols can be used as an indirect way of having clients present personal needs and meanings, as well as emotions. Asking Chinese clients to bring their favourite pictures to the session, for example, can change the focus from the person to the objects.
- ***Re-labelling.*** By using a concept the client is familiar with—for example, their own way of labelling a problem or issue—therapists can not only help clients understand their difficulties, but also alleviate the anxiety about exploring their problems in a therapeutic situation.
- ***Applying Chinese traditional medicine theory.*** This is highly recommended for working on depression with Chinese clients. Feelings are often not directly expressed by Chinese clients. According to the theories of Chinese traditional medicine, physical symptoms are very much related to one's emotional well-being. Thus, descriptions of physical symptoms such as headache, sleeping difficulties or eating problems are easily used by

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Dan Zhang, MD, MSc, PhD

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play therapy

A way to help children who are experiencing problems

Kathy Eugster
Barbara Tredger

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Barbara is President of the BC Association for Play Therapy and a child and family therapist in private practice and with Family Services of Greater Vancouver

When parents and other adults are worried about a child's behaviour, they usually want to seek help for that child. One of the best ways to help children is through an approach known as play therapy.

Play therapy is a treatment approach specifically developed to help children between the ages of three and 12. A play therapist is trained to help a child who is struggling with problems to explore and resolve these problems through the use of play.

Children express themselves much better by playing than by talking. In play therapy, children are provided with specially chosen toys and play materials with which they can play out what they have difficulty saying with words. Children will play using their imaginations in ways that are related to events that have happened in their lives. For example, a child who has been in a car accident may play by crashing toy cars together over and over. A child who has seen his parents fighting may use puppets to act out these conflicts seen at home.

In play therapy, children do not have to talk about their problems to feel better. Play therapy allows children to distance themselves from feelings and memories that would normally be too difficult for them to talk about directly. When children play with toys in ways that are similar to difficult situations that have happened in their lives, the associated upsetting feelings and memories begin to fade.

In play therapy, children will play in ways that help them make sense of a confusing world. Through play, children can get a better understanding of what has happened in their lives. By playing out a scene where a child toy gets hurt and then gets help from a toy doctor, the child may begin to understand that getting hurt was not his or her fault. In addition, the child will gain a sense of hopefulness and realize that help can be available after a hurtful incident.

During play, creative thoughts are encouraged and children can find solutions to their problems. For example, a child may play out different endings to a particular make-believe story, finding one particular ending that feels good. This is similar to what an adult does by talking to someone about different ways to solve a particular problem.

In play therapy, a child can also pretend to be different characters. This gives him or her an idea of what it feels like to be in another person's shoes. Again, this is like an adult talking with someone and then understanding things from different points of view. This ability to experience and understand different perspectives helps a child to develop a sense of empathy toward others.

Children will often feel more in control of their lives and more self-confident after being involved in play therapy. The net result is that problem behaviours will frequently decrease or disappear altogether.

Play therapists have recently been evaluating research that has been conducted over the past 50 years on the effectiveness of play therapy. They have found that play therapy is an effective treatment for children experiencing a wide variety of social, emotional and behavioural problems. It is also an excellent way to help children recover and heal from stressful or traumatic experiences.[1] Play therapy has been used for multiple mental health concerns, such as anger management, grief and loss, divorce and trauma.[2,3] Play therapy has also been used successfully to treat anxiety, depression, AD/HD, pervasive developmental disorders, academic and social developmental issues, physical and learning disabilities, and conduct disorders.[4] Play therapy can also be used successfully in conjunction with medication.[5]

Play therapy is different than regular play and to be effective requires the presence of a trained therapist. In British Columbia, the BC Association for Play Therapy (BCAPT) supports mental health professionals who are interested in obtaining training in the field of play therapy. BCAPT has been active since 1993 in advocating for the emotional well-being of children through advancing

play therapy | continued from previous page

and promoting the professional practice of play therapy. BCAPT conducts educational and professional meetings and conferences, collaborates with other professional organizations, and provides support to professionals and students in the field of play therapy. BCAPT has had close ties over the years with the California-based Association for Play Therapy (APT), which was founded in 1982 and grants the credentials of Registered Play Therapist and Registered Play Therapist-Supervisor to those mental health professionals who meet their requirements.

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between two cultures | continued from page 14

clients in discussion of their issues and problems. Counselling will be more acceptable and effective if it can assist clients to talk about the symptoms of their excessive anger, worry and thinking. In terms of practice, questions like: "What happened to you?" Or "What did you do?" is preferable to "How do you feel?" The focus should be on helping Chinese clients express their distress in a way that they can maintain "face" by not talking about their emotions.

- ***Involving family members.*** Traditional customs also influence Chinese clients who have difficulty opening up to an "outsider." Most Chinese clients are very much concerned about not making direct statements to others, and worry about "losing face" for themselves and their families. Therefore, they are very careful about what and how to say things to a "stranger." Family members whose English is more advanced can also help some clients overcome possible language and cultural barriers.
- ***Respect clients: Avoid stereotyping.*** If you not sure, ask. Interpretation out of context and beyond the facts is inevitably limited, offensive and harmful, whatever the intent. The therapist needs to understand clients within the clients' cultural context, to avoid generalizing beyond what is known, and to keep an open attitude without stereotypical assumptions regarding their clients and other people.

Music Therapy
Helping youth find their voice

Noele Bird, MMT, MTA, FAMI
Beth Clark, MM, MT-BC, NMT

Noele and Beth are music therapists in private practice in Vancouver. Noele directs a nationally recognized program for high-risk youth in Vancouver called I'm Dangerous With Sound. Beth specializes in rhythm-based music therapy with youth and facilitates Youth Living With Loss, an integrated creative arts program for bereaved youth

Music therapy is an allied health profession; that is, practitioners have formal training and credentials from professional associations. Music therapists use music in various ways to help clients—including youth with many different needs—make changes in their lives. We develop treatment programs based on the unique needs of our clients. Music therapy can stand alone as a form of treatment, or may complement other therapies. This article will discuss how music therapy helps youth who are dealing with mental health and addictions issues.

Music is a highly valued part of life for most young people, and for this reason we find little resistance to music therapy treatment on the part of youth.[1] Working through music allows us to draw on the creative strengths of our clients—strengths that might otherwise not be developed.[2] Music can be used in creating a supportive space where youth feel safe.[3] We help youth understand how music can assist them as they make changes in their lives. One youth may learn to cope with her anger through playing drums. Another youth may tell his story of recovery through writing a song.

Goals and tools

Music therapy is used with youth who have mental health issues including conduct disorder, attachment disorder and depression.[4,5,6] Music therapists may see youth in schools,[5] hospitals[7] or within residential program settings.[4] Common issues for youth in mental health treatment include self-expression and self-esteem, depression, aggression, socialization and coping with stress.[8] Some of the tools used in music therapy are improvisation (improv), drumming, song writing, song choice, listening and analyzing the words to songs.[2,9]

Music therapists who serve youth with addictions work toward goals that are similar to those for youth with mental illness. Focus is placed on self-awareness and expression, coping skills, communication and values. Through writing song lyrics, relaxation, performing music and improv, youth build trust, express feelings, improve self-esteem and learn to create healthy alternatives to a drug-use lifestyle.[1,10-12]

Drumming with juvenile offenders

For more information on rhythm-based music therapy, phone Beth at 778-995-5735 or visit www.bethclark.ca.

This program for youth in a correctional facility uses rhythm-based music therapy. Youth explore drumming improv, song creation and playing music from many cultures. Sessions provide ways to express anger and other emotions. Youth develop musical, leadership, communication and coping skills, as well as greater self-awareness.

Youth Living with Loss

For Youth Living with Loss, contact the North Shore Palliative Care Family Bereavement Program at 604-988-3131, extension 4701.

This creative-arts based support program, which is offered within the North Shore Palliative Care Family Bereavement Program, is designed for youth who are dealing with the death of a family member or friend. These youth are at risk for substance use, school failure and mental health issues. The program helps youth build a support system with peers and adult mentors. The approach comes from the belief that youth who are grieving are in need of acceptance, understanding and connection.

Youth strengthen coping skills and explore ways to share their stories through music improv, relaxation, writing songs, journalling and visual art. Through these healing processes, youth are able to deal with feelings of guilt, anger and isolation. They can access this program for as long as they feel it is needed.

I'm Dangerous with Sound

For more information on I'm Dangerous With Sound, phone Noele at 604-879-3964 or visit www.noelebird.ca.

This is a music performance project for high-risk youth. It is aimed at providing a creative and healthy alternative to a drug lifestyle, through the discovery of the creative self in music improv. It is based on the idea that one of the most helpful things in the recovery process is reducing harmful activities and offering alternatives.

The project is built on the talents and strengths of group members. Youth explore poetry, movement, theatre, song writing, drumming, and music improv to create an original public performance. Through an experience that involves creativity, self-expression, and peer support, participants develop social skills, teamwork, leadership skills, and self-confidence. Youth in the project finish with a feeling of belonging and a sense of accomplishment.

Walking with youth on their journeys

Music therapy has long been used in treating people who have mental health issues. Now there is an increasing focus on ways to meet the needs of high-risk youth. We believe in creating opportunities for change and 'walking' with youth as they discover their own answers. Music therapy can help young people find their voice in the midst of the challenges they face.

acknowledgements

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related resources

Canadian Association for Music Therapy: www.musictherapy.ca
Canadian Music Therapy Trust Fund: www.musictherapytrust.com
Music Therapy Association of British Columbia: www.mtabc.com
American Music Therapy Association: www.musictherapy.org
Music Therapy World: www.musictherapyworld.net

No Worries

How interpersonal therapy can help depressed adolescents

Elizabeth Baerg Hall, MD, CCFP, FRCPC

Elizabeth is a psychiatrist with the Mood and Anxiety Disorders Clinic at BC Children's Hospital (BCCH), specializing in group and individual psychotherapy with adolescents. Together with Ministry of Children and Family Development and BCCH colleagues, she is heading a project to bring interpersonal therapy for adolescents to BC

Fifteen-year-old Sam was upset and irritable. He broke up with his girlfriend on a whim and was having trouble finding his way again. Fighting shattered his good reputation as a team player on the soccer field. His grades dropped. He couldn't sleep and lost weight. He just didn't feel like himself any more. To make matters worse, he had lost many old friends during the time he was with his girlfriend. Rather than reaching out, he withdrew into loneliness and despair.

Depression—a great challenge at any time of life—can feel like too much for an adolescent to bear. Although finding a name for the near-constant sadness or bad moods may bring relief to parents, friends and the young person him or herself, there is often confusion about what to do next.

First, it is good to get some information about depression. It is most important to know that depression is a treatable illness. Depression is common among youth, affecting 5% to 8% of adolescents.[1] It is best to get help rather than tough it out alone. Many adolescents experience suicidal ideas during depressive episodes. These ideas need urgent and special attention.

There are things that adolescents and their families can do to help heal depression. To begin with, teens should make sure they are getting enough regular sleep, healthy food and exercise. Omega-3-fatty acids, taken in pill form at 1000 mg daily or by eating fish such as salmon, can also help. Changes in the school program, such as reducing course load or stopping extracurricular activities, may be needed, but it is best to keep going to school regularly. Parents may need to lower their expectations, staying firm but loving.

The next thing to consider is where to get help for the depressed mood. The first choice for a young person with mild to moderate, clear-cut depression is counselling. By going to therapy, young people learn a set of skills that will be available to them for life. Sometimes medicines, such as fluoxetine (Prozac) can be helpful in treating adolescents with severe or long-lasting depressions. Medicine and psychotherapy together are best in these more complicated cases.[2]

Among the large number of therapies available for adolescents, two short-term therapies are scientifically proven. Cognitive-behavioural therapy (CBT) looks at how a person's thoughts, beliefs and behaviour act together to create a depression and it encourages the young person to change these patterns in order to get well. There is a helpful online book based on this approach called *Dealing with Depression*.[3] CBT is available throughout BC.

Interpersonal therapy for adolescents (IPT-A) is based on interpersonal therapy (IPT) for adults, which has been further developed by Drs. Klerman and Weissman at Columbia University.[4,5] Over a period of 12 to 15 weeks, teens examine their feelings and behaviours towards others and learn skills to improve the depression. They become more aware of how everyday things that happen in their lives affect their moods. As well as feeling better, they feel more powerful through applying these new skills to address problems that come up. Parents are involved along the way. BC Children's Hospital and the Ministry of Children and Family Development are committed to providing youth in this province access to this other effective and helpful treatment for depression.

Using IPT-A, Sam and his therapist reviewed the important relationships in his life to see if there were any things he could change to improve the depression. Together they learned that he did not like talking about his feelings, leading to depression and isolation. He had been unhappy with his girlfriend, but he didn't talk about these feelings. This led him to feel irritable and, before he knew it, he impulsively broke up with her. Although he knew the relationship needed to end, he had regrets about the way he broke up with her. This led to guilty feelings. He had trouble letting go as he struggled with these mixed feelings.

Next, Sam and his therapist came up with a plan to help him feel better. Sam learned a new way to talk about his feelings that wasn't so scary and that didn't leave him feeling overwhelmed. He

practised this in his counselling sessions and at home. He remembered how good he used to feel when he would call his friends to go out, and he started making those calls again. He prepared for what he would say when they asked him why he hadn't been around recently. He dealt with his feelings about the ending of his romantic relationship, and eventually he felt able to move on. He practised what he would say the next time he saw his former girlfriend at school.

Within eight weeks, Sam was feeling much better. By 10 weeks, his depression was completely gone. He was pleased to have made these changes in his life using interpersonal therapy since he had wanted to get better without using medications. Sam spent the last therapy sessions reviewing his depression symptoms so he could seek help more quickly if they came back. He had learned how important it was for him to stay connected to his friends. He felt clearer about what he wanted in his friendships and romantic relationships. In the next relationship, he was sure he wouldn't let himself get so isolated from his friends. Sam had good and bad days like normal teens, but he was no longer depressed. He was educated about depression and knew a lot more about his strengths and weaknesses as a person.

This is the goal of interpersonal therapy for depressed adolescents. As well as feeling relief from the depression, young people can feel good about their new skills, improved self-understanding and better relationships in the world around them. i

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Dealing with Depression

A self-care program for youth

Merv Gilbert, PhD, R. Psych

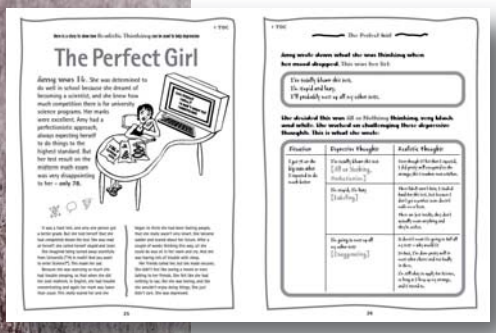
Merv is a psychologist who provides clinical and consultation services to individuals and families, government and the private sector, and he works at BC Children's Hospital

The need

It has been estimated that 3.5% of children and adolescents, or about 35,000 British Columbia youth, suffer from depression in any given year.[1] This rate increases significantly during adolescence, particularly for girls. It is even higher if we include those youth with 'low mood' or who have depression in addition to family, social or school difficulties, or who have depression along with another physical or psychiatric disorder. The lifetime burden of depression is huge for the affected individuals, their families and society at large. Episodes of depression repeat for many people and, for some, may be a chronic disease.

So, there is a strong argument for providing early, accessible and effective assessment and treatment for depressed youth. There are two types of treatments that have proven to be helpful for such teens: medication and psychological treatments (cognitive-behavioural therapy and/or interpersonal therapy). Medications have been the primary treatment to date, but concerns have recently been raised about their safety and side effects. Psychological treatments do not have these safety issues, but are not easily available within the public health care system for most teens.

In response to this situation, the Child and Youth Mental Health Branch, Ministry of Children and Family Development, looked for innovative ways of improving access to care for depressed youth. One approach that has been very useful in providing care for a number of concerns, including mental health disorders, is called *self care*.



Taking aim with self care

A self-care approach means providing consumers with information, about the management of their particular health condition, that is:

- based on the best available evidence on effective assessment and treatment strategies
- timely, so it can be available to individuals who are at risk for, or in the early stages of, a mental disorder
- accessible to everyone, especially those who may not use conventional health services
- complementary to, or supportive of, other psychological or medical interventions
- available for free, or at low cost, in multiple ways, including print and on the Web

Fortunately, such a program existed for depressed adults: the *Antidepressant Skills Workbook*.[2] We used this as a framework and developed a guide for teens based on up-to-date scientific literature about what is most useful for helping depressed youth. The challenge was to adapt this format for youth, recognizing that child and youth mental health needs, issues and expectations are unique.

We wanted to make sure that the content, examples, illustrations, format and style were appropriate. We recognized that we were not the best judges of that, so went to those who are: teenagers. We held a series of meetings with both depressed and non-depressed youth, gave them draft copies of a guide, and asked them about its clarity, appearance and usefulness. We also met with parents, school counsellors, mental health practitioners, physicians and other concerned adults to get their input, as we recognized that they would be important in supporting youth to access and use the guide.

Antidepressant skills for teens

The result of this process is *Dealing with Depression: Antidepressant Skills for Teens*.[3] It provides useful information and skills about managing mood for teenagers between ages 13 and 17. It is not intended to diagnose depression or to be a substitute for medical or psychological mental health treatment, but may complement such care when it is required. It is probably most appropriate for youth experiencing low mood or mild depression.

Dealing with Depression talks about the difference between depression and feeling sad and provides a model of depression that emphasizes the relationship between thoughts, feelings, emotions, actions and our physical state. Three core skills are then described: realistic thinking, problem solving and goal setting. These are accompanied by worksheets and brief stories about teens effectively using the skills. Finally, the guide provides suggestions to enhance motivation to change, manage lifestyle issues and deal with possible relapse.

The creation of *Dealing with Depression* was accompanied by a set of recommendations to ensure that the guide would be accessible and useful for as many youth, their families and concerned adults as possible. These recommendations included:

- providing free electronic and print copies
- distributing to mental health, education and other governmental agencies concerned with children
- forming partnerships with professional, private sector and public sector organizations to help promote the guide
- translating the guide into different languages
- transcribing the guide into a 'talking book' for youth who have difficulties with reading
- publicizing the guide at appropriate public and professional conferences and media events
- developing brief workshops for parents and professionals on how best to introduce the guide to youth, and how to support them appropriately as they go through it

Dealing with Depression is unique, but is nevertheless only one component in a broad response to the challenge of addressing the mental health needs of children, teens and families. It was produced because of the efforts and support of government and professionals, but came alive because of the honest input from those involved—youth and families. We hope that this effort will reach those who need it, and help them to build and sustain their psychological health and well-being. i

Print copies of Dealing with Depression can be obtained from the Child and Youth Mental Health Branch, Ministry of Children and Family Development, by calling 250-387-9749, or e-mailing MCF.ChildYouthMentalHealth@gov.bc.ca.

The guide is also available for download in French and English—including a 'writable' version that allows users to complete the exercises on their computer—at the Centre for Applied Research in Mental Health and Addictions website at www.carmha.ca

footnotes

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Youth Psychiatric Inpatient Services

"Kind of like an umbrella"

Judy Y. Smith

Judy is a freelance writer living in Vancouver

The bad news is, this summer Abbotsford was dubbed Canada's theft capital.[1] The good news: a new adolescent psychiatric unit is under construction in this BC city, and medical experts say one will likely help the other.

"Kids with mental health problems who don't get proper treatment are much more likely as adults to have problems with substance abuse, being unemployable, dropping out of school and becoming delinquent," says Dr. Derryck Smith, head of the Department of Psychiatry and medical director of mental health programs at BC Children's Hospital, and head of the Division of Child and Adolescent Psychiatry at UBC.

Roughly 150,000 children and youth in BC experience significant distress that affects their functioning at home, school, with peers or in the community, according to government statistics.[2] These distresses cover a wide range: anxiety, conduct, attention-deficit and depressive disorders; obsessive-compulsive and eating disorders; schizophrenia and psychosis. And while treating ill children and youth before they act out is important, treating them differently than adults is critical.

Tanis Evans, unit team leader of Kelowna's two-year-old adolescent psychiatric unit, says youth with serious mental health issues do better in a space developed specifically for them. And even with the best resources, these illnesses—especially in their acute phase—are hard to diagnose unless the patient is viewed 24 hours a day over a period of time. "Unless you're very accurate in your diagnosis," says Evans, "you're not going to have a treatment plan that matches what the youth requires."

Before the unit opened in Kelowna, the problem of teen suicide, including a high profile case involving a promising young local hockey player, became impossible to ignore in the region. But Evans is proud to say there have been no suicides since. "We get positive feedback from families; kids leave here feeling positive; families feel empowered. They still have a young person with severe problems, but hopefully with some strategies and direction."

Evans worked at Surrey Memorial Hospital in the 'bad old days' when sick teens were housed in the adult psychiatric ward. It was during that time that Surrey mom Donna Murphy had her suicidal son Kelly admitted—not realizing their problems would be far from over.

"Just as I was wheeling him there, an older woman in a very zombie-like state walked out of her room. Kelly became very frightened," says Murphy. "Older people are just really sick. And they [the adolescents] get on the older peoples' nerves. I mean, they're kids. They're bouncing all over the place and they drink all the milk and they make too much noise and it's very scary for the adults. So it's much better for them to be in units for adolescents."

Kelly spent two months in the adult psychiatric unit—a terrifying experience for him and his family. After his release, he vowed never to go back. Without community services to rely upon—and still feeling hopeless—Kelly took his own life at age 18.

"He was in the hospital for so long, and if he'd had people trained to work with youth, I think it could have been different. I will never know," Murphy reflects.

Murphy's anger and pain motivated her to fight for a Surrey adolescent psychiatric unit. She was on its planning committee. Her own experience, plus extensive research, led her to believe shorter hospital stays, as a way to stabilize the kids, are better. "If they stay too long they can either become more depressed or institutionalized."

Frank Fung, Fraser Health's director of mental health and addictions services for Abbotsford, Mission and Chilliwack, agrees.

"Hospital is kind of like an umbrella. You don't walk around every day with an umbrella—well, unless you're Michael Jackson," says Fung. "You use it when it rains, and it keeps you dry—and you use the same principle in looking at inpatient service: when you need it, you use it, and then when it quits raining, you close it up. I like to use the same approach [for youth mental health delivery]. We're going to use the Surrey model, except a shorter

some mental illness precursors in youth

- changes in behaviour, such as an active child becoming withdrawn
- changes in feelings, such as becoming worried, guilty, anxious or angry
- changes in thoughts, like lowering self-esteem, self-blame or even suicidal thoughts
- difficulty coping with day-to-day life
- lack of sleep or appetite, or low energy
- intense fear of becoming fat
- odd or repetitive movements, such as spinning or hand-flapping
- unusual ways of speaking or a private language

Any of these symptoms can morph into self-medication by abusing drugs and alcohol, or can escalate into hurting others by violence, thefts and vandalism.

length of stay, maybe two weeks." Abbotsford's new hospital, to be completed in 2008, will include a six-bed adolescent psychiatric unit—the first in the Fraser Valley. Fung is currently fine-tuning program content, talking to his counterparts in Surrey, and consulting with the grass roots on how the program should be integrated with community services.

"It is complex, because it's new to our area. We haven't had an adolescent psychiatric unit in our existing hospital, so this is new territory for us. The unit must also be supported by community services, and must work with the families—that's most important. Abbotsford's hospital is already integrated with the community, but with the new unit, the link will be even stronger."

Adolescent unit leaders seek to give children and youth more coping and emotional skills and ensure they are plugged into existing community supports. Evans says her unit's credo is that "children will do well if they can." After all, a hospital stay may be short—but it can affect the rest of a child's life.

footnotes

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Dialectical Behaviour Therapy

For youth who self-harm

Lisa C. Vettese, PhD, CPsych

Lisa is a registered clinical psychologist in private practice. She is also completing a research fellowship, sponsored by the Canadian Institutes of Health Research, at the Centre for Addiction and Mental Health in Toronto, Ontario

Teenagers who self-harm deliberately injure or hurt themselves, often in an attempt to cope with overwhelming emotional pain. Examples of self-harm include self-hitting, cutting, scratching, burning and poisoning. Self-harm usually starts during puberty and adolescence, with a high number of incidents occurring between ages 16 and 24.[1,2] Self-harm can be done with or without the intent to die; however, regardless of intent, self-harm carries the risk of suicide. If left untreated, self-harming behaviour can become more extreme and carry on into adulthood.

Dialectical behaviour therapy (DBT) is a pioneering approach to treating self-harm.[3] DBT addresses the underlying causes of adolescent self-harm, including difficult family interactions and difficulties controlling emotions. Adolescent DBT, as developed by Alec Miller and colleagues, uses dialectic (testing thoughts and beliefs through discussion) and behavioural strategies in an intensive 16-week treatment program.[4] DBT provides individual therapy, family skills training and phone consultation for the client, and team consultation for the therapist.

Philosophical perspective

The theory behind DBT is based on dialectical philosophy, which emphasizes the joining of opposites. DBT is considered dialectical because it blends seemingly opposing therapeutic styles. The DBT therapist takes a dialectical approach by strategically balancing such goals as:

- Pushing clients to change versus accepting clients exactly as they are in the moment
- Being warm and supportive versus being more irreverent (being matter-of-fact or deadpan when the client presents problem behaviours)
- Challenging dysfunctional behaviour versus being validating, which includes focusing on the aspects of the clients' feelings and intentions that make sense (e.g., the desire to find relief from emotional pain)

DBT is also dialectical insofar as the therapist aims to help youth and family members replace extreme viewpoints, which can cause family conflict

and emotional distress, with more balanced perspectives that take into account all family members' views and feelings.

DBT is behavioural because it draws on the strategies of cognitive-behavioural therapy. Cognitive-behavioural strategies include helping youth and family members analyze the triggers and consequences of their problems and learn new ways to think about problems and their solutions.

Primary treatment targets

In DBT, there are four primary treatment targets, which are approached in a specific order:

1. Life-threatening behaviours are targeted. These include suicidal thinking, suicidal threats, active self-harm, and triggers of self-harm. One trigger is invalidation, which can include critical comments from others, or other people discounting the youth's perspectives and feelings
2. Behaviours that interfere with therapy are targeted; for example, missing therapy sessions and other factors that make it difficult for the adolescent or family member to get to treatment
3. Behaviours that interfere with the quality of life are targeted. For instance, clients are assisted in reducing behaviours that create depression, social isolation and poor communication among family members
4. Clients' behavioural skills are targeted. For this target, a therapist evaluates clients' coping skills, and teaches new skills to aid progress in therapy

Secondary treatment targets

There are many treatment targets that do not fall easily within the primary treatment targets addressed in DBT. These secondary targets can be thought of as tensions within individuals, and between family members. These tensions can escalate as people take opposing sides, or fall into all-or-nothing thinking. These opposite perspectives create actual feelings of tension within the teenager and the family, and trigger some of the primary problems, including 'acting out' behaviour that is targeted in DBT.

Secondary treatment targets include family members' behaviours such as:

- Swinging between extreme strictness and extreme permissiveness
- Labelling normal teen behaviours as unhealthy, while not responding adequately to unhealthy behaviours
- Wavering between encouraging adolescent dependence versus forcing independence

When addressing secondary targets, one goal of a DBT therapist is to help teenagers and family members become more dialectical in their thinking. That is, therapists help family members avoid opposite and defensive positions, by helping them to consider what is well-founded in their own and in other family members' perspectives. By doing this, a therapist can help family members to support and value each other, thereby reducing out-of-control emotions within the adolescent and within their family.

Treatment structure

Components of weekly treatment include the following:

- ***Weekly individual therapy:*** The teens attend this session alone or accompanied by family. The purpose of individual therapy is to develop skills and motivation in both youth and parents.
- ***Weekly family skills training:*** Teens and their family members meet in groups to learn a range of skills, including emotion regulation, mindfulness skills, interpersonal effectiveness, and distress tolerance. They also learn a dialectical approach to life, which involves learning to see the different sides of a problem with nonjudgemental awareness. This is referred to in DBT as "walking the middle path."
- ***Telephone contact:*** Teens and parents can access their individual therapists to request real-time, on-the-spot skills coaching.
- ***Weekly consultation team meetings:*** Therapists obtain training and supervision to support successful treatment.

Stages of treatment

DBT is delivered in four stages:

1. Stage one lasts for 16 weeks and focuses on achieving control over self-harming behaviour
2. Stage two focuses on reducing post-traumatic stress
3. Stage three focuses on increasing self-respect
4. Stage four focuses on increasing a client's capacities to experience joy

footnotes

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A Year "Down Under"

ORYGEN Youth Health

Steve Mathias

Steve is a staff psychiatrist at BC Children's Hospital and the Maples Adolescent Treatment Centre

In 2005, as a fourth-year psychiatry resident, I was given the opportunity of a lifetime: with the support of UBC's Department of Psychiatry, I travelled "down under" to Melbourne, Australia. There,

I worked for one year at ORYGEN Youth Health in the Substance Use Research Recovery Focused (SURRF) program.

ORYGEN Youth Health is a service provided to the northwestern and western suburbs of Melbourne. Servicing a region of over 800,000 people, ORYGEN grew from its early beginnings as the Early Psychosis Prevention and Intervention Centre (EPPIC), founded by world renowned psychiatrist Dr. Patrick McGorry. Today, ORYGEN has over 300 clinicians and researchers working with youth, 15 to 24 years of age, in all areas of mental health. The ORYGEN inpatient unit and a multitude of clinical programs are located at three sites in Melbourne.

The 24-bed inpatient unit is available for those young people needing a brief hospital stay due to concern for their safety. ORYGEN prides itself in using low doses of medications and using a hands-off approach, minimizing the use of restraints and seclusion in what is often the youth's first contact with mental health.

The numerous clinical programs address the common mental health problems of youth: psychotic, mood, anxiety, substance use, eating and personality disorders. The care model is that of case management, where a therapist is assigned a caseload ranging from 20 to 35 people. Therapists see the youths regularly, helping them attend vocational programs, schools and various groups. The therapists provide supportive therapy to the youth and, whenever possible, their parents, while serving as a link to medical staff. ICM, or Intense Case Management, is a group of energetic, highly committed workers who support the treatment of challenging youth, either because of the severity of their illness or because of social factors such as drug use and homelessness. The Youth Access Team (YAT) is available 24 hours a day, taking phone calls and doing home visits to youth in crisis. YAT is also responsible for all intake assessments and acts as the referral point for all the other clinics.

The SURRF (Substance Use Research Recovery Focused) program was established in 2003 under the leadership of Dr. Dan Lubman and is funded mostly through research grants. In my brief time with SURRF, I was involved in several research projects. I worked with various drug and alcohol agencies, educating staff on mental illness issues and consulting on youth who had both addictions and mental illness. I also worked with the ORYGEN inpatient unit and several of the clinical programs to increase staff awareness about the impact of substance use on mental illness. I trained staff on how to assess for substance use as well as on the use of motivational interviewing techniques.

Some of my most satisfying work came as a case manager within SURRF, as part of an ongoing study of youth suffering with both depression and substance use disorders. To them, I was "Doctor Steve from Canada"—somewhere between a celebrity and a circus act! My interactions with new patients began with them guessing, based on my accent, where I was from—they usually guessed Ireland or the United States!—followed by a conversation about Canada or my travels in Australia. My trump card, especially with the young men who often didn't want to talk, was my interest in the Western Bulldogs, an Australian Rules Football team, perennial underdog and local fan favourite. Most of my patients either "barracked" (cheered loudly) for the Bulldogs or had a soft spot for them. Being able to talk "footy" was incredibly useful in establishing rapport.

Attempting to simultaneously address substance use and mood symptoms is a challenge, since one often triggers or perpetuates the other. The youth cutting back on his marijuana use often sees his irritability increase. Or, attempts to improve mood may include drinking more alcohol. The pilot project involved the design of a treatment manual, combining motivational interviewing techniques to address substance use, with cognitive-behavioural therapy (CBT) to address mood and anxiety issues. Therapy was focused on current stresses and was very much patient-centred and -directed.

I discovered that CBT was beneficial for many of the youths who had grown up with neglect, low self-esteem or low self-worth. Learning how to correct their negative thoughts, or how to challenge their automatic assumptions that the world was unsafe or that their future was without hope, was new and exciting. While change occurred gradually and over several months, it was rewarding when my patients stopped seeing the world around them as a frightening place.

I cherish my year working with the 'Aussie' youth of Melbourne. I made friendships that will last a lifetime and I am indebted to UBC, the University of Melbourne, ORYGEN Youth Health and Dr. Dan Lubman for providing me with this memorable and valuable opportunity. "Go Doggies!"

related resources

ORYGEN Health Centre: www.orygen.org.au

FRIENDS for Life

Resilience-building and anxiety prevention

Kelly Angelius

Kelly lives in Victoria and is Manager of the FRIENDS for Life program in BC. She has worked for the Ministry of Children and Family Development, Child and Youth Mental Health (CYMH), for the past 11 years. Kelly has also been a Provincial CYMH Consultant and a CYMH Clinician.

To learn more about the FRIENDS for Life program in BC, visit www.mcf.gov.bc.ca/mental_health/index.htm, or e-mail Kelly at MCF.CYMHFRIENDS@gov.bc.ca

The FRIENDS for Life program, developed in Australia, is a world-leading early intervention and prevention program. Evidence shows that FRIENDS for Life reduces the risk of anxiety disorders and builds resilience (emotional strength) in children. The research shows that up to 80% of children showing signs of anxiety no longer display those signs for up to six years after completing the FRIENDS program. For children who are not anxious, research shows that FRIENDS significantly increases their level of self-esteem while reducing their feelings of worry and depression.[1]

Anxiety is the most prevalent of all mental disorders in children and youth, affecting nearly 7% of children in BC. This is approximately 65,000 children. Anxiety disorders are often difficult to detect and if left untreated may develop over years into adult anxiety disorders or, in many cases, depression.

The good news is that the FRIENDS program is being offered to grades four and five students throughout the province, in support of the Child and Youth Mental Health Plan for British Columbia.[2] It was introduced as a pilot project in seven school districts in the spring of 2004. Based on the success of this pilot project, FRIENDS was launched throughout the province in the 2004/2005 school year. The Ministry of Children and Family Development (MCFD), in cooperation with the Ministry of Education, is now moving FRIENDS into its third year of implementation. To date, over 45 school districts and many independent and private schools are involved—exposing over 47,000 BC children to the program.

FRIENDS is based on a cognitive-behavioural model, which addresses cognitive (mind), physiological (body) and learning (behaviour) processes that contribute to anxiety and depression. FRIENDS helps children to identify the thoughts they have about themselves and others, and teaches them how to talk positively to themselves (mind). FRIENDS also addresses the physical reactions our bodies experience when we are feeling worried, nervous or afraid, by teaching children how to respond to body clues through awareness and relaxation activities (body). Finally, FRIENDS teaches children new skills (behaviour) such as problem-solving, rewarding self and facing fears.

FRIENDS has been designed for use in classrooms. Teachers guide students through a 10-week series of activities, including home-based assignments, designed to help them manage their feelings and teach them how to cope with worry and difficult situations. At the end of the program the children can keep their FRIENDS workbook for future reference. They are reminded of the skills they have learned through the acronym "FRIENDS," which stands for:

- ***F**eelings*
- ***R**emember to relax*
- ***I** can do it*
- ***E**xplore solutions and coping step plans*
- ***N**ow reward yourself! You've done your best!*
- ***D**on't forget to practise*
- ***S**mile. Stay calm*

All children experience anxiety and worries as part of their normal development. What we also know is that some children cope with difficult situations in more effective ways than others. This is why the program is being implemented to all grade four and five students—so all children can benefit from the important life skills taught in FRIENDS.

Of equal importance is that parents and caregivers are also included. MCFD contracted the FORCE Society for Kids' Mental Health to introduce the parent portion of the program into school districts throughout BC. The FRIENDS parent training program was offered at 15 locations in »

footnotes

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MDA's Moving Beyond Support Group

Relax, share and grow

Moving Beyond, a support group of the Mood Disorders Association of BC, has been going strong for two years now. Members of the group have similar life experiences, and our shared mental health concerns allow us to support each other in times of confusion. Together, we discover new ways to appreciate life and move beyond all-too-familiar challenges. You don't need a mental health diagnosis to take part. The only condition is that you be a young adult between the ages of 17 and 29.

A word from the facilitator . . .

Being a group facilitator for Moving Beyond has been very rewarding. Moving from being a participant to gradually taking on more responsibility in the facilitation role has been a very empowering experience.

Growing together

Each of us is on our own pathway to recovery, but we share the common bond of experiencing or suspecting what is known as a psychiatric experience. With our peers, we transition through different stages of recovery together.

Having fun

What I enjoy most when attending the group is how easy it is to laugh and be in the present moment for the two hours I'm there. Whether the group is involved in some kind of activity or just socializing, everyone has a part to play.

Learning to become aware

Learning is another important aspect encouraged by Moving Beyond. We learn through sharing our experiences—sharing what worked well for us when we were in circumstances similar to that of another group member.

Sharing our experiences

We do rounds, each of us telling our stories about how the previous week has been for us. This is a time to listen and a time to be heard. To have our stories heard is to speak our truth. Our experiences aren't denied, and our symptoms become familiar—they are experiences common to those in the group.

Building community

Many members are dedicated to coming to Moving Beyond week after week. We are "The Regulars." Seeing these familiar faces creates such a sense of community. And there are others who drop in to see what Moving Beyond is all about. So come check us out; see what it's all about. We would be happy to have you as part of our community—as a "Regular."

Christie McRae

Christie is a mental health worker and has been a part of Moving Beyond for two years. She is currently working on a documentary about youth and mental illness intended to improve education and reduce the stigma surrounding mental health issues

MDA's Moving Beyond Support Group for Young Adults (17 to 29 years)
Monday evenings,
6 p.m. to 8 p.m.
Light refreshments served
Contact Johannes at 604-873-0103 or e-mail mdabc@telus.net

Together, we discover new ways to appreciate life and move beyond all-too-familiar challenges

FRIENDS for life | *continued from previous page*

the 2005/2006 school year, and will be offered at another 15 locations in 2006/2007. This component serves as both a networking and a learning opportunity for parents whose children are receiving the FRIENDS program. Not only do parents become aware of the tools and life skills that their children are learning through FRIENDS, but the parents also learn how best to support their children in using these skills at home. Parents learn how to recognize and respond to signs of anxiety not only in their children, but also within themselves.

Strengthening Families and Youth Voices

Building bridges

Melissa Bax

Melissa is Youth Programs and Public Education Coordinator, as well as the local Strengthening Families and Youth Voices Project Coordinator, for Canadian Mental Health Association for the Kootenays, in Cranbrook

The Strengthening Families and Youth Voices (SFYV) project is an exciting two-year initiative in our community, hosted by the Canadian Mental Health Association for the Kootenays. Cranbrook is one of five sites across the province[1] that has spent the past year networking and supporting parents and youth who have been, or are currently, involved with formal mental health services. The overall goal of our project is to increase the voice of parents and youth in their treatment and support planning. More importantly, the project's intent is to bring parents and youth together in groups to provide peer support.

We are into the second year of the project and I am happy to announce that we have successfully built support networks within a parent group and a youth group. This wouldn't have been possible without tremendous dedication by members of both groups—and, in particular, Liza, who is a parent of a child with a mental illness.

Liza has an unbelievable passion for the area of mental health. From the moment she first became involved with the project, Liza believed that the parents of our community needed a support group. Entirely on her own, she developed and promoted the Supporting Parents of Challenging Kids (SPOCK) group. Every two to three weeks, Liza, along with her husband Kevin, provide a safe place for these parents to come together to talk about their parenting successes and struggles. In June, Liza reported that approximately 11 parents regularly attend the meetings; three of them are male.

SPOCK has seen some amazing outcomes. At our last parent focus meeting, Liza noted: "Couples and caregivers used to fight about their parenting styles; now they talk about it. And they are parenting differently because of the opportunity to have a place where it is safe to talk about the struggles and challenges."

Leslie, who is also a member of our parent focus group and a regular attendee at SPOCK, made the following comment: "Just to know that I can pick up the phone and talk about how I am feeling, and to know that Liza or other parents understand what I'm going through is unbelievably reassuring."

Our project would not be complete without talking about the amazing work that our youth group has done in the last year. Every week, four to five or more youth get together at a local coffee shop to support each other and talk about mental illness issues. These youth have promoted themselves by developing a brochure. They have ideas about putting together an "art-fest," which would display some of their very personal artwork, poetry and other artistic work that expresses their struggles and successes in dealing with mental health issues.

The youth who attend the group would have not come together if it hadn't been for the hard work of outreach workers and project assistants Julie Luhowy and Amber Cuthill. Julie and Amber meet regularly with the youth to support them in various aspects of their lives that are beyond the scope of the project. They also assist in achieving the youth group's goals and objectives. Our youth have worked through issues of bullying, stereotyping, stigmatization, rejection and isolation. They have found common ground in talking about their issues in a youth-friendly, safe environment.

This project started with the intent to build bridges between professional mental health resources and parents, youth and community. I believe we will attain our goal of parents and youth having more input into their treatment decisions. The dedicated work of all the people involved has made this project special. Because of the commonality of the parents' and youths' stories, the friendships, relationships and peer support networks that have developed will continue to grow long after my rewarding work as project coordinator ends in March of 2007.

footnote

1. The other four SFYV pilot sites and host agencies are: Canadian Mental Health Association, North and West Vancouver branch, in the lower mainland; Kitimat Child Development Centre in northern BC; Canadian Mental Health Association, Cowichan Valley branch, in Duncan on Vancouver Island; and Maple Ridge/Pitt Meadows Community Services Society in the Fraser Valley.

YPPP
The Youth Parenting and Pregnancy Program

The Youth Pregnancy and Parenting Program (YPPP) was developed to fill a gap that was identified in the care and special needs of pregnant and parenting teens. While care has been available, it has been patchy and irregular, with pregnant youth having to attend several programs at various locations around the city in order to access needed services.

YPPP is a youth-centred model designed for young Vancouver mothers 22 years old or younger (age range 12 to 22) and their families. It operates out of Evergreen Community Health Centre in East Vancouver every Thursday afternoon.

YPPP Services include:

- complete prenatal, postnatal and 24-hour emergency care
- prenatal, parenting and life skills education
- pregnancy outreach provided by Healthiest Babies Possible[1]
- social work, nutrition counselling, and youth-focused psychological and drug and alcohol counselling
- breastfeeding support
- doula services (a doula is a person who supports a woman during labour and in childbirth)
- transportation vouchers to attend the program and medical appointments
- a hot meal program and an opportunity to meet other pregnant and parenting youth
- translation services in many languages
- First Nations support
- peer mentorship program
- fathers' support group
- computer resource room
- fun activities/crafts/scrapbook making

A multidisciplinary team provides care to youth, including two family physicians, a nurse-coordinator, the Healthiest Babies Possible staff (including dietitians and outreach support workers), a First Nations advocate, a youth clinic counsellor, an addictions counsellor, youth/family support workers (through Westcoast Family Resources), and a doula coordinator. Other support services include access to an obstetrician and to a BC Women's Hospital social worker. Volunteer doulas attend labour and births with the participants.

The program has contributed to improved access by its participants to medical care, nutrition and lifestyle counselling, youth psychological counselling, addictions counselling and postpartum and parenting groups. Some early indications of the program's success are:

- healthy infant birth weights
- high breastfeeding rates
- high participation rate of mothers
- involvement of fathers (in both the program, and in the parenting process)
- higher confidence in parenting as shown through a self-assessment survey
- high return rate of mothers to school
- increased connection to community support programs
- participant volunteering and mentoring

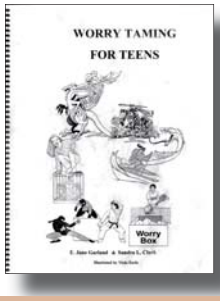
Dimithra Hippola

Dimithra is a primary care and Youth Parenting and Pregnancy Program physician at Evergreen Community Health Centre in Vancouver

YPPP has created an environment where youth feel comfortable seeing health care providers

footnotes

1. Healthiest Babies Possible is a prenatal outreach program of Vancouver Coastal Health, which supports women living in Richmond and Vancouver to have healthy pregnancies and improved lifestyles, with a focus on nutrition.



Book Review:
Worry Taming for Teens

By E. Jane Garland and Sandra L. Clark; Vicki Earle (Illustrator). Vancouver, BC: Children's & Women's Health Centre of BC, 2002. 96 pp. Review by Malis Valenius

Mailis Valenius

Mailis is a freelance researcher and writer. In 2005 Mailis completed a Gastown Vocational Services work practicum at the Canadian Mental Health Association in Vancouver

E. Jane Garland, MD, FRCP (C), and Sandra L. Clark, PhD, RPsych, wrote this manual while working at the Mood and Anxiety Disorders Clinic of the Department of Psychiatry at BC Children's Hospital in Vancouver.

Worry Taming for Teens is a manual written for teenagers to help them cope with anxiety in their everyday lives. It provides tools that can empower teens to reduce anxiety and take charge of their lives.

The manual is written in a creative and interesting manner that is sure to hold the attention of teens. Cartoon-type illustrations help break up and highlight notable points in the text. The book includes a wealth of anxiety coping strategies for teens, as well as useful pointers to help parents maintain a calmer family life, and the workbook style allows teens to add their own anxiety coping strategies. One caution: the information on medication, however, may be dated now and should be discussed with a doctor.

Anxieties, or "worry dragons," are defined in the manual as worries, thoughts and scared feelings that follow you, frighten you and will not go away. Some worries only surface once in a while, such as when you have a test or have to talk in front of class. Sometimes, people worry constantly. And some worries and anxieties are normal and are necessary to stay safe and out of trouble. For example, a little anxiety can ensure you get your homework done. However, too much worrying is not good for you.

Teenagers worry about things like school, making friends, romantic relationships and doing well in sports. They worry about their physical appearance and about what other people think of them. In addition, teens think about the environment, global economics, jobs, health and family problems. While some worry helps to motivate them to be active in solving these problems, too much worry is a waste of energy—and can become a problem.

The authors provide a number of tools for "worry taming," including time management (scheduling), overcoming procrastination (delaying or putting something off), mental imagery (thought-stopping and "worry trapping"), relaxation, changing self-talk and challenging perfectionism (a belief that one must be perfect). In addition, the manual talks about friendships and groups, sleep, "fuelling up" (eating healthily), mental rehearsal (imagining handling a situation calmly), laughter and exercise. Drs. Garland and Clark stress that while medication may be recommended in some cases, it should always be combined with anxiety coping strategies.

One of the tools listed above is mental imagery. An example of this is using your imagination to create a place, such as a drawer or a box with a lock, to put your worries into for safekeeping. This is "worry trapping." You can choose a convenient "worry time" to take your worries out of the box and look at them more carefully—and think about ways of resolving them. You might talk them over with someone else. The authors

YPPP | *continued from previous page*

For more information on the Youth Pregnancy and Parenting Program, call the Evergreen Community Health Centre at 604-872-2511, or visit www.vch.ca/community/Docs/Community_Health_Evergreen_Brochure.pdf

YPPP has created an environment where youth feel comfortable seeing health care providers. Youth come back routinely, build trust, and say that they see the program as being positive and non-judgemental. Flexibility and quick access to the needs of clients seems to be central to the program's success. In order to sustain the involvement of mother and baby over the long term, a fathers group has started and a mentorship program has helped more isolated pregnant youth to connect with their community.

The program has increased awareness—in other care providers such as nurses, physicians, doulas and social workers, as well as the youths themselves—of the needs of pregnant and parenting youth (beyond their health needs). The program is actively working with other community groups to address the broader social, economic and education needs.

also suggest picking a particular time to worry—not more than 15 to 20 minutes at a time. They suggest "thought-stopping" if worries come outside of an established worry time.

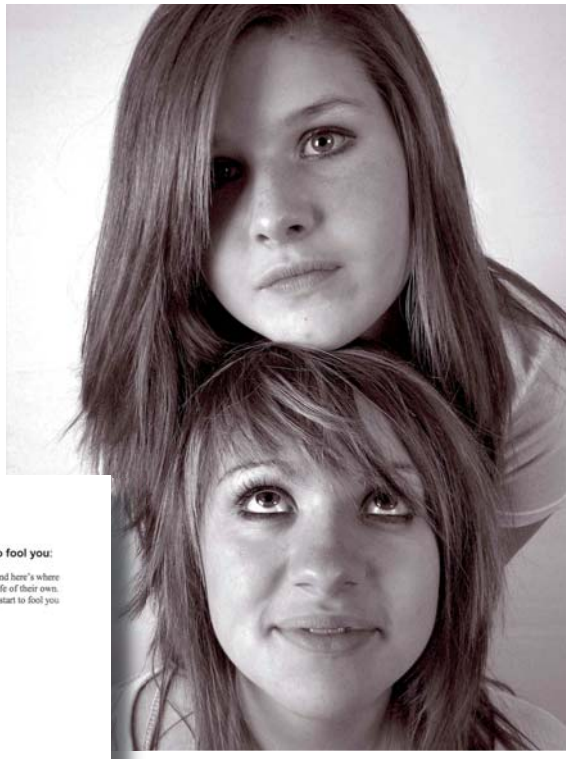
Thought-stopping is an effective tool used in many areas of mental illness and addiction. It involves the interruption of invasive thoughts by visually imagining a stop sign, or imagining the act of putting your worries into a box. In such situations, distract yourself by doing fun things or finishing other tasks. Worries can be like a tape recorder—playing over and over again. To deal with your worries, you can imagine pressing the "off" button of the tape recorder. You can then imagine switching the tape on and off, to take control of your worries.

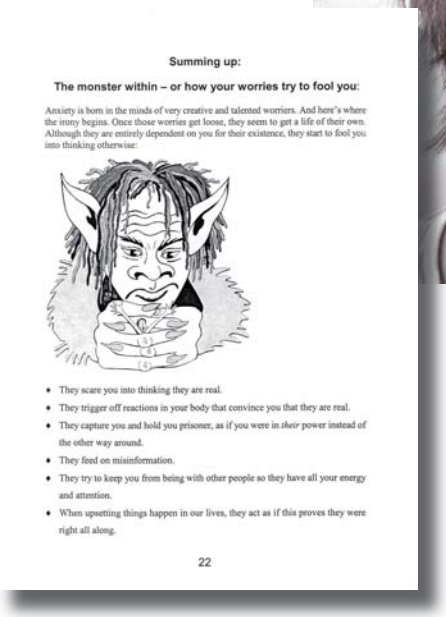
With more advanced tools, such as self-talk, you can master your worries by listening closely to what they say and then challenging them. Again, you can set aside special worry time to listen to your worries rather than allowing them to interfere with the rest of your life. To carry the tape recorder analogy one step further, the authors mention "changing the tapes" by changing self-talk from negative to positive.

After you have mastered the techniques of worry taming, you will have "tame thoughts," "friendly daydreams" and "a mind full of creative ideas." Then you can use your talent for creative imagination to work on real problems, such as writing an essay or doing a project for school.

I have used some of the tools outlined in the manual over the years and know they work if applied diligently. I have used self-talk to change negative self-talk to positive self-talk, time management at work, relaxation (and yoga), spending time with friends, sleeping well, healthy eating, laughter and regular exercise. I have also successfully used mental rehearsal when I've had to do public speaking or presentations.

The success of the manual will be determined by the comments from teens who have used the anxiety coping strategies discussed. Sometimes results do not happen overnight, but they come gradually over time with the right attitude and proper motivation to effect change.





Summing up:

The monster within – or how your worries try to fool you:

Anxiety is born in the minds of very creative and talented worriers. And here's where the irony begins. Once those worries get loose, they seem to get a life of their own. Although they are entirely dependent on you for their existence, they start to fool you into thinking otherwise:

- They scare you into thinking they are real.
- They trigger off reactions in your body that convince you that they are real.
- They capture you and hold you prisoner, as if you were in *their* power instead of the other way around.
- They feed on misinformation.
- They try to keep you from being with other people so they have all your energy and attention.
- When upsetting things happen in our lives, they act as if this proves they were right all along.

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related resources

Other books in the "Taming Worry Dragons" series published by the Children's & Women's Health Centre of BC

The Kid's Guide to Taming Worry Dragons, by Sandra L. Clark and E. Jane Garland (2004). An illustrated, pocket-sized overview of worrying. Similar to, but a much more condensed version of, the manual for teens.

Taming Worry Dragons: A Manual for Children, Parents, and Other Coaches, by E. Jane Garland and Sandra L. Clark (2000). Anxiety coping strategies for kids eight to 12 years old, with tips for parents and other coaches. Can be adapted for younger and older children.

Taming Worry Dragons: Classroom Manual (Group Facilitator): A Psychoeducational Group Program for the Prevention of Anxiety, by Sandra L. Clark, E. Jane Garland and Christina Short (2004). An eight-week, classroom-based program for children ages eight to 12 on how to cope with anxiety, though can be adapted for both younger and older children. For use with The Kid's Guide to Taming Worry Dragons.

Facilitator's Manual: Coping Skills for Children with Anxieties (Learning How To Tame Worry Dragons), by Sandra L. Clark (2000). An eight-week session program for teaching children anxiety coping skills, to be used with Taming Worry Dragons: A Manual for Kids, Parents and Other Coaches.

Visit www.cw.bc.ca and click on Bookstore

Support Organizations

- Anxiety Disorders Association of BC: anxietybc.com
- BC Schizophrenia Society: www.bcss.org
- Canadian Mental Health Association, BC: cmha.bc.ca
- Centre for Addictions Research of BC: carbc.uvic.ca
- FORCE Society for Kids' Mental Health Care: www.bckidsmentalhealth.org
- Jessie's Hope Society for Promoting Positive Body Image (formerly ANAD): www.jessieshope.org
- Mood Disorders Association of BC: www.mdabc.net

Treatment Providers

this list is not comprehensive and does not imply endorsement of resources

don't forget all the resources listed at the end of Visions articles as well

- To find a family doctor in BC: www.cpsbc.ca
- BC Ministry of Children and Family Development, Child/Youth Mental Health: www.mcf.gov.bc.ca/mental_health
- BC Children's Hospital, Child and Youth Mental Health: www.bcchildrens.ca/Services/ChildYouthMentalHlth
- BC Psychological Association: www.psychologists.bc.ca
- BC Association of Clinical Counsellors: bc-counsellors.org
- BC Association for Play Therapy: www.vcn.bc.ca/bcapt
- Music Therapy Association of BC: www.mtabc.com
- BC Art Therapy association: www.bcarttherapy.com

Youth Research

- UBC's Children Mental Health Policy Research Program: www.childmentalhealth.ubc.ca
- McCreary Centre Society: www.mcs.bc.ca
- Canadian Association for Adolescent Health: www.acsa-caah.ca
- Offord Centre for Child Studies, Ontario: www.knowledge.offordcentre.com
- Center for the Advancement of Children's Mental Health, Columbia University: www.kidsmentalhealth.org
- Research and Training Center on Family Support and Children's Mental Health, Portland State University: www.rtc.pdx.edu
- Association for Child and Adolescent Mental Health, UK: wwww.acamh.org.uk

Youth-oriented websites:

- Youth in BC: www.youthinbc.com
- Psychosis Sucks: www.psychosissucks.ca
- Kids' help phone: 1-800-668-6868 or kidshelpphone.ca
- Centre for Suicide Prevention: www.suicideinfo.ca
- Youth Suicide Prevention: www.youthsuicide.ca
- Mind your Mind: www.mindyourmind.ca
- Canadian Health Network: go to www.canadian-health-network.ca and click on Children or Youth
- Face the Issue: www.facetheissue.com
- It's All Right (stories and blogs of youth characters affected by mental illness): www.itsallright.org
- Young and Healthy: www.youngandhealthy.ca and click on the Body, Mind and Soul icon.
- Alberta's Youth and Substance Use site: zoot2.com
- Talk to Frank (Youth and Substance Use): www.talktofrank.com
- Check Yourself (Teens and Drugs/Alcohol): www.checkyourself.com

Publications

- What are Child and Youth Mental Health Services? www.mcf.gov.bc.ca/mental_health/publications.htm
- Getting help for children with mental health concerns & Child and Youth Mental Health Services tip sheets: www.heretohelp.bc.ca/articles
- Grip (teen mental health magazine): www.griponlife.ca
- Dealing with Depression: Antidepressant skills for teens: www.carmha.ca/publications
- Guidelines for Adolescent Depression in Primary Care. www.kidsmentalhealth.org/GLAD-PC.html
- Garland, E.J. & Clark, S.L. (2000). Taming Worry Dragons & Clark, S.L. (2000). Tools for Taming and Trapping Worry Dragons: Children's Workbook and the accompanying facilitator's manual
- Carr, A. (2001). What works with children and adolescents? A critical review of psychological interventions with children, adolescents and their families. Taylor & Francis.

Documentaries

Produced by the Knowledge Network for the BC Ministry of Children and Family Development. Available from the National Film Board of Canada at www.nfb.ca

- Beyond the Blues: Child and Youth Depression
- Fighting Their Fears: Child and Youth Anxiety
- Map of Mind Fields: Managing Adolescent Psychosis
- Struggle for Control: Child/Youth Behaviour Disorders
- Taking care: Child and youth mental health [web tools] www.knowledgenetwork.ca/takingcare

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

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