

crosscurrents

WINTER 2009/10
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The Journal of Addiction and Mental Health



The digital couch

DR. GOOGLE

Online self-assessment
makes link to treatment

MYSPACE IS YOUR SPACE

Internet blurs professional
and private boundaries

THE NET GENERATION

What you need to know
about your young clients

BEING THERE

Can you build a therapeutic
alliance online?

Snapshots of recovery

Photovoice project exposes
path to wellness

Focus on the positive

Treatment for bipolar disorder
embraces self-management



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

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Centre de toxicomanie et de santé mentale

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www.camh.net/publications/Cross_Currents/index.html

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I'm Learning How to Live Without You in My Life, Lorette Luzajic, mixed media, 16" x 16"

Lorette is a writer and artist who uses mixed media to "document her wild mood swings and passion for visual art." View her art at the Touched By Fire gallery at www.touchedbyfire.ca



note from the editor

How comfortable are you with technology? It's an important question for mental health and addiction professionals to ask themselves because the Internet is having a big impact on clinical work. In traditional face-to-face practice, therapists are hearing about their clients' online experiences, just as therapists online are working with clients on issues in their "offline" lives.

The Internet has become a common and prevalent resource for everyone. Individuals with mental health or addiction issues and their families often turn to the Internet to find information, share experiences or express themselves. Mental health and addiction professionals are also starting to take advantage of the possibilities of the Internet, running along a continuum from information dissemination to prevention, assessment, diagnosis, treatment and aftercare.

This issue of *CrossCurrents* examines some of these areas, and considers the possibilities and pitfalls of the Internet for clinical work. Avril Roberts examines how online self-assessment offers a unique opportunity to help people access care. Lesley Young

introduces us to the "Net generation" and explores the implications of the Internet for working with young clients. In another story, Anne Ptasznik takes us into the world of mental health bloggers, including the controversial "pro-ana" bloggers. With new technology come new ethical concerns, which Patricia Nicholson explores in her story about how social networks are blurring the lines between private and professional boundaries. We also see technology in action, with one online counsellor and her client describing how they develop a therapeutic rapport online. In the Last Word column, Hilarie Cash, executive director of ReSTART: Internet Addiction Recovery, North America's first inpatient "detox" centre for Internet addiction, argues that Internet addiction is a valid disorder requiring specialized treatment. Visit the Last Word column at www.camhcrosscurrents.net to have your say in this debate.

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Check out *CrossCurrents* on the web. We have launched an online edition with interactive features like discussion boards and blogs. Visit us at www.camhcrosscurrents.net. We encourage you to get involved and to send us your ideas about how we can make *CrossCurrents* better.

a view from CAMH

When the Internet and social media came onto the scene, bandwidth was an issue. It was difficult to use the Internet as an interactive device when video streamed slowly, speech broke up and you didn't know whether the delay in getting a response to your witty comment was because the person you were communicating with hadn't received the message or had taken offence and cut you off.

But with bandwidth issues now mostly resolved, especially in high-income countries, new concerns have taken over. Some involve ethical and legal questions about how this new interactivity affects clinical work, the focus of this issue of *CrossCurrents*. Another issue has been quality.

A standard essay question in 8th grade English studies in Toronto is whether you can trust

Wikipedia – one of the better policed sites. It's a common concern for people looking for health information online. Can they trust the website? Is it sponsored by a pharmaceutical company, with all the possible conflicts of interest? Is it developed by an interest group with a particular axe to grind? These questions can be hard to answer. So often, other quality issues dominate decision making: Is the information presented in a way that allows you to identify the facts you need without being overloaded by jargon? Is the website up to date?

Anyone who regularly uses the Internet will have encountered these problems and found ways of dealing with them. For the general public, CAMH has been offering online information and telephone services for years, but we're realizing that health professionals have the same problem as the general public in accessing

good information online. It is in this context that CAMH's Policy, Education and Health Promotion department has launched KnowledgeX (<http://knowledgex.camh.net>), where professionals can find information about mental health and addiction issues and interact with one another. You'll also find *CrossCurrents* online at www.camhcrosscurrents.net. Check out the extra features and join in the conversation!

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Photovoice exposes the path to recovery

NED MORGAN

Dawn Betts was reeling from a diagnosis of borderline personality disorder, dysthymia and depression when she was invited to participate in a program called Photovoice, offered through the Canadian Mental Health Association (CMHA) branch in the northern Ontario city of Thunder Bay. Betts knew little about photography. “But I was at a point in my recovery where, to get better, I was going to go down that avenue,” she says.

Developed at the University of Michigan School of Public Health, Photovoice puts cameras into the hands of those who don’t normally have a voice in society. It has proved well-suited to the mental health community. A study of a U.S. Photovoice exhibit published in 2009 in the *Archives of Psychiatric Nursing* found that the photos helped people with mental health problems articulate their experience of stigma and identity loss to clinicians. Another U.S. study published in 2008 in *Perspectives in Psychiatric Care* found that Photovoice increased empathy towards people with mental health problems among both the general public and clinicians.

Joanne Books, manager of education and training at the Thunder Bay CMHA, was drawn to Photovoice in part because of its immediacy. “Photography provides easy access to the creative process,” she says. “You don’t have to be a professional artist to take pictures that tell a story.” Books and case manager George Drazenovich recruited eight participants, and after discussions of photo ethics and exercises such as collage and reflective journaling, gave them disposable cameras.

As the artists immersed themselves in the project, they became a tight group, keen to help one another interpret the multiple levels of meaning in their photographs. In April 2007, the Thunder Bay Art Gallery launched an exhibit of 40 of the group’s photographs. The exhibit’s overwhelming success convinced the group to make a multimedia presentation and present it to hospitals, mental health agencies and other audiences. The project has been so successful, in fact, that the Mental Health Commission of Canada has selected it as an anti-stigma demonstration tool for its “Opening Minds” campaign.

Photovoice artist Annie Jollymore was a young achiever, completing a master’s degree in clinical psychology by age 21, before dissociative identity disorder and borderline personality disorder led to 20 years in the mental health system. One of Jollymore’s photos (shown here) depicts a stained glass window in her living room. Her accompanying text reads: “Emerging from psychic shadows into the light.” The window’s ornate design obscures the view outside, but coloured light flows into the dim interior. Jollymore explains: “In recovering from mental illness, some days are very bleak and you feel the darkness is taking you back. But I can focus on that stained glass window, the brightness, the vibrancy, and know that that world is out there.”

About two months into the project, Jollymore obtained a position as systemic advocate at People Advocating for Change Through Empowerment, a local consumer/survivor initiative, where she applies lessons from the project: “Photovoice talks about people’s strengths, their ability to recover – their inner resources and their community resources that allow them to live a good life.”



Annie Jollymore’s photo: “Emerging from psychic shadows into the light.”

For Betts, Photovoice changed her ideas about mental illness. “I was taken aback by the intelligence of my peers,” she says. “Just listening to them talk about their photos and their recovery process – everybody was at a different point in their recovery. I was the one with the newest diagnosis. I wasn’t even at the acceptance stage.”

One of Betts’ photos shows a seagull in flight on an overcast day. The accompanying text reads: “A tiny insignificant speck surrounded by grey.” She explains: “That’s what life feels like when I’m in full depression ... People said this photo really enlightened them as to what it feels like to be depressed.”

This enlightenment goes a long way in fighting stigma, says Books: “We presented to about 80 clergy, and one minister had tears in his eyes. He said, ‘I always thought of myself as a progressive thinker, but when I saw this, I realized I still have a lot of misconceptions about mental illness. This has challenged the way I think.’”

Photovoice has certainly challenged Books: “It has shown our agency that art is a powerful way to raise awareness of social issues and an important part of the recovery process,” she says. “I don’t think we knew how big this would get. Now we’re saying, ‘Wow! What else can we do?’” ■

Visit www.camhcrosscurrents.net for more photographs from the Photovoice project.

Exploring the brave new world of online psychotherapy

JOHN SULER

John Suler is a clinical psychologist, whose online book, *The Psychology of Cyberspace* (www-usr.rider.edu/~suler/psycyber/psycyber.html), is a comprehensive guide to issues in online clinical work. *CrossCurrents* asked him to discuss what he thinks are the most common myths about clinical work online.

Myth: Online therapy is individual e-mail or chat therapy.

Fact: Although clinical work on the Internet began as one-on-one psychotherapy by means of e-mail and chat programs, it has extended far beyond those communication tools. Today, a wide range of interventions are being conducted online using video-conferencing, group and social networking environments, interactive programs, visual and audio files, and even within virtual worlds such as Second Life, where clients and therapists interact in fabricated graphical environments using visual “avatars” to represent their physical selves.

Myth: Text alone cannot convey the richness of human experience.

Fact: This myth is endorsed by skeptics who believe that the visual and auditory cues provided by clients, such as voice dynamics, facial expression, attire and body language, are absolutely necessary to understand a person’s state of mind. While few people would doubt the importance of these cues, few people would also doubt the power of the written word to express human experience, as clearly evident in the history of literature, poetry and journalism. Entire forms of psychotherapy, such as bibliotherapy, are based on the assumption that writing can be therapeutic. Throughout history, some of the most interpersonally powerful dialogues between people have been through letters. Why then would we doubt the psychological richness of e-mail or chat?

Of course some people are more expressive writers than others, which might mean they are better candidates for text-based therapy. However, one might argue that the development of writing ability and style are themselves important indices of psychological change. The history of text communication via the Internet also shows us that people are remarkably versatile and creative in finding new ways to express themselves within a seemingly limited communication environment, as evident by the development of emoticons such as the smiley, parenthetical expressions that convey body language or “sub-vocal” thoughts and feelings (sigh), VOICE ACCENTUATION via the use of capital letters, and trailers ... to indicate a transition in thought or speech. Finally, according to the principle of the online disinhibition effect, people might be more honest, expressive and authentic when communicating via text than they would when facing the clinician eyeball to eyeball.

Myth: Physical presence is necessary for effective therapy.

Fact: This myth overlaps with the one above in that it assumes visual and auditory cues are critical. As I mentioned, visual and auditory presence is possible via video-conferencing and immersion into imaginary graphical/avatar environments. But what about close physical observations of clients or actually interacting with them physically, as in somatic therapies or the simple shaking of hands?

Isn’t this close, personal, tactile, kinesthetic, and therefore special aspect of physical human presence lost in cyberspace?

In some respects, yes. However, technologies for transmitting physiological information (e.g., heart rate, blood pressure, galvanic skin response) are already available, and those for sending kinesthetic sensations are developing rapidly (you can now shake someone’s hand via cyberspace!). As for the special personal quality of being physically present with someone, it is important to note that some people feel more real and present in cyberspace than they do in person.

Myth: Effective therapy for serious disorders is not possible online.

Fact: This myth again boils down to the belief that effective therapy requires an in-person encounter. The question is not so much whether online therapy works with serious disorders, but rather, which serious disorders can be treated online, and how. It is not hard to imagine a person with a paranoid disorder or severe social anxiety preferring to converse with a therapist online rather than face-to-face. Nor is it difficult to envision people so psychologically or physically disabled that they cannot leave their place of residence, which makes online therapy a logical choice. Although we might see such Internet-mediated interventions as a first step that eventually leads to in-person work, we should also consider the possibility that online therapy might be the treatment of choice for some serious disorders.

Myth: Offline psychotherapy principles are the same as online therapy principles.

Fact: Many traditional theories about psychotherapy can be translated into online work. However, it would be naïve to think that the medium does not significantly affect the message. Online work calls for a new set of principles – a theory of cybertherapy – that guides us in understanding when, how and for whom the various communication resources of cyberspace are therapeutic. Online clinicians are now searching for principles that reveal what combinations of text, sight, sound, virtual presence, group interactions, imaginary versus realistic environments, and synchronous or asynchronous communication are therapeutic for which people. We are in the process of developing a theory that helps us analyze the potentially curative ingredients of different communication tools and for deciding what environments are therapeutic for which people.

Myth: Any experienced clinician can do online work.

Fact: To be a good online psychotherapist, it is necessary to have good training and experience in traditional psychotherapy, whatever that style of psychotherapy might be. However, this is not sufficient. Online therapy is significantly, and in some cases drastically, different than offline work. Not only does one have to learn the nuts and bolts of Internet communication technology, but also the new principles of online clinical work that are rapidly emerging. Books, journal articles, workshops and training courses are now available for clinicians who wish to venture into the world of online psychotherapy. One excellent resource is psychologist Azy Barak’s online reference list at <http://construct.haifa.ac.il/~azy/refindx.htm>. ■

Focus on the positive: Treatment for bipolar disorder embraces self-management

ASTRID VAN DEN BROEK

Stew Ludtke's diagnosis came in 1999 when he finally dragged himself to his doctor to talk about his nightmare of an experience. He was having delusions, hallucinations and frenetic bursts of energy, compelling him to work 14 hours a day building a five-storey house all by himself. The physician diagnosed Ludtke, then 45, with bipolar disorder and prescribed a combination of medications. He also referred Ludtke to a short-term psychotherapy program and later a psychiatrist. But Ludtke felt that something was missing. That's why he decided to get involved with support groups for people with bipolar disorder through the Mood Disorders Association of British Columbia. "That's where my recovery started," says Ludtke. "Medication has come a long way, but you don't just rely on a pill."

Today, Ludtke facilitates the Comox Valley mood support group in Courtney. Along the way, Ludtke has developed his own strategies for managing his mood swings and emotions: "I stopped drinking to try and control my moods, and I quit caffeine because I thought it was keeping me up at night," he says. "I also exercise regularly, which helps me feel a change in my body and get energized. For my recovery, I'd say medication accounts for about 30 per cent, the support group another 30 per cent, and the rest comes from me."

The role that self-management plays in Ludtke's recovery comes as no surprise to Dr. Greg Murray and Dr. Erin Michalak. Murray, director of clinical psychology programs at the Swinburne University of Technology in Australia, and Michalak, an assistant professor in the Department of Psychiatry at the University of British Columbia in Vancouver, recently completed a study that found that wellness factors play a significant role in recovery. The study is one of several being conducted by the international Collaborative REsearch Team to Study Psychosocial Issues in Bipolar Disorder (CREST.BD).

It is a significant finding because bipolar disorder, characterized by high and low mood swings, affects a surprising

number of Canadians. The Public Health Agency of Canada estimates that one per cent of Canadians over age 15 have experienced symptoms matching the bipolar disorder diagnosis. It also estimates that about one in 50 adults aged 25 to 44 and 45 to 64 have experienced bipolar-like symptoms at some point in their lives. According to a 2002 Mental Health and Well-Being Survey by Statistics Canada, nearly nine out of 10 Canadians who had experienced bipolar symptoms reported that these symptoms interfered with their lives.

Coping with this disruption has traditionally relied on medication, supplemented with talk-based therapy, but many find that this medical approach fails to recognize the role of self-management, mobilizing the person's own resources in their recovery. "Bipolar disorder is a serious mental illness that remains poorly understood," says Murray. "The first line treatments are still medication, which works for the majority of people, but it doesn't work as well as we

their lives are dominated by bipolar disorder. And for others, it is just a feature of their lives that they manage well and that rarely interferes with their goals. We decided to ask these people [who managed well] about the strategies they use as effective tools for managing bipolar disorder." The study is currently in press with the *Journal of Affective Disorders*.

One common wellness point that people in the study identified was sleep. Managing the sleep-wake cycle is one of the key issues a therapist will address with clients. "It's an important part of psycho-education," says Murray. "The sleep-wake cycle is a very important point of vulnerability. The study found that high-functioning people identified the critical need to manage sleep as one of the things they had learned about themselves."

So it was with 54-year-old Sophia van Norden, board chair of the Mood Disorders Association of British Columbia. Part of her self-management strategy included switching

For some people, their lives are dominated by bipolar disorder. And for others, it is just a feature of their lives that they manage well and that rarely interferes with their goals. What strategies do these people use as effective tools for managing bipolar disorder?

would like." With a complex medication regimen that often includes anti-depressants, antipsychotics and mood stabilizers, finding the right balance for each person can be difficult. "Over the last decade or so there has been a lot of interest from professionals and patients in discovering what else we can add to improve outcomes in bipolar disorder," says Murray.

In the CREST.BD study, researchers consulted with 33 people with bipolar disorder to learn what self-management techniques were and weren't working for them. "One of the interesting features of bipolar disorder is that two people can have the same level of symptoms but have very different functional outcomes," says Murray. "For some people,

to part-time work from her stressful full-time job, which included extensive travel, wreaking havoc on her sleep cycle. "Getting enough sleep prevented me from bouncing around mood-wise and gave me the ability to roll with the punches," says van Norden. "If unexpected problems happen during the day or your kids or husband are having a meltdown, it gives you tools to think, rather than panicking," she says, noting that these days she logs a solid – and regular – eight-hour sleep a night.

Along with other strategies, such as keeping active during the daytime and being socially engaged, CREST.BD also found that broader wellness approaches, such as eating well, avoiding alcohol or other addictive



substances and monitoring moods, are critical. “That means being proactive and not waiting for the signs of a change in mood, but actually sitting down when you’re feeling OK and writing down a plan, sharing it with important people, so they know the plan as well, and making sure that everyone involved in the plan knows their role and has agreed to it,” says Murray.

What also proved interesting along the way was discovering what didn’t work, and dispelling treatment myths, such as the role of introspection, which is central to cognitive-behavioural therapy. “For our group, the particular strategy of monitoring your thoughts, working out which ones are effective and which ones aren’t, modifying them if necessary, testing hypotheses that come from your thoughts – was not described as paramount,” says Murray. Instead, individuals seemed to focus not on being analytical, but on being more meditative. “They weren’t judging or analyzing or critiquing their

thoughts,” says Murray. “It was more that they were interested in simply being mindful of what was going on inside their heads in a more accepting way, in a more Eastern or Buddhist way, if you like.”

These findings resonate with Debbie Radloff-Gabriel, an occupational therapist with the Mood Disorders Research and Treatment Service at Providence Care Mental Health Services in Kingston, Ontario. She sees self-management strategies as part of the mosaic that includes medication and psychotherapy. She is quick to add that each mosaic is a personalized one. “One of the challenges when someone has bipolar disorder is that the sand is always shifting under their feet,” she says. “Learning how to manage the various ranges of experience and yet still do the things that are important to them is a way forward. Self-management is one of the keys.”

Recognizing the role of self-management strategies on the road to wellness has

implications for clinical practice. Murray sees the results of the CREST.BD study as a positive reframing of living with bipolar disorder. “You could see it simply as ‘Bipolar disorder is a serious mental illness with a high risk of suicide,’” says Murray. But the findings offer a more hopeful perspective: “Bipolar disorder is potentially a major burden in people’s lives, but our confidence is growing that we can moderate those outcomes. For each person, we should aim for good quality outcomes, rather than assuming that this is going to be a disastrous feature of their lives.”

It is this positive focus that needs to frame the therapeutic relationship. “Encouraging a focus on wellness has to do with where the clinician starts the story,” says Murray. ■

For more information about the self-management study and other CREST.BD studies, visit www.crestbd.ca

SELF-MANAGEMENT TIPS FROM THE EXPERTS

In the CREST.BD study, people with bipolar disorder who manage well identified six major wellness strategy themes. These strategies constitute “tips from the experts” that can be offered to clients to increase hopefulness and improve their engagement with psychosocial interventions.

1. Sleep, rest, exercise and diet. Regular and healthy sleep, eating and exercise are inexpensive strategies within one’s control that reflect common sense.

2. Ongoing monitoring. Learning to pay close attention to one’s moods and involvement in activities in order to judge when to make changes.

3. Reflective and meditative practices. These range from yoga and meditation to journaling, praying and creating art.

4. Understanding bipolar disorder and educating others. This involves finding information on the Internet, attending groups, charting cycles and stressors and talking to health care practitioners, and sharing this information with family and friends.

5. Connecting with others. Social interactions help to maintain wellness, especially during times of stress.

6. Enacting a plan. This can be an informal or formal plan for dealing with an impending manic or depressive episode and usually involves getting assistance from others.



Risk-taking teens show surprisingly mature brain structure

New research indicates that, contrary to what might be expected, teens who engage in dangerous behaviours, including drinking, smoking, taking drugs and drinking and driving, have brains that are in some respects more adult in form than those of their risk-averse peers. Researchers at the Emory University School of Medicine in Atlanta, Georgia, used diffusion tensor imaging to measure white matter organization in the brains of 91 adolescents. They assessed dangerous behaviour using the Adolescent Risk Questionnaire (ARQ), which measures thrill-seeking, rebellious, reckless and antisocial behaviours. Compared to more cautious adolescents, those who engaged in risky behaviour had increased fractional anisotropy (FA) and decreased transverse diffusivity (TD) in their frontal white matter, both indicators of a more mature brain structure. The researchers found that much of the correlation between risk scores and FA and TD resulted from correlations with what they termed rebellious behaviour (drinking, smoking, taking drugs). However, they note that white matter correlations accounted for no more than 25 per cent of the variation in ARQ scores, indicating that other unknown factors also play a role in determining an individual's propensity for dangerous behaviour. The association of risky behaviour with more mature brain structure may reflect the fact that these behaviours provide adolescents with more "life experience," or it may be that precocious development of the brain leads them to engage in behaviours considered more appropriate for adults than adolescents.

PLoS One, August 2009, v. 4(8), doi:10.1371/journal.pone.0006773. Gregory S. Berns et al., Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, Georgia.

Heroin maintenance therapy more effective than methadone

Prescription heroin appears to be more effective than methadone in maintenance therapy for people with heroin addiction, according to research from the University of British Columbia in Vancouver. The study involved 251 long-term heroin users in Vancouver and Montreal, 111 of whom were randomly assigned to receive oral methadone, while 115 received injectable diacetylmorphine (the active ingredient in heroin). In addition, 25 participants were assigned injectable hydromorphone for the purpose of validating self-reported use of street heroin. The injectable medications were self-administered under supervision at treatment clinics. After one year, 88 per cent of participants who received heroin remained in treatment, compared with 54 per cent of those who received methadone. Rates of illicit drug use and other illegal activity were reduced by 67 per cent in the heroin maintenance group, while the methadone group saw a 48 per cent reduction. The heroin maintenance group also showed greater improvement in physical and mental health, economic well-being, employment and family and social relationships. However, those given heroin experienced more serious adverse events (51 in total), including 11 overdoses and seven seizures, which resulted from the study drug. Methadone treatment resulted in only 18 adverse events, none resulting from the study drug. The authors recommend that heroin maintenance therapy be provided in settings where medical personnel are available for prompt intervention. Although the authors conclude that methadone should remain the treatment of choice for most people with heroin dependence, they assert that prescription heroin is a "safe and effective adjunct treatment" for people who do not benefit from methadone treatment.

New England Journal of Medicine, August 20, 2009, 361: 777–786. Eugenia Oviedo-Joekes et al., School of Population and Public Health, University of British Columbia, Vancouver, British Columbia.

Mental health and/or addiction treatment more common among sexual minorities

Men and women who are lesbian, gay or bisexual are significantly more likely than heterosexuals to receive treatment for mental health or substance use disorders, according to a study from the University of California, Los Angeles. The study was based on interviews with 2,074 California adults who were selected for sexual orientation minority status. Twenty-nine per cent of the sample had received treatment for mental health, alcohol or other substance abuse problems in the previous 12 months. However, lesbian and bisexual women were much more likely to receive such treatment, at 55 per cent, compared with 43 per cent of gay and bisexual men, 27 per cent of heterosexual women and 17 per cent of heterosexual men. Even among those who had no diagnosed disorder, 44 per cent of lesbian and bisexual women nonetheless received treatment, compared with 31 per cent of gay and bisexual men, 17 per cent of heterosexual women and 10 per cent of heterosexual men. The higher rates of treatment among sexual minorities may be due to cultural norms favouring help-seeking among sexual minorities, as well as to greater exposure to discrimination, violence and other stressful life events. The differences in treatment may also reflect cultural norms among gay and lesbian communities that see therapeutic services as "appropriate places for coping with the stresses associated with being a sexual minority." Furthermore, they may reflect a persistent tendency to view homosexuality as a mental illness. Future research into the effects of treatment for sexual minorities who do not have diagnosable disorders could help determine whether such treatment can reduce the likelihood that an individual will progress to more severe levels of illness.

BMC Psychiatry, August 14, 2009, v. 9(52), doi:10.1186/1471-244X-9-52. Christine E. Grella et al., Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, California.



Motivational interviews improve effectiveness of CBT for anxiety

Research at York University in Toronto has found that people with generalized anxiety disorder (GAD) respond much better to cognitive-behavioural therapy (CBT) when they are given motivational interviews prior to therapy. The researchers recruited 76 people with GAD, 38 of whom were assigned to receive CBT preceded by four weekly motivational interview sessions, while another 38 received CBT alone after a four-week waiting period. The motivational interviews were designed to increase participants' motivation by reducing their ambivalence about changing their patterns of worrying. Six participants dropped out of treatment with CBT alone, while only four dropped out when given pre-treatment with motivational interviews. At the end of treatment, those given motivational interviews showed significantly lower scores on the Penn State Worry Questionnaire than those who received CBT alone. Ninety-two per cent of those who received pre-treatment had normal worry scores after completing the therapy, compared with 71 per cent of those given CBT alone. Not only did those given pre-treatment benefit more from the CBT, but the motivational interviews alone provided some reduction in their worry scores even before they began CBT. Those with high levels of worry showed the greatest benefit from motivational interviews. Among this subgroup, 81 per cent of those who received pre-treatment no longer met diagnostic criteria for GAD after completing CBT, compared with 56 per cent of those who received CBT alone. The authors conclude that further research into augmenting CBT with motivational interviewing is warranted for people with severe levels of anxiety.

Journal of Anxiety Disorders, 2009, doi:10.1016/j.janxdis.2009.07.014. Henny A Westra et al., Department of Psychology, York University, Toronto, Ontario.

Risk-taking teens show surprisingly mature brain structure

New research indicates that, contrary to what might be expected, teens who engage in dangerous behaviours, including drinking, smoking, taking drugs and drinking and driving, have brains that are in some respects more adult in form than those of their risk-averse peers. Researchers at the Emory University School of Medicine in Atlanta, Georgia, used diffusion tensor imaging to measure white matter organization in the brains of 91 adolescents. They assessed dangerous behaviour using the Adolescent Risk Questionnaire (ARQ), which measures thrill-seeking, rebellious, reckless and antisocial behaviours. Compared to more cautious adolescents, those who engaged in risky behaviour had increased fractional anisotropy (FA) and decreased transverse diffusivity (TD) in their frontal white matter, both indicators of a more mature brain structure. The researchers found that much of the correlation between risk scores and FA and TD resulted from correlations with what they termed rebellious behaviour (drinking, smoking, taking drugs). However, they note that white matter correlations accounted for no more than 25 per cent of the variation in ARQ scores, indicating that other unknown factors also play a role in determining an individual's propensity for dangerous behaviour. The association of risky behaviour with more mature brain structure may reflect the fact that these behaviours provide adolescents with more "life experience," or it may be that precocious development of the brain leads them to engage in behaviours considered more appropriate for adults than adolescents.

PLoS One, August 2009, v. 4(8), doi:10.1371/journal.pone.0006773. Gregory S. Berns et al., Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, Georgia.



Suicide risk among older adults related to personality

Older adults who are considered strong-willed, obstinate and controlling, and who are reluctant to share their feelings appear to have an elevated risk of suicide, according to new research from the Oslo University Hospital in Norway. Researchers conducted qualitative interviews with 63 informants (relatives, family doctors and home care nurses) regarding 23 people over age 65 who had committed suicide. Many of them could be characterized as "survivors," with more than half experiencing illness, poverty or loss of close relatives in childhood or adolescence, and many also had to cope with similar hardships later in life. These older adults tended to be action-oriented achievers whose lives revolved around their work. Most informants characterized them as strong-willed and obstinate individuals who were very controlling in their relationships with others. They were generally reluctant to share their feelings and kept a distance in their relationships. Their need to control their surroundings, as well as their inability to accept their own limitations and need for help, may have left these older adults unable to adapt to changing circumstances later in life and to develop new coping skills. In light of their findings, the authors conclude that therapy for older adults at risk for suicide should aim to "ensure that elderly people are given confirmation of their personal value when their functional capacities and ability to take action diminish."

International Psychogeriatrics, October 2009, v. 21: 903–912. Ildri Kjalseth et al., RVTS, Oslo University Hospital, Oslo, Norway.

People with psychiatric disorders more likely to use psychoactive herbal medication

Users of herbal medication and dietary supplements (HMDS) are more likely than non-users to be seeking help for mental health problems and to be dissatisfied with their health care, according to a study from the Desert Pacific Mental Illness Research, Education and Clinical Center in Los Angeles. Using data on 9,585 individuals from the Healthcare for Communities national household telephone survey, researchers looked at respondents' use of HMDS and psychiatric medication, psychiatric diagnoses and use of mental health services. They found that HMDS users did not have significantly higher rates of psychiatric disorders, alcohol and substance use disorders, or psychiatric medication use. However, HMDS use was strongly associated with a perceived need for mental health services and dissatisfaction with health care. HMDS users were also more likely to have seen a mental health provider or a primary care physician in the previous year. Although individuals with psychiatric disorders were not more likely to use HMDS in general, they were more likely than those without such disorders to use psychoactive HMDS such as St. John's wort or melatonin. Given that 14 per cent of those who use HMDS also use psychiatric medications, the authors see a need for healthcare providers to talk to their clients about HMDS and to "familiarize themselves with the risks, side effects, and contraindications of more commonly used HMDS."

Community Mental Health Journal, August 18, 2009, doi:10.1007/s10597-009-9235-2. Noosha Niv et al., Desert Pacific Mental Illness Research, Education and Clinical Center, Los Angeles, California.



Dr. Google

Online self-assessment makes link to treatment

BY AVRIL ROBERTS

SEARCH GOOGLE FOR “DEPRESSION TEST” OR “ALCOHOLISM TEST” AND you’ll get 23.1 million and 9.4 million results, respectively. Clearly, self-assessment is alive and well on the Internet, that modern-day source of second opinions, sometimes even the “doctor” of choice. But whimsical Facebook quizzes aside, many evidence-based mental health and addiction screeners are appearing online, potentially reaching more people than actually seek mental health and addiction services. Online self-assessment tools not only educate; they also offer unprecedented opportunities to help people access care.

Screeners such as the Free Anxiety Screening Test and Check Your Drinking Survey make it easy for people to self-diagnose their mental health or substance use problems in the privacy of their homes, day or night, bypassing many of the usual barriers to seeking help in-person – stigma, embarrassment, location, anxiety and lack of awareness of the degree of the problem.

The anonymity of the Internet also allows people to be more candid about the extent of their substance use or mental health issues and possibly more receptive to information from a perceived non-judgmental source. “It fits with where society is going in terms of how people obtain information about anything, in this case, health information,” says Dr. Michael Van Ameringen, co-director of the Anxiety Disorders Clinic at McMaster University Medical Centre in Hamilton, Ontario.

In a survey of 200 visitors who completed the Free Anxiety Screening Test posted on the home page of McMaster University’s Anxiety Disorders Clinic (www.macanxiety.com), Van Ameringen found that 70 per cent were women, the mean age was 32, and 91 per cent had at least a high school education. Sixty-one per cent said they were concerned that they had an anxiety problem and 17 per cent were trying to confirm a diagnosis. However, 15 per cent said they were testing themselves because they don’t have a family doctor and another 14 per cent said they don’t feel comfortable discussing anxiety with their doctor. “We didn’t expect that at all,” says Van Ameringen. “If you can’t talk to your doctor or don’t have one, that’s a big issue for mental health professionals to deal with.”

More than 90 per cent of the respondents met DSM-IV criteria for an anxiety or mood disorder, most frequently social phobia, major depression and generalized anxiety disorder. Following the self-assessment, 58 per cent planned to seek further assessment from a health professional, and 31 per cent were going to look for more information online.

“You can see that people are using this kind of test to get ready for treatment or to find out more about their condition,” says Van Ameringen. “There’s probably a lot of fear about getting mental health treatment, so online self-assessment could be useful for moving people in the direction of treatment.”

Van Ameringen has seen people arrive at his clinic with printouts of online screeners, particularly for adult attention-deficit/hyperactivity disorder and social phobia. Noting that even if people assess themselves, they may not be able to get treatment immediately, Van Ameringen sees a role for more psychoeducation online. His clinic’s website links to specialized anxiety treatment services in Canada, among other resources.

Research also shows that web-based screening tools for addiction can be effective, not only educating people about substance use, but also motivating them to change. A recently published randomized controlled trial of the Check Your Drinking (CYD) survey (www.alcoholhelpcenter.net or www.checkyourdrinking.net), looking at drinking outcomes, found that problem drinkers who were directed to CYD had about a 30 per cent reduction in weekly alcohol consumption at three-month and six-month follow-ups, compared to a one drink a week reduction among the control group, which received a written description of CYD and was asked whether they thought its components would be useful.

The research, published in the December 2009 issue of *Addiction*, involved Ontario adults age 19 and older who were not treatment-seekers; they were already participating in a general population telephone survey and met criteria for risky alcohol consumption. Similar results were achieved in an Australian study, published in 2009 in the *Archives of Internal Medicine*, where university students completed a web-based version of the Alcohol Use Disorders Identification Test.

CYD asks 18 questions about the person’s drinking habits, provides personalized feedback on the person’s alcohol use and offers normative feedback comparing the participant’s drinking to that of people of the same age, gender and country of origin (Canada, U.S. and U.K., primarily.) It was developed for Evolution Health Systems Inc. by Dr. John Cunningham, Canada Research Chair in Brief Interventions in Addictive Behaviours at the University of Toronto and a senior scientist at the Centre for Addiction and Mental Health.

Cunningham theorizes this type of intervention works because “humans are social animals. They don’t want to think of themselves

as being abnormal or weird, so providing information that yes, you're drinking more than 95 per cent of other males your age can be a surprise," he says. "But if it's presented in a non-judgmental way, it can get people thinking about their drinking and motivate them to reduce a bit."

Cunningham also consulted on the Check Where I Am with Weed quiz posted on www.whatswithweed.ca, which takes a harm reduction approach to getting youth to assess their cannabis use. He notes that these online screeners attract people who don't necessarily seek out or may not even want formal treatment – problem drinkers, as opposed to people who are severely alcohol dependent, women, older people and youth. He sees screeners as offering "one good option in a palette of different things people could try."

A Quebec study led by Dr. Michel Perreault, a researcher at the Douglas Mental Health University Institute in Montreal, and associate professor in the Department of Psychiatry at McGill University, further illustrates the Internet's reach. The study, published last year in the *International Journal of Victimology*, used an online questionnaire to explore obstacles to care for anxiety disorders. More than 700 people completed the quiz – 653 had an anxiety disorder and 61 were family caregivers. Forty-three per cent arrived via support group websites.

The high response rate and the fact that people persevered through a multi-part questionnaire, even when given opportunities to exit, suggested to Perreault that even in hard-to-reach populations, "people are highly motivated to learn more about themselves and their conditions and the services available to them." The three main treatment barriers that people identified were symptoms; not knowing where to go for a diagnosis, treatment or other services; and issues

of access, particularly a lack of funds or insurance coverage for a psychologist.

Recognizing that the Internet is often the first place people look for information, the CYD study concludes: "The Internet could increase the range of help-seeking options available because it takes treatment to the problem drinker rather than making the problem drinker come to treatment." It's an opportunity that extends to mental health and addiction services in general. ■

TO POST OR NOT TO POST: 10 ISSUES TO CONSIDER

Kate Dewhirst of the Toronto-based law firm Dykeman Dewhirst O'Brien LLP identifies key issues to consider before posting self-assessment tools or treatment information online:

1. Who owns the intellectual property in the material being posted?
2. What are the expectations of users? Have you made clear (through disclaimers, terms of use and notices) the limited purposes for which the materials can be used?
3. What legal jurisdictions apply? Are you relying on provincial, state or federal laws? Are you targeting users in other jurisdictions? Could those jurisdictions have laws you need to follow?
4. Are there privacy or confidentiality issues to manage? What happens if users self-identify?
5. Are you providing a list of local services, or are you endorsing certain services over others? Are you legally liable for making referral recommendations if those services turn out to provide sub-standard care?
6. Are there clinical scope of practice, jurisdictional and competency issues? Do users think they are receiving clinical advice?
7. What happens if someone relies on your advice to their detriment?
8. Is this the best advice you have? Is it up-to-date? Who should rely on it?
9. What disclaimers, notices and terms of use do you need to properly equip people using your site?
10. Will you monitor the site and its usage? Have you set out your own privacy policy for your site?

LINKING INFORMATION TO TREATMENT

One website that has embraced the Internet's potential to link information-seeking to treatment is eMentalHealth.ca, which launched in 2005 as a directory for child and youth mental health services around Ottawa. The site now includes treatment and information resources for families and adults and has recently expanded beyond Ottawa. It provides the missing link between information and treatment characteristic of most websites: "On our site, if you read about depression, it links to local help for depression," says co-founder Dr. Michael Cheng, a child and family psychiatrist at the Children's Hospital of Eastern Ontario in Ottawa. "It can take weeks or even months to see a mental health professional, but if people know about treatment options earlier, there's potential to get help much sooner," he says.

Completing any of the public domain self-assessment questionnaires yields an explanation of your score and links to local resources and information. The service listings encompass publicly funded mental health and addiction services, private practice professionals and commercial operations.

The site has not been marketed specifically to health professionals, but they are among its biggest users. A work in progress, eMentalHealth.ca is seeking partners – organizations and communities that might be interested in creating and managing the local database for their areas or linking their own online resources to the site.

Check out this story at
www.camhcrosscurrents.net
 for a list of clinician-recommended online
 self-assessment tools for your clients.

The Net generation

Welcome to their world

BY LESLEY YOUNG

Client: "Nobody at school likes me anymore. They say horrible things about me in front of everyone else.

I was so upset I flipped out on Nagus."

Therapist: "Who is Nagus"

Client: "Oh, he's my BFF avatar I talk to all the time."

Therapist: "Your what?"

IF YOU'RE OVER THE AGE OF SAY, 30, YOU MIGHT IDENTIFY WITH THIS fictional scenario. For the record, an "avatar" is a character that can be personalized and used to interface with others online, for example, in virtual games. Given that the adolescents and teenagers you may work with have grown up immersed in the Internet, you need to understand how they operate in the cyber world – and how it may affect issues they grapple with.

For these cyber youth, what happens online is as important as what happens in their offline world. "Studies show that teenagers and young adults spend as much time on their virtual identity on places such as Facebook and MySpace as on their 'real' identity," says Avrum Nadigel, a Toronto-based adolescent and family therapist. "To ignore that virtual identity in a clinical setting is a serious problem."

Faye Mishna, interim dean at the Factor-Inwentash Faculty of Social Work at the University of Toronto, agrees: "Not only do clinicians tend to underestimate [the impact of cyberspace], but most parents don't realize the extent to which it affects their children." The cyber world is as likely as the offline world to create situations that may trigger a predisposition to a mental health problem, exacerbate an existing one or even contribute to its development.

According to Statistics Canada, 96 per cent of Canadians age 16 to 24 went online in 2007. In the general population, 20 per cent of home Internet users reported contributing content by posting images, writing blogs or participating in discussion groups. Of these, more than 50 per cent were under 30. It's a trend that continues to grow.

What is also growing are questions about the potential implications of the virtual world for the mental health of youth. "Their decision-making process is still being formed," explains Dr. Alexa Bagnell, a psychiatrist at the IWK Health Centre in Halifax, Nova Scotia. Young people may be impulsive and unable to appreciate the extent of the consequences of their actions. Yet the online consequences can be profound, given the scale of the Internet, where young people can be shunned on Facebook or humiliated with an embarrassing online photo that hundreds of their peers can see.

But the Internet can also be a place where youth who may not have many friends can connect with people. For the average youth, research shows that offline relationships are enhanced by online connections. "It can be a place that is very supportive and positive, a place where kids can be themselves and express their own identity and be connected," says Mishna.

The online world also poses challenges, says Nadigel. Young people without a community of positive adults in their lives may find a community of peers online who are more than happy to listen and understand where they are coming from, he says. "In that case, you may end up with the blind leading the blind." He adds that if someone is going to act out, there are fewer barriers to engaging in bad behaviour online.

Nadigel highlights how the Internet may influence mental health development, with the caution that it remains to be seen whether or exactly how these influences play out over time.

False sense of intimacy. Nadigel is noticing a tendency among adolescents, especially young girls, to assume they know someone because they have connected online, for example, they've seen their photos and information on Facebook. "Often they meet a person online and have a sexual relationship with him the first time they meet in person," he says. When it doesn't turn out the way they expect, they are disappointed. Over time, Nadigel says this could interfere with the ability to form strong, trusting bonds with others.

Anonymity. Nadigel would like to believe that people who hide behind anonymity are benefiting most of the time (for example, a gay rural youth reaching out to others). “But I don’t think that is the case,” he says. “My hunch is that people use anonymity more often to ‘as if.’” “As if” is the clinical term for acting like someone you are not. Online anonymity allows you to create, say and do things you never would offline. The long-term impact on social and mental behaviours is not known, but Nadigel says a false sense of anonymity may lead youth to make bad judgment calls.

Voyeurism. Teenagers tend to get caught up in voyeurism more than anonymity online, says Nadigel. Everybody “knows” everybody. “The question is, how fulfilling are those relationships?” says Nadigel, who thinks the Internet will exacerbate a predisposition to narcissism in teenagers who may already be struggling with healthy relationships.

All the web’s a stage. Nadigel is always surprised at how much youth reveal about themselves online, without any thought to repercussions down the road. The Internet has enabled anyone to be a star, in so far as it presents, potentially, a worldwide audience. The result is that many young people are unwittingly putting themselves in precarious positions.

While clinicians need to keep in mind that the Internet is an integral part of many young people’s lives, Nadigel says that therapy

UNDERSTANDING ADOLESCENTS

Identity experimentation and exploration.

Adolescents are beginning the life-long journey of trying to understand who they are. Questions like “What do I want to do with my life?” and “What kind of person am I?” are intense. Some of the answers can be found in cyberspace.

Intimacy and belonging. Exploring new intimate relationships, sexual and non-sexual, are a major part of exploring identity. Cyberspace offers an endless array of new and different types of people for youth to get to know.

Separation from parents and family. The search for self-identity coincides with a need for independence, and adolescents may pull away from parents. Cyberspace enables exciting adventures and unique encounters that adolescents can be ambivalent about because they are safe in their home.

Venting frustration. Between puberty, the search for self-knowledge and the weight of expectations, teens can get emotional. Cyberspace is an easy-in, easy-out place to vent.

itself, free of distractions and information overload, is a counterbalance to the rapid, anxiety-triggering universe young people are living in. Just having access to anything and everything 24/7 is creating an anxious generation. “Our job is to provide young people, perhaps for the first time, with a healthy experience with an adult in a safe environment to explore their identity,” says Nadigel. Over time, clients can take the experience and its accompanying sense of calm with them.

Nadigel suggests that clinicians working with youth get comfortable with the technology. “You have to ‘get’ what they are doing and be comfortable sharing their world,” he says. (See Cyberspace 101 sidebar.) Clinicians may even incorporate therapy practices using technology the way adolescents do. In addition to teaching teenage clients mindfulness meditation to cope with external pressure, Nadigel sometimes sends a text-message with a specific tip (e.g., how to take three deep breaths). “I’m using a modern-day technology to teach a thousand-year-old tradition to a teen about centering herself in math class,” he says.

Once Nadigel gains their trust, his adolescent clients usually are happy to share their virtual worlds with him, walking through their Facebook and MySpace profiles, for example. “I engage them about facets of their page, building more trust, and when the moment presents itself, I explore some issues with them: What is the young person getting out of this? What do they really want out of life? It’s not different than what we normally do in therapy, but it’s a new avenue to peer into.”

Like traditional therapy, epiphanies take time and trust, and with young kids, often involve therapy with the entire family, says Nadigel. He reminds clinicians that there is tremendous peer pressure on kids to be crazier, sexier, cooler online, and that the process of getting them to understand the consequences of actions in cyberspace can be an uphill battle. “But it shouldn’t be avoided or overlooked,” he says. ■

CYBERSPACE 101

In case you’re not as Internet savvy as your young clients, here’s where they may be hanging out online.

Websites. Pages or collections of pages that adolescents can visit and read.

E-mail dyads and groups: E-mail is a powerful, flexible means to communicate; the e-mail itself becomes a psychological “space” in which the adolescents live together. Groups can communicate on “list-servs.”

Chat rooms, Instant Messaging (IM) and MUDs (Multi-User Dimensions). A favourite of teens because they communicate in “real time.” This includes text messaging by cell phone. In some multimedia chat environments, the text conversation occurs in a visual room, and participants use visual icons called avatars to represent themselves. They can resemble the participant, or their fantasies.

Message boards. Like an electronic bulletin board, people post messages but not in real-time. Groups are often devoted to a theme. These can be homes away from home for many teens.

Blogs. Like e-mail and IM, blogs are a kind of online journal or diary. Teens often use them to talk about their day. They can be set up for restricted access, but blogs are often wide open, for anyone to see.

One entry at a time

Bloggers create communities of support – but with some risks

BY ANNE PTASZNIK

CRISTINA, 34, BEGAN BLOGGING IN 2006, JUST WEEKS AFTER BEING diagnosed with bipolar disorder. When she went online looking for people who shared her experience, most of them were bloggers. She decided to try it herself. “I used to journal when I was younger, and I missed it,” she says in a phone interview. “I thought it would be a good way to cope and get my feelings out.”

Journaling and writing have long been used in psychotherapy, based on the principle that emotions and experiences can be better “understood, mastered and assimilated when explored through language,” says Dr. John Suler, a psychology professor at Rider University in Lawrenceville, New Jersey, and author of the online book *The Psychology of Cyberspace*. But while many psychotherapies encourage people to talk about their issues, Suler says that for some people, putting words to their experience is easier in writing.

But there’s a fundamental difference. Journal writing can be kept private, whereas blogging is public, not only inviting information exchange and support for people who write about their mental health issues, but also exposing them to potential discrimination and abuse. Yet, according to a 2005 America Online survey, almost 50 per cent of people used blogs as a form of self-therapy. Suler says there is no empirical evidence that mental health bloggers are particularly exhibitionistic or narcissistic; so what motivates them to expose their struggles publicly? Some say it is the public nature of blogging that provides benefits beyond the therapeutic value of writing – obtaining and giving support, becoming part of a community, educating the public and fighting stigma.

Cristina says that the potential shame and stigma from being identified as someone with a mental illness is a small price to pay for the “peace, understanding and acceptance” she has gained from Raw Writing for the Real World of Bipolar (www.bipolarchica.com). Her

blog was recognized as one of the top 10 bipolar blogs for 2009 by Psychcentral.com, a popular online mental health network. “You find out who you are when you blog,” says Cristina. “All of you is laid out for the world to see. It’s a good way to see your reflection and to find out if you love yourself enough to continue in this life.” Suler says that anticipating and writing for an audience “stimulates a valuable process of trying to see oneself through the eyes of others – trying to see oneself more objectively.”

James, 34, from Colorado, who has been blogging as Handsome B. Wonderful since 2005, refers to his Letters from the Sanitarium blog (www.sanitariumletters.blogspot.com) as a sort of online group therapy. “If I didn’t have the Internet to interact with others like me, I’d feel so alone, isolated and trapped,” he tells me in an e-mail. James, diagnosed with schizoaffective disorder, explains: “We really are there for each other and look after one another. If a mental health blogger hasn’t posted in a while, we check in on them.” Blogging also provides an outlet for people who might be afraid of traditional group therapy or for those with disorders like his for which there are few support groups. “If you come from a country that isn’t very advanced in psychiatry, blogging is a life-line that many isolated patients desperately need,” James explains.

Madalyn Marcus, a doctoral candidate in clinical psychology at York University in Toronto, and one of the authors of a study that analyzed the blogs of young people with mental health problems (see sidebar), was struck by the sense of connection these isolated young people felt online that they weren’t necessarily experiencing in the “real physical world.” The blogs provided a space for support, even allowing readers to check on one another, for example, when one of them had talked about suicide the previous day.

But Suler warns that not everyone online is supportive or

WHAT ARE YOUNG MENTAL HEALTH BLOGGERS SAYING?

Mobilizing Minds, a national five-year research project, conducted a qualitative study of the blogs of eight young adults (18–25) who wrote about their mental health problems over six months. Consistent with offline research, several key themes emerged:

- a pervasive lack of control over all-consuming mental health problems, while simultaneously feeling that they “should” have control over them
- a profound sense of disconnection and alienation
- lack of support from the community (including mental health professionals), which in turn perpetuates and disconnects young adults on many levels
- failure to seek help because of the lack of support and disconnection

The researchers recommend that mental health professionals help young people decrease their sense of disconnection and alienation by designing systems that give young people a voice, encouraging opportunities for peer support, developing supports in non-medical environments and educating friends and family about how to best offer support and reduce stigma. For more information, visit www.mobilizingminds.ca

benign. “People do all sorts of acting out in cyberspace, and they are looking for targets,” he says. Transference reactions, where people misperceive others based on their own needs and fears, are common, and he says bloggers can easily become the target of these hostilities.

James admits that he was initially worried about receiving negative comments. He has had the occasional “outright mean” person visit his site and tell him that he is “lazy, irresponsible and a whiner.” He either deletes these or responds just as strongly. He says it can be depressing when he has expressed strong emotions and no one has commented, but he mostly blogs to express himself without filtering his thoughts from “other people’s fears of strong emotions.” Besides, he knows that many people read his blog and support him, whether or not they comment. “I am always amazed at the compassion, empathy and intimacy shown by complete strangers,” he says.

Ashley’s blog, *Overcoming Schizophrenia* (<http://overcoming-schizophrenia.blogspot.com>), has helped her to “come out” as having a mental illness, not just online, but offline as well. Prior to starting the blog, Ashley, 24, from Atlanta, Georgia, was private about her diagnosis. She began blogging a year after being diagnosed with paranoid schizophrenia in 2007, when she landed in jail and then a state psychiatric hospital. Ashley originally intended to use the blog to track her moods and feelings, but she quickly shifted its focus to educating others and sharing her experiences with treatment so others would know that “recovery and healing are possible.” Blogging even motivated Ashley to start *Embracing My Mind, Inc.*, through which she runs offline support groups.

But the supportive role of blogs has stirred controversy, notably around pro-ana (anorexia) and pro-suicide blogs. Yum originally started her pro-ana blog (yummy-secrets.blogspot.com) because she was “looking for others who would not judge me for my actions, because they were going through similar experiences.” Concerned about the misinformation that abounds on other pro-ana and weight loss sites, Yum also wanted to share her knowledge of mental and

physical health as she learned more about her eating disorder. She admits that people who are pro-ana use these blogs to “trigger” or motivate themselves to maintain their habits, but she doesn’t consider herself responsible for triggering someone, because, as she explains, people with eating disorders who want to be triggered can – and will – use anything as “thinspiration.” People read a warning before entering Yum’s site, but according to the National Eating Disorder Information Centre (NEDIC), these warnings merely feed people’s curiosity to visit pro-ana sites.

NEDIC also warns that pro-ana blogs may encourage harmful behaviours and normalize, even glamourize, eating disorders. But Kat, 18, who has a popular pro-ana blog, *Quest for Perfection* (<http://proanaquest.blogspot.com>), disagrees: “I never made it seem glamorous, unless people think that passing out on the side of the road is glamorous.” Kat started blogging to express her thoughts and feelings, not thinking she would have any readers. She says she does not want people who don’t have an eating disorder to develop one because they are reading her blog, but if people have made that decision, even knowing it could be dangerous, she wants to support them. She wants to dispel the belief that pro-ana bloggers are evil people trying to ruin girls’ minds. “America has all kinds of really messed up views on dieting,” she says. “If girls are searching pro-ana blogs, it means something else has triggered it.” But at the same time, Kat admits that her blog keeps her tied to her eating disorder.

While Kat says that finances prevent her from seeing a therapist, some bloggers share their blogs with their therapists. James, however, says that blogs are a “no-go area” for therapists, and that people in treatment should be able to choose whether or not their therapist reads their blog. “Blogs are often places where clients can freely write about therapy sessions without fearing to threaten the relationship,” he says. Some bloggers might censor their writing, knowing their therapist is reading it, and for people with paranoia, James says that lurking can reinforce that fear of being watched.

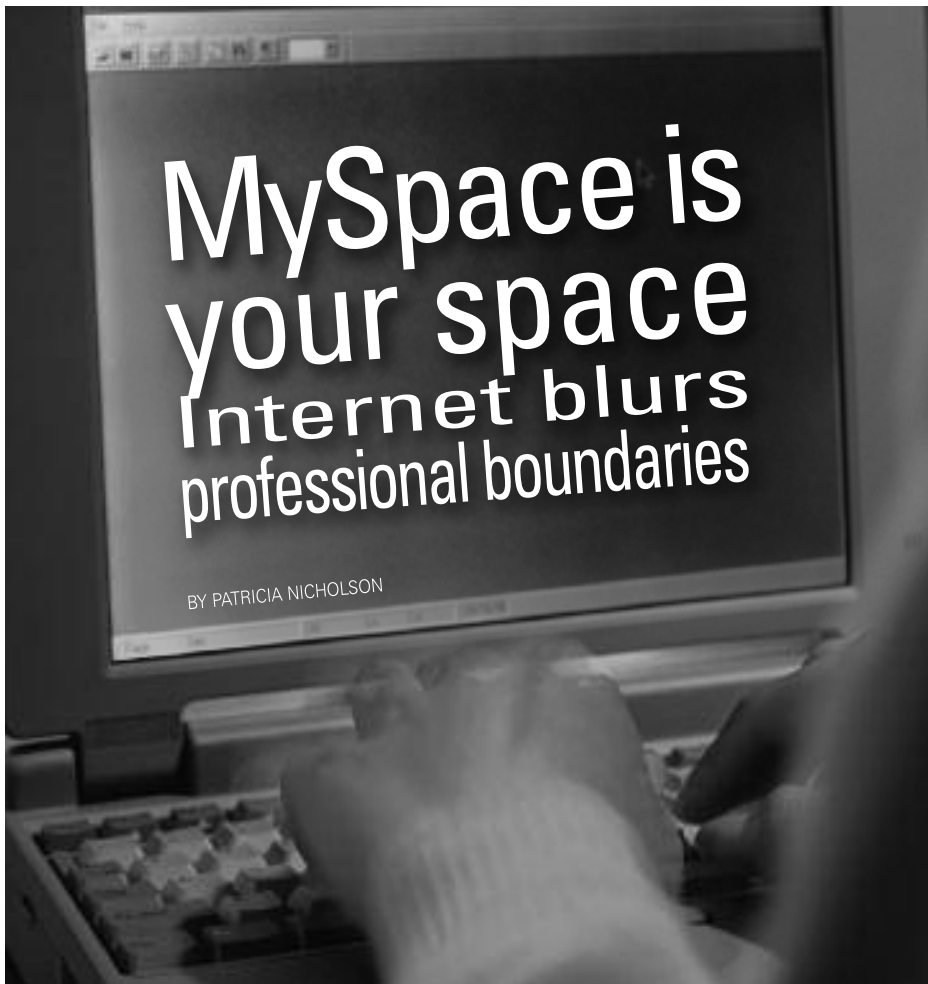
But Marcus at York University says that blogs can help therapists gain insight into the experiences of their clients, including how isolating and all-consuming mental illness can be, and how to best offer support. However, she agrees that although blogs are public, reading a client’s blog could breach confidentiality. If the client is open to this, it can be worked out together, along with discussing the pros and cons of blogging. Ultimately, Marcus says blogging is a decision clients need to make for themselves: “They may look back and be concerned at the level of detail they disclosed,” she says. “Or they may look back and feel proud that they were able to share their story, support people and get support.” ■

Should therapists read their clients’ blogs?

Should they lurk on discussion boards?

How can mental health and addiction professionals engage with social networking media to help people?

Share your thoughts at
www.camhcrosscurrents.net



BETWEEN POSTING VACATION PHOTOS ON Facebook and “tweeting” real-time information, private life can become quite public. But public versus private is not the only distinction becoming murkier as more of life is lived online. For people who work in the mental health and addiction fields, professional versus personal boundaries are also blurring.

It’s a trend that prompted Crisis Response Services Kenora Rainy River District to develop a new technology and ethics policy after program co-ordinator Kyla Storry got a Facebook friend request from a client. “I explained to him in person that our relationship is a professional relationship only, and that doing things like adding him on Facebook to my personal page is definitely outside of the ethical boundaries of the client-therapist relationship,” she says.

By clarifying that client contact should be job-related and take place during working hours, the policy ensures that staff are clear

about what’s appropriate online. “That gives them the ability to clearly state to a client that it’s not appropriate and the reasons why,” Storry says.

The Centre for Addiction and Mental Health in Toronto has also recently amended its policy on therapeutic boundaries to include a statement about technology. “It is basically a caution to staff, saying that they need to be mindful of the use of technology and social networking sites,” says Jane Paterson, deputy chief of professional services. “We want people to think about such issues and not put themselves in compromising situations.”

Applications such as Internet dating sites that may be used by care providers and their clients are just one example of new ways in which the boundaries between the personal and professional can shift. “Twenty-five years ago that wasn’t a possibility,” says Paterson. “But technology raises different ways in which boundary violations may occur.”

Dr. Jeffrey Barnett, a psychologist in independent practice and a professor at Loyola University in Baltimore, Maryland, says online friend requests might not seem like a boundary issue to younger clients, for whom social networking seems to be second nature. “It’s how they communicate,” says Barnett.

But friend requests are only one form of online interaction that clients and therapists may run into, either deliberately or accidentally. Clients may seek out information about therapists on the Internet, with or without their knowledge. These searches can range from appropriate curiosity about a therapist’s background and research interests, to the alarmingly intrusive.

Barnett recommends using the highest privacy settings on social networking sites, and being mindful that whatever is out there might be viewed by clients. He also recommends a proactive approach to controlling information online. One good way to do that is to have a professional website with all the information you think clients should have – photo, credentials, type and location of your practice. “If your website answers a lot of the questions potential clients have about you, then they might not search much more,” Barnett says. “If there’s a void, they will keep looking.”

But Barnett notes that some online information is not under our control. “I have a colleague who was in a community 10k race and someone took a picture of her crossing the finish line,” he says. That picture is on the website of a running club, so when clients Google her, they not only get her professional credentials, but also a photo of her in sweaty running clothes. “That’s not necessarily a bad thing,” Barnett says. “It just highlights that this line between professional and private that used to exist is evaporating, and we have to be cognizant of that.”

An article in the *Journal of the American Medical Association* last September, which documented inappropriate Internet activity by medical students, resonated with Barnett, who says new graduates have grown up online and often don’t differentiate between personal and professional. “This is how they communicate and live, and they need to be indoctrinated in the role of the professional,” says Barnett. For example, he had to speak to a student about a suggestive e-mail address – something along the lines of

sexydiva3@hotmail.com. “We had to talk about why that might not be appropriate for e-mailing clients,” he says.

When University of Washington graduate student Keren Lehavot surveyed graduate students (most of whom were student therapists), she found that a substantial number used social networking sites. Two-thirds of the MySpace users used their real names on the site, but only 60 per cent limited access to their online information. About one-third had posted photos or personal information they said they wouldn’t want clients to see.

Lehavot also found that while 7 per cent of the student therapists said they knew clients who had retrieved therapist information online, 27 per cent had checked online information about clients.

Barnett has concerns about checking up on clients. “Are we violating their trust if we start searching for them online?”

That’s one of the questions Dr. Keely Kolmes, a psychologist in private practice in San Francisco with a background as a computer consultant, is exploring. For younger, Internet-savvy therapists, it may seem natural to search for information about clients. Kolmes and her colleague Dr. Dan Taube at Alliant International University in San Francisco are surveying psychotherapists about their experiences with finding client information – accidentally or deliberately – on the Internet.

“I was curious to discover the frequency of encounters that people were having online with their clients, and what the impact was on the clinical relationship,” says Kolmes. “We’re hearing that this is an issue, and that it feels different than encountering patients offline outside of therapy.” Kolmes plans to report the findings in March. (Visit www.drkkolmes.com/blog.)

In her own online life, Kolmes was an early Internet adopter and has had a personal presence online since 1993. “My professional presence feels newer to me,” she says. “But I felt like I really needed to create a distinct professional identity on the Internet because I feel strongly that there’s a need to separate the two.” While maintaining that separation can be challenging, Kolmes says it is worth the effort to maintain personal space and a personal life. “It’s like the difference between my home and my office,” she says. ■

Be an online-savvy practitioner

Dr. Keely Kolmes, a licensed psychologist in private practice in San Francisco, often fields questions about online boundaries from other clinicians. Her top recommendations for life online:

- **Take responsibility for your web presence.** Use two different e-mail addresses and be mindful of who you share each with. Google search your personal and professional information occasionally to see if your identities cross paths.
- **If you use social networking, make distinctions between your professional and personal use.** Keep in mind that anything you put online might be seen by a wide audience, and assume that online means permanent – even if you delete it, it’s still out there somewhere.
- **Understand and use privacy settings depending upon how you use social media.** Therapists who aren’t tech savvy may not be aware of how much they are revealing.
- **Continue to get consultation on clinical and ethical issues when they arise.** Document your consultations.
- **Develop a social media policy for your practice.** Make sure clients understand your policy. Include it in informed consent and discuss it with clients.

How to avoid close encounters of the online kind

Search engines and social networking dominate discussions about online boundary issues. But Dr. Keely Kolmes notes other places where therapists and clients might cross paths electronically.

- Professional networking sites such as LinkedIn can be more of a gray area, but keeping your profile and contacts non-public is wise.
- If you have a professional blog, be sure that case comments don’t identify clients – even to themselves. Consider the ramifications of allowing comments on your blog: What would be the effect if your clients left comments?
- Mailing lists. You and a client may have a shared interest or issue, and may turn up on the same e-mail list.
- Online dating sites and personal ads are another potential point of extra-therapeutic contact.
- When buying or selling items on sites like Craig’s List, don’t use your professional e-mail address.
- Some therapists have found their practices turning up on review sites such as HealthGrades and Yelp, even if they didn’t request a listing. This can be an ethical problem because it might be interpreted as a request for client testimonials.



In your clinical practice do you see the Internet blurring boundaries between your private and professional lives – either intentionally or accidentally?

Share your thoughts at
www.camhcrosscurrents.net

Being there

KATHY

These two stories convey an important message: Therapy is about communication and connection. As the tools of communication evolve to meet the demands of the 21st century, what stands firm in the therapy process is the therapeutic alliance that lies at its heart. CrossCurrents asked Dawn Schell, a counsellor with Therapy Online, and her client Kathy to write about how they experience “being there” in therapy, despite having only met once.

I met Dawn in 2008 when she led a weekend retreat. Dawn and I had a natural rapport, so I was excited to start online counselling with her, focusing on my anxieties about raising a son with bipolar disorder. I had experienced face-to-face counselling and knew how important it was to develop a strong alliance with the therapist. I was curious to see how we would develop this connection online, with 100 kilometres separating us.

Dawn works for an online counselling company whose web site clearly outlines the counselling process. It was wonderful to be able to write to Dawn whenever I wanted. I know that journal writing can be therapeutic, but I have never been able to stick with it.

I’m amazed at the sense of “being there” that Dawn creates. When we are in a session, she always welcomes me into the “room,” and I feel her presence as she invites me to sit beside her. She develops a sense of natural conversation by inserting comments beside my remarks, often identifying feelings and empathizing with my experiences and thoughts. She tells me how she feels, for example “[sad],” or she describes herself as “[smiling].” She writes “hmmm” to indicate her thought process.

Online counselling helps to clarify my own thought process. I can rethink and rewrite my comments. I couldn’t do that in face-to-face counselling. I can reread Dawn’s comments, which are often profound and moving. I can respond whenever and however I wish. I can even print out the sessions to reflect on. In the past, when I left an in-person session with a therapist, I often felt better, but I couldn’t always recall exactly what we talked about.

In looking back at some previous sessions with Dawn, I realize how often I don’t answer her questions in subsequent sessions. I do consider responses to her questions, but I don’t feel that I have to answer them, nor does she pester me for answers. In this way, I feel that I have more control over what we discuss, and I like that. This process has allowed me to have more responsibility for my healing. Dawn has always responded to my questions or requests for more information. It has been delightful to receive e-mails from her that simply list websites she thinks might interest me. That makes me feel like she really cares.

I find online counselling to be more helpful than face-to-face. It can happen anytime, any place. I encourage other counsellors to consider it. Perhaps a one-time meeting would be helpful, but if you can provide a clear description online of your areas of expertise, your values and beliefs, clients will have a good sense of who you are. When Dawn describes the room she is in, when she describes her feelings in response to my comments, when her empathy comes through loud and clear, this fosters a natural, positive relationship. Online, no one is looking at you, at your hands, at your clothes. These superficialities are removed and a more authentic experience is possible. That’s what I have with Dawn.



How one therapist and her client connect online

DAWN

I couldn't help but smile when I read Kathy's e-mail describing a difficult situation with her son. I was smiling because, even in the midst of the frustration that clearly came through in her message, she could write about the situation with humour. It was a moment in our therapeutic relationship where I felt like I was in the room with Kathy, although she was sitting at her computer at home, and I at mine in my office. Like countless other moments in our therapy, this one reinforced my amazement at being able to feel such a natural rapport with a client I was "seeing" as an online counsellor.

I have never met most of my clients in person. Since I met Kathy that one time and she asked me to do online counselling with her, I had more background information than I usually do with online clients. That was a bonus in establishing our rapport in therapy. I could visualize her, hear her voice, picture her smile. But that physical presence isn't necessary.

When I first heard about online counselling I didn't think it would be possible to build a strong connection with clients without being physically present together. How could I translate the counselling skills I had developed over 19 years into a therapeutic relationship that relied purely on text to communicate and connect? How could I be "present" with clients in a meaningful way online? Yet, here I am, four years later, doing it, and it seems to work. For me and for Kathy.

At first, it was difficult to translate onto a computer screen what I do every day in person as a counsellor. It was awkward and seemed unnatural to have to stop and think about what I was doing, my facial expression, what my tone of voice would sound like in person – and how I would convey that to clients purely in writing. Then I thought back to my early days of counsellor training (flash back to Simon Fraser University in British Columbia in 1984). It was awkward then too. So I had to remind myself to be patient and to practice, practice, practice.

I had to learn how to translate the physical components of counselling skills – my voice, my body language – to my fingers. I had to learn how to provide clients with as much context as possible – describing my surroundings and conveying my gestures, facial expression and tone of voice in a natural way. Mastering these techniques takes time and can feel artificial at first, but these are rich nuances key to creating an online environment that captures the complexities of expression in face-to-face work.

A part of the ongoing therapeutic process with Kathy (and all my clients) is that I ask questions, I never assume, I ask for clarification. Not different from face-to-face counselling, really.

Still, I know from experience that online is not the format for everyone. But I do know – and Kathy tells me – that it is possible to build a strong therapeutic relationship online [not that I'm biased ... grinning]. ■

COMING UP TO TECHNO SPEED

These resources discuss issues related to clinical work online, including practical, ethical, legal and licensing considerations. You'll also find links to training.

Association for Counselling and Therapy Online
www.acto-uk.org

International Society for Mental Health Online
www.ismho.org

International Conference on the Use of the Internet in Mental Health
<http://bccooltv.mcgill.ca/ListRecordings.aspx?CourseID=2133>

The Psychology of Cyberspace
<http://www-usr.rider.edu/~suler/psycyber/psycyber.html>

Therapy Online
www.therapyonline.ca

University of Toronto Faculty of Social Work Certificate in CyberCounselling
www.socialwork.utoronto.ca/conted/certificate/Cybercounsel.htm



Ethical, legal and licensing issues in clinical work online

BY ANGELA PIRISI

Online therapy is emerging as a legitimate, sometimes even the preferred method of delivering mental health and addiction services. Still, clinical professionals may be reluctant to work online because they are not sure what the ethical and legal issues are. Here, Dr. Carole Sinclair, chair of the Canadian Psychological Association's Committee on Ethics, explores some of these concerns.

Are there any special licensing considerations for providing therapy online?

"Jurisdictional boundaries don't really exist yet," says Sinclair. "To my knowledge, no North American psychology jurisdiction has established a rule that says a psychologist registered in that jurisdiction cannot treat a client in another jurisdiction." However, you need to know and observe not only the licensing regulations of your own jurisdiction, but also the licensing requirements in the client's jurisdiction. Do they prevent your provision of online services in the jurisdiction because you are not licensed there? Being familiar with other types of laws of the jurisdiction where the client lives (e.g., mandatory child abuse reporting laws) is also vital. Each jurisdiction has the legal responsibility to protect those who live in that jurisdiction. Clients need to know where to go to complain if they believe they have been harmed. It is necessary to balance the benefits and risks of extending services beyond your jurisdiction. Check with your local professional governing body, since rules may vary for different clinical professions.

What is the interpretation of boundaries of competence for online therapy?

You cannot practice outside the scope of what you are licensed and competent to provide face-to-face. "In addition, when it comes to the Internet, it's not just professional competence that matters, but technological competence as well, such as understanding how to protect client privacy and how best to use electronic media," says Sinclair. How well can you transfer counselling skills to the online context? Can you aptly replicate the in-person experience? Make sure you are properly trained in both online technology and online therapy techniques.

What do you need to explain to a potential online client in order to obtain informed consent?

What counts is defining the parameters and limits of the online care process. Practitioners should explain to the client the nature of online therapy and discuss the benefits (e.g., convenience, comfort, discretion), risks (e.g., potential insufficiency, privacy limitations) and the possibility of technological failure (e.g., your e-mail is down). Informed consent is also about setting appropriate boundaries and explaining them to your clients. "It goes back to our third principle in the CPA Code of Ethics – integrity in relationships. For example, it is not reasonable to expect 24/7 service, but you should outline when and how you will be accessible and how quickly clients can expect a reply in the case of asynchronous counselling (e.g., e-mail)." You should also explain what to do if there is a technology failure, and suggest back-up communication methods such as the telephone, as well as suggesting emergency back-up when you're not available, such as local support and crisis services.



What are some privacy issues and how can you protect privacy?

"Interception of or unauthorized access to online communication is a possibility, particularly if an e-mail account is shared with others in the household, or if there is shared computer access," says Sinclair. Establishing password access, asking for return receipts, having code names and using encryption methods can help to protect privacy breaches. However, nothing is 100 per cent guaranteed.

What confidentiality issues may arise in clinical work online?

The same principles apply as in face-to-face clinical work. In terms of storing and releasing client information, it is important to keep on record only whatever is reasonably necessary for the care of your client (e.g., to assist your own memory or for continuity of care) or for legal purposes. You do not have to download everything produced online for storage in the clinical record, nor do you have to keep the e-mail messages indefinitely.

What is the clinician's liability in crisis situations and how can you reduce your risk?

Imagine that a client is suicidal, but you don't know this and don't reply soon enough to stop him from following through. By establishing parameters during the initial assessment, you reduce both the likelihood of this happening, as well as your liability if it does. If you state that you are only available at certain times, arrange emergency back-up care (e.g., another clinician or local face-to-face resources), you have done a great deal to reduce your liability and protect your client. "The standard is to refer clients to local hospital emergency services, although you may also have to build in other alternatives for some clients," says Sinclair. Also, review your liability insurance to see what it covers in terms of e-services.

What are some ethical and legal concerns around corresponding with clients via e-mail?

E-mail is becoming a common way to communicate with clients, not only as a method of counseling, but for practical reasons like arranging in-person appointments. "The greater issue regarding e-mail is privacy at home, so ask your client upfront: 'How do you want me to communicate with you? Is there an e-mail address I shouldn't use? How much do you want your family to know?' Set standards to make that discussion part of your initial communication," says Sinclair. As for saving e-mails, Sinclair advises clinicians to store only information that is relevant to treatment with that client. ■

SHEILA LACROIX

Untangling the web: How to evaluate online health information



About 80 per cent of Internet users look for health information online. But relying on the Internet can be scary. We all know what frequently comes up through popular search engines like Google – online pharmacies, private clinics, snippets from magazines, and now that everyone's blogging, all sorts of first-hand commentary. Even if items are from reputable sources, for example, a news story reporting on a recently released scientific study, it may just lead to link after link, ending with an inaccessible research article or information that is difficult to understand.

Most likely, some of your clients or their families have asked you for reliable online sources of mental health and addiction information. Here are tips for how to evaluate information online, so that you can educate yourself and your clients.

Separating the wheat from the chaff

A common rule of thumb for a first go at evaluating web information is the rather appropriately called CRAAP test. Look for:

Currency
Relevance
Authority
Accuracy
Purpose

The CRAAP test is widely published on the Internet, so you can easily find more guidance on these points. For health information, the issue of authority is particularly important. If the creator of the content is a trusted source on the particular health topic and serves the public, the other items should fall into place. Trusted publishers could be research centres of excellence, government agencies, professional associations, advocacy and support organizations or health departments.

The Internet landscape continues to change and increase in complexity. The source of websites is no longer obvious from the web address. Now there are offspring websites, many based on partnerships, with generic names, where the association may not be apparent from the web address. The main page should clearly indicate the source. Look for the logo representing the source, with wording such as "sponsored by" or "a project of." For example, eMentalHealth.ca (www.ementalhealth.ca) is a project one of whose partners is the Provincial Centre of Excellence for Child and Youth Mental Health (www.onthepoint.ca). Alcohol Screening (<http://AlcoholScreening.org>) is an online screening tool sponsored by Join Together and the Boston University School of Public Health.

What about research? It's always tempting to pursue exciting news about studies related to your specific area of interest, or doing research through PubMed (<http://pubmed.gov>) or MedlinePlus (<http://medlineplus.gov>). The **National Network of Libraries of Medicine** provides an excellent guide for evaluating research reports. See <http://nmlm.gov/pnr/hip/criteria.html>

A valuable general resource is the **Guide to Healthy Web Surfing**, published by MedlinePlus (www.nlm.nih.gov/medlineplus/healthywebsurfing.html). It expands on the CRAAP guidelines with health and safety in mind.

Here are some additional pointers you can share with clients who want to do their own online research.

- Beware of claims of a remedy that will cure all.
- Avoid commercial sites selling services, medications or paraphernalia. Many sites may have commercial components or have partnerships with private companies, such as a pharmaceutical firm. A site that is primarily commercial has profitability as its bottom line.
- Check for contact information and use it for your questions if something is unclear.
- Look for content developed by health professionals or health organizations, with onsite information about the qualifications of the contributors. Personal stories provide great peer support, but the presence of sensational testimonies could be a flag that something is being sold or a philosophy pushed.
- If personal information is solicited, be sure there is a privacy policy. Don't offer any information that makes you uncomfortable or seems unnecessary.
- Look for help and information from more than one source and share this with your health practitioner if possible. Most good sites will offer options and choices, not simply, "Call for an appointment..."

Resources for youth in a wired world

Young people may be particularly vulnerable to poor information because they tend to rely on their cyber peers and the Internet as they surf, text and network with an extended audience. Here are some trustworthy Canadian sites for young people, some with content developed by youth.

Kids Help Phone www.kidshelpphone.ca. The website of this national phone counselling, referral and Internet service gives children and youth a place to ask questions and share stories.

Mind Your Mind <http://mindyourmind.ca>. An award-winning youth-to-youth website that includes a professional portal.

Psychosis Sucks www.psychosissucks.ca/epi/. The Fraser South Early Psychosis Intervention Program website site promotes early detection.

Xperiment.ca www.xperiment.ca. A drug prevention website developed as part of the Canadian Centre on Substance Abuse Drug Prevention Strategy for Canada's Youth.

Yoo Magazine Health Literacy Program www.yoomagazine.net. Individuals or school and community groups can register.

Does treatment for Internet addiction miss the mark?

BY HILARIE CASH AND COSETTE DAWNA RAE

According to the National Institute on Drug Addiction, the most effective way to treat addiction is to treat comorbid psychological problems concurrently. This is certainly the case at reStart: Internet Addiction Recovery Program in Washington. Some argue that programs designed for Internet addiction are too narrowly focused and that pathological use of computers is only a symptom of other problems. We argue that Internet addiction may reflect other issues, but that is a legitimate, specific disorder in itself that requires targeted treatment.

It is not uncommon for people with a technology-related behavioral addiction to report depression and anxiety, but it is not always clear whether these co-morbid conditions are the cause or the result of an impulse control disorder. Other co-morbid conditions that we commonly find as we work with people on an in-patient or out-patient basis are Asperger's syndrome, social anxiety disorder, attention deficit disorder and attention-deficit/hyperactivity disorder.

The first phase of treatment involves an in-depth assessment and evaluation. By taking a thorough individual and family history we can begin to formulate ideas about co-morbid conditions. Our clinical experience has been that after several weeks away from video games and the Internet, our clients generally begin to improve. Depression and anxiety begin to lift.

Many of our clients come to us after having seen other mental health professionals who did not deal directly with the addiction, choosing, instead, to see the addiction as a manifestation of other problems that needed to be addressed first. We also hear from clients and their caregivers that many therapists have dismissed the possibility of a behavioural addiction, and in some cases, have actually encouraged individuals with excessive use patterns to continue their problematic behaviour. This failure to treat the process (behavioural) addiction directly, as one would deal with a chemical addiction, is, in our opinion, reminiscent of the early days of chemical dependency treatment when co-morbid conditions went untreated until someone was "clean and

sober." Perhaps it is because so many professionals in the mental health field are not trained to recognize, assess or treat technology-related behavioural addictions that this situation persists, despite growing evidence that Internet addiction disorder (IAD) is a new and fast-growing disorder.

The following case study illustrates our approach.

Bill (not his real name) was a 17-year-old client whose family had been living on the East Coast. He appeared to have been a well-rounded kid who played the cello, participated in sports, socialized with friends and did well in school. Bill's world turned upside-down when his father left the family and maintained little contact with his children. Bill's mother moved with her children to a new state to be closer to relatives. It was at this point that Bill began playing video games. The games were clearly an escape from the pain of losing his father, friends and all that was stable and familiar to him. His mother tried, ineffectively, to control his excessive gaming. Prior counselling proved ineffective as Bill's video game use, depression and anxiety intensified. When his mother sought our help, Bill, who was about to turn 18, was flunking out of high school and refused to participate in any meaningful family activities, including meals and chores. He was unwilling to communicate with his mother. The only time he left the house was to visit friends with whom he could game.

Bill only agreed to come to reStart after a family intervention, where he was given the choice to either come to reStart or leave the house. He decided to join our program. His assessment identified him as depressed and anxious. The treatment plan we developed for him involved, among other things, teaching him about the nature of addiction and preparing him to re-enter a life that would involve moderate use of computers, helping him understand and express his feelings about what had happened with his parents and helping him develop real-world social skills and constructive skills for managing his emotions.

Over the course of the program, Bill made progress in all areas. When he left, he was much more socially confident and engaged, he was not depressed, and he had a relapse-prevention plan in place. He reported that the mindfulness training he had received had been the single most useful tool he had acquired.

It seems that the underlying problem is not whether Internet addiction treatment centres are too narrowly focused, but whether individual providers are skilled in assessing, evaluating and treating technology-related behavioural addictions along with other co-morbid conditions.

Hilarie Cash, Ph.D, and **Cosette Dawna Rae**, MSW, LSWAIC, are co-founders of reSTART: Internet Addiction Recovery Program in Washington.

Do you think programs designed for Internet addiction are too narrowly focused?

Is pathological use of computers only a symptom of other problems, such as depression and social anxiety disorder?



Share your thoughts
on our Last Word blog at
www.camhcrosscurrents.net

CANADA

Early Years Conference 2010

February 4–6, Victoria, British Columbia
Contact: UBC Continuing Professional Education, 2194 Health Sciences Mall, Rm.105, Vancouver, BC V6T 1Z3
tel 604 822-0054
toll-free 877 328-7744
e-mail ipinfo@interchange.ubc.ca
www.interprofessional.ubc.ca/Early_Years_2010.html

Promising Practices, Promising Futures Alberta FASD Conference

February 8–9, Calgary, Alberta
tel 780 422-6494
e-mail amanda.Amyotte@gov.ab.ca
www.child.alberta.ca/FASD

4th Annual Healthy Workplaces in Action Summit: Working Together to Deliver Quality Care

February 25–26, Ottawa, Ontario
Contact: Sally Cleford, Face 2 Face Events Management, 39 Aintree Place, Ottawa, ON K2M 2G5
tel 613 288-9239, ext. 101
toll-free 866 306-5714
fax 613 599-7805
e-mail sally@f2fe.com
www.qwqhc.ca/summit-2010.aspx

4th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder

April 14–17, Vancouver, British Columbia
Contact: UBC Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm.105, Vancouver, BC V6T 1Z3
tel 604 822-0054
e-mail ipconf@interchange.ubc.ca
www.interprofessional.ubc.ca/Adults.html

Spirituality: The Invisible Ingredient in Health and Healing

May 6–7, Vancouver, British Columbia
Contact: Providence Health Care
e-mail eturtle@providencehealth.bc.ca
www.crish.org/documents/SpiritPoster07.pdf

Canadian Psychological Association 71st Annual Convention

June 3–5, Winnipeg, Manitoba
Contact: Catherine McNeely, CPA, 141 Laurier Ave. W., Ste. 702, Ottawa, ON K1P 5J3
tel 613 237-2144, ext. 323
toll-free 888 472-0657
fax 613 237-1674
e-mail convention@cpa.ca
www.cpa.ca/convention/futureconventions/

Grounding Trauma Conference

June 21–23, Moncton, New Brunswick
tel 905 877-6547
e-mail gt@cast-canada.ca
http://cast-canda.ca/GroundingTrauma2010.html

13th World Congress on Pain

August 29–September 3, Montreal, Quebec
Contact: International Association for the Study of Pain, Conference Secretariat, 111 Queen Anne Ave. N., Ste. 501, Seattle, WA 98109-4955 USA
tel 206 283-3011

fax 206 283-9403
e-mail iaspedesk@iasp-pain.org
www.iasp-pain.org/Montreal

Canadian Psychiatric Association 60th Annual Conference

September 23–26, Toronto, Ontario
e-mail conference@cpa-apc.org
www.cpa-apc.org

UNITED STATES

SECAD 2010: National Association for Addiction Professionals and National Association of Addiction Treatment Providers Conference

February 21–24, Nashville, Tennessee
tel 603 836.0329 or 603 836.0332
e-mail mraggiani@vendomegrp.com or mgoff@vendomegrp.com
www.secad10.com

2010 Annual Meeting of the Society for Research on Nicotine and Tobacco

February 24–27, Baltimore, Maryland
Contact: SRNT, 2810 Crossroads Dr., Ste. 3800, Madison, WI 53718
tel 608-443-2462, ext. 145
e-mail meetings@srnt.org
www.srnt.org/meeting/2010/index.html

Anxiety Disorders Association of America 30th Annual Conference

March 4–7, Baltimore, Maryland
Contact: ADAA, 8730 Georgia Ave., Ste. 600, Silver Spring, MD 20910
tel 240 485-1032 or 240 485-1031
fax 240 485-1035
e-mail conference@adaa.org
www.adaa.org/conference&events/AnnualConference.asp

American Association for Geriatric Psychiatry 23rd Annual Meeting

March 5–8, Savannah, Georgia
Contact: AAGP, 7910 Woodmont Ave., Ste. 1050, Bethesda, MD 20814-3004
tel 301 654-7850, ext. 110
fax 301 654-4137
e-mail registration@AAGPonline.org
www.aagpmeeting.org/invite.html

23rd Annual Children's Mental Health Research and Policy Conference

March 7–10, Tampa, Florida
http://rtckids.fmhi.usf.edu/cmhconference/

17th Biennial International Conference on Infant Studies

March 10–14, Baltimore, Maryland
e-mail icis2010programoffice@srcd.org
http://icis2010.isisweb.org/submissions/

International Association of Eating Disorders Professionals Annual Symposium

March 11–14, Orlando, Florida
Contact: IAEDP, P.O. Box 1295, Pekin, IL 61555-129
toll-free tel 800 800-8126, ext. 80
tel 309 346-3341
e-mail iaedpmembers@earthlink.net
www.iaedp.com/coming%20soon.htm

4th Annual Conference of the International Society for the Study of Drug Policy

March 15–16, Santa Monica, California
Contact: RAND Drug Policy Research Center, RAND Corporation, 1776 Main St., P.O. Box 2138, Santa Monica, CA 90407-2138
e-mail dprc@rand.org
www.rand.org/multi/dprc/issdp2010/index.html#

31st Annual Meeting of the Society of Behavioral Medicine

April 7–10, Seattle, Washington
Contact: Society of Behavioral Medicine, 555 East Wells St., Ste. 1100, Milwaukee, WI 53202-3823
tel 414 918-3156
fax 414 276-3349
e-mail hlafave@sbm.org
www.sbm.org/meeting/2010/

American Society of Addiction Medicine 41st Annual Conference

April 15–18, San Francisco, California
Contact: ASAM, 4601 N. Park Ave., Upper Arcade #101, Chevy Chase, MD 20815
tel 301 656-3920
fax 301 656-3815
e-mail lwatson@asam.org
www.asam.org/annualmeeting.html

American Academy of Psychoanalysis and Dynamic Psychiatry 54th Annual Meeting

May 20–23, New Orleans, Louisiana
Contact: AAPDP, 1 Regency Dr., P.O. Box 30, Bloomfield, CT 06002
toll-free tel 888 691-8281
e-mail info@AAPDP.org
http://aapdp.org/index.php/meetings/

6th International Conference on Clinical Ethics Consultation

May 11–14, Portland, Oregon
Contact: Ethics 2010, 333 South State St., Ste. V-324, Lake Oswego, Oregon 97034
e-mail ethics@providence.org
www.ethics2010.org

American Psychiatric Association 163rd Annual Meeting

May 22–26, New Orleans, Louisiana
Contact: APA, 1000 Wilson Blvd., Ste. 1825, Arlington, VA 22209-3901
tel 703 907-7300
e-mail apa@psych.org
www.psych.org

118th Annual Convention of the American Psychological Association

August 12–15, San Diego, California
tel 202 336-6020
e-mail convention@apa.org
www.apa.org

ABROAD

18th European Psychiatric Association European Congress of Psychiatry

February 27–March 2, Munich, Germany
Contact: EPA, 1–3, Rue de Chantepoulet, P.O. Box 1726, CH-1211 Geneva 1, Switzerland
tel 41 22 908 0488
fax 41 22 906 9140
e-mail epa2010@kenes.com
www2.kenes.com/epa/Pages/home.aspx

18th World International Family Therapy Association Congress

March 17–20, Buenos Aires, Argentina
Contact: Congress Secretariat, Paragon Conventions, 18 Avenue Louis-Casali, 1209 Geneva, Switzerland
tel 41 22 5330948
fax 41 22 5802953
e-mail ifta2010@paragon-conventions.com
www.paragon-conventions.com/IFTA2010

17th International Symposium about Current Issues and Controversies in Psychiatry

April 15–16, Barcelona, Spain
Contact: Geyseco, Marina, 27 Bajos (Villa Olímpica), 08005 Barcelona, Spain
tel 34 93 2212242
fax 34 93 2217005
e-mail controversias@geyseco.es
www.geyseco.es/controversias

International Harm Reduction Association 21st International Conference

April 25–29, Liverpool, England
Contact: Conference Consortium Ltd., Warsaw Office, ul. Wiktorska 8 lok. 1, 02-587 Warsaw, Poland
tel 44 203 2861741
e-mail info@ihraconferences.com
www.ihra.net/Liverpool/Home

Europad 2010

May 28–30, Zagreb, Croatia
www.europad.org/europad2010.asp

3rd International Conference on Community Psychology

June 3–5, Puebla, Mexico
tel 52 222 2290700, ext. 12399 or 12314
fax 52 222 2290783
e-mail exec.committee@3iccp2010.org
www.3iccp2010.org

1st International Congress on Borderline Personality Disorder

July 1–3, Berlin, Germany
Contact: CPO Hanser Service, Paulsborner Str. 44, 14193 Berlin, Germany
tel 49 30 300 669 15
fax 49 30 300 669 40
e-mail borderline-congress@cpo-hanser.de
www.borderline-congress.org

20th Congress of the International Association for Cross-Cultural Psychology

July 7–11, Melbourne, Australia
Contact: Australian Psychological Society, Level 11, 257 Collins St., P.O. Box 38, Flinders Lane, VIC 8009, Melbourne VIC, Australia
tel 613 8662 3300
fax 613 9663 6177
e-mail conference@psychology.org.au
www.iaccp2010.com/

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