

crosscurrents

WINTER 2007/2008
VOL 11 NO 2

The Journal of Addiction and Mental Health



Early interventions with at-risk youth

HIDDEN RESILIENCE Can “delinquent” behaviour be a good thing?

DOUBLE WHAMMY When early psychosis and substance use go hand in hand

STRENGTHENING ABORIGINAL FAMILIES Culture key to reaching at-risk youth

NOTHING BUT BLUE SKIES Helping young people emerge from the cloud of depression

From boys to men Health promotion helps youth make the transition

The mad genius Treating artists with bipolar disorder requires creativity



Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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WINTER 2007/08
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Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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Issued four times a year.

Annual subscriptions are \$16.00 in Ontario (\$8.03 for Ontario students, seniors, patients, clients, consumers and family members), \$26.70 in Canada and \$36.95 in the U.S. and internationally (includes shipping and handling and taxes).

Published by the Program Development Department
CENTRE FOR ADDICTION AND MENTAL HEALTH
A PAHO/WHO Collaborating Centre
Affiliated with the University of Toronto

Winter 2007/08
Vol. 11 No. 2
ISSN: 1481-3122

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#3608

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Winter Play, Louise Wiatrowski, watercolour on paper, 20" x 16"

Louise studied art at the American Academy of Art in Chicago and the Pratt Institute in New York. She worked as a wallpaper designer, children's book illustrator and animator.



CANADA

Early Years Conference 2008

January 31–February 2,
Vancouver, British Columbia
toll-free tel 1 877 328-7744
fax 604 822-4835
www.interprofessional.ubc.ca/Early_Years.htm

**International Society on Infant Studies
16th International Conference**

March 26–29, Vancouver, British Columbia
www.isisweb.org

**Society for Social Work Leadership
in Health Care 43rd Annual Meeting
and Conference**

April 2–5, Montreal, Quebec
Contact: 100 N. 20th St., 4th flr,
Philadelphia, PA 19103 USA
tel 215 599-6134
fax 215 564-2175
e-mail info@sswlhc.org
www.sswlhlc.org

**3rd National Biennial Conference on
Adolescents and Adults with Fetal
Alcohol Spectrum Disorder**

April 10–12, Vancouver, British Columbia
toll-free tel 1 877 328-7744
fax 604 822-4835
www.interprofessional.ubc.ca

**American Society of Addiction Medicine
39th Annual Medical-Scientific Conference**

April 10–13, Toronto, Ontario
Contact: ASAM, 4601 N. Park Ave., Upper
Arcade, Ste. 101, Chevy Chase, MD 20815 USA
tel 301 656-3920
fax 301 656-3815
e-mail email@asam.org
www.asam.org/AnnualMeeting.html

2008 World Congress for Psychiatric Nurses

May 22–24, Regina, Saskatchewan
Contact: Registered Psychiatric Nurses
Association of Saskatchewan,
2055 Lorne St., Regina, SK S4P 2M4
tel 306 586-4617
e-mail rpnas@rpnas.com
http://worldcongress.rpnac.ca

2008 National Social Work Conference

May 22–25, Toronto, Ontario
Contact: Ontario Association of Social Workers,
410 Jarvis St., Toronto, ON M4Y 2G6
tel 416 923-4848
fax 416 923-5279
e-mail info@oasw.org
www.socialworknationalconference2008.org

UNITED STATES

**22nd Annual San Diego International
Conference on Child and Family
Maltreatment**

January 28–February 1,
San Diego, California
tel 858 966-4972
e-mail sdconference@chsd.org
www.chadwickcenter.org

**International Neuropsychological
Society Annual Conference**

February 6–9, Waikoloa, Hawaii
Contact: INS, 700 Ackerman Rd., Ste. 625,
Columbus, Ohio 43202
tel 614 263-4200
fax 614 263-4366
e-mail ins@osu.edu
www.the-ins.org/meetings

**21st Annual Research Conference:
“A System of Care for Children's Mental
Health – Expanding the Research Base”**

February 24–27, Tampa, Florida
Contact: Research and Training Center for
Children's Mental Health, Department of
Child and Family Studies, Louis de la Parte
Florida Mental Health Institute, University of
South Florida, 13301 Bruce B. Downs Blvd.,
Tampa, FL 33612-3807
tel 813 974-4661
fax 813 974-6257
http://rtckids.fmhi.usf.edu/rtccconference

**Society for Research on Nicotine and
Tobacco 14th Annual Meeting**

February 27–March 1, Portland, Oregon
tel 608 443-2462, ext. 145
fax 608 443-2478
e-mail meetings@srnt.org
www.srnt.org/meeting/2008/index.html

**National Association of Clinical Nurse
Specialists Annual Conference**

March 5–8, Atlanta, Georgia
Contact: NACNS, 2090 Linglestown Rd.,
Ste. 107, Harrisburg, PA 17110
tel 717 234-6799
fax 717 234-6798
e-mail nacnsorg@nacns.org
www.nacns.org

**2008 International Counseling
Psychology Conference: “Creating
The Future – Counseling Psychologists
in a Changing World”**

March 6–9, Chicago, Illinois
e-mail conferenceplanner@icpc2008.org
www.internationalcounselingpsychologycon-
ference.org

**American Psychological Association
Work, Stress and Health Conference 2008**

March 6–8, Washington, DC
Contact: Wesley Baker, Conference
Coordinator, American Psychological
Association, Public Interest Directorate,
750 First St. N.E., Washington, DC 20002-4242
tel 202 336-6033
fax 202 336-6117
e-mail: wshconference@apa.org
www.apa.org/pi/work/wsh.html

**American Association for Geriatric
Psychiatry Annual Meeting**

March 14–17, Orlando, Florida
Contact: AAGP, Rachel Bieber,
7910 Woodmont Ave., Ste. 1050,
Bethesda, MD 20814
tel 301 654-7850, ext. 111
e-mail meetinginfo@AAGPonline.org
www.aagpmeeting.org

**Center for Psychiatric Rehabilitation
From Innovations to Practice
Conference: “The Promise and Challenge
of Achieving Recovery for All”**

April 14–15, Cambridge, Massachusetts
tel 617 353-3549
fax 617 353-7700
e-mail mfarkas@bu.edu or joanrapp@bu.edu
www.bu.edu/cpr/conference/index.html

**College on Problems of Drug
Dependence 70th Annual Meeting**

June 14–19, San Juan, Puerto Rico
e-mail ebgeiler@temple.edu
www.cpdd.vcu.edu

ABROAD

**14th Biennial Winter Workshop on
Schizophrenia and Bipolar Disorder**

February 3–7, Montreux, Switzerland
Contact: Congress Secretariat, Khim Schenk,
The Events Management Company,
Route de l'Ancienne Scierie, 10, 1263
Crassier, Switzerland
tel 41 22 369 2436
fax 41 22 369 2446
e-mail wwschiz@bluewin.ch
www.winterworkshop.org/lp/14WWreg/14W
Wreg?1=1

**2008 International Gambling Conference:
“Looking Forward – New Directions in
Research and Minimising Public Harm”**

February 21–23, Auckland, New Zealand
tel 64 9 921 9999, ext. 7232
fax 64 9 921 9877
e-mail maria.bellringer@aut.ac.nz
www.pgfnz.co.nz/2008conference

**International Society for Affective
Disorders 4th Biennial Conference**

March 14–17, Cape Town, South Africa
Contact: ISAD, Secretary WPA Section
of Affective Disorders, Institute of Psychiatry,
King's College London, P072 De Crespigny Park,
Denmark Hill, London SE5 8AF United Kingdom
tel 44 20 7848 0295
fax 44 20 7848 0298
e-mail enquiry@isad.org.uk
www.isad.org.uk//conference.asp

**3rd World Congress on Women's
Mental Health**

March 16–20, Melbourne, Australia
Contact: Waldron Smith Management,
61 Danks St. W., Port Melbourne VIC 3207
tel 61 3 9645 6311
fax 61 3 9645 6322
e-mail iawmhcongress2008@wsm.com.au
www.iawmhcongress2008.com.au

**16th World International Family
Therapy Association Conference: “Glob-
al Family and Globalizations – Family
Therapy in the 21st Century”**

March 26–29, Porto, Portugal
Contact: Paragon Conventions, 18 Avenue
Louis-Casaï, 5th flr., 1209 Geneva,
Switzerland
tel 41 22 747 7930
fax 41 22 747 7900
e-mail ifta08@paragon-conventions.com
www.paragon-conventions.com/ifta2008

**2nd International Conference of
the International Society for the
Study of Drug Policy**

April 3–4, Lisbon, Portugal
e-mail enquiries@issdp.org
www.issdp.org/conferences.htm

**18th World Congress of the International
Association for Child and Adolescent
Psychiatry and Allied Professionals**

April 30–May 3, Istanbul, Turkey
tel 90 312 454 00 00
fax 90 312 454 00 24
e-mail iacapap2008@flattour.com.tr
www.iacapap2008.org

**International Harm Reduction Association
19th International Conference**

May 11–15, Barcelona, Spain
Contact: Harm Reduction 2008, Conference
Consortium, 34 Bloomsbury St., London
WC1B 3QJ United Kingdom
tel 44 207 462 6997
fax 44 207 462 6999
e-mail info@ihraconferences.com
www.ihra.net/Barcelona/Home

EUROPAD 8 Conference

May 29–31, Sofia, Bulgaria
www.europad.org

**World Psychiatric Association Thematic
Conference on Depression and Relevant
Psychiatric Conditions in Primary Care**

June 19–21, Granada, Spain
tel 34 902 430 959
e-mail info@wpa2008granada.org
www.wpa2008granada.org

**6th International Congress of
Cognitive Psychotherapy**

June 19–22, Rome, Italy
Contact: FEDRA Congressi S.A.S.,
Via Achille Barilatti, 61, 00144 Rome, Italy
tel 390652247328
fax 39065205625
e-mail info@fedracongressi.it
www.iccp2008.com

**3rd International Conference
on Teaching Psychology**

July 12–16, St. Petersburg, Russia
e-mail info@ictp-2008.spb.ru
www.ictp-2008.spb.ru

14th European Conference on Personality

July 16–20, Tartu, Estonia
Contact: Secretary General of the ECP14,
Department of Psychology, University of
Tartu, Tiigi 78, Tartu 50410, Estonia
tel 372 7375902
fax 372 7376152
e-mail ecp14@ecp14.ee
www.ecp14.ee

**34th Biannual Congress of the
International Association of Schools
of Social Work**

July 20–24, Durban, South Africa
Contact: IASSW 2008 Congress, c/o Artful
Conference and Event Specialists, P.O. Box
30232, Mayville, 4058, Durban, South Africa
tel 27 31 261 5933
fax 27 88 031 261 5933
e-mail iassw2008@infosia.co.za
www.iassw2008.co.za

This issue of *CrossCurrents* focuses on early treatment for at-risk youth between the ages of 12 and 25. Early intervention is important because evidence shows that detecting and treating problems early leads to better outcomes. We all know that catching cancer in its early stages often means a better prognosis. The same holds for mental health and substance use issues. Early intervention promotes as full a recovery as possible and reduces the long-term disability and human and economic costs associated with mental health and substance use problems.

Given the importance of this phase of development, when psychological, social and vocational paths and independence are established, it is not surprising that mental health and substance use issues, however brief or mild, can derail development and limit a youth's potential. Untreated conditions lead to high rates of school failure, unstable employment and poor family and social functioning – realities that are much more difficult to change once they are entrenched.

A sad reality is that mental health and substance use problems are easily the key

health issue for young people in their teens and early 20s. The onset of mood, psychotic, personality, eating and substance use problems tends to occur between the early teens and mid-20s, and peaks in the early 20s. The prevalence of mental health and substance use problems is about 20 per cent among adolescents aged 13–17, and increases to about 27 per cent among young adults aged 18–24, the highest prevalence rates across the lifespan. Epidemiological data indicate that about 75 per cent of adults with a mental health issue experienced its onset by age 24.

The articles in this issue examine how early treatment and intervention can help youth stay on track. Nova Scotia social worker Michael Ungar opens with a discussion of how “delinquency” can be reframed as hidden resilience. Other articles examine treatment approaches to co-occurring first episode psychosis and substance use, eating disorders and depression. An article on mental health promotion outlines how clinicians and communities can integrate this perspective into early intervention with children and youth. The Q&A shows how a cultural adaptation of a family-based intervention is meeting the needs of Aboriginal youth and



families. The issue closes with a provocative piece that discusses ethical and practical challenges in early psychosis intervention.

Enjoy this stimulating issue. Send us your comments, suggestions and ideas. Write a letter to the editor expressing your thoughts on our stories. It is your input that furthers the dialogue around mental health and addiction issues.

Hema Zbogor
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a view from CAMH

Changing the trajectory. Those three words encompass much of the mission of early intervention programs in mental illness and substance abuse. We are all too familiar with the long-term sequelae of untreated and/or under-treated disorders – on our downtown street corners, on our disability support lists and in our egregious outcomes of those who have seen no better option in a dark moment than to kill themselves. While the literature on the brain impact of untreated illness is still evolving, the personal, familial and even societal impact needs little further elucidation.

And yet there is reason for hope. This issue of *CrossCurrents* highlights some innovative programs that should fuel our optimism – that these young people need not suffer the ravages of disorders in the ways that earlier generations have. Some of them will never see the inside of a traditional

psychiatric or addiction inpatient facility – for all the right reasons.

Part of early intervention often includes identifying populations at increased risk. Our concepts of risk must be broad, ranging from genetic vulnerability to early suggestive symptoms to poverty and psychosocial disadvantage – which may themselves be byproducts of stigma and discrimination.

These initiatives are part of a larger trend in health care toward early intervention. Children's hospitals now have lipid clinics with an aim to lowering adult atherosclerosis; biopsies, blood tests, dietary changes and the like are part of a more global effort to control one's body and one's destiny with regard to disease and mortality. But as we try harder and harder to intervene before problems are formally declared in

the traditional sense, the ethical issues loom large. Every diagnostic identification, every therapeutic intervention, carries the possibility of both error and risk. We must grapple with the ethical dimensions of what may intuitively seem like worthwhile efforts.

David S. Goldbloom, MD, FRCPC

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From boys to men: Health promotion helps youth make the transition

St. Margaret's Public School is just round the bend on a picturesque road in Scarborough, Ontario. The school is quiet as I enter. Most kids have dashed out after the school bell. But while it's peaceful now, Lew Golding knows how hectic it can get. As co-leader of an innovative value-based program aimed at students in their last year of elementary school, he has had to contend with the many demands of a classroom of 30 boys, many of whom live in single-parent homes and neighbourhoods endemic with crime and poverty.

"Teachers were saying, 'It's not possible to contain these guys for an hour,'" says Golding, who is manager of the Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY) at the Centre for Addiction and Mental Health in Toronto. "But the kids were engaged and focussed, and they absorbed the information from the program." Golding is referring to Passport to Manhood, a program developed by the Boys and Girls Club of America. The program aims to build positive values and provide role-modelling for adolescent boys making the important transition to teenhood.

Each session in the 14-week program covers different topics, such as substance abuse, dealing with authority and relationships. "They all tie into one goal – providing a basis for the boys to understand what being a true, representative man is," says Golding.

That's where Golding's work becomes so important. "The school is surrounded by public housing; there is a lot of visible crime, and in many cases some of these boys are challenged to engage in it," says Golding, as he ushers me over to a classroom window and points to a building behind the school. "At lunchtime, that staircase is where some kids hang out and get involved in ... situations," he says. "The distractions are ever-present, so we provide this program as a counterweight."

St. Margaret's principal, Jeannine Joubert, has witnessed the program's positive results. "The boys seemed to be validated as young men, as valid members of the community," she says. "The social dynamics within the group allowed less assertive boys to be heard within their comfort zone." Joubert says the program's impact can still be felt five months after the fact: "Emotional intelligence became more obvious in the boys after they completed the program."

"The boys face serious decisions such as whether to join a gang and issues of crowding, poverty and racism," says Joubert. "They also face the usual growing up issues of getting to know their talents, their purpose, their passion. Few of our students have male role models and this program provided that."

Passport to Manhood's interactive sessions rely strongly on role play and discussion. In fact, Golding says, the program has increased the amount of role play because it was so popular with students. At a follow-up interview session with four boys who attended the program, all four agreed that the role play elements stayed with them the most. As for what they enjoyed the most or found to be most useful, two boys cited the visual aid that mapped out drugs, their effects and their street names, and the other two mentioned role playing.

"The boys face very serious decisions such as whether to join a gang and issues of crowding, poverty and racism. They also face the usual growing up issues – getting to know their talents, their purpose, their passion"

But while Golding believes Passport to Manhood is useful in building positive values among youth who might be at a socio-demographic disadvantage, he concedes that the program cannot help all youth. "One boy was dismissed because he developed a reputation for trying to control the school," he says. "We had a session on youth violence and gangs and he would shoot looks across the room that restricted students who were fully engaged through these subtle threats of violence." At first Golding and his co-leaders worked to include the boy in the program, but eventually they had to confront the issue head-on. "We had to decide whether it was in the best interest of the group to keep him and lose time trying to keep him on track or to

maintain this resource for the other 30 or so boys. When we decided he was no longer invited, it was like a cloud was lifted off the group."

As the follow-up session draws to a close, we all stand and Golding extends his hand. The boys, grinning, each take turns shaking his hand and looking him in the eye – a ritual Golding calls "the Man-shake," which he included at the close of each session to reinforce the relationship between him and the students, and as a physical reminder of their emerging role as decision makers in their own lives. It's a moment the boys obviously relish, and one that Golding sees as particularly important: "Each week during the program, the Man-shake became more firm. The stronger it was, the more we believed the boys to be connecting with the materials and gaining confidence."

Although the program at St. Margaret's has now wound down, SAPACCY plans to partner with other youth service providers to offer it in other communities, once feedback from focus group participants has been integrated and funding has been secured.

At a time in their lives when the lure of criminal activity and rebellious attitudes towards authority figures are reinforced by the neighbourhoods in which they live, confidence, Golding believes, is key. Through Passport to Manhood, Golding is betting that prevention now can ensure that the same kids who shake his hand won't be those he meets at his clinical office in a few years, under very different, and more difficult, circumstances.

Dan Werb

Family physicians get tool to tune in to adult ADHD

KIM GOGGINS

When Denise Difede was in high school, she could never understand why her notebooks weren't as neat as the other girls', why her locker was a disaster, why every plan to start a project early inevitably fell through. "I've always felt not quite in with the rest of the world," says the 45-year-old receptionist. "As I matured, I still had problems with organization and procrastination – starting a project and never finishing it, missing appointments, not writing things down. I was completely disorganized."

It wasn't until four years ago, when her three children were diagnosed with attention deficit/hyperactivity disorder (ADHD), that Denise realized she might also have the condition, characterized by hyperactivity, impulsivity and concentration difficulties. An assessment by a psychiatrist confirmed her suspicion.

Difede is one of the "lucky" ones, because her children's psychiatrist agreed to treat her, and her family doctor became involved. Dr. Umesh Jain, chair of the Canadian ADHD Resource Alliance (CADDRA) in Toronto, says the situation for most adults with ADHD is critical because few psychiatrists and family physicians are prepared to diagnose and treat them. Yet about four per cent of adults have ADHD, according to a study published in a 2006 issue of the *American Journal of Psychiatry*.

To combat the problem, CADDRA recently released the 2007/2008 Canadian ADHD Practice Guidelines (CAP-G), which help family doctors diagnose and treat ADHD and monitor progress.

While males are frequently linked to the hyperactive, impulsive symptoms of ADHD, females, like Difede, tend to be quiet daydreamers and often go undiagnosed because they are not disruptive. As teens become adults, hyperactivity and impulsivity decrease, but problems related to concentration and organization may become more debilitating as the demands of adult life increase. "Many adults feel an internal restlessness all the time versus outward hyperactivity," says Heidi Bernhardt, national director of CADDRA and the Centre for ADD/ADHD Advocacy, Canada.

The lack of resources for those with ADHD is a serious problem. "There are not enough child psychiatrists to see the children, let alone this huge population of adults," says Dr. Derryck Smith, former head of psychiatry at B.C.'s Children's Hospital in Vancouver. "Until about five years ago, adult psychiatrists did not even recognize that adult ADHD exists, even though they were seeing these patients."

Detecting and treating adult ADHD can also be challenging because it is often accompanied by comorbid conditions. In fact, research has found that between 80 and 90 per cent of adults with ADHD have comorbid conditions such as depression, anxiety or substance use problems, which can translate into misdiagnosis and ineffective treatment if ADHD isn't worked into the equation. "I get many calls from adults who have been seeing psychiatrists or family doctors or psychologists for years to treat their anxiety or depression," says Bernhardt. "Frequently, these people have years of therapy or medication with no success because the underlying cause isn't being treated."

"People with ADHD should be primarily treated by their family doctors, but the problem is that family doctors are very poorly trained," says Smith, who is now in private practice. "Many family doctors don't feel comfortable managing children with ADHD, and feel out of their depth treating adults."

That's where CAP-G comes in. CADDRA's aim for 2008 is to train more physicians to use the guidelines. More emphasis on adult ADHD in medical school curricula is another goal, as well as educating other people who commonly see adults with the condition, such as teachers, who often consult with parents about their children's behaviour.

Through the development of a national continuing medical education project, 200 more psychiatrists will also be trained in adult ADHD so they can then teach physicians. "If you don't train more psychiatrists, you can't then train the family doctors," says Jain, who is a psychiatrist at the Centre for Addiction and Mental Health in Toronto. "If psychiatrists make better diagnoses, family doctors will accept the diagnoses and continue the

What does adult ADHD look like?

According to Dr. Thomas E. Brown of the Yale University School of Medicine, ADHD involves a developmental impairment of executive function, which involves skills used in planning, selective attention, motivation and impulse control. Adults with ADHD have problems in six major areas:

- Activation** – Problems with organization, prioritizing and starting tasks.
- Focus** – Problems with sustaining focus and resisting distraction, especially with reading.
- Effort** – Problems with motivation, sustained effort and persistence.
- Emotion** – Difficulty regulating emotions and managing stress.
- Memory** – Problems with short-term memory and memory retrieval.
- Action** – Problems with self-control and self-regulation.

There are three subtypes of ADHD: predominantly inattentive, predominantly hyperactive/impulsive and combined. In adults, **hyperactivity** is characterized by an inability to relax, restlessness and nervous energy and talking excessively. **Impulsiveness** involves volatile moods, blurting out rude or insulting remarks and interrupting others. **Inattentiveness** is characterized by "tuning out" unintentionally, inability to focus on mundane tasks and constantly losing and forgetting things.

Source: Centre for ADHD/ADD Advocacy, Canada

medication and lifestyle strategies for dealing with ADHD. As doctors get familiar with ADHD, they'll start making their own diagnoses."

As director of the Toronto-based Attention Deficit Resource Network, Difede knows she is fortunate to have help. She recalls many times she has witnessed clients in tears because they have nowhere to turn.

"The most frustrating thing is that treatment will turn people's lives around," says Jain. "If you give them the right medications, the right intervention strategy, it makes a profound difference. You can help people in a very short period of time." ■

THE MAD GENIUS

Treating artists with bipolar disorder requires creativity

KAREN SHENFELD

“Darling, all night I have been flickering, off, on,” wrote American poet Sylvia Plath in the central stanza of “Fever 103.” In this poem, as well as in others published in her final collection, *Ariel*, Plath used violent images to evoke the landscape of an anguished mind. She composed these poems in the early winter of 1963, in a frenzied burst of productivity that came amid a period of despair. Then, on February 11, after sealing off her apartment kitchen so her two children would not be harmed, she took a bottle of sleeping pills and stuck her head in a gas oven.

The tragic details of Plath’s death are as well known to readers of literature as her famous poems. They have also strengthened the popular notion that there is a correlation between mental illness and creativity. Research has indeed shown evidence of a correlation, more specifically, that creative people have a higher rate of bipolar disorder than do members of the general population.

The list of modern artists who have been diagnosed with the disorder – which features extreme mood swings from mania to depression – includes writer Ernest Hemingway, painter Jackson Pollack, film director Francis Ford Coppola, comedian Robin Williams and humourist Art Buchwald. Biographical accounts strongly suggest that Michelangelo, Vincent van Gogh, Edvard Munch, Virginia Woolf, Edgar Allen Poe and Hans Christian Andersen could also be added to the list.

The higher prevalence of bipolar disorder among creative individuals was first empirically observed in the research of neuroscientist and psychiatrist Dr. Nancy Andreasen.

Beginning in 1974, Andreasen compared the mental health of 30 writers who had been leaders of the University of Iowa’s Writers’ Workshop program with that of a control group. Andreasen followed these writers for 15 years. She found that 43 per cent had bipolar disorder, compared to only 10 per cent in the control group.

*“If my devils were to leave me,
I am afraid my angels will take
flight as well”*

– German poet Rainer Maria Rilke

More recently, John Hopkins University psychologist Dr. Kay Redfield Jamison surveyed 47 eminent British visual artists and writers, questioning them about their mood states and treatment history. She found that 38 per cent of had sought treatment for mood disorders, a rate roughly 30 times greater than that found in the general population. In a radio broadcast with National Public Radio in 2005, Jamison, who herself has bipolar disorder, stated: “Intense experience and suffering instruct us in ways that less intense emotions can never do.”

Not all experts agree on the connection. “There is no scientific proof of the link between bipolar disorder and creativity,” says Dr. Albert Rothenberg, a psychiatrist at Harvard University. In a 2001 issue of *Psychiatric Quarterly*, Rothenberg argues that studies by Andreasen and Jamison show “serious flaws in sampling, methodology, presentation of results, and conclusions.” He is also critical of more recent studies conducted by scientists

at Stanford University. That team assessed levels of creativity and temperamental differences in individuals with bipolar disorder or unipolar major depressive disorder, comparing them to controls.

“Our studies have shown evidence of the relationship between bipolar disorder and creativity and that the relationship may be mediated in part through temperament,” says Dr. Terence A. Ketter, a member of the Stanford team.

The team’s results have been published in four articles in 2005 and 2007 in the *Journal of Affective Disorders*. Rothenberg, however, questions the scientific validity of the team’s definition of creativity and of the tools used to assess creativity. “The cultural zeitgeist has swung towards the romanticization of abnormality,” he argues. “It’s important for artists with bipolar disorder to know that their illness does not facilitate their creativity.”

Teresa Hsu is an artist in northern California. Her delicate watercolours, featured here, depict natural objects – beach stones, fallen leaves, flowers and fruits. “Being bipolar *has* enhanced my urge to make art,” she says. “It has heightened my artistic sensitivity, especially to colour. One of my manic episodes occurred during the autumn,” she relates. “I remember looking at the leaves of the trees and seeing their reds as so vibrant. I had the urge to create constantly. I was making 10 to 20 paintings a day.”

But Hsu concedes that mania can cloud one’s judgments. And she adds, “My depressions take me to a very dark place.”

The highs and lows of bipolar disorder can indeed be debilitating. Manic episodes

Artwork by Teresa Hsu

can feature severe anxiety, rage and psychosis. Periods of depression can include suicidal ideation. In fact, 10 to 15 per cent of people with bipolar disorder die by suicide, compared to one per cent of the general population.

Despite the severity of the disorder, creative people may be hesitant about first seeking, and then continuing, treatment. Some complain that psychotropic medication makes them feel drugged, lethargic and restless, leading to intellectual disturbances, lack of concentration and memory problems. Hsu says, "When I was first hospitalized for depression, my biggest fear was being drugged into a haze. I had a terrible reaction to the first medication they put me on. It made me feel even worse."

Experts agree that treating creative people poses clinical challenges. "Medications, per se, don't cause trouble, but creativity can be hindered if you medicate people to the point that their emotions or cognitive abilities are blunted," says Ketter.

Rothenberg agrees: "High levels of cognitive capacity are required for creative activities. A major treatment issue for creative persons with bipolar disorder is the risk of cognitive impairment."

Widely prescribed since the 1970s, lithium carbonate remains "the standard and best drug for treating bipolar disorder," says Rothenberg. "But for treating creative people, who need their full capacities to do their work, the best alternative may be lamotrigine, a newer anticonvulsant that has also been shown to control the shifting from mania to depression." Other prescribed anticonvulsants include carbamazepine and

valproate. "These medications may be effectively used alone or in combination with lower, and consequently less impairing, doses of lithium" says Rothenberg.

Rothenberg feels that artists, who tend to be self-reflective, can also gain special benefit from psychotherapy. He favours longer-term, insight-building psychodynamic therapy, which he believes is intrinsically appealing to creative people and provides the most lasting results. Ketter, on the other hand, supports briefer cognitive-behavioural therapies that directly address the symptoms of bipolar disorder. He also recommends dialectical behavioural therapy (DBT), originally developed to treat borderline personality disorder. "DBT can give creative people with bipolar disorder techniques to be mindful of their emotional experiences and to channel those experiences in productive ways."

Dr. Ron Ruskin, a psychiatrist at Toronto's Mount Sinai Hospital, cautions: "Creative people are often highly intelligent, sensitive and observant. They will be continually evaluating their healers. When treating an artist with bipolar disorder, the therapist should be able to empathize with the patient's experience to develop a positive rapport and trust."

As an artist, as well as a psychiatrist, Ruskin is acutely aware of his patients' stressors and lifestyles. Artists often have to promote their own work and face continual rejection and financial strain. "Artists may be staying up all night to write or paint and not make time to eat, sleep or exercise," Ruskin says. "Therapists can help creative patients set up healthier schedules." If patients wish to show or discuss their art or writing or music

in therapy sessions, Ruskin is willing to let them do so. "Art is a crucial way that artists express themselves, so I wouldn't want to close the door on that opportunity," he says. "However, if patients only want to talk about their work, a therapist may have to set limits."

But treatment doesn't mean limiting artists' talents and potential. Jim Allen is an award-winning Canadian photographer who has focused his lens on such eminent Canadians as Adrienne Clarkson, Margaret Atwood, John Candy and Wayne Gretzky. In his spare time, he paints, plays jazz piano and is writing a book about his experience with bipolar disorder. No matter how he's feeling, working on his art acts as a stabilizer. "Through therapy, I've recognized that I have been given the gift of creativity," says Allen. "The best way to cope with bipolar disorder is to work to develop my gift, in conjunction with taking medication." ■

Reading and resources

Creativity and Madness: New Findings and Old Stereotypes, by Albert Rothenberg (Johns Hopkins University Press, 1990)

Strong Imagination: Madness, Creativity and Human Nature, by Daniel Nettle (Oxford University Press, 2001)

The Price of Greatness: Resolving the Creativity and Madness Controversy, by Arnold M. Ludwig (Guilford Publications, 1995)

Touched with Fire: Manic Depressive Illness and the Artistic Temperament, by Kay Redfield Jamison (Free Press, 1996)

Family-based treatment shows promise for teens with bulimia

A recent study from the University of Chicago has found family-based treatment (FBT) to be more effective than supportive psychotherapy (SPT) in treating teenagers with bulimia nervosa. Researchers conducted a randomized controlled trial of 80 patients aged 12 to 19 years. Forty-one were assigned to FBT and 39 to SPT. Participants were included in the study if they binged and purged at least once a week over a period of six months and met other DSM-IV criteria for bulimia. FBT focused on helping parents disrupt their children's bingeing, purging and restrictive dieting and on helping teenagers address underlying problems believed to be responsible for their bulimia. At the end of treatment, 39 per cent of FBT participants were no longer bingeing and purging compared with only 18 per cent of SPT participants. At six-month follow-up, these abstinence rates had declined, with 29 per cent of FBT participants and 10 per cent of SPT participants still abstinent from bingeing and purging. The FBT group also showed an advantage in terms of the number of participants who experienced a partial remission of bulimia symptoms. At the end of treatment, the FBT group showed a greater reduction than the SPT group in vomiting, compensatory behaviours and restraint, although this advantage largely disappeared by the six-month follow-up. The authors express some concern with the relatively low overall abstinence rates and say their results "highlight the challenge in achieving successful treatment for most patients with [bulimia nervosa]."

Archives of General Psychiatry, September 2007, v. 64: 1049–1056. Daniel le Grange et al., Department of Psychiatry, University of Chicago, Chicago, Illinois.

Genetics influence effectiveness of bupropion treatment for smoking

New research from the University of Toronto demonstrates that variations in a particular gene help to determine whether smokers are able to quit smoking using the drug bupropion. The gene in question, CYP2B6, metabolizes both nicotine and bupropion and is genetically variable. Researchers genotyped 326 individuals who smoked at least ten cigarettes a day, of whom 147 (45%) had the CYP2B6 *6 variant of the gene and 179 (55%) had the CYP2B6 *1 variant. Participants then received ten weeks of treatment with either bupropion or placebo. In the CYP2B6 *6 group, those receiving bupropion had significantly higher abstinence rates at the end of treatment than those given placebo (33% vs. 14%) and this advantage was maintained after the six month follow-up (31% vs. 13%). No such advantage was observed in the CYP2B6 *1 group, where the abstinence rates were 31 per cent for bupropion compared with 32 per cent for placebo at end of treatment, with both declining to 22 per cent at the six month follow-up. Notably, the abstinence rates on placebo for this group were comparable to those achieved with bupropion for the CYP2B6 *6 group at the end of treatment, but were lower than those of the CYP2B6 *6 group at the six month follow-up. These findings suggest that individuals with the CYP2B6 *6 variant can benefit substantially from treatment with bupropion. While individuals with the CYP2B6 *1 variant derived no such benefit, their abstinence rates on placebo were already surprisingly high and they may further benefit from alternative therapies.

Biological Psychiatry, September 15, 2007, v. 62: 635–641. Rachel Tyndale et al., Neuroscience Department, Centre for Addiction and Mental Health, Toronto, Ontario.

Clinicians don't always adhere to guidelines in treating depression

Primary care clinicians often fail to adhere to clinical guidelines for depression, according to the RAND Health Program in Santa Monica, California. Researchers used data from three randomized clinical trials conducted as part of the Quality Improvement for Depression (QID) collaboration between 1996 and 1998. The "studies involved 1,131 primary care patients with major depression or dysthymia (low-grade depression) at 45 primary care practices in the United States. Clinicians in the QID studies were encouraged to provide collaborative care for patients. Results were based on patients' self-reports. More than 70 per cent of clinicians were able to identify depression and provide adequate follow-up in the initial months of treatment. However, only 46 per cent of patients received the minimum treatment with antidepressants (at least two months) or psychotherapy (at least four visits). When patients failed to respond to treatment, just 38 per cent had their psychotherapy or antidepressant treatment changed. Among patients with panic disorder or alcohol dependency symptoms, only 30 per cent were referred to an appropriate specialist. Suicidality was assessed and given appropriate treatment in only a quarter of all cases. A mere 26 per cent of elderly patients completed a minimal course of treatment. The authors indicate a need for clinicians to improve the detection and management of patients who respond poorly to treatment, to collaborate more with mental health specialists and to make greater efforts to ensure patients complete treatment.

Annals of Internal Medicine, September 4, 2007, v. 147: 320–329. Kimberly A. Hepner et al., RAND Health Program, Santa Monica, California.



Alcohol dependency link to interpreting negative emotions

People with alcohol dependency display diminished brain activity in response to displays of negative emotions, according to research from the National Institute on Alcohol Abuse and Alcoholism in Bethesda, Maryland. Eleven individuals with alcohol dependency and 11 controls were asked to rate the intensity of emotions seen in images of faces displayed on a computer screen. The images showed expressions of happiness, sadness, anger, fear and disgust. While participants performed this task, researchers used functional magnetic resonance imaging to measure brain blood oxygen level dependent (BOLD) responses. Both participants with alcohol dependency and controls showed comparable accuracy in their ability to identify the intensity level of emotional expressions. However, participants with alcohol dependency showed less overall brain activity (BOLD response) during these tasks, and this was particularly evident in the rostral affective division of the anterior cingulate cortex (ACC). During the evaluation of facial expressions showing fear, disgust and sadness, participants with alcohol dependency showed significantly less brain activity than controls in the ACC. The only time participants with alcohol dependency showed significant activation was when evaluating angry facial expressions, and in these cases, BOLD responses were comparable to those of controls. Participants with alcohol dependency as well as controls showed comparable overall BOLD responses when evaluating happy facial expressions. The researchers suggest that since negative facial emotions provide people with important cues for flight or avoidance, difficulty in interpreting them may play a role in the difficulties in social interaction and communication common among people with alcohol dependency.

Alcoholism: Clinical and Experimental Research, September 2007, v. 31: 1490–1504. Jasmin B. Salloum et al., Laboratory of Clinical and Translational Studies, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Bethesda, Maryland.

High stress reactivity in infants of mothers with depression

Teenage mothers who exhibit symptoms of depression and overcontrolling behaviour toward their offspring are more likely to have infants with high levels of stress reactivity, according to research from Toronto General Hospital. The study examined 212 four-month-old infants of teenage mothers during a laboratory visit. Sixty-two of the infants (32%) had a mother with a diagnosis of major depression, and 20 per cent of these mothers had an episode of major depression during pregnancy. Cortisol levels in the infants' saliva were measured before and after infants were stressed by having their arms restrained for brief periods of time. The infants of mothers with depression exhibited significantly lower cortisol levels on arrival at the laboratory compared with infants of mothers with no history of depression. Moreover, the former showed a significant increase in cortisol levels after being stressed. Given that postpartum depression had no effect on infants' cortisol levels, these results lend some support to the theory that depression can be transmitted biochemically from mother to infant. In addition, the researchers found normal initial cortisol levels among infants of mothers who displayed overcontrolling behaviour with their offspring, but they did see a significant increase in those cortisol levels after the infants were stressed. Future research could help to determine whether the increase in cortisol levels is stable over time. The authors also recommend further research to determine whether these infants are vulnerable to stress-related mental illness later in life.

Journal of Clinical Psychiatry, September 15, 2007, v. 62: 573–579. Rima Azar et al, University Health Network, Women's Health Program, Toronto General Hospital, Toronto, Ontario.



Cocaine use linked to low education

Cocaine use has declined significantly among the well educated over the last 25 years, but its use has remained constant among people who are poorly educated, according to researchers at Johns Hopkins University in Baltimore, Maryland. Their findings were based on analysis of data on educational achievements and cocaine use among American adults aged 19 to 50 from 1979 to 2002 in the National Survey on Drug Use and Health. In the 1970s and early 1980s, the high price of powder cocaine limited its use, but the advent of inexpensive crack cocaine after 1985 led to an explosion of cocaine use among the urban poor. Persistent cocaine use was initially lowest among high school dropouts, and remained relatively constant over the course of the survey. Persistent use was initially highest among college graduates, peaking in 1982, then declining dramatically and falling below the rates for high school dropouts. High school graduates also saw their rates of persistent cocaine use fall below the rate for non-high school graduates, with the decline beginning in 1985. These findings are consistent with the idea that people who are well educated are more able to understand the risks of unhealthy behaviours and have the resources to protect themselves and modify their behaviour. The researchers state that the results also point to the need for intervention programs that better target persistent cocaine users with limited education.

American Journal of Public Health, October 2007, v. 97: 1790–1793. Valerie S. Harder and Howard D. Chilcoat, Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland.



Telephone outreach effective in treating depressed employees

Researchers with the National Institute of Health in Bethesda, Maryland, have found that a telephone outreach program can provide cost-effective treatment for employees with depression. They initiated a randomized controlled trial involving 604 depressed employees covered by a managed behavioural health plan. Of these, 304 employees were enrolled in a telephone outreach and care management program, while the remaining 300 entered usual care, receiving services normally available to workers. Those in the telephone care program were encouraged to undergo either psychotherapeutic or antidepressant therapy, and those who refused were given cognitive behavioural psychotherapy over the phone. Depression severity was measured at six and 12 months. At six months, 18 per cent of those in the telephone intervention group reported recovery, compared with 13 per cent of the usual care group. At 12 months, this advantage had increased, with a 26 per cent recovery rate in the intervention group and an 18 per cent rate in the usual care group. The intervention group also reported a significant advantage over the usual care group in improvement of depressive symptoms. They were more likely to retain their jobs and, on average, worked two hours more per week than workers in the usual care group. The authors estimate that the annual value of the increase in hours worked among intervention participants to be an average of \$1800, greatly exceeding the \$100 to \$400 cost of the telephone outreach and care.

Journal of the American Medical Association, September 26, 2007, v. 298: 1401–1411. Philip S. Wang et al, Division of Services and Intervention Research, National Institute of Mental Health, Bethesda, Maryland.

Hidden pathways to resilience

How “delinquent” behaviour can be a good thing

BY DR. MICHAEL UNGAR

TORRIN TAKES UP SPACE. YOU NOTICE HIM WHEN he enters the classroom the two or three times a week he attends. Some students give him high fives; others shrink into their seats as he passes on the way to his desk in the back corner. Torrin is big – six-foot-three, 15-years-old. Everyone knows him including the police. He fights; he drinks; he smokes weed. He steals cars for money. He impresses everyone with his talent for getting in trouble. Only when he is sitting in class, his shoulders hunched over a tattered exercise book, does he look like the child he still is.

Torrin's delinquency and substance abuse are not without cause. Understood as a set of strategies to cope with an environment that presents Torrin with limited opportunities, his navigations through his community are best seen as reasonable adaptations. If we talk with Torrin, we'll hear that he is doing the best he can with what he's got. That means coping with a chaotic home life, a learning disability, multiple moves and the quiet neglect of two parents trying to keep their own lives together.

Current trends in counselling have seen a convergence of concepts that can help us work better with young people like Torrin. Resilience, strengths-based interventions, positive psychology, developmental assets and theories of thriving are combining to shift our emphasis towards young people's capacities to adapt and how youth make good use of limited resources. The focus needn't be on their problems alone.

Surveys of young people's strengths cluster capacities into internal and external resources. Work by Resiliency Canada shows that the more assets a child has, the more likely he or she is to develop pro-social behaviours. International studies, however, show that children's development of strengths is not linear. The turmoil of junior high school, for example, has been shown to deplete both internal resources like self-esteem and external resources like quality relationships with parents.

Resilience is an umbrella concept that accounts for positive developmental outcomes among children exposed to complex patterns of risk and the processes that protect children from developing badly when exposed to adversities like poverty and abuse. We once thought resilience was mostly an individual's capacity to survive and thrive. Thankfully, the term has been wrestled back from the neoconservative right who were looking for an excuse to put all the blame for Torrin's failings on Torrin.

Resilience is better understood as a balance between an individual's capacity to navigate resources and his or her environment's capacity to provide those resources in meaningful ways. Young people only take advantage of opportunities that mean something to them. Internalized mental schemas, reflecting culture and values, play a big part in what young people say they need to make their lives better.

Understanding Torrin's behaviour is easier when we look for signs of adaptation within a challenging environment – his hidden resilience. After all, Torrin occasionally attends school. He values the opinions of those around him (an audience to the stories he likes to tell about himself). He is goal directed, even if those goals are mostly antisocial. He maintains a sense of self-esteem through his problem behaviour. He likes showing off his strength and enjoys bragging about how much he can drink and smoke. Though he might deny it, he wants adults to notice him.

Torrin's hidden resilience is the place to begin if we as counsellors want to engage him in helpful conversations. What story does Torrin tell himself when he looks in the mirror? Who does he see? Someone strong? Respected by his peers? Feared?

If our goal is to help Torrin change, we must first understand that he secures through his behaviour access to four key messages: “You belong,” “You're trustworthy,” “You're capable” and “You're responsible.” That Torrin hears these messages through his delinquency and self-harming behaviours shouldn't lead us to think he is necessarily failing. On the contrary, the challenge is to find sufficiently powerful substitutes to help Torrin hear these messages in socially acceptable ways.

In this sense, resilience is related to the opportunities young people like Torrin experience. The power of intervention is that it can provide youth with alternative paths to powerful identities. But the new stories they tell must be as powerful as those they leave behind.

Those stories aren't as difficult to create as one might think, though often they require convincing people to change their perceptions of youth like Torrin. With some help from his community, Torrin has found part-time work as a labourer. And because of his size, he has been asked to help monitor the door at a late-night facility where young people play basketball. At school, he is enrolled in a carpentry class where he and six other students are building a shed that will be auctioned off at a school fundraiser.

Torrin also sees a social worker at school, dropping by now and again to talk. By her office door she has wisely placed a mirror. Each time Torrin leaves, he glances at himself. Though Torrin never says anything as he walks away, his social worker has been wondering lately if he sees anything in the reflected image that he likes. Likes better than what he saw before. ■

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Double whammy

When early psychosis and substance use go hand in hand

BY ANNE PTASZNIK



IN JULY 2006, PAUL HUMPHREYS LEFT HIS TORONTO home and walked to a subway station an hour away. He boarded a train, but fearing that some passengers were going to attack him, he jumped off, crossed the platform and dove onto the tracks, breaking his glasses and cutting his head open. Fortunately, no trains were coming. The police took Paul to a local hospital he had visited several times previously. The 23-year-old was also using drugs – primarily cocaine, but also marijuana, alcohol and ecstasy.

Paul's experience with substances is not unusual among individuals experiencing a first episode of psychosis. According to the Canadian Mental Health Association, first-episode psychosis (FEP) – with a lifetime prevalence of about three per cent – typically occurs in a person's late teens or early 20s – a time when many young people use alcohol and other drugs.

Research has shown that early intervention for psychosis reduces psychotic symptoms and hospital readmissions; however, the complex issues involved in co-occurring substance use and psychosis can make detection, diagnosis and, ultimately, treatment and recovery particularly challenging.

Indeed, clinical research has found that substance use during psychosis increases negative outcomes, including treatment non-adherence, relapse, rehospitalization, poorer social functioning and higher treatment costs. Alcohol can interact with antipsychotic medication, compounding the medication's sedating effects and exacerbating depression.

Given these risks, it makes sense that identifying and reducing substance use and abuse should be a key target for early psychosis intervention services.

Cannabis and alcohol are the most commonly used substances among young people with FEP. A 2007 study in *Acta Psychiatrica*

Scandinavica found that 33 per cent of its sample, with an average age of 25, met DSM-IV criteria for cannabis abuse or dependence and 35 per cent met criteria for alcohol abuse or dependence. Some first episode programs report that more than 80 per cent of clients use substances.

Various hypotheses have been developed to explain these high rates of substance use. One theory suggests that substances are used to self-medicate early symptoms of psychosis. Another theory posits that substances trigger psychosis in individuals with an underlying vulnerability. According to a third theory, some common variable underlies both substance use and psychosis.

Although causality is still debated, a growing body of evidence, such as that summarized in a 2007 issue of *Current Psychiatry Reviews*, shows that substance use, in the review's case, cannabis, in combination with genetic or environmental factors exerts a causal influence on the onset of psychosis in individuals at risk. "There is now consistent evidence that cannabis use, particularly heavy use in early adolescence, increases risk of psychosis by as much as 40 per cent," says Dr. Heather Milliken, until recently director of the Nova Scotia Early Psychosis Program in Halifax.

But detecting the signs that something is wrong can be difficult. Milliken says that changes in behaviour that signal early psychosis are often attributed to the ups and downs of adolescence or to drug use and may not be recognized as indications of a psychotic disorder.

Other experts agree: "Many times families think in the early stages of psychosis that their kids are stoned when their behaviour mimics what look like negative symptoms," says Sabrina Baker, a family worker with the Centre for Addiction and Mental Health's (CAMH) First Episode Learning Employment Advocacy Recreation Network (LEARN) program in Toronto, which provides social, educational and vocational support for individuals with FEP. Negative

symptoms include social and emotional withdrawal, flat affect and low energy. Positive symptoms include hallucinations, delusions and thought disorders.

Some drugs, such as amphetamines and cocaine, can cause a condition known as drug-induced psychosis. This psychosis can last up to a few days and is often characterized by hallucinations, delusion, memory loss and confusion. It usually results from prolonged or heavy use and responds well to treatment.

Experts advise that young people who experience changes in functioning, such as difficulties at school or becoming increasingly isolated, and who exhibit persistent and worsening odd behaviours or preoccupations with bizarre ideas should be referred for assessment.

Paul: I'd go to work, get paid and then go and do drugs. When I ran out I'd go back to work again ... I think my dad might have known a bit. I stayed in my room, played a lot of computer games, tried to hide it.

Because psychosis is a phased illness, it is sometimes only in retrospect that families recognize the early signs (see sidebar). Corrine, Paul's 32-year-old sister, says the entire family was affected by their mother's death in 1985, leaving their father with four young children to raise; but while the other siblings were social and active, Paul was different. He kept to himself, had school difficulties and did not get involved in sports or other activities. He began smoking cigarettes, progressed to marijuana and then other drugs.

Paul: I went to see my sister one day. I didn't have any shoes on. I believe I was in bare feet. I was just kind of not thinking straight.

A few days after Paul's subway jump, Corrine drove Paul to the emergency department at CAMH, where he was admitted and later transferred to the inpatient Early Psychosis Unit, where he remained for about two months. More recently, he entered the outpatient First Episode Psychosis Clinic.

Dr. Donald Addington, head of psychiatry for the Calgary Health Region in Alberta, says the key to treatment is to address psychosis and substance use issues simultaneously. Most FEP programs assess for substance abuse and then integrate treatment into individual and group counselling, family intervention, cognitive-behavioural therapy, psychoeducation and wellness or recovery groups. Clients who do not respond to integrated treatment are usually referred to substance use programs in the community.

Taking a psychoeducational harm reduction approach is critical. Milliken says that if staff come on too strong, about drinking, for example, it makes building the therapeutic alliance more difficult. It also means that when clients start feeling better and resume socializing, they may stop taking their medication or may not be honest about using substances.

Baker uses expressive arts to help clients explore positive activities. "Often people's lives have broken down and it's important to have something to wake up for," she says. "The arts can inspire a freedom of self-expression that can be healing and transformative."

Corrine: When Paul was in the hospital, we put everything on hold – school, work, our social lives. It was all for Paul, but we needed to do it for ourselves, too, to try to start a family healthy from the start.

FOUR PHASES OF FIRST EPISODE PSYCHOSIS

Prodromal phase

This period prior to the development of psychotic symptoms features early warning signs, especially negative symptoms, which reflect an absence or distortion of normal functions. These prodromal indicators, for example, mood swings and appetite changes, may be difficult to distinguish from transient states associated with developmental or life stages and circumstances. These indicators take on greater meaning as prodromal indicators if the person experiencing them is at higher risk due to their family or developmental history. Not everyone experiences a prodrome.

Acute phase

This phase is characterized by positive symptoms, which reflect an excess or distortion of normal functions, including hallucinations, delusions and thought disorder. It is usually during this phase that the person presents for treatment. Treatment goals include resolving the psychosis, preventing or treating accompanying conditions such as substance abuse and promoting adjustment and psychosocial recovery.

Early recovery phase

This phase constitutes the first six months following acute treatment. The focus is on developing a psychosocial framework for further recovery as positive symptoms recede. Interventions include individual and family counselling and other cognitive and skills-based therapies.

Late recovery phase

This phase follows the early recovery phase for six to 18 months. Decisions must be made about length of maintenance medication and other treatment supports. The goal is to continue to promote full recovery and prevent relapse. Relapse rates of 50 per cent within 10 months following the end of medication have been reported for first episode cases.

Source: Fraser South Early Intervention Program

Family intervention is another evidence-based best practice for FEP. A study published in a 2005 issue of *Schizophrenia Research* looked at family members participating in family counselling and a short-term family group at the Calgary Early Psychosis Program. Clients showed significant reductions in moderate levels of stress in the first year; those with more severe stress showed improvement in the second year.

Paul's father and two siblings attended LEARN's family psychoeducational group, which Baker facilitates. Families learn about psychosis, including medications, side-effects, symptoms, treatment and relapse. They learn how substances, stress and other factors can trigger psychosis in a person with an underlying vulnerability, and how important it is to take care of themselves.

Families and clients indeed face big challenges, given the double

stigma of mental illness and substance use or addiction. Baker says that some families may have a harder time accepting that their loved one has psychosis than a substance use problem, while for others, it's the reverse. Some families are referred for additional help because they may have their own mental health issues or may be self-medicating to cope with stress. Because alcohol is socially sanctioned and some parents smoke marijuana themselves, clients and their families may not understand why substance use can be problematic. In such cases, Baker explains that for those at risk for psychosis, drugs can exacerbate symptoms and interfere with recovery.

Sometimes families end up feeling like the police and ask for a "hermetically sealed" program where there is no access to drugs, in the hope that once medication begins working, their relative will make better choices. Baker helps families understand that although families can positively impact their relative's recovery, ultimately, their relative needs to become an active participant in recovery.

Paul: I'm just trying to find a job that I can like and work at for a while. Alcohol is a bit of a temptation; my new doctor doesn't want me to drink. Personally, I know that if I have a beer or two a week, it's not going to make me go back to using hard drugs.

If clients adhere to treatment, 80 to 85 per cent will have a remission of psychotic symptoms, says Milliken. But what about substance use? Few studies have actually examined whether early intervention programs decrease substance use. Existing studies have shown that concurrent treatment does reduce use. The prevalence of substance abuse at the Calgary program dropped in one year from 52 to 33 per cent and continued to decline. In a multi-site study at four Ontario early intervention services, published in a 2007 issue of *Schizophrenia Bulletin*, substance abuse and use rates were significantly lower after 12 months of treatment.

However, even with treatment, many clients continue to use drugs. A 15-month follow-up study of 103 FEP clients in Melbourne, Australia, showed that only one in five clients ceased substance misuse. However, the study, published in a 2006 issue of *Schizophrenia Research*, found that among the more than 50 per cent who continued using substances, severity and frequency were reduced. These individuals also tended to be younger, single males who had not completed secondary school and who had more severe cannabis use before entering the program.

The challenge is intensified for clients who use crack cocaine or the stimulant methamphetamine, which has been a significant problem on the West Coast. Approximately 10 to 20 per cent of people who abuse crystal methamphetamine, a form of the drug, develop psychosis, according to Dr. Bill MacEwan, clinical director of the Fraser South Early Psychosis Intervention Program in British Columbia. A one-time high of 50 per cent of MacEwan's clients taking methamphetamine has now decreased to about 10 per cent, due in part, he suspects, to a major public health campaign. The problem is particularly challenging because stimulants affect parts of the brain involved in cognition, which makes cognitive-behavioural therapy, the basis of most FEP programs, difficult.

MacEwan believes that for young people to stop using drugs, take medication, come to groups and see a doctor regularly requires

a "big, big change," particularly for clients who have no family support or who live in shelters or on the street, or who are involved with the sex trade. Even a client in MacEwan's program who has family support and who has recently stopped using cannabis and is tapering off of alcohol took two years to engage in treatment.

Sabrina: I think Paul's family has played a large role in believing in him and having hope in Paul's future, even when things seemed really futile.

Recently, Paul started a new job assisting a pastry chef. But the family has also just discovered that Paul has started using drugs again. Corrine understands that relapse is part of recovery and remains committed to supporting Paul. For these families, sometimes what looks like the end of the road to recovery is just the beginning. ■

SEE THE SIGNS

Knowing the common symptoms and behaviours associated with early psychosis goes a long way in getting young people the help they need. Here are some of the signs:

Changes in thinking patterns

- has difficulty concentrating or following a conversation
- experiences difficulty remembering things
- shows jumbled or disconnected thinking

Unusual or false beliefs (delusions)

- believes one is being followed

Changes in perception (hallucinations)

- hears, sees, smells, tastes or feels something that is not there
- experiences unusual physical sensations

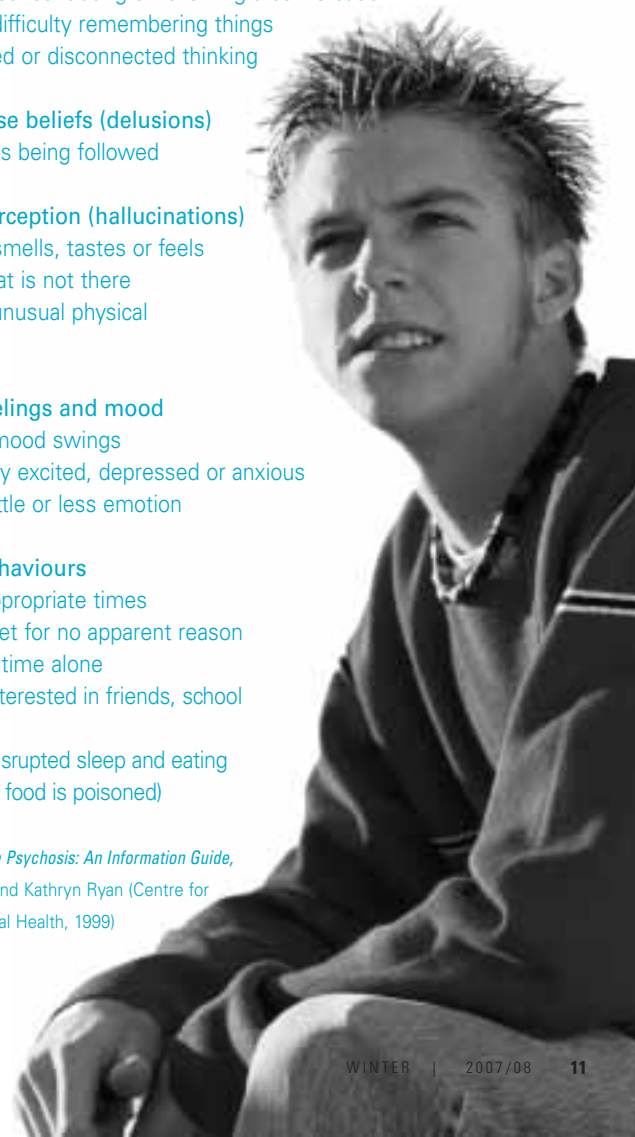
Changes in feelings and mood

- experiences mood swings
- feels unusually excited, depressed or anxious
- shows very little or less emotion

Changes in behaviours

- laughs at inappropriate times
- becomes upset for no apparent reason
- spends more time alone
- seems less interested in friends, school or work
- experiences disrupted sleep and eating patterns (fears food is poisoned)

Source: *First Episode Psychosis: An Information Guide*, by Donna Czuchta and Kathryn Ryan (Centre for Addiction and Mental Health, 1999)



Why weight?

Early treatment for eating disorders gives youth and families hope

BY AVRIL ROBERTS

ADOLESCENCE IS A TIME OF GAINING EXPERIENCES that help us move from childhood to adulthood; however, it is also a time when disordered eating attitudes and behaviours can begin to emerge. The most common age of onset is between 14 and 25, but research suggests eating disorders are increasingly seen in children as young as 10.

Consider these alarming statistics: A 2001 study published in the *Canadian Medical Association Journal* found that of 1,739 Ontario schoolgirls aged 12 to 18, 27 per cent said they engaged in bingeing or purging; 23 per cent said they were dieting and 8 per cent reported self-induced vomiting. The study noted that disordered eating attitudes and behaviours increased gradually throughout adolescence. These startling findings are echoed across Canada.

The prevalence of disordered eating and eating disorders in young girls is troubling, because the behaviours, if continued unabated, can place youth at risk for full-scale anorexia or bulimia, which can become chronic, even life-threatening.

Dr. Leora Pinhas, psychiatric director of the Eating Disorders Program at the Hospital for Sick Children in Toronto, says that starvation affects an adolescent's brain at a critical time, when the frontal lobes are developing. Children who are malnourished are also usually quite isolated because they avoid settings where there might be food. Their ability to focus and concentrate may be impaired. And most tragic, mortality rates for people with eating disorders sit between eight and 10 per cent, according to the American Psychiatric Association.

The prevalence of disordered eating and eating disorders in young girls is troubling, because the behaviours, if continued unabated, can place youth at risk for full-scale anorexia or bulimia, which can become chronic, even life-threatening.

Given these risks, early intervention is crucial. "If caught early, most of these disorders can reverse completely," says Pinhas. Dr. Daniel le Grange, director of the Eating Disorders Program at the University of Chicago in Illinois, agrees: "It's like cancer stage zero – If it's treated aggressively early, cancer can be prevented from developing into later stages or becoming terminal. And disorders are easier to treat when they are short in duration. Eating disorders are no exception."

However, detecting eating disorders in the early stages – generally within the first year of developing symptoms – can prove difficult. Pinhas says that secrecy and denial are barriers. And in a society that values thinness, "It's hard to just eyeball whether it is OK or whether it is tipping into not being healthy," says Pinhas. Preconceptions can also make eating disorders difficult to detect. "We see girls from different countries where we think girls are thinner than average anyway, so we might underestimate how ill they are." Younger children

don't always use language that is food-, weight- or shape-focused, complaining instead of stomach upset or giving other reasons for not eating, which lead to investigating gastrointestinal or other causes.

Le Grange adds that families often don't realize there is a problem: "It happens at the time adolescence starts, so parents will often say, 'It's just a phase. She'll snap out of it.'"

Despite these challenges, treatment programs are hoping to catch youth early before the disorder becomes chronic. The treatment of choice for young clients is a family-based strategy, specifically, the Maudsley approach, developed in the 1980s to treat anorexia. "This outpatient treatment mobilizes parents to take on the role nurses would have if the adolescent were admitted to a specialist inpatient unit," says le Grange. "Parents use their capacity and leverage over feeding their children to make sure they get the amount of food they should in order to regain weight. Once the weight is regained, psychosocial issues are addressed if they are part of the presentation." The approach typically involves 15 to 20 treatments over six to 12 months.

The Maudsley approach has recently been validated in the first study in the United States to evaluate treatment for adolescents with bulimia. Led by le Grange and published in 2007 in the *Archives of General Psychiatry* (see p. 6 this issue), the study found that youth aged 12 to 19 with bulimia who received family-based treatment were less likely to continue bingeing and purging than youth who received supportive psychotherapy that explored issues underlying the disorder. The results held at six-month follow-up.

At the Outpatient Eating Disorder Clinic at Sick Kids in Toronto, which sees about 100 new clients a year, early treatment options include the Maudsley approach, multi-family group therapy based on Maudsley principles and a psychoeducational group for parents and kids. The clinic also offers separate support groups for parents and kids.

Children and adolescents under 18 with an eating disorder are accepted, whether or not they meet DSM-IV diagnostic criteria. "If a child has a problem that is affecting their functioning and it's related to their eating, they are accepted," says Pinhas, provided they have a doctor's referral and after they undergo medical, psychological and nutritional assessments.

A pediatrician monitors the youth's medical status. A psychiatrist is available if there are co-morbid disorders or if psychopharmacology is indicated. A dietitian works with parents to determine how much the youth needs to eat and develops a meal plan. A social worker provides family support or family therapy.

Pinhas describes the Maudsley approach and multi-family group therapy as problem-based. "If your child isn't eating enough to keep herself safe, you should be worried. How are you going to help your child eat? What can you put into place in terms of how you manage your child to help change her mind about the eating disorder?"

In one of the early tasks, families are observed eating a meal, in order to reveal how the family works and provides support, encouragement and ideas. If parents negotiate too much around a child's eating habits – "Just eat this carrot; it's OK if you don't eat anything else" – one objective could be to help parents build perseverance and

larger expectations about what their child needs to do, without being punitive or over-controlling.

The parents' role is critical because "often kids are not our customers," says Pinhas. "They may not be interested in changing this behaviour because it's socially desirable. Parents are the ones who are concerned about their children, their eating, growth and long-term potential, so they're highly motivated. Also, parents are the ones the children live with."

Families first attend the psychoeducational group called Why Weight? based on a program developed at Southlake Regional Health Centre in Newmarket, Ontario. Up to eight families meet one evening a week for eight weeks to learn from one another what works and what doesn't.

In 2008, Sick Kids plans to offer a transitions therapeutic group for youth who will be turning 18, preparing them to move into the adult health system, where the onus is on the individual, not the family, to seek and participate in treatment. The hospital also offers inpatient treatment for youth who are medically unstable and a day hospital program for those whose eating disorder is severe, chronic or complicated by comorbid issues.

Across the country in British Columbia, the Healthy Attitudes program also strives to veer youth off the path to a chronic eating disorder. The program offers one-on-one counselling, nutrition information and support to young people aged 13 to 24 with eating disorder symptoms, disordered eating or anxiety about food, weight or body image.

Begun as a pilot project in 1996 out of the South Community Health Office of the Vancouver Coastal Health Authority, Healthy Attitudes served 49 new clients in 2006 – 46 females, three males – and currently has 20 clients. The program accepts only young people who have not been in a hospital-based program or received extensive medical treatment. "We serve people who would not get accepted by tertiary care programs because their symptoms are not severe enough," says counsellor Sonia Usmiani. Hospital eating disorders programs can have waiting lists of up to one year – a year that can make all the difference in a young girl's recovery.

Referrals can come from anyone. For teenage girls, referrals from friends are common and youth can attend the program without parental consent. Following a telephone screening by the community health nurse, an intake meeting and a team assessment, a nurse, registered dietitian and counsellor are available one afternoon a week, with extended hours for counselling an additional afternoon every other week. A physician is on call. Clients must stay connected with their family doctor throughout treatment.

While youth may be ambivalent or resistant at first, Usmiani says, "Once they get a sense of what this is about, they're usually very eager and compliant."

Healthy Attitudes starts with the premise that eating disorders are anxiety-based. It teaches youth how to manage both the anxiety and the eating disorder. "We address the underlying issues that are interfering with that person's happiness and we also address the beliefs, behaviours and feelings that are the eating disorder itself," says Usmiani.

Clients can continue in the program for as long as their recovery takes. Once they leave, return visits, months later, are not uncommon. "There's nothing linear about working with eating disorders," says Usmiani. "Progress usually happens in phases. The youth can come



STARTLING STATISTICS

Eating disorders are the third most common chronic illness in adolescent girls.

Young girls have indicated in U.S. surveys that they are more afraid of becoming fat than they are of cancer, nuclear war or losing their parents.

Among Canadian females, 37% at age 11, 42% at age 13 and 48% at age 15 say they need to lose weight.

52% of girls begin dieting before age 14.

71% of adolescent girls want to be thinner despite only a small proportion being over a healthy weight.

Health Canada found that almost one in every two girls and almost one in every five boys in grade 10 either were on a diet or wanted to lose weight.

Source: National Eating Disorder Information Centre

and go and we stay with them wherever they are." However, if disordered eating behaviours persist for a long time with no sign of improvement, the program will refer the client to a more suitable resource. The team also intervenes if a client is medically at risk.

Surveying the big picture of interventions for eating disorders, Merryl Bear, director of the National Eating Disorder Information Centre, says there is room for improvement: "Along the continuum of interventions, from health promotion through to treatment and clinical services, there are big gaps." For example, there is a shortage of interdisciplinary treatment programs so that parents often have to patch together the services of a doctor, dietitian, psychotherapist and family therapist, partly at their own expense, while in the midst of a crisis with their child.

Training and awareness also fall short. "Many medical practitioners are ill-equipped to recognize, identify or manage patients with an eating disorder," says Bear. And Pinhas notes, "Among mental health professionals, there is a stigma around eating disorders. They are perceived as being harder to treat and there is a myth that people don't recover." ■

Mental health promotion matters

Harnessing the strengths of children and youth

BY MARIANNE KOBUS-MATTHEWS AND SUZANNE JACKSON

IN SOME WAYS, IT IS OBVIOUS THAT PROMOTING MENTAL health is a good idea for children and youth. Positive mental health is a fundamental building block for learning, development, healthy relationships and employment. The road through childhood and adolescence is often a bumpy one, due to a myriad of internal and external forces and challenges. It is particularly important when working with at-risk youth to recognize the contribution that positive mental health offers in meeting these challenges, and to address the risk and protective factors that influence mental health. In a health care system that has traditionally focused on illness and disease and where mental health promotion is often overlooked, best practices guidelines can help clinicians and community-based service providers integrate mental health promotion practices into their work with youth.

Best Practice Guidelines for Mental Health Promotion

Programs: Children and Youth is a web-based resource that provides support and best practice advice for health and social services professionals working with at-risk youth, families and whole communities to promote mental health. For clinicians, the guidelines underscore the fundamental importance of positive mental health in addressing many of the challenges that face at-risk youth. Mental health promotion has an important role to play in prevention, treatment and recovery.

This resource, developed by the Centre for Addiction and Mental Health in Toronto, the Centre for Health Promotion at the University of Toronto and Toronto Public Health, identifies the 10 best practices that will help practitioners improve or develop mental health promotion interventions.

Here, we outline these 10 practices and provide examples of mental health promotion in action around the world.

1 Address risk and protective factors, including the determinants of health, that indicate possible mental health concerns

Assess which factors and health determinants can be modified and develop a plan to enhance protective factors, reduce risk factors and influence health determinants relevant to the population of concern. Risk factors are characteristics of individuals, their families, social networks, communities and environment that make it more likely for problems to develop. They include individual vulnerabilities such as substance use and stressful environments such as isolation. Protective factors, such as coping skills and social support, enable people to cope with everyday events by acting as buffers in the face of adversity. They moderate the impact of stress on the well-being of individuals, families and communities. Health status is also influenced by the determinants of health, which include personal, social, economic and environmental factors like income, shelter, peace, food and employment. The determinants of health interact with protective and risk factors to influence the quality of life.

2 Intervene in multiple settings, with a focus on schools

Develop strategies to intervene in multiple settings such as daycares, schools, homes and communities with a focus on schools as a key setting. Examples of interventions in multiple settings include school-wide events, links between the school and the community around youth-friendly issues and parenting programs for pre-school children in libraries, community settings and schools.

3 Focus on skill building, empowerment, self-efficacy and individual resilience and respect

Build the skills of both young people and their parents. Incorporate into the intervention a focus on individual and parental skills

training, family communication and management skills, dealing with feelings of loss, conflict and anger in a respectful manner.

4 Train non-professionals to establish trusting relationships

Train supervised non-professionals to establish caring and trusting relationships with children and youth. Train youth to be peer supports and educators where appropriate, for example, through mentorship programs in community settings like schools or Big Brothers/Big Sisters programs, and through peer relations and peer tutoring.

5 Involve multiple stakeholders

Involve multiple stakeholders by including students, school staff, parents, family members and community members in program planning, development and implementation, and ensuring the intended audience is directly involved in planning and decision-making.

6 Provide comprehensive support systems that focus on peer and parent-child relations and academic performance

Facilitate the development or improvement of a strong support network for the population of concern, including emotional, social and physical support through school, community and health services, and by providing tangible assistance such as transportation in order to allow individuals to attend group sessions.

7 Adopt multiple interventions

Plan a comprehensive approach by using multiple strategies that include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. Also, use strategies to reach multiple audiences in formats appropriate to their needs and preferences.

8 Address opportunities for organizational change, policy development and advocacy

Work toward these goals by mobilizing parents, teachers and youth; monitoring upcoming legislation and government initiatives to influence change that incorporates a mental health promotion approach; implementing strategies to assess the organizational climate and create health promoting schools and workplaces; and identifying policy initiatives to influence school culture.

9 Demonstrate a long-term commitment to program planning, development and evaluation

Demonstrate this commitment by conducting a situational assessment to help design an intervention and define its target audience. Involve members of the target group from the start, and ensure that the length and intensity of the intervention is appropriate and will achieve the intended outcomes. Regularly revise program objectives to ensure that progress toward goals is met and ensure that data collection methods and mechanisms are in place.

10 Ensure that information and services provided are culturally appropriate, equitable and holistic

This goal can be achieved by facilitating access for parents and children to culturally relevant, supportive social networks; providing understandable, culturally appropriate information; facilitating participation from minority groups and considering the possible consequences to socially disadvantaged families; and providing a holistic and integrative approach to dealing with mental health issues.

To access *Best Practice Guidelines for Mental Health Promotion Programs: Children and Youth*, visit www.camh.net and do a keyword search.

Marianne Kobus-Matthews is a senior health promotion consultant at the Centre for Addiction and Mental Health.

Suzanne Jackson is director of the Centre for Health Promotion at the University of Toronto.

MENTAL HEALTH PROMOTION IN ACTION

These mental health promotion initiatives from around the world illustrate best practices in action.

Dinosaur Children's Social Skills Program

This 18- to 20-week health promotion and prevention group program at the Centre for Addiction and Mental Health (CAMH) in Toronto is designed to strengthen children's social skills and emotional competencies such as communicating feelings, managing anger, practising friendship and developing problem-solving skills. Children's groups are complemented by parent groups (Incredible Years Parenting Program), all of which aim to improve quality of life. Culture, ethnicity, social environment and lifestyle are considered in order to understand and respond to the health needs of clients. Protective factors addressed include coping skills, personal values, resilience, social support and positive life events; risk factors addressed include negative life events and stress. Children and families are involved whenever possible during all stages of program development.

Web link: Go to www.camh.net. Under Child, Youth and Family Resources, follow the Child, Youth and Family Program link and choose Better Behaviours Service.

Gatehouse Project

This Australian secondary school project was developed at the Royal Children's Hospital in Melbourne in 1996 to promote student engagement and connectedness as a way to improve emotional well-being and learning outcomes. Through a school-based adolescent health team, protective and risk factors are identified in each school. The three priority areas for action include building a sense of security and trust, enhancing skills and opportunities for good communication and building a sense of positive regard through participation in school life.

Web link: www.rch.org.au/gatehouseproject

Miyupimaatisiwin Wellness Curriculum (MWC)

MWC is a Canadian school-based suicide prevention program developed in 2000 to promote healthy lifestyle choices to counteract the long-term incidence of suicide, as well as substance abuse and violence.

It focuses on "wellness" and targets children from kindergarten to Grade 8. This holistic program emphasizes Aboriginal culture and was developed with the Cree community to encourage active participation of the family and community.

Web link: www.mcgill.ca/files/tcpsych/Report9_Eng.pdf. This document on the McGill University web site provides contact information for MWC.

Olweus Bullying Prevention Program

This Norwegian-based multi-component school-based program was designed in the 1980s to prevent or reduce bullying in elementary, middle and junior high school students (age 6–15). It works in three areas: school-wide interventions that include staff training and development of school-wide rules against bullying; classroom-level interventions that include class parent meetings and regular classroom meetings about bullying; and individual-level interventions that involve individual meetings with children who bully and their parents.

Web link: www.clemson.edu/olweus

Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY)

Run by CAMH, SAPACCY is an empowering and capacity-building program that targets a diverse clientele of black youth aged 13 to 24. It uses a strength-based approach that enables young people to discover their talents, and through intervention, helps youth transition from drug-related behaviours to pursuing education or attending work-training programs. The program has collaborated with many community agencies and also engages in youth advocacy by raising awareness about violence and drugs. Examples of collaboration include work with Toronto Police Services through the Empowering Student Partnership Program and the City of Toronto Working Group on Youth Gangs.

Web link: Go to www.camh.net. Under Child, Youth and Family Resources, follow the Child, Youth and Family Program link and choose SAPACCY.

Nothing but blue skies

Early intervention helps youth emerge from the cloud of depression

BY DR. KATE HARKNESS

THE TRANSITION FROM ADOLESCENCE to adulthood is a time of great stress as young people take on the pressure and responsibility of independent living, professional employment and adult relationships. While most young people negotiate this transition successfully, many do not. Indeed, young adulthood is the period of greatest risk for the onset of serious mental illness, including major depression. According to recent reports, one in seven young people aged 18 to 25 has experienced a first onset of depression and 50 to 60 per cent of these will experience multiple episodes throughout their lives. The onset of major depression in young people is associated with poor educational attainment, occupational functioning and physical health, and disrupted interpersonal relationships.

Given the devastation wrought by depression, intervening as early as possible is crucial to prevent the often life-long cycling of depressive episodes. Treatment needs to start as soon as the depression begins. Unfortunately, the vast majority of young people experiencing first onset depression do not receive treatment. Intervention must also involve rigorous research. Through targeted, multi-disciplinary research, scientists are identifying the complex interplay of biological, psychological and environmental factors that cause depression with the ultimate goal of refining and improving prevention and treatment strategies.

A new five-year study, The Blue Sky Project, is taking on this research challenge by examining factors that cause the first onset of depression in young adulthood – the first study of its kind. Funded by the Canadian Institutes of Health Research, the study brings together researchers from the Centre for Addiction and Mental Health in Toronto and Queen's University in Kingston, Ontario.

The Blue Sky Project looks at 18- to 29-year-olds experiencing a first depressive episode and provides thorough assessment, antidepressant medication and close monitoring. The study examines the mechanism through which a genetic predisposition to depression interacts with environmental

stress throughout childhood and young adulthood to cause the first onset of depression. Depression runs in families, and a big reason for this is that particular genes are passed down from parent to child. How does this genetic risk turn into depression? And, if we are born with our genes, why doesn't depression emerge until much later? Exciting new research conducted by scientists around the world has shown that the effect of genes on depression is not direct, but instead acts through the environment. People with an at-risk genetic profile are much more likely to get depressed in the face of stress than people without this profile.

Many types of stress can trigger depression, from severe abuse or neglect in childhood to the break-up of a relationship or job failure in adulthood. However, not everyone who experiences such stressors becomes depressed. Why are some people resilient to stress while others fall into depression? Again, the answer lies in the important interaction between genes and the environment. Specifically, we are testing the hypothesis that individuals with a specific genetic variant in the serotonin system will be more likely to get depressed in the face of stress and will require less severe levels of stress to get depressed, than individuals without this genetic profile. This particular genetic make-up colours a young person's perceptions of the world, such that he or she reacts to stresses in the environment much more strongly than do other people, with potentially devastating consequences to their psychological well-being for the rest of their lives.

Participants in the Blue Sky Project receive 16 weeks of antidepressant medication and are closely monitored for up to 18 months by a psychiatrist with expertise in treating depression. In this way we are able to see how a genetic sensitivity to stress also affects response to treatment. Currently, the best treatments for depression involve medication or psychotherapies, such as cognitive-behavioural therapy or interpersonal psychotherapy. However, these treatments, either alone or in combination, are only effective in about 70 per cent of clients. It is our hope that the results of this study and

First-ever guidelines for managing teen depression

For the first time, primary care providers in North America will have clear guidelines and a toolkit for managing adolescent depression. North American researchers established the Guidelines for Adolescent Depression in Primary Care (GLAD-PC), targeting youth aged 10 to 21.

Because of long waiting lists to see mental health professionals, family doctors, pediatricians and nurses are becoming the first, and sometimes only, clinicians to identify, manage and treat adolescent depression. However, they often feel inadequately trained, supported or reimbursed for managing this disorder.

GLAD-PC provides guidelines for identifying, assessing, treating and managing adolescent depression in primary care settings. The guidelines and accompanying toolkit are available at no cost at www.glad-pc.org.

depression will open the door to even more effective pharmacological and psychological treatments. For example, future psychological treatments could focus on helping young people understand and alter their stress sensitivity. This could involve helping them identify and modify personality characteristics, thought patterns and response styles that may in part be genetically determined and that lead them to be particularly sensitive to stress, as well as helping them identify stressors in their environment so they can develop more adaptive ways of responding to and coping with these triggers. ■

For information about the Blue Sky Project, call 416 979-4294 or visit www.blueskyproject.ca.

Dr. Kate Harkness is an associate professor at Queen's University in Kingston, Ontario, and co-principal investigator on the Blue Sky Project.

Strengthening Aboriginal families through prevention

BY LESLEY YOUNG

STRENGTHENING FAMILIES FOR THE Future (SFF) is a psychoeducational prevention program focusing on family strengths. Founded by Dr. Karol Kumpfer in 1988 at the University of Utah, the program targets families with children from ages 7 to 11 at risk for substance use problems, depression, violence, delinquency and school failure.

During 14 consecutive weekly sessions, parents and children enjoy a meal together, break apart for separate skills development sessions and come back to practise their learning together. Outcome studies have found the program to improve stress and anger management skills and to reduce substance use among youth.

The program has a definite structure, but it also recognizes the need to adapt to the needs of the communities it serves. To this end, initiatives are underway to adapt SFF to Aboriginal communities across North America. To learn more, *CrossCurrents* interviewed Ceceilia Tso, an American Indian trainer of trainers for the Strengthening Families Program (SFP – the U.S. equivalent of SFF), who provides training throughout the United States and Canada. Also interviewed was Daniel Manitowabi, a social worker and clinical manager for the mental health program at M'Nendamowin Health Services on Manitoulin Island in Ontario, who was trained by Tso. Along with the two other Manitoulin-area health services, Manitowabi's program received funding for SFF through the National Youth Suicide Prevention Strategy of the Ontario-region First Nations and Inuit Health branch of Health Canada. Thirty-four frontline staff

have been trained to tailor SFF to their communities' cultural needs. The program is expected to be launched at three locations for up to 30 families with 12- to 16-year-olds this year.

What are the unique issues of Aboriginal communities that can be addressed through Strengthening Families?

Manitowabi: The poor health status of Aboriginal peoples is clear. There are higher rates of illness and poverty and lower life expectancy than the rest of the population. We also have high rates of substance use and suicide. Suicide among youth is particularly high. Poor health, social and economic conditions put Aboriginal families and individuals at higher risk for substance use, mental health issues and problem behaviours, all of which can be targeted through a program like Strengthening Families if it is adapted to the specific needs and culture of Aboriginals. We felt that delivering this culturally appropriate program to First Nations families would strengthen protective factors and reduce risk factors.

Why is it important to tailor programs like Strengthening Families to a specific culture?

Tso: By bringing in cultural elements, the program resonates with more families. They are more receptive to learning from their own people and relate better to cultural elements, even if it is a simple thing like using a talking stick (an implement used in Aboriginal culture to indicate that someone is speaking and everyone must listen). When someone uses that symbolic item, it hits close to home and has more meaning for families. In the same way, if someone presents an eagle feather, it will garner instant respect, which could not be as easily attained without the impact of cultural meaning.

Manitowabi: The community and family values of Strengthening Families are in line with the strong Aboriginal traditional of taking care

of one another. That is why we include extended family in the program—grandparents are quite involved with kids in Aboriginal culture. We build on the family aspect of SFF to make it reflect the Aboriginal emphasis on family.

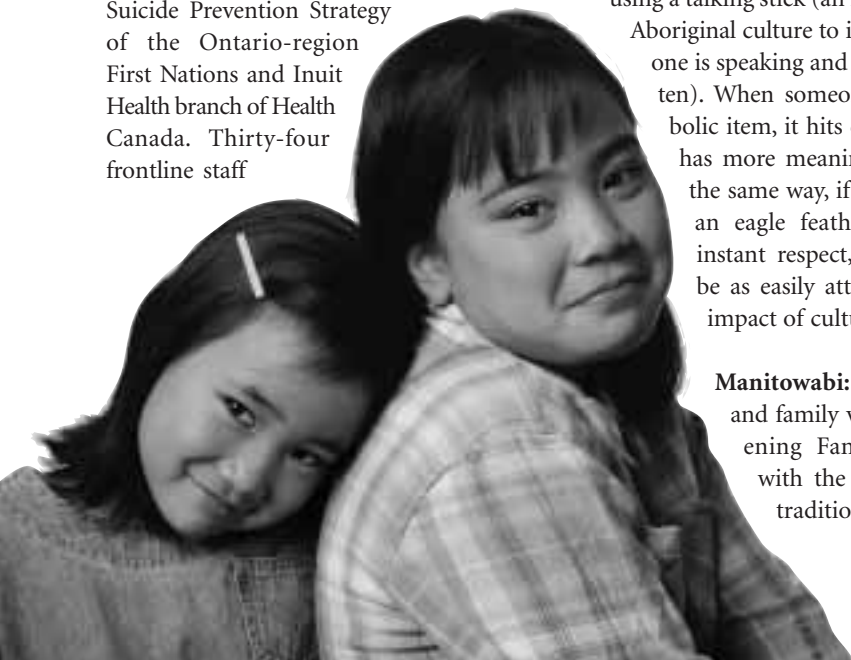
How can the program be tailored to the needs of Aboriginal communities?

Tso: It's a good idea to make sure group leaders are Aboriginal. The program requires a minimum of two leaders for the parent group, two for the child group and a site coordinator. It is also incredibly effective to have a medicine man attend at least the first session. We also suggest having both a male and female leader so everyone feels comfortable discussing topics or concerns with at least one leader.

Elders should be invited to join the group. Many of the ties that bind Aboriginals with their traditions, such as elders, have been broken and this is a way to help mend them. When I was going through a difficult divorce, I went through Strengthening Families myself (which gave me a new perspective and practical experience as a trainer) with my young daughter and son, and my aunts and grandmother. At graduation, the elders conducted a ceremony and gave each child a baby blanket they had made. I had no idea the effect it would have on my kids. My son, who is now 11, still sleeps with the blanket! Given how much respect they have in the Aboriginal community, elders have a big impact, especially on children, if they join a group.

Why is the communal meal particularly important for Aboriginal people?

Tso: The meal component of Strengthening Families helps families bond. We recommend including extending family like grandparents, aunts and uncles and foster parents. Having a meal together is a very traditional aspect of Aboriginal families. Yet few at-risk families do. The dinner is also an opportunity to meet with group leaders in a relaxed atmosphere, as well as to network with other families, so families realize they are not alone.



How can the meal be adapted culturally?

Tso: Potlucks should be avoided. That creates too much work for the families; the meal is supposed to be an incentive for families to attend. We suggest providing a traditional Aboriginal meal. The dinner is also an opportunity to bring a guest speaker to talk about nutrition, provide prevention education or expose families to more traditions during the meal. One tribe I worked with held a bear dance, which an elder attended and explained to the families.

Manitowabi: I agree that incorporating traditional food is an excellent idea. Addressing proper nutrition is important, given the high incidence of diabetes in our community. We hope to bring in a dietitian to do a short prevention session as part of the program.

How can Strengthening Families skills training be tailored to meet the needs of Aboriginal communities?

Tso: First, it's important to point out that adapting Strengthening Families to a particular culture does not mean changing the actual material. Cultural adaptation means adding a cultural element to help demonstrate a particular life skill from the program, rather than actually modifying the material, which essentially removes part of the lesson or the skill.

My favourite example is on the lesson on dealing with stress. We ask the children and the parents in their separate groups what kind of stresses they think our ancient

ancestors faced. It is important that the kids themselves come up with the answers. They may answer war, sickness or disease. Then we talk about some of the stressors we deal with today, such as crime, divorce and poverty in rural or urban areas. Then we ask the kids to come up with some strategies our ancestors may have used to help them deal with the stress. This may include prayers, sweat lodges, ceremonies, pow-wows and beading. We then talk about how the kids and their families can use these strategies themselves when they feel stressed.

During this lesson, another adaptation is to make little medicine bags at the same time, filled with sage and what is called an animal fetish – the animal you see yourself as. These can be used during prayer or quiet time.

Manitowabi: We plan to incorporate some of the Seven Grandfathers Teachings, which are Aboriginal ethics relating to truth, honesty, bravery, love, humility, respect and wisdom into the program.

How can at-risk Aboriginal families be recruited to the program?

Tso: Recruitment should target areas with many high-risk families. Get the word out at tribal courts, social service facilities and at local pow-wow and cultural events. Once you've run one session, word spreads about how much fun or how useful the program is. This breaks down a lot of misconceptions that the program is therapy or incredibly

READINGS ON CULTURAL ADAPTATIONS

C.W. Dent et al., "Is Current Drug Abuse Prevention Programming Generalizable across Ethnic Groups?", *American Behavioral Scientist*, 1996, vol. 14:1.

K.L. Kumpfer et al., "Cultural Sensitivity in Universal Family-Based Prevention Interventions," *Prevention Science*, 2002, vol. 3:3.

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Washington, DC: American Psychological Association Books, 2005.

K.L. Kumpfer et al., "Effective Culturally-Valid Prevention Programs for American Indian Youth," *Journal of Primary Prevention*, in preparation.

K. Resnicow et al., "Cultural Sensitivity in Substance Use Prevention," *Journal of Community Psychology*, 2000, vol. 28.

W. Turner, "Cultural Considerations in Family-Based Primary Prevention Programs in Drug Abuse," *Journal of Primary Prevention*, 2000, vol. 21:3.

difficult work. Fliers are a great tool, too, but nothing works like word of mouth.

What are some key challenges to implementing Strengthening Families in Aboriginal communities?

Tso: There are a lot of barriers to the program in Aboriginal communities, including poverty. Even something as seemingly simple as not having money for gas can prevent some families from attending. So you need to take transportation into account. Car pooling may be one answer. One agency had a van that drove people to the program. Language can also be a barrier and part of the reason why we prefer Aboriginal group leaders. However, a translator may still be necessary sometimes. There is also a range of literacy levels, so leaders need to be aware that they may need to give instructions orally, not written.

Manitowabi: Distance is a challenge for us. Some of the communities are an hour or more apart, so we are establishing three different locations for the program. Funding is quite challenging as well. We are very excited to be running the program, and depending on whether we get renewed funding, we hope to run the program for at least one more year. ■

For more information about the American Indian Strengthening Families two-day training workshop, available across Canada and the United States, contact the LutraGroup at lutraGroup@att.net.



Working with families of psychiatric inpatients

Working with Families of Psychiatric Inpatients: A Guide for Clinicians focuses on situations commonly encountered by psychiatric residents in their work with inpatients and their families. The authors suggest that skilled intervention with families improves outcome and reduces the risk of relapse and re-hospitalization. They cite research about the role and influence of families in illness and treatment and explore several models of illness and recovery, primarily the biopsychosocial model.

Strength and resilience in families and protective and risk factors are illustrated, and the authors briefly discuss specific illnesses and the unique pressures and historical perspectives on family function or dysfunction in the face of such challenges.

The strength of this book is in its detailed case scenarios of meetings with patients, families and residents. Particularly enlightening are the specific interventions for “difficult” situations, which feature hostile, domineering, challenging or silent family members. The authors provide simple and direct interventions and strategies for managing these situations and discuss how to set limits and re-direct and re-focus the family meeting so it does not become stuck in a non-productive conflictual mode.

The authors also address mistakes that residents new to family work often make, as well as the fears and anxieties residents may

have about working with challenging families. The relationship of the resident’s supervisor and the importance of supportive mentoring are discussed, as are the anxieties, concerns and perspectives of families themselves and how they may incorporate these dynamics into their encounters with residents.

The authors discuss risk management and ethical issues and touch on issues of confidentiality, suicidality, medication, family member alienation and legal concerns. Follow-up care and the value of psycho-educational support groups for families and patients after discharge are also discussed, as is research about what families identify as important and helpful in their engagement with residents. A checklist of core competencies for work with families is a helpful self-evaluation tool.

In an effort to keep the book manageable, some topics are covered only briefly but may serve as stepping stones for further education. Cross-cultural and diversity issues are one example. The families presented follow the traditional heterosexual model and little mention is made of alternative families or LGBT family structures. Caregiver burden is discussed, but the issues of women as primary caregivers and stigma and mental illness and their impact on the family are only slightly acknowledged.

The focus of learning, mentoring, support and working together is almost

exclusively illustrated by the relationship between resident and supervisor, with little mention of other members of the multi-disciplinary team, such as social workers or patient advocate workers, who have much to contribute to the education and skill development of the resident, as well as providing support and therapy to the family.

The writing is mostly warm and engaging, particularly as it seeks to reassure residents that their anxieties about working with challenging families are common but not insurmountable. The examples and strategies are clear and straightforward; more of this kind of practical and encouraging dialogue would be helpful.

The research pertaining to the importance of family work is extensive and well documented and encourages residents to enrich their scope of practice beyond medication management and pathology. This book would be of primary interest to psychiatric residents and their supervisors, but other practitioners may find it helpful in better understanding the challenges faced by residents new to inpatient family work. ■

Working with Families of Psychiatric Inpatients: A Guide for Clinicians. Alison M. Heru and Laura M. Drury. Johns Hopkins University Press, 2007, 192 pp. \$20US.

Kate Tschakovsky is a social worker at the Centre for Addiction and Mental Health in Toronto.

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SHEILA LACROIX

At-risk youth

Canadian Centre on Substance Abuse, www.ccsa.ca

Hot off the press is *Substance Use and Harm in the General Youth Population*, found under *Topics, Population, Youth*. The second chapter deals with non-mainstream youth, recognizing that heavy substance use may relate to attempts to cope with “toxic environments” at the root of trauma or other psychological problems. In the final chapter, gaps in the quality and availability of age-appropriate services for mental health and addiction are acknowledged. Another document in the Youth section is *Harm Reduction Policies and Programs for Youth*. Harm reduction approaches promote a population-based approach, but acknowledge that some youth are engaging in risky behaviours that could lead to harm. Harm reduction strategies for non-mainstream youth are reviewed.

Centre for Children and Families in the Justice System, www.lfcc.on.ca

The mandate of this organization includes supporting young offenders and their families. This involves engaging in research to improve programs and services. One initiative is studying the effectiveness of multi-systemic therapy (MST), an intensive home-based intervention involving the whole family, for serious young offenders who would otherwise be placed in custody. There are three MST resources to consult: the original 2002 study, *Seeking Effective Interventions for Serious Young Offenders*; *One Step Forward: Lessons Learned from a Randomized Study of Multisystemic Therapy in Canada* and the final results of the three-year follow-up. Explore the web site further for other services and projects targeting at-risk children and youth such as children of incarcerated mothers and children exposed to family violence.

Early intervention in psychosis: Future or fad?

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DR. RICHARD WARNER

Early intervention in psychosis has generated much interest and optimism. But is this enthusiasm backed by satisfactory research evidence? To answer this question we have to understand that “early intervention” refers to two different approaches – intervention before and after the onset of psychosis. The problems, risks and potential benefits are quite different for each.

The belief that early intervention in fully evident psychosis will lead to better outcomes is based on data showing that the duration of untreated psychosis (DUP) is associated with worse course and outcome. It is unlikely, however, that this association is a direct effect of prolonged psychosis. A substantial proportion of those who present with a first episode of a schizophrenia-like condition will recover rapidly, and samples of patients with a shorter duration of illness will include more good-prognosis cases and will have better overall outcome. In fact, the association between DUP and poor outcome only holds true for cases of recent onset, and the studies that do not include recent cases fail to show an association between DUP and outcome. Some researchers have gone so far as to suggest that untreated psychosis may be toxic to brain function, but this appears unlikely, since nearly all recent studies demonstrate no association between DUP and cortical atrophy or decreased cognitive functioning.

Claims for the benefits of early intervention go back two centuries. Nineteenth-century madhouse proprietors claimed that the deranged were more easily restored to health if they were admitted early. The British Metropolitan Commissioners of Lunacy cited tables demonstrating that cures were more likely when patients are admitted within three months of onset. Their enthusiasm led to the Lunatics Acts of 1845 and the construction of a national network of county asylums. We look back now with a sense of superiority on the self-promotion of the early asylum proprietors and the lack of scientific rigour, but the data currently being offered in support of early intervention suffer from the same weaknesses.

Over-enthusiastic early intervention can be dangerous for those experiencing an episode of good-prognosis psychosis, which is destined to go into early remission without drug treatment. A World Health Organization study found that 15 per cent of those presenting with a schizophrenia-like illness in the developed world recovered within four months and stayed well for two years. The Soteria projects in California and Berne, Switzerland, and a multi-centre study in Finland demonstrated that medication is not essential for good outcome. Medicating at the earliest appearance of symptoms, without thought for the natural history of the condition, may lock the person experiencing a brief psychosis into a long-term career as a psychiatric patient.

As for the claim that we can prevent psychosis by intervening before the illness has become fully evident, this effort requires effective screening to detect those at risk. Patrick McGorry and colleagues at the PACE clinic in Melbourne, Australia, the best-known centre for this work, report that their screening instrument is capable of 80 per cent accuracy in their clinic. But the instrument is not that accurate in routine use. In the PACE sample, 35 per cent developed psychosis within one year. Probability theory tells us that if the same instrument were used to screen a general population sample with the usual rate of occurrence of psychosis of around one per cent, it would be correct only seven per cent of the time, and if it were applied to a clinic population where the risk of developing psychosis in a year was, say, five per cent, the instrument would be correct only 30 per cent of the time. In fact, in another Australian clinic, the PACE instrument only achieved nine per cent accuracy. False-positive rates of the order of 70 to 90 per cent are clearly unrealistic for intervening with medication or other forms of treatment.

McGorry speculates that a variety of interventions may be effective in preventing schizophrenia in high-risk cases. The suggested approaches include antipsychotic medication, family intervention and “lifestyle restructure.” Given the expected

number of false positives, the potential for harm is significant. Should we prescribe antipsychotic medications for someone with no positive symptoms? How much harm will be done to people who will never develop the illness to tell them they are at risk for schizophrenia, need treatment and must adjust their life goals? In a pre-illness treatment study conducted by PACE, participants were assigned to preventive treatment with cognitive therapy and the antipsychotic drug risperidone or to a control group with supportive psychotherapy. Only three of 31 preventive treatment participants developed psychosis after six months compared to 10 of the 28 in the control group. Thus, the onset of psychosis may have been delayed in about seven of the experimental group. We have to set this against the fact that 21 participants in the experimental group were told they were at risk for schizophrenia when they were not, and took risperidone unnecessarily. How does one decide, moreover, how long the 28 symptom-free participants taking risperidone should continue on medication? For three-quarters of the group, the medication is unnecessary, but one doesn't know who those individuals are.

Prevention specialists ask a series of questions to determine if a screening program will do more harm than good. Does the burden of disease warrant screening? Is there an effective preventive intervention? Is there a good screening test? Will the program reach those who would benefit? Can the healthcare system handle the screening? Will the screen-positive individuals comply with the intervention? In the case of schizophrenia, the answer to the first question is a resounding “yes,” but to the remainder, the answers are “no” or, at best, “doubtfully.” Looked at in this light, pre-illness screening for schizophrenia is unlikely to succeed. Nor is early intervention in fully evident psychosis likely to yield the hoped-for benefits.

Richard Warner, MB, DPM, is director of Colorado Recovery in Boulder, Colorado, and professor of psychiatry at the University of Colorado.

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