

crosscurrents

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"Us" vs "them"

Stigma in health care

AN EXPERIMENT IN DISCOMFORT

Resident/consumer group
challenges barriers to recovery

THE COURAGE TO COME OUT

Social worker confronts
stigma in the workplace

NURSE RATCHED LIVES ON

Film portrayals perpetuate
courtesy stigma of nursing

FATAL FLAWS

The black mark of borderline
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**The virtual
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Lessons from
community partners

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Welcome, Monika Szopinska, photograph, 12" x 18"

Monika enjoys travel photography and capturing mood
and atmosphere.



This is an issue of *CrossCurrents* that you may not want to read. It forces us to confront our own contributions as health care providers in perpetuating stigma and discrimination against people with mental illness and addiction. We may think we are immune; after all, we work in this sector because we want to help people. Many health care providers I spoke with told me, “We don’t have that problem here.”

Yet consumers tell a different story. We solicited input from people with mental health and addiction issues. What became clear from the many submissions we received was the pervasiveness of stigma and discrimination in the health care system. People told us again and again that stigma is the single most important barrier to their quality of life, more so than the illness itself.

Stories like these describe the experience of stigma, but we know little about what interventions work in reducing it. This issue of *CrossCurrents* focuses on action. We hear first about Opening Minds, the 10-year anti-stigma campaign of the Mental Health Commission of Canada that in its first year is targeting stigma and discrimination among health care professionals, with the

goal of developing promising practices. Next, Anne Ptasznik spends time with a group of psychiatry residents and consumers that meets informally in non-clinical settings, providing the valuable contact and context needed to combat stigma.

Social worker Cheryl Peever’s personal story shows that clinical knowledge does not always translate into effective workplace practices when mental illness or addiction is a workplace issue. Ned Morgan examines how the stigma that extends to those who work with people with mental health and addiction issues is perpetuated through film portrayals of mental health nurses. Other stories look at stigma in the emergency department and the black mark of borderline personality disorder. In her Last Word column, Jan Wallcraft asks whether public anti-stigma campaigns developed by psychiatrists do more harm than good. Visit the Last Word column at www.camhcrosscurrents.net to have your say.

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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

Discussions have moved away from investigating what to do about how the public thinks about mental illness and addiction towards changing what people do. Discrimination is now considered by many to be the most important target for change. This has echoes of the position of the black civil rights movement: “You do not have to live next to me, just give me my equality.” The reasoning is that it is difficult to change people’s minds, and you may not know if you have, but you can change people’s actions, and measure and enforce them. Actions are important. They lead to the ubiquitous impact of discrimination, from the level of services funding right through to the way people with lived experience are treated.

Where it gets murky is whether it is possible to change self-stigma – the negative images that people with mental illness and addiction

have of themselves – without changing people’s attitudes to mental illness and addiction.

CAMH has a long history of working on stigma. A simple search of the CAMH web site produces more than 600 hits. Many people consider the launch of the CAMH Foundation’s anti-stigma campaign, “Transforming Lives,” which includes people from all walks of life, to have been an important turning point in the social discourse about mental illness and addiction in Ontario.

Now CAMH can add its voice to that of a national body. The Mental Health Commission of Canada has launched its national anti-stigma campaign, Opening Minds, which you can read about in this issue. The campaign is documenting what is happening across Canada and will evaluate promising practices. As a doctor who on a regular basis has to battle

with other doctors to get equitable care for the physical illnesses that my patients experience, I applaud the campaign for making health care providers one of its first two target audiences. I also welcome the challenge to health care providers that this issue of *CrossCurrents* provides.

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The virtual doctor is in: Using technology to reach kids in crisis

HELEN BUTTERY

Kirsten* and her mother, Carol*, have an appointment with an adolescent psychiatrist – virtually, that is. They are seeking help because 12-year-old Kirsten struggles with anxiety, depression and night terrors that started after she was sexually abused four years ago. When Kirsten and her mother arrive at the hospital in their northern Ontario community, a nurse ushers them into a room, where they sit in front of a large television mounted with a video camera. The nurse leaves and Kirsten and Carol turn their attention to the television. They are met by the pleasant gaze of an adolescent psychiatrist, hundreds of kilometres away at Ontario Shores Centre for Mental Health Sciences in Whitby. The psychiatrist smiles, introduces herself, and the session begins.

This scene is part of the Virtual Emergency Room (VER), which since its inception in 2008 in the Central East Local Health Integration Network has spread across Ontario. Stretching from Scarborough in Toronto's east end to Algonquin Park in the province's north, the program uses live, two-way video conferencing, supported by the Ontario Telemedicine Network (OTN). These telemedicine ERs link youth experiencing mental health crises with three psychiatrists from Ontario Shores, and take referrals from three other hospitals – Lakeridge Health, Peterborough Regional Health Centre and Ross Memorial Hospital. The hope is to expand the program province-wide.

It's a realistic goal because OTN is the largest telemedicine network in the world. The network is linked with nearly 900 Ontario sites, including public health units, addiction treatment centres and rural nurse practitioners. The OTN is a valuable resource, since Ontario faces an uneven distribution of medical professionals, explains CEO Dr. Ed Brown. Through the VER, it aims to even the geographical playing field of expertise by linking and integrating resources. For instance, Peterborough may not have a child psychiatrist, but a referral can be made through the VER and a case assessed within 72 hours. In Kirsten's case, her sexual abuse counsellor made a referral to the VER, and less than two weeks later, she had an appointment with a youth psychiatrist.

Last year, OTN conducted 53,000 virtual consultations. Of these, nearly half, including Kirsten's, involved mental health issues. Particularly successful in the mental health field, telemedicine uses the most straightforward application of this technology – to talk. "You don't need fancy equipment," says Brown. The technology is excellent, and you can be treated for mental illness just as you would if you were physically in the office with the doctor."

Without this virtual lifeline, youth in crisis might have to wait months for a consultation – if they get help at all. Currently, only one in six youth under age 18 with a mental illness receive appropriate help in Ontario, says Brown. The VER is working to improve these odds, expediting a process often mired by distance and wait times. At Ontario Shores, for instance, the three youth psychiatrists participating in the VER provide on average seven consultations a week.

Dr. Gabrielle Ledger, one of those youth psychiatrists, explains the importance of getting immediate help: "Diagnostically, seeing the person when they are having the symptoms is very helpful," she says. Imagine, for instance, having a gallstone attack and having to wait six months for a doctor and then being asked to recall how it felt and the specific details. It's the same for mental health issues. "When we see kids early on in an illness, we can assess the situation when everything is fresh and get a good sense of what the story is and what the important issues are," says Ledger.

Referrals often come to Ledger and the other psychiatrists through emergency room or family physicians. For instance, a teenager who starts having panic attacks at school is referred to the VER by her family doctor. Or, after a suicide attempt, a youth ends up in the local emergency room, where the social worker involved makes a VER referral. "It's a way to bridge existing services and support the health care team," says Ledger.

Ontario faces an uneven distribution of medical professionals.

The Virtual Emergency Room aims to even the geographical playing field of expertise by linking and integrating resources.

In Kirsten's case, she hit what her mother describes as a "therapy roadblock." Kirsten needed support beyond what was available in her small northern community. "Her counsellor couldn't get Kirsten past her fear and depression," says Carol. That's what prompted their visit to the VER. During her session, Kirsten underwent full psychiatric and family function assessments and was screened for other mental health symptoms. "She divulged personal, private information that she hadn't talked about before," says Carol. The psychiatrist then gave Kirsten and her mother feedback on the most likely diagnosis, even prescribing psychotropic medication.

In fact, the psychiatrist's options don't stop at the prescription pad. Virtual psychiatrists can fill out a Form 1, which is used to keep a person in hospital for up to 72 hours for further psychiatric assessment when there is risk of harm to themselves or others, or when they are deemed incapable of consenting to treatment. For Ledger, this ability demonstrates that virtual consultations are considered as valuable and robust as face-to-face assessments.

The technology also reflects how young people communicate: "Children are already using these technologies in their daily living, through Skype (an Internet calling service) and webcasts," says Ledger. "It only makes sense that we would use this technology to reach them. The doctor is, virtually, in."

*not their real names

“They’re real people”: Nurses play role in combating stigma

KIM GOGGINS

In almost 30 years of working as a psychiatric and general nurse, Charlotte Ross has never been attacked by a client with mental illness. Nor have her colleagues who teach with her at Douglas College in Coquitlam, British Columbia. Yet this scenario is one of the most common fears of the nursing students they train.

“We have to get past their first day of rotations where they’re expecting people to be violent and have very disordered behaviour, like in the movies,” says Ross. “But after that first day when they talk to patients, they come out saying, ‘They’re just regular people with an illness. They’re real people.’ It’s quite an eye-opener for the students.”

Challenging these stereotypes early in training is important because health care professionals often reflect the public’s stereotypes of people with mental health problems, which means they themselves can perpetuate stigma and discrimination in a profession that is supposed to help people. Although one of the most common myths about people with a psychiatric illness is that they are violent, statistically, says Ross, they are more likely to be victims of violence. “They’re a far more vulnerable population than a dangerous one,” she says.

While fear that people with mental illness may erupt into violence is the biggest myth, Ross says that most health care professionals feel some degree of compassion for people with mental illness. But that empathy does not extend toward individuals with addiction or those who self-harm. In those situations health care providers tend to blame the person, says Ross, whose literature review of stigma in the nursing profession, which she wrote with Dr. Elliot Goldner, appears in a 2009 issue of the *Journal of Psychiatric and Mental Health Nursing*.

“Nursing staff in emergency departments (when patients were suicidal or in psychiatric crises), and intensive care units (for care post-suicide attempt) in particular, were found to hold blaming/hostile attitudes, and were often reported to have treated this client population in a demeaning manner for these reasons,” the review reports. Ross’ own experience as a nurse and nurse educator has exposed her to similar situations.

“These misconceptions are related to not understanding that these are illnesses,” says Ross. “There remain aspects of the stigma of blame, especially with self-harm. You really sense – and I’ve heard it – the feeling of wasting resources on somebody who doesn’t want to live. Some health care workers don’t have any conception of the fact that this person is actually dying from the illness. The illness is psychiatric, which is leading to behaviour that can kill them.”

The literature review found one study where only 10 per cent of nurses agreed with the statement “People who commit suicide are mentally ill.” Another study yielded similar results.

Fragmentation – not wanting to treat psychiatric symptoms in a medical setting – is another manifestation of stigma that Ross has seen first hand and in research. “I tell my students, ‘We don’t stop at the neck.’ I have seen it in psychiatric settings – not attending fully to medical and physical issues. There’s a lack of treating the whole person.”



The consequent negative effect on client care is one of the chief reasons mental health consumers identify for not seeking or continuing with treatment, according to the literature review. “You can’t provide care if you have hostility, which means the therapeutic relationship that is integral to the nursing relationship is not there,” says Ross. “What you have then is a task orientation without much caring behind it.”

However, Ross adds that sometimes it is not about hostility and blame, but that health care professionals were never taught what to do. “They don’t have the basic skill base to assess or provide appropriate psychiatric care to their client population, despite their best intentions,” she says. Key to combating stigma and discrimination are education and contact with psychiatric clients early on. “Nursing students pick up their biases from society,” says Ross. “But the literature showed something interesting: The people who have connections to a person with mental illness in their private life had much less stigma.”

More attention to psychiatry is required in general medical training, urges Ross, who says that Canada falls behind other countries when it comes to training health care professionals in this area of medicine. She also calls for the establishment of behavioural expectations that medical professionals advocate for people with mental illness when they hear colleagues making derogatory comments, rather than making it discretionary. “If you hear colleagues making negative comments, you have to do something about it, both as a ‘professional and as a citizen,’” Ross says. “Take action.” ■

“If you hear colleagues making negative comments, you have to do something about it, both as a professional and as a citizen. Take action.”

Partnering with ethnoracial communities to take culture seriously

CAROLYN MORRIS

The first thing clients of Punjabi Community Health Services in Brampton, Ontario, are asked to sign is a consent form that allows counsellors to talk with the client's family. Because extended families are central to Punjabi culture, it is often necessary to convince a client's father of the need for mental health treatment, or to counsel wives or siblings who might not know how to deal with a family member's addiction. The agency will still provide services if the client refuses to sign, but manager Amandeep Kaur says treatment in that case often isn't as effective as when the family is involved.

In a recent example, six sisters who were worried about their brother's drinking got counselling, as did their husbands, about how to stop enabling their brother's problem. Counsellors began the brother's treatment by focusing first on his family.

Achieving this type of culturally appropriate care in mental health and addiction services was the focus of a recently completed five-year provincial project, *Taking Culture Seriously in Community Mental Health*. Led by the Centre for Community Based Research (CCBR) in Waterloo, the participatory action research project – research “with” and not “on” people – brought together multi-disciplinary researchers, mental health practitioners and members of five different cultural communities in Toronto and Waterloo – Spanish-speaking Latin American, Mandarin-speaking Chinese, Polish, Punjabi Sikh and Somali.

The project went beyond merely identifying problems and brainstorming solutions to applying its findings through various demonstration projects. It was carried out in three phases – data collection through interviews and focus groups, development and applications for funding of demonstration projects, and project evaluation.

The project serves a growing need. While immigration grows steadily in Canada, especially in large urban areas, many newcomers do not have access to effective mental health services. “The old way of doing business is not working too well,” says Joanna Ochocka, executive director of the CCBR.

The study's main finding, as its name suggests, is that the mental health system must take culture seriously by not only seeking advice from members of diverse ethnoracial groups, but by also allowing them to become stakeholders. “Diverse cultural groups, policy makers and practitioners need to work differently and collaboratively,” says Ochocka. “There are many things that cultural groups need to do to feel stronger and define their needs, but they should also be recognized partners.”

Punjabi Community Health Services developed one of the study's six demonstration projects. The agency obtained resources to provide mental health services and an addiction program for the Punjabi Sikh population in Toronto's Peel region. The project provides therapy tailored to the needs of the community and combats stigma around mental health problems through a weekly TV call-in show in Punjabi. The project has had a lot of success in increasing comfort with what is traditionally a taboo subject for this community and adapting to clients' culture. Involving extended families in treatment, as in the case of the six sisters and their brother, is one example.

A common theme emerging from the study is that adaptation needs to be reciprocal; cultural groups and mental health providers learn from one another. One demonstration project led by the Kitchener Downtown Community Health Centre hired seven point people, or “navigators,” from different ethnoracial groups to link members of their communities with services and to educate service providers about cultural sensibilities. “It's a lot about breaking the stigma,” says Alida Abbott, the project co-ordinator. But navigators also play an important role in educating service providers about particular needs of their community members, and they often act as interpreters.

Language barriers can be challenging, but they aren't the only obstacle to good mental health care, says Amandeep Kaur. If service providers speak someone's language but know little else about the culture, they can easily obtain basic information, but

when it comes to counselling, it becomes more complicated. The differences in cultural values run a lot deeper than vocabulary. For example, in some cultures, including Punjab, the literal translation of “mental health” is a derogatory word. Mandarin has no word for mental health. If service providers use the term, they could scare people away from treatment. Navigators help service providers understand the client's cultural framework.

But understanding cultural frameworks doesn't mean adhering to stereotypes, says Ana Luz Martinez, a settlement worker at the Kitchener-Waterloo Multicultural Centre, who was hired as one of 10 community researchers for *Taking Culture Seriously*. “You cannot say that Latin Americans behave in a certain way, because everybody's different,” she says. Martinez stresses the need for service providers to be open and adaptable, to be able to adjust to a client's needs. She would also like to see more service providers from different cultural backgrounds – she knows of just two Spanish-speaking counsellors in her area.

But for practitioners who may not speak the language or be familiar with a client's culture, there are still ways of providing better care. One theme that came up often in focus groups and from navigators was that people felt they were not given time to express themselves and that service providers didn't listen to them. Martinez says this is often the case when counsellors give more attention to the interpreter than to the client. “If there is no empathy with the client, the service isn't provided to the client, it's provided to the interpreter,” she says. She has also seen clients become nervous when an intake person asks personal questions over the phone. Some people get intimidated and simply hang up.

Several of these concerns were captured in front of an audience of service providers and policy makers in *Other End of the Line*, a play commissioned by the project and produced by the Multicultural Theatre Space. To a frenetic drumbeat, a man wearing a white lab coat looks down at his clipboard and asks mechanically, “Can I have



your name, please?” The woman beside him answers nervously, “Um, my name is ...” Without letting her finish, the man bombards her with more questions, as he scribbles away: “Can I have your family name, and that’s perfect, can I have your address, your postal code...?” The scene feels inhumane, and especially alienating for someone who might already be vulnerable and confused.

Encounters with an unfamiliar medical system aside, the immigration experience itself can put newcomers at increased risk of developing mental health issues. “People struggle with employment, with life adjustments, with parenting,” says Ochocka. Sometimes they have experienced trauma. Martinez herself was a refugee from Guatemala, who lived in a refugee camp in

Mexico before coming to Canada. She says that the immigration system should be more proactive in pointing newcomers toward counselling services they may need.

But people will not seek help if they don’t think the system can provide it. Many communities are distrustful of Western mental health practices. “In Canada, some doctors just rush you to medication,” one focus group participant said. “That is what most people are afraid of.” Many cultures have a more holistic approach to mental health, and fear they will be labeled mentally ill and given prescriptions. By creating more space for ethnic diversity and by adapting professional training programs to embrace various cultural perspectives, the mental health system could become more responsive to the needs of ethnoracial communities.

With the study’s focus on translating theory into practice, strategies have emerged that community mental health and addiction agencies across the country can apply to make their services more culturally appropriate (see sidebar). As funding dries up for some of the demonstration projects, such as the cultural navigator initiative, participants hope to secure sustained financing to keep them going. They hope to see more ethnoracial groups become involved as stakeholders in Canada’s mental health system. “This is not only about the research project, with its start and end dates and its budget,” says Ochocka. “This type of community-university research partnership is part of a bigger agenda, a movement.” ■

TAKING CULTURE SERIOUSLY: RECOMMENDATIONS

Policy makers

- Facilitate change at the level of structure while simultaneously working toward better processes.
- Challenge power inequities and racism within the system and acknowledge their consequences.
- Develop flexible funding structures to accommodate innovative, collaborative, culturally appropriate practice.
- Focus on improving accessibility across all services.
- Support collaborative, interconnected policy development (across sectors, including cultural-linguistic communities) to challenge racism and discrimination.
- Increase accountability on all levels.

Mental health practitioners

- Engage in reciprocal outreach and ongoing collaboration with cultural-linguistic groups through cross-cultural consultations

and partnerships and by developing a diverse work force.

- Challenge power and racism within and outside the organization by recognizing that “cultural competency” involves reciprocal collaboration and by increasing community awareness efforts around mental health and service use.
- Promote holistic understandings of wellness and illness.

Cultural communities

- Mobilize the community through increased dialogue and stigma-busting efforts and by engaging with mental health services to increase knowledge and skills for both sides.
- Make use of internal resources by recognizing community strengths and validating and encouraging mental health practitioners from within the community. Develop ongoing collaboration strategies. Be a bridge. Nurture bridges.

To read more about Taking Culture Seriously in Community Mental Health, visit www.takingcultureseriouslycura.ca

What are you doing to provide culturally competent care?

Access this story online and share your experience at
www.camhcrosscurrents.net



Drawing helps older children report emotional experiences

Drawing is known to facilitate young children's reports about previous emotional experiences and is often used for clinical assessments and legal purposes. Now, a new study from the University of Otago in New Zealand has demonstrated that drawing can also be useful in facilitating reports from older children up to age 12. Researchers asked 90 children between age 5 and 12 to either tell or both draw and tell everything they could remember about a past event that made them feel happy, sad, scared or angry. Children reported more information when they were asked to draw during the interviews, and this was true for older children as well as younger children. Parents attested to the accuracy of the reports, indicating that only eight of 252 reported events never happened. Drawing had no effect on report accuracy. It turned out that interviewers asked more open-ended questions (e.g., "Can you tell me more about that?") and gave more minimal responses (e.g., "Uh huh," "Really," "Wow") when the children were asked to draw. The number of minimal responses, in particular, was highly correlated with the amount of information provided by children in all age groups. These findings indicate that drawing can be useful in facilitating clinical and forensic interviews with children of all ages.

Applied Cognitive Psychology, November 24, 2009 online, doi: 10.1002/acp.1650. Tess Patterson and Harlene Hayne, Department of Psychological Medicine, University of Otago, New Zealand.

Therapeutic alliance improves supportive psychotherapy outcome

The development of a therapeutic alliance between therapist and client over the course of psychotherapy can lead to significant improvements in the client's level of social, occupational and psychological functioning, according to research from the Hôpital Purpan in Toulouse, France. Using data from a previously published study, researchers studied 74 individuals who received 10 weeks of acute outpatient treatment for major depression. Thirty-nine participants were given the antidepressant clomipramine, combined with supportive psychotherapy, and 35 received clomipramine and psychodynamic psychotherapy. Supportive therapy "focused on empathic listening, guidance, support and alliance, while psychodynamic therapy emphasized the development of an empathic relationship between patient and therapist who, together, investigate interpersonal difficulties in relation to past life-events." The researchers found that therapeutic alliance increased over time in both treatment groups. Among participants who received supportive therapy, this increase in therapeutic alliance translated into improved social, occupational and psychological functioning. However, the benefit from the therapeutic alliance appeared to be related more to the perception of collaboration between client and therapist toward a common therapeutic goal than to the perception of the therapist as a provider of help. Among those who received psychodynamic therapy, there was a significant relationship between the therapeutic alliance and improvements in functioning at two weeks, but this relationship was no longer evident after the full 10 weeks of treatment. The authors conclude that the therapeutic alliance may not be the main active therapeutic factor in psychodynamic therapy, but that it is more active in supportive therapy.

Psychiatry Research, December 30, 2009, v. 170 (2–3): 229–233. Lionel Cailhol et al., INSERM, Hôpital Purpan, Toulouse, France.

Health and appearance motivate adolescents who don't smoke

Adolescents who choose not to smoke appear to be motivated primarily by concerns about health and physical appearance, rather than by restrictions and smoking bans, according to a study from Heidelberg University in Germany. A total of 707 non-smoking students aged 12 to 15 were interviewed as part of the German SToP ("Sources of Tobacco for Pupils") Study. Participants were asked to write down their motives for not smoking, yielding 1,324 statements that were categorized and evaluated by researchers. Health-related concerns were most frequently mentioned as a motivation for not smoking, appearing in 78 per cent of all statements. Fear of cancer and a desire to maintain physical fitness were the most common health-related concerns. No participants mentioned cardiovascular disease, cerebrovascular disease or chronic obstructive pulmonary disease as concerns, even though these are the most common health consequences of smoking. An aesthetic aversion to the effects of smoking tobacco, such as odour or yellowing teeth and nails, was mentioned in 39 per cent of statements. A lack of perceived benefits from smoking was cited 25 per cent of the time, and economic motives were cited 21 per cent of the time. Only nine per cent of statements indicated concern about possible economic, legal or social sanctions, such as parental and school smoking bans or legal age limits. This finding is surprising, given the known effectiveness of tobacco taxes and bans on the sale of tobacco to minors. The authors speculate that young non-smokers may simply be too young to have had any experience with such measures, or they may not perceive such external limitations as the true motive for their decision not to smoke.

Health Policy, 2009 online, doi: 10.1016/j.healthpol.2009.10.007. Sven Schneider et al., Mannheim Medical Faculty, Heidelberg University, Mannheim, Germany.



Young male binge drinkers expect to be unhappy later in life

Young men who believe that happiness declines with age are more likely to binge drink, according to research from Queen's University Belfast in Northern Ireland. Researchers used data from a 2007 survey of 1,036 citizens of Northern Ireland over age 15. Participants were questioned about the frequency of binge drinking and a range of other health-related issues. Researchers asked participants how happy they currently were and how happy they expected to be at the ages of 30 and 70. They were also asked how happy they estimated the average person is and how happy that person would be at 30 and 70. No differences were found between the self-reported happiness levels of young people and older people. However, young people tended to believe that happiness declines with age. Just more than half of participants were classified as binge drinkers – 59 per cent of males and 45 per cent of females. Young men who expected lower levels of happiness in old age were more likely to binge drink. There was no such correlation for females. The authors suggest that young men's underestimation of happiness later in life increases the likelihood that cultural ideals of masculinity (toughness, strength, invulnerability, risk-taking, competitiveness and living for the moment) will be expressed through binge drinking. The authors conclude that it may be worthwhile to remind young men of the benefits of reducing alcohol consumption, as well as informing them about the reality that happiness is common in old age.

Journal of Happiness Studies, November 12, 2009 online, doi: 10.1007/s10902-009-9174-1. John Garry and Maria Lohan, School of Politics, International Studies and Philosophy, Queen's University Belfast, Belfast, Northern Ireland, United Kingdom.

Ketamine harmful to cognition and mental health

Ketamine has become increasingly popular in recent years as a club drug. New research from University College London in the United Kingdom has found that heavy use of ketamine can harm cognitive function and psychological well-being. The study followed 150 participants over the course of one year, dividing them into five groups of 30: frequent users used ketamine more than four times a week; infrequent users used it at least once a month; abstinent users had not used the drug for at least a month; polydrug users used other drugs; and non-drug users did not use illicit drugs at all. Researchers found that cognitive deficits were largely confined to frequent ketamine users, among whom increased ketamine use over the year was correlated with declines in spatial working memory and pattern recognition memory. Former ketamine users showed no cognitive deficits, suggesting that although impairment from ketamine may be cumulative, cognitive function can recover after people stop using the drug. Frequent users also experienced more dissociative symptoms, and delusional symptoms increased in a dose-response relationship with the amount of ketamine used. Both frequent and abstinent users experienced increases in depression scores over the course of the year. The authors recommend that health education campaigns target ketamine users, who are still largely unaware of the dangers of using the drug and its potential for dependency.

Addiction, 2009 online, doi: 10.1111/j.1360-0443.2009.02761.x. Celia J.A. Morgan et al., Clinical Psychopharmacology Unit, University College London, London, United Kingdom.



Women and men misuse painkillers for different reasons

The reasons for misuse of opioid painkillers appear to differ along gender lines, according to research from Harvard Medical School in Boston, Massachusetts. Working with pain management centres in five U.S. states, researchers recruited 335 females and 275 males prescribed opioid painkillers for chronic non-cancer pain. Participants were followed for five months, answering a series of questionnaires and providing urine samples at the end of the study for toxicology assessment. The participants' physicians also completed substance misuse behaviour checklists. At the five-month follow-up, women were more likely to self-report misuse on a drug use questionnaire, while men were more likely to be flagged for misuse by their physicians. There were no gender differences in actual opioid misuse as measured using urine toxicology screens and either self-report or physician report – about one-third of both women and men were found to have misused their medication. On questionnaires examining risk for substance misuse, women were more likely to mention risk factors such as psychiatric diagnoses and a history of physical and sexual abuse, while men were more likely to report legal and behavioural problems and a history of alcohol or other drug problems. The authors suggest that efforts to reduce opioid misuse should emphasize educating women about avoiding painkillers to deal with anxiety and sleep disturbances and more closely monitoring men's behaviour. Women may also benefit from antidepressant medication and cognitive-behavioural therapy.

The Journal of Pain, 2009 online, doi: 10.1016/j.pain.2009.07.016. Robert N. Jamison et al., Departments of Anesthesia and Psychiatry, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts.

Pharmacy-based interventions improve medication adherence

A pharmacy-based intervention can increase the likelihood that people with serious mental illness will take their medication as required, according to a new study from the Department of Veterans Affairs in Ann Arbor, Michigan. The study involved 118 Veterans Affairs patients who had schizophrenia, schizoaffective disorder or bipolar disorder. They were all being given long-term treatment with antipsychotic medication and had medication compliance rates under 80 per cent in the previous year. Sixty of the patients received usual care, which included visits with a psychiatrist, non-medical mental health visits and group visits. Another 58 per cent were assigned to a Meds-Help pharmacy-based intervention involving unit-of-use packaging of patients' medications, a medication education session, refill reminders sent by mail and notification of clinicians when patients failed to fill prescriptions within 7 to 10 days. Compliance rates were reassessed at 6 and 12 months. At the beginning of the study, the average compliance rates were 54 per cent for the Meds-Help group and 55 per cent for the usual care group. At six months, the compliance rates had increased to 91 per cent for the Meds-Help group, compared with 64 per cent for the usual care group. At 12 months, Meds-Help patients still had 86 per cent compliance rates, while rates for the usual care group were only 62 per cent. Given that their results are comparable with those previously reported for people with diabetes and hypertension in a similar intervention, the authors conclude that a pharmacy-based intervention can be as effective in increasing compliance among people with serious mental illness as among people with other chronic medical conditions.

Schizophrenia Bulletin, November 21, 2009 online, doi: 10.1093/schbul/sbp121. Marcia Valenstein et al., Department of Veterans Affairs Serious Mental Illness Treatment, Research, and Evaluation Center, Ann Arbor, Michigan.

Changing minds, opening minds

Anti-stigma campaigns aren't just for the public

BY ELLEN NIELSEN

"You are not making any sense. Go home and come back when you are able to make sense."

THESE ARE THE WORDS ONE CALGARY, ALBERTA-BASED LAWYER heard from her family doctor, after she became incoherent and disoriented in court and a concerned colleague rushed her to the doctor. Despite her psychotic state, Dora Herceg did go home that day. She was later diagnosed with schizoaffective disorder, with bipolar and neurological aspects.

Most health care workers would be horrified to know a person in need of care was treated this way. After all, health care workers generally choose their professions because they care about people and want to make a difference.

It would be one thing if Herceg's experience were an anomaly. Unfortunately, she, like many others with mental health issues, reports that she regularly experienced stigmatizing attitudes and behaviour on her journey through the health care system.

Stigma is a term once used to refer to a mark branded into the skin of slaves and criminals, so others would know to shun them, especially in public. It may no longer be acceptable to mark people for the purpose of stigmatizing them, but stigma still exists. Mental illness is one area where this mark remains.

It emerged clearly through the cross-country hearings of the Standing Senate Committee on Social Affairs, Science and Technology, as part of the federal government's look at the status of mental health in Canada. The hearings constituted the most extensive public consultation process ever conducted in Canada on the subject. What was repeated over and over in the course of 130 hours of hearings, with more than 300 witnesses, was that stigma is the issue consumers

identify as the biggest problem they face – more so than the illness itself. Consumers described how stigma affects the way they feel about themselves, how it discourages them from seeking treatment, and, consequently, how it affects the amount of time it takes them to recover – if at all.

Describing stigma is one thing, but acting on it is another. When the Mental Health Commission of Canada was formed out of the hearing recommendations, it was this need to act that prompted the development of its Opening Minds campaign, a 10-year anti-stigma/anti-discrimination initiative designed to change the attitudes and behaviours of Canadians towards those with mental illness. Although stigma pervades society, the campaign's initial focus is on two groups – youth and health care professionals.

Health care workers have been targeted because it is on the front lines of health care that people seeking help have reported some of the most deeply felt stigma and discrimination. Research has found that people with mental illness often report feeling patronized, punished or humiliated in their contact with health care providers. Psychiatrist and stigma researcher Dr. Graham Thornicroft has found that they may be spoken to as if they were children, ignored in decision-making, and written off as incapable of responsibility. Health care workers also often view people with mental illness as difficult, less deserving of care, manipulative, attention-seeking, annoying and in control of their own behaviour – remember the advice Dora Herceg's doctor gave her?

Despite strong evidence that recovery is much more common than people think (including for those with severe mental illness), some health care providers continue to believe that mental illness automatically consigns people to a slow and difficult downward slide. This profoundly affects hope and recovery in a population that needs support and understanding.

Stigma can translate into long wait times because mental health conditions are not considered serious. When Dora's husband took her to the ER later on that day her doctor sent her home, they were shuttled into a quiet area to "wait it out." It wasn't until 12 hours later that Dora and her husband saw a second ER doctor, who realized Dora needed to be admitted right away.

Stigma also leads to a 70 per cent misdiagnosis rate. The doctor at the walk-in clinic Dora and her husband visited before going to the ER thought she was pregnant – as though that is how pregnant women behave! Stigma is also implicated in the average 10-year delay from first seeking help to getting an accurate diagnosis.

Another manifestation of stigma is diagnostic overshadowing, a dismissal of other, physical conditions as "all in your head," which means these issues go untreated. Thornicroft and other researchers have found that people with mental illness who seek treatment for physical problems often receive sub-standard levels of care, resulting in higher rates of infections; post-operative complications, including death; and longer stays in hospital.

Given the serious consequences of stigma and discrimination, it's important to develop effective stigma-busting strategies. To this



WHAT ARE YOU DOING TO FIGHT STIGMA?

Leaders in high-profile mental health professions, for example, the Canadian Psychiatric Association, have spoken publicly about stigma among their ranks. According to Dr. Manon Charbonneau, past-president of the Canadian Psychiatric Association, “Stigma is not solely the domain of others. As professionals we need to be conscious of our own stigma-prone behaviours or the internalized stigma we may perpetuate.” So what are the mental health professions doing to combat stigma and discrimination within their ranks?

Association of Faculties of Medicine of Canada. The AFMC has acknowledged at senior levels the potential for undergraduate and graduate education to combat stigma and discrimination toward people with mental illness in the medical professions.

Canadian Association of Occupational Therapists. At the 2008 annual conference of the Canadian Association of Occupational Therapists in Whitehorse, Yukon, Terry Krupa accepted the Muriel Driver Memorial Lectureship Award, which honours excellence in the profession. Her address to the audience focused on stigma towards people with mental illness among occupational therapists.

Canadian Medical Association. In 2008, the CMA passed motions aimed at ending discrimination in health care towards people with mental illness. These motions call for collaborative action between physicians and psychiatrists to ensure better access to mental health care and for improved funding for mental health services, which lags far behind other areas of health care.

Canadian Psychiatric Association. The CPA commissioned Dr. Heather Stewart, the Mental Health Commission of Canada’s senior consultant for its Opening Minds campaign, to design a survey of CPA members. In this Putting the Squeeze on Stigma campaign, psychiatrists were asked to describe the stigma they, their colleagues and clients have experienced, as well as to share their experience of what works to combat that stigma. The stories have been compiled into a compendium that you can find on the CPA web site at www.cpa-apc.org

Canadian Psychological Association. In the 2009 winter edition of *Psynopsis*, a psychology newspaper published by the CPA, executive director Karen Cohen called on psychologists to confront stigma, and to begin by acknowledging its existence within their profession. Read the article at www.cpa.ca/publications/psynopsis/

Mood Disorders Society of Canada. The MDSC has called upon health care professionals to confront stigma and discrimination within their ranks and to develop an action plan to deal with them. At the MDSC’s 2006 stigma research workshop, attendees identified stigma and discrimination as expressed by health and mental health professionals as their number one priority. Read the report, *Stigma and Discrimination – As Expressed by Mental Health Professionals*, at www.mooddorderscanada.ca. Search for the title under Publications. A progress report, *Stigma Research and Anti-Stigma Programs: From the Point of View of People Who Live with Stigma and Discrimination Everyday*, can also be found.

end, the MHCC last year sent a nation-wide invitation for programs already doing stigma-reducing work with its two initial target groups to get involved with Opening Minds. Of the almost 250 submissions from programs that target youth and health care workers, 18 were selected for the health worker component. Examples of these pilots are provided throughout this issue of *CrossCurrents*. The projects will be evaluated, and the findings will be used to create resources so the best programs can be replicated nationally. Opening Minds will also conduct a gap analysis to identify areas that still need to be addressed. The campaign will also target stigma in other groups and settings, including the workplace.

Opening Minds is also partnering with a “Mental Health Table” made up of national organizations representing professionals in the medical community, including the Canadian Medical Association, the College of Family Physicians of Canada, the Registered Psychiatric

Nurses of Canada, the Canadian Psychological Association and the Canadian Psychiatric Association. Some of these professional organizations are also running their own stigma-busting campaigns targeting members of their respective professions (see sidebar).

Ultimately, the vision is to create a Canada where all citizens are supported in their efforts to be physically and mentally healthy, and where those in need of help are able to get it – and where those to whom they turn can provide it. ■

For more information about Opening Minds and to read Dora Herceg’s story, visit www.mentalhealthcommission.ca. Under Initiatives & Projects, select “Opening Minds.”

Ellen Nielsen is a senior communications advisor to the Mental Health Commission of Canada.

***CrossCurrents* asked consumers of mental health and addiction services to share their personal stories of stigma and discrimination within the health care system.**

Read about their experiences online. Access this article at www.camhcrosscurrents.net and follow the sidebar link, “What consumers say about stigma.”

www.camhcrosscurrents.net

An experiment in discomfort

Resident/consumer group challenges barriers to recovery

BY ANNE PTASZNIK

THE WOMEN I MEET IN THE RECREATION ROOM OF A SUPPORTIVE housing apartment complex in downtown Toronto have an obvious camaraderie. They take gentle verbal pokes at one another, fuss appreciatively over one woman's latest knitting project, and share birthday cake.

What strikes me most are the frequent insider jokes and edgy laughter, which stem, perhaps, from their shared experience of dealing with the challenges wrought by the mental health system – some as psychiatric consumer/survivors and others as psychiatrists-in-training. The group, known as RACI, or the Residents and Consumers Initiative, meets monthly in each other's homes over dinner in an effort to get to know one another informally.

This sort of contact and context can go a long way in challenging the stigma and discrimination consumers sometimes experience from the very people who are supposed to help them. Dr. Patrick Corrigan, lead researcher with the National Consortium on Stigma and Empowerment based at the Illinois Institute of Psychology, has found that frequent contact with people with mental illness can actually intensify stigma among mental health professionals – a seeming irony that in fact makes sense when one considers that context matters. Clinicians tend to see people at their worst, in clinical settings, where the narrow focus on diagnosis doesn't afford a view into people's lives when they are not in crisis, where recovery is possible.

What does open a window into those lives is spending more time in normalized settings with people who have recovered or are well on their way. It's a particularly valuable approach for students-in-training, says Corrigan, so they "learn early that psychopathology is only one side of the illness coin; recovery is the other."

Dr. Priya Raju, a third-year psychiatry resident at the Centre for Addiction and Mental Health (CAMH) who co-founded the group, says that RACI's informality breaks through the barrier between professionals and consumers, altering the "subtle stigma and power dynamics" involved in psychiatry training. RACI emerged from a chance encounter between another psychiatry resident and a speaker from Voices from the Street, a leadership program for people who have experienced poverty and homelessness. Raju and the other resident, Dr. Rachel Kronick, who has since moved on to a residency in Montreal, met with Pat Capponi, a mental health and anti-poverty activist, and several other consumer/survivors over lunch, and RACI was born. Attendance varies, but at the group's core are seven consumer/survivors and five residents from the University of Toronto's Department of Psychiatry. Other health professionals are also welcome.

The group's founders thought it would be novel to meet with people with histories of mental illness outside of a clinical setting. When someone mentions their illness in the group, it's a tangential part of the conversation, not the central feature of their lives. It's a different perspective from formal training, where the focus when consumers are invited to speak to residents is the person's illness. RACI lets residents see "the other side of the illness coin." "We gossip

about movies, make jokes, hang out," says Raju. When group participants learn about an aspect of someone's mental health experience, she explains, it is "in a way that does not make us see people only through that lens."

It is a lens that is bringing stigma into focus across the country. Dr. David Goldbloom is senior medical advisor at CAMH and vice-chair of the Mental Health Commission of Canada, which is developing a national campaign against stigma and discrimination called Opening Minds (see p. 8–9). Health care professionals are one of its first targets. "We tend to see people when they're feeling at their worst and those who don't get better quickly," says Goldbloom. "That leads to a sample bias in our overall perceptions of the impact of mental illness. Because the people who get well don't need us anymore, we tend not to see them." Goldbloom sees RACI as one way of addressing stigma by getting at medical residents' attitudes while they are still young and "pre-cynical." They'll see "a person with a whole set of strengths and weaknesses, quirks and foibles, talents and promise, who happens to have a mental illness that they're going to try to help."

Capponi, too, sees RACI as a step in the right direction: "The worst thing is to be asked to recommend a good psychiatrist to someone in need and you can't come up with a name," she says. "I'm glad we have this chance of influencing and getting to know and to trust these new psychiatrists." Before RACI, Capponi was more accustomed to older psychiatrists, some of whom she says were "set in their ways and surrounded by privilege and attitude." RACI has changed that perspective. "I never would have thought of psychiatrists as young and vulnerable and questioning," she says. Capponi believes RACI has been a healthy learning experience for residents and consumers, one that requires participants to be "reasonable, open-minded and prepared to engage. If you want to change people's hearts and minds you have to be able to listen, and you don't listen to people by shutting them down," she says.

The group's capacity to listen showed itself over dinner one evening when Raju admitted to having delivered electroconvulsive shock therapy (ECT). She was met with a short silence and a gasp. But then the first questions were about how the experience was for her. "It was the most lovely response I could have gotten," says Raju. Capponi says about that particular evening, "It helped that we already like each other and are aware of each other." The group talked about how they would never have real agreement on this subject. Capponi knows ECT is part of psychiatric training and believes that the reactions of consumers in the group weren't "done with a cudgel." Rather, their reaction was, "Listen, I understand why you did that, but you have to look from our side; it is barbaric and damaging and frightening." Raju says that discussion has influenced how she would raise ECT as a treatment option with patients.

Dr. Andrew Howlett, a third-year psychiatry resident who has been attending the group for two years, appreciates seeing the strengths and resilience of consumers. "It sheds light on what's possible, why it's good to have an imagination and to focus on a person's

strengths, even in vulnerable times or when they're not well," he says. The group has helped Howlett to understand other issues that people with mental health problems face, including poverty, unemployment and homelessness.

Violet*, a survivor of childhood trauma who has been attending RACI for about one year, also appreciates this broader perspective: "Understanding that having certain things, like a home, a job, a sense of value and worth, can heal you a lot faster than any medication," she says. "If we have understanding and supportive professionals that don't allow their training to make assumptions, they will find that their work is actually more productive and effective in the long run."

But Raju sometimes wonders whether three hours a month with the group can rival the realities she faces through long hours spent with people in the emergency room or on inpatient units. Although she knows intellectually that mental illness exists on a continuum, "it's really hard to combat experience," she admits. Often the people who return to the emergency room over and over again have had schizophrenia for 20 or 30 years and are still quite ill. Still, Raju believes RACI is having a positive impact. Compared to her colleagues, she says, "I've had more exposure to dynamic, passionate, articulate people with psychiatric histories. Maybe even three hours a month is a fair bit more than most people get." ■

*not her real name

CHALLENGING STIGMA FROM THE START

Opening Minds, the national anti-stigma campaign of the Mental Health Commission of Canada, is targeting health care providers in its first phase. Among its pilot projects are these unique contact-based programs that are opening the minds of students, before they enter practice.

Nursing. For 10 years, the psychiatric nursing program at Brandon University in Brandon and Winnipeg, Manitoba, has involved a recovery narrative assignment as part of its fourth-year psychiatric rehabilitation and recovery course. Each student meets with a consumer over the course of four months to learn from and reconstruct that person's story of recovery. "The assignment takes students out of the medical model and makes them really listen to the individual's story," says Jane Karpa, one of the course instructors. "One student commented that this is the toughest assignment she has ever done, but that it was also the most satisfying."

Social work. The social work program at York University in Toronto features a three-hour section that addresses different types of stigma. The session has two facilitators – a consumer/survivor and a social work instructor. Students learn about mental health recovery as a critical concept in social work through discussions with consumers and a film, *Extra Ordinary People*, which documents their experience. According to one student, "Understanding the recovery concept helped me to better understand mental illness and the power of support and hope."

Occupational therapy. The first-year occupational therapy program at the University of Alberta in Edmonton includes a client-educator program. Over the course of two months, students meet with consumers in order to learn about and challenge the myths of mental illness. One student reflected on her original attitude: "When hearing about clients with depression, I was not very compassionate because, well, everyone gets sad at one point or another, so why can't they just deal with it?" After having taken the course, she has a new attitude: "I came to realize that this is not an easy way out of responsibilities or life's challenges."



Do you see examples of stigma-busting in your practice or training?

Access this story online and share your experience at

www.camhcrosscurrents.net

The courage to “come out”

Social worker confronts stigma in the workplace

BY LESLEY YOUNG

“I was depressed and went to see a psychiatrist. He told me with such arrogance that what I really needed was to find a job.”

“When I was admitted to an ER for self-cutting, I overheard one nurse comment to another: ‘I know her parents – they’re good people and well off, so she must just be trying to get attention.’”

THESE ARE JUST TWO OF THE MANY COMMENTS PROVIDED BY consumers, whose feedback about stigma and discrimination by health care providers was solicited by *CrossCurrents*. They don’t come as a surprise to social worker Cheryl Peever, who has witnessed similar situations in health care settings. “People don’t always realize how their language can make others uncomfortable or even create a hostile work environment,” she says. Peever knows, because she herself has experienced mental health and addiction issues. “I would think, If only colleagues knew I was one of ‘those people’ and I turned out well – maybe they would see ‘those people’ in a different light.”

Peever says that working in an acute setting and seeing people at their worst makes it easy to forget that recovery is possible. “Sometimes you lose sight of the success stories,” she says. Peever had battled years of alcohol and cocaine addiction until she was treated for depression and began her recovery, which included going back to school to become a social worker. Peever has now been clean for 18 years and is manager of the Women’s Program at the Centre for Addiction and Mental Health (CAMH) in Toronto.

Working within the health care community, Peever had experienced the stigma of mental illness and addiction first-hand. But even so, she was unprepared for how deep it ran. “Taking clients to appointments in the community showed me that the stigma was not confined to health care. I witnessed it in government offices, banks and community services,” she says. Whenever she casually challenged a negative remark, she was chided for being naïve. “People acted like discrimination was justified,” says Peever. “I was told I was wasting my time, that people don’t want to get better, that they’ve done this to themselves.” But Peever has a different perspective: “To me, those are

the people who are naïve, and I would think, ‘If only you knew ...’”

After sharing her story with a trusted colleague who was struggling with a family member’s addiction, Peever was encouraged by the colleague to enter CAMH’s Courage to Come Back Awards, which recognize Ontarians who have overcome mental illness or addiction and use their experience to help others. “I said, ‘Absolutely not,’” says Peever. “I had worked long and hard to get where I was professionally and personally, and the thought of exposing my history to colleagues and strangers was horrifying.” Looking back, Peever says that this is a prime example of how stigma causes people to self-silence.

But when the 2006 awards came around, Peever found the courage “to come out,” as she puts it. When she learned she would be a recipient of the award, her first reaction was fear and dread. “Exposing myself in that way made me the most vulnerable and scared I have ever been,” says Peever. Deep down, she hoped that sharing her personal experience would provoke honest discussion with colleagues. “I wanted to challenge people’s beliefs and present a different picture of who an addict is and what someone with mental illness can achieve.”

Some people were clearly supportive. “For that, I will always be grateful,” says Peever. But there were other reactions too. Negative and derogatory remarks. Uncomfortable silence. Furtive support. “Some people would sneak into my office and say they were really proud of me,” says Peever. “But they said they didn’t want to say it in front of anyone else.”

The award announcement struck a chord. Peever received dozens of phone calls from people working in health care who shared their personal stories, who had encountered stigma in the workplace, and who worried about their job security if they disclosed. It was

validating and deflating at the same time. “Hearing from colleagues confirmed that I wasn’t just being paranoid or thin-skinned,” says Peever. “But it also revealed that stigma and discrimination are real phenomena felt at all levels of health care organizations.”

Peever theorizes about why colleagues find it so hard to discuss mental health and addiction issues on a personal level. “Historically, it hasn’t been talked about,” she says. “We know how to talk about it in relation to clients, but we don’t know how to discuss it in relation to ourselves. That perpetuates a culture of ‘us’ versus ‘them’ and makes conversations difficult to navigate.”

When Peever hosts workshops about mental health and addiction in the workplace, she tells employers and managers, “Having someone in your workplace with a mental health issue does not reflect on you as a boss. How you respond to it does.” And since one in four people will experience mental health or addiction issues, chances are we all know someone. “Only about three per cent of people are chronically disabled by their illness,” says Peever, “so where are the rest? They are your friends, neighbours and colleagues.”

Thinking in those terms helps us shake the idea that people don’t recover, says Peever. “If you know somebody, it’s harder to discriminate. We should be able to talk about a mental health issue as though it were any other health issue. Talking about it is a rich way to share experiences and deepen understanding.”

Over the years, Peever has received support from colleagues who formed the Unusual Suspects, a group of CAMH employees who have

experienced mental health or addiction challenges. “Some people have disclosed, some haven’t, but we are there to support each other,” says Peever. “It helps that there are others dealing with some of the same experiences.”

Peever has seen a noticeable shift in her workplace, where more employees have disclosed and had positive experiences. “If a colleague confides in you, you should feel honoured that they trust you,” says Peever. “It’s incredibly hard to talk about, so having a colleague disclose to you says they respect you.” Ultimately, Peever says that keeping mental health and addiction issues a secret only hinders discussion and dialogue, especially about stigma and discrimination.

At an organizational level, CAMH has made steps towards combating stigma by recruiting employees with mental health or addiction issues through the Employment Works! initiative. In its five year history, it has hired more than 160 people, not including 12 peer support workers. “These recruits often become the most committed employees, who are thankful for the opportunity to demonstrate their skills and abilities,” says Diana Capponi, the initiative’s co-ordinator.

While Peever copes with occasional scrutiny, she generally doesn’t mind her presence being a challenge to the status quo. “My goal is attitude change, but I will settle for behaviour change, even if people are a little less likely to make certain comments around me,” she says. Today, Peever is at peace with her decision to have opened up. “Now, I bring all of myself to work, rather than keeping a large part of who I am hidden. Someday, I hope everyone can do that.” ■

BEYOND “US” VS “THEM” IN THE HEALTH CARE WORKPLACE

We may see our clients as the “other” – as the group we serve, which is lesser in some respects – weaker, less resourceful, less capable. We consider ourselves, the professionals, as strong, knowledgeable and competent. We differentiate to safeguard ourselves from our overwhelming feelings when we see clients’ unmet needs for health, meaning and autonomy. But this strategy can frustrate our need for connection, inclusion and integrity.

So what happens when we hear that a colleague has a mental illness or addiction – when one of “us” is now one of “them”? We may experience a range of feelings – frustration that the person wasn’t strong enough to keep it together, anger at workplace factors that contributed to the illness, fear of becoming ill ourselves, and mistrust in the person’s reliability.

We may entrench ourselves in beliefs about our colleague that assign them to the “other” group – weakness, incompetence, lack of professionalism, lack of intelligence. This disconnects us from our colleagues, our clients – and essentially, from ourselves.

These strategies can help shift our perspective:

Listen to success stories. Hear from people who have a mental illness and addiction and who have remained at or returned to work

successfully. Use the free video resource called *Working Through It* (www.gwlcentreformentalhealth.com/wti). You can also invite speakers, for example, through the Mental Health Works Speakers Bureau (www.mentalhealthworks.ca/speakers_bureau.asp).

Focus on health and safety at work. Put mental health on your meeting agendas to discuss psychological safety, practices that promote or hinder mental health and workplace culture around inclusion and accessibility. Use the tools at Guarding Minds at Work to identify issues (www.guardingmindsatwork.ca).

Foster a supportive workplace culture. Social support is a key protective factor against workplace stress. When we engage in exclusionary behaviour at work, we damage our social support safety net and reduce its ability to protect us all.

Think about mental illness as a physical illness. Consider how you respond to colleagues with chronic or episodic illnesses like diabetes or asthma. Do you think differently about their strength, competence or professionalism? Think about people with mental illness or addiction in the same way – that they are still strong, competent and professional, and that they may need assistance and accommodation when they are unwell, just as do other people with chronic or episodic illnesses.

Donna Hardaker is a workplace mental health specialist with the Canadian Mental Health Association, York Region.

In the shadow of Nurse Ratched

Film portrayals perpetuate courtesy stigma

BY NED MORGAN

Nurse Ratched remains an unfortunate byword for the mental health nurse

MAINSTREAM FILM HAS NEVER BEEN very kind to mental health nursing. More often, it has either undersold the role of nursing – pushing it to the fringes as window dressing to the work of doctors – or promoted a stigmatized and distorted view of nurses as uncanny instruments of punishment and control.

Ann Greene, a British Columbia-based mental health nurse, witnesses the power of film to influence and reinforce popular portrayals of her profession when she takes nursing students onto psychiatric units. “Many student nurses still relate the whole role of the nurse to *One Flew Over the Cuckoo’s Nest*,” she says. “Everybody seems to know about it.”

Trina Gouthro, a public health nurse in Truro, Nova Scotia, says these damning portrayals hurt both the profession and the people it serves. “Such film depictions are highly problematic because they contribute to a mistrust and fear of mental health nurses by the public, which may deter some people from seeking the care they need,” she says.

It’s a sort of stigma by association, attaching itself to those who work with that highly stigmatized population – people with mental illness. This “courtesy stigma,” as it is called, has been examined in the experience of psychiatrists and has been implicated in the devaluation of and low recruitment into the profession. Mental health nursing may arguably be even harder hit by the stigma.

Keri De Carlo, a mental health nurse and nurse educator at St. George Hospital and Community Health Service in Sydney, Australia, has examined these popular portrayals. In an ethnographic analysis that explored how mental health nursing was depicted in 19 American films from 1942 to 2005, De Carlo concluded that mental health nursing was considered abnormal, secret and dangerous work. The study, published in a 2007 issue of the *International Journal of Mental Health Nursing*, found that films depicted the role of mental health nurses overall as one of “custodial companionship” and “doctors’ handmaidens.”

“Film is an influential social agent that replicates and reinforces stereotypes,” says De Carlo. “Negative stereotypes and perceptions of mental health nursing are replicated and reinforced through the media, serving to sustain mental health nursing in a stigmatized position.”

Gouthro traces this stigmatized position to the perception that mental health nursing is “low-class work requiring no skill or expertise.” In a recent article in *Issues in Mental Health Nursing*, Gouthro argues that the decision to enter mental health nursing may be perceived as a personal flaw in the nurse, be it psychological or intellectual. As the most widespread transmitter of ideas and images, film certainly reinforces these notions. “Stigmatizing portrayals of mental health nursing in film can contribute to the distorted view of mental health nurses

as controlling and untherapeutic,” says Gouthro.

It’s a distorted view that stigmatizes mental health nurses even within the nursing field. Greene, a former board member of the Canadian Federation of Mental Health Nurses (CFMHN), has experienced the stigma since beginning her career in the 1970s. “On my first day on the job as a graduate nurse, a registered nurse who was getting close to retirement asked me, ‘Why would you start your career in psych nursing? This is where you end your career.’”

With more than 60 years of stereotyped portrayals in mainstream film and television (see sidebar), is there an end in sight to the real-world stigma of the profession?

“Mental health nursing is still seen as the country cousin, and it’s not valued in the same way as medical or surgical nursing,” says Greene. She is concerned about the erosion of mental health nursing within undergraduate nursing programs across the country. “The CFMHN did a cross-country environmental scan of nursing schools and found that many offer no course in mental health nursing and that clinical hours are minimal.”

However, Greene sees some positive developments, particularly where nursing schools are introducing relational practice into their curricula. “That really is the core of mental health nursing – entering into therapeutic relationships with patients.”

De Carlo sees the problem as latent in

the larger medical profession: “I talk a lot to general nurses, and our world is still seen as strange, a bit deviant, weird, exotic,” he says. “The geographical space that psychiatric nursing occupies has changed from large, isolated institutions to being attached to a general hospital. But our world is still seen as secret, full of crazy people who are expected to be eccentric, different.” ■

SHRINK WRAP

The depiction of psychiatry in films reveals a fixation with the darker aspects of the history of psychiatry – for instance, the Victorian-style asylum – that continues to cast its long shadow. The image of the asylum as a cursed, forsaken place has been showing up in films from *Bedlam* (1946) to *12 Monkeys* (1995) to *Shutter Island* (2010).

Pinpointing film’s stigma toward psychiatrists is trickier, since it comes in many forms. According to Dr. Peter Byrne, consultant liaison psychiatrist at Newham University Hospital in London, UK, “Popular cinema, from Hollywood and elsewhere, has continued to portray mental health professionals in mostly a negative light.” This may be due to ignorance, for as Byrne points out, “the people who comprise this industry learned their psychiatry at the cinema ... cinematic education began with the coercion and cruelty of *Cuckoo*, and the asylum looks every bit as bad as *Shock Corridor* (1963).” Byrne notes that while psychiatry has also been idealized in film – he cites *Spellbound* (1945) and *Ordinary People* (1980) – this is relatively rare. Byrne asks, “Where is the drama in a helpful psychiatrist supporting his or her patient?”

Non-network television drama may be bucking this trend by offering nuanced and relatively true-to-life psychiatrist characters. HBO’s *The Sopranos* (1999–2007) featured the sympathetic psychiatrist character Dr. Jennifer Melfi (Lorraine Bracco). Each episode of the current HBO series *In Treatment* (2008–) focuses on a different client of Dr. Paul Weston (Gabriel Byrne). Though at times extremely troubled in his own life, Dr. Weston is clearly a helpful psychiatrist who supports his clients.

Fact or fiction?

Mental health nurses on the screen

The Snake Pit (1948)

One of the first major U.S. feature films to deal at length with mental illness, *The Snake Pit* can be commended on many levels, but not for its depiction of nurses. Committed to a state mental hospital for women, Virginia Cunningham (Olivia de Havilland) is transitioned through various wards. The treatment she receives from a kindly psychiatrist contrasts with the treatment she receives from nurses, who range from bustling no-nonsense matrons to power-hungry persecutors. Nurse Davis (Helen Craig) dislikes Virginia and is stopped short of maltreatment only when doctors intervene.

Valley of the Dolls (1967)

This popular but critically derided film of a bestselling pulp novel about the intersecting lives of three women and their relationships, careers and addiction to prescription pills shows nurses in a private sanatorium as emotionless and dedicated to unimaginative routine. Neely O’Hara (Patty Duke), a singer who is addicted to pills and has a mental breakdown, is put through the paces by heavysset nurses who administer little more than enforced hydrotherapy.

One Flew Over the Cuckoo’s Nest (1975)

Nurse Ratched (Louise Fletcher), head of a psychiatric ward, uses group therapy to pursue her coolly spiteful agenda of total control. Thanks to Fletcher’s Oscar-winning performance, Ratched has become an unfortunate byword for the mental health nurse. But if the film is viewed as an allegory of a totalitarian state (which the director and author of the original book intended it to be), it becomes clear that the character is not meant to be an accurate portrayal of a mental health nurse. Sadly, it continues to be viewed as such.

Terminator 2: Judgment Day (1991)

Sarah Connor (Linda Hamilton) believes that a cyborg travelled back in time to kill her. She lands in a psychiatric facility, where her psychiatrist, though ineffectual, is not unsympathetic. The male nurse-attendants, however, routinely beat patients and (it is suggested) sexually abuse them. The film is a dystopia, where the accepted values of the world we know are turned upside down; the nurse-attendants play to this element of the story by acting out the violent antithesis of a nurse’s true work.

Changeling (2008)

In this Oscar-nominated film based on a true story, Christine Collins (Angelina Jolie) is committed to the psychopathic ward of the Los Angeles County General Hospital in 1928 under false pretences. Having already been at the mercy of corrupt police, she is now thrust into a world where nurses are grim-faced agents of domination, stripping and hosing their victim down and subjecting her to humiliating examinations. When Christine is seconds away from a dose of punitive electroconvulsive therapy, the camera focuses on the face of the nurse controlling the machine, showing her Aryan-type features suffused with impersonal cruelty.

House (2004–)

The popular series about an unconventional, drug-abusing medical doctor finds him institutionalized for addiction and mental illness at the beginning of its sixth season. In the group therapy scenes (reminiscent of *Cuckoo*) the contrarian Dr. House is at loggerheads with the doctor in charge; unlike in *Cuckoo*, a doctor, not a nurse, conducts the therapy. Ann Greene, a mental health nurse who has seen the show, comments: “In *House* [season six, episode one], the nurses were all in the background, doing coercive interventions or acting as medication dispensaries. All the therapeutic interaction was done by the psychiatrist. In real life, that’s the nurse’s role.”

"Why are you wasting our time?"

Shunned in the emergency room

BY AVRIL ROBERTS

"Get that schizo out of my emergency department! If you want to admit her, admit her to your ward, but get her out of here – and tell her to take care of her diabetes!"

THAT IS THE RECEPTION MICHELE MISURELLI GOT FOUR YEARS AGO, on arriving at an emergency department with skyrocketing blood glucose levels and fears that she might go into a diabetic coma. "My psychiatrist managed to get me a space on his psych ward and had me admitted for my diabetes," says Misurelli. "I should have been on a medical ward, but they didn't think I qualified. They thought I was playing games with them."

"The attitude is that we are a nuisance, that we are faking it, that we don't have any grounds to be there," says Misurelli. "We get told, 'This is an emergency department. We're dealing with gunshot wounds, knifings and heart attacks. Why are you wasting our time when there are people who are sick? If you just give yourself a good kick, you wouldn't be here.'"

It's an attitude that plays out in emergency rooms across the country. People with mental illness and addiction say they experience stigma and discrimination by ER staff, from reception to medical personnel, regardless of whether they are seeking medical or psychiatric care. In the ER, because they are in contact with health care providers at a time of crisis or vulnerability, this stigma can be particularly devastating.

Consumers tell us about the many forms that stigma and discrimination in the ER can take:

Disrespectful words. Calling people "frequent flyers," "problem patients," and "heavy users." Joking about people's physical or mental health conditions.

Dehumanizing body language. Rolling eyes and knowing glances. "You go up to the desk and the nurses immediately put their heads down and ignore you like you're invisible."

Judgmental attitudes. "Oh, you're here again?" Viewing addiction as a lifestyle choice, not as an illness. When one addiction agency in Ontario approached the head of a local ER with an offer to have an addiction worker on hand, gratis, the offer was declined with the comment, "Well, it's their choice, isn't it?"

Exclusion or refusal of care. Misdiagnosing or ignoring a medical problem because someone has a history of mental illness or addiction.

Harsh interventions. "Raising your voice can get you sedated." Excessive use of force by security.

Discriminatory policies and procedures. Mandatory undressing for psychiatric patients. Segregation of people in locked rooms regardless of legal status, behaviour or elopement risk.

Posted signs indicating expected behaviours. "You are required to behave as if you don't have a problem because staff are not trained in mental health matters and can't deal with you at the level of your emotional distress."

Lack of privacy. "There's no such thing as being discreet. You have to go up in front of everybody else. It's everybody's business."

Inappropriate triage and long waits. "You can wait eight to 10 hours while they take everybody else." "It's like apartheid. The physical disorders get preference and they're legitimate, but the mental disorders are considered a pain in the butt." In a study published in the *Canadian Journal of Emergency Medicine* in 2008, all of the 27 men with a history of suicidal behaviour and substance use who were surveyed had negative expectations about the visit. "The hospital is always my last resort," said one man. "I end up feeling worse, and the waiting ..."

Yet despite the fact that emergency departments are seeing more and more people with mental health and addiction issues – either for those issues or for unrelated physical complaints – progress in combating stigma and discrimination has been slow.

As part of Alberta's participation in an emergency room pilot project of the World Psychiatric Association's (WPA) Open the Doors global anti-stigma campaign in the late 1990s, recommendations for emergency room standards were presented to the Canadian Council on Health Services Accreditation (now Accreditation Canada). These recommendations concerning privacy, security, safety, patient and family rights, training and patient satisfaction were not incorporated into national hospital accreditation standards until 2008, so their impact has yet to be seen.

In the meantime, Misurelli, who sat on the WPA committee, is

pinning her hopes on the Mental Health Commission of Canada's 10-year anti-stigma campaign, Opening Minds, which is currently targeting stigma among health care providers: "It takes a national effort and it takes consumers to speak for themselves and turn to the service providers and say, this is what's wrong, this is what's needed and this is how it's going to go," says Misurelli.

Emergency rooms are a good starting point because they represent the front line where stigma and discrimination are likely and where professional disciplines work together. These three pilot projects of Opening Minds are leading the way.

In Nova Scotia, the Cape Breton District Health Authority has initiated a project in which front-line staff from a local emergency department will each spend a day at the Crossroads Clubhouse community-based recovery program in Sydney. "Emergency department staff see people with mental illness at their worst," says Dr. Linda Courey, director of mental health and addiction services for the health authority. "By interacting with them when they are well and functioning, ER nurses may begin to see people with mental illness as regular people who may get ill from time to time, not as troublesome diagnoses."

The goal is to have all ER nurses at the Cape Breton Regional Hospital complete the training. The two nurses who have attended so far said that it was a powerful experience. The next step will be a meeting between the Family Working Group and emergency department staff and management to share experiences and ideas for improvement.

In related initiatives, the health authority is educating mental health and addiction clients about emergency department functions and processes because, Courey says, "some of the difficulties arise out of unrealistic expectations." One of the meetings was about recent changes in the Canadian triage scale and why some people wait longer than others.

The emergency department at the Cape Breton Regional Hospital recently added a private room for people who are agitated or feel overwhelmed. There are also plans to circulate compliment cards (as opposed to complaint cards) as a strategy for providing positive feedback to ER staff and supporting behavioural change.

Between January and March 2009, Ontario's Central Local Health Integration Network (LHIN) held 13 one-hour anti-stigma workshops with 208 emergency room staff at five area hospitals. The curriculum was designed with input from Central LHIN Consumer/Survivor Network members. These Understanding the Impact of Stigma workshops involved hearing consumers' stories, challenging myths about mental illness and addiction and engaging in small group discussions. Each participant was asked to make a personal commitment to eliminate stigmatizing behaviours in the workplace and in daily life.

"We thought that an experiential approach would help participants recognize their own stigmatized views and start to break that down," says Arla Hamer, who was chair of the Central LHIN Mental Health and Addiction Education Work Group at the time. "Hearing consumers' stories of the impact of stigma in their lives and what

made a difference in their recovery is intended to raise understanding and awareness of stigma."

For current chair Lori Kerr, two things stood out when she observed several of the sessions: "The surprise of participants in realizing that they project stigma, and their realization that even within an organization one person can effect change."

Constantin Nastic, a consumer, offers an example. "A hospital worker bent down to eye level and put her hand on my arm. Her kindness and words of caring gave me hope. The way she looked in my eyes. The tone of her voice. She could have done the same thing a 100 times before and it wouldn't have made a difference, but at that moment, it did."

The project has also instilled hope that attitudes and behaviour can change. Before- and after- measures of participants' knowledge, attitudes and intention to change behaviour showed significant improvements. One of the biggest shifts was in the perception of recovery, which Hamer attributes to hearing consumers' stories: "Consumers were able to demonstrate that recovery is possible and that it is an active process."

One participant commented, "We have a lot of repeat patients. I will treat these patients as if it's the first time I've met them. I will not judge them based on past visits." Ninety-two per cent of participants expressed a strong desire to learn more about mental health and addiction. To facilitate that learning, a resource manual has been sent to each participating location.

The workshops yielded an added bonus. "They helped consumers appreciate the challenges of the ER nurses, so there was learning on both sides, which was a benefit we didn't foresee," says Hamer.

In Castlegar, British Columbia, an emergency team leader and a mental health and addiction services team leader are collaborating on a program that will highlight triage, in addition to exploring stigma, mental health and addiction issues. The training will be delivered to all emergency department nurses and physicians in the health service area.

"We noticed that we were not triaging patients with mental health complaints in a timely manner, and physicians were not accepting them in their order of triage," says Cheryl Whittleton, emergency team leader at Castlegar Health Centre. "They would look at other patients who were quick, perhaps a sore throat or sore foot, before mental health clients with a higher acuity level. One of our goals is to educate emergency staff and physicians on the importance of seeing mental health and addiction patients based on the triage level they were assigned."

This focus on triage dovetails with recent revisions to the Canadian Triage and Acuity Scale (CTAS), which is the recognized standard for emergency department triage in Canada. As of January 2009, CTAS educational materials contain clearer definitions of mental health complaints. For example, depression and suicidal or deliberate self-harm are divided into sub-categories, each with a recommended level of triage.

Jim Fenning, team leader with Arrow and Slocan Lakes and Castlegar Mental Health and Addiction Services, welcomes these changes. "We're trying to be more specific about how these situations are handled," he says. ■

Fatal flaws

Why therapists don't want clients with borderline personality disorder

BY PATRICIA NICHOLSON

Rita Mohan spent years seeking treatment for her daughter Lisa's borderline personality disorder (BPD). During that time, two health care providers told her that BPD was not a psychiatric condition. Security guards escorted Lisa from a hospital when a doctor accused her of faking symptoms. Eventually, Lisa was greeted with irritation rather than compassion at the emergency room.

"Lisa at her worst was overdosing three times a week and swallowing razor blades and cutting herself," Mohan says. "The paramedics and the people in emergency got fed up with seeing her. A large part of the reason for the stigma is because the symptoms of BPD are behavioural."

Lisa's struggles were dismissed simply as bad behaviour until she was diagnosed with what was considered a legitimate mental illness – bipolar disorder. "As soon as she got the bipolar diagnosis, what a difference it made," says Mohan, who founded the Ottawa Network for Borderline Personality Disorder, which support families of people with the disorder. "Suddenly people were treating her like she was worthwhile, like she was a human being after all."

Lisa has since found effective therapy and no longer has symptoms of BPD, but her experience is not uncommon. Mental illness in general is a target of stigma, but BPD is one of the most stigmatized, says Dr. Shelley McMain, clinic head of the Borderline Personality Clinic at the Centre for Addiction and Mental Health in Toronto. "Part of the reason why there is a dearth of specialized treatment services for people with BPD is the stigma associated with the diagnosis," she says, adding that BPD is more common than either bipolar disorder or schizophrenia, but that it is not as well-known, nor are there many readily available treatment options.

Contributing to the stigma is the pejorative nature of many traditional descriptions of the disorder, for example, "manipulative" and "difficult." McMain says these negative associations may reflect the lack of resources that health care professionals have had to treat BPD, which wasn't recognized as a

psychiatric condition until 1980. In fact, until about 20 years ago, it was considered untreatable. "People diagnosed with BPD were unpopular with clinicians, in part because having the disorder didn't seem to relate to the development of a treatment plan," says McMain.

Even now, symptoms such as self-harm, suicidal behaviour and intense emotions can make treatment a challenge. "Those types of behaviours often evoke anger, frustration or helplessness in health care providers," McMain says. The negative associations may have contributed to the historical reluctance to treat people with BPD. "However, that has changed dramatically over the past 20 years through considerable progress in understanding and treating BPD," says McMain.

Not only is BPD treatable; it also has a more optimistic prognosis. Recent long-term research has found that most people with BPD get better. The most promising treatment is dialectical behaviour therapy (DBT), a form of cognitive-behavioural therapy that focuses on helping people move from behavioural dyscontrol to increased control.

"DBT is really changing how people feel about the disorder," says Perry Hoffman, president of the National Education Alliance for Borderline Personality Disorder (NEA-BPD) in Rye, New York. "It's effective, not only for the patient, but also for the provider, because you have guidelines to follow."

Still, long waiting lists remain a serious barrier to care. It doesn't help that people with BPD are often excluded from other mental health programs and vocational programs because they are viewed as high maintenance, says Hoffman.

Stigma may also explain the lack of researchers and research funding devoted to BPD. "Far fewer people are researching BPD than other psychiatric illness because you lose a lot of sleep at times with patients, worrying about them," says Hoffman, adding that funding continues to lag behind that for other disorders.

It's a problem that motivated Hoffman to found NEA-BPD in 2001, with a group of consumers and family members who wanted



to build awareness of BPD. The organization hosts conferences and has secured two National Institute of Mental Health grants. "We go down different avenues to build public awareness and to change the perception of the illness," says Hoffman.

One of those avenues is to make sure new clinicians don't perpetuate the stigma. NEA-BPD is presenting a workshop specifically for psychiatric residents at this spring's annual meeting of the American Psychiatric Association. "We have to get involved early in order for new psychiatrists to hear the most current information and research, which will change perceptions about this disorder," says Hoffman. "It has to start with the psychiatric community because if there's stigma there, it will mushroom out."

It might also move inward in the form of internalized stigma. "A lot of people with BPD have trouble with the label," says Amanda Wang, who has BPD and founded Rethink BPD, which runs a peer-led support group in New York City. "They feel it's a life-changing disorder, compared to depression or bipolar disorder, because it has the stigma of not being treated well, or of patients being difficult or manipulative. People feel that kind of stigma," says Wang. She adds that people who come to the support group are often relieved to meet others living with the disorder.

Wang says she has been lucky not to have personally encountered negative attitudes from health care providers. Unfortunately, members of her support group have. Rethink BPD hopes to complete a documentary film that tells people's stories and challenges the stigma. Says Wang: "People will see first-hand what stigma can actually do to someone's life, and how it makes it more difficult to get the treatment we need." ■

“Why did mommy go?” Explaining a parent’s addiction treatment

Mommy’s Gone to Treatment and *Mommy’s Coming Home from Treatment* are illustrated children’s books that explore from a child’s perspective the family challenges of coping with a parent going into residential addiction treatment. The first book chronicles the experience of Janey, a pre-teen who is not sure how to interact with her family when her mother goes away for treatment. Janey’s father is responsible for explaining that mommy has a disease called addiction, where she sometimes finds it hard to get out of bed or gets very angry with Janey. The book chronicles Janey’s interactions with her father and grandmother and her weekly visits to her mother at the treatment centre. Janey is an observant girl who notices that her family is acting differently. She asks a lot of questions that ultimately help her to understand why her mother is in treatment.

In *Mommy’s Coming Home from Treatment*, Janey wakes up one day fantasizing about how things will be better when her mother returns home. However, Janey’s dream is not quite realized when her mother returns. The book explores Janey’s talks with her family as she begins to understand that things are going to be a little different at

home (e.g., mommy has to attend an evening group); however, Janey is assured that things will be better for her mother and the family.

The books, written for 4- to 8-year-olds, explore various aspects of children’s fears of what it means for a parent to have an addiction. The story highlights important discussions that should occur, given how children can internalize the family’s confusion. At the end of each book are suggestions for how parents can talk to their children about addiction treatment, including excellent tips, such as focusing on the positive and using simple, honest language. The illustrations depict a wide and realistic range of emotions and actions.

However, the books focus on the disease model, rather than exploring other theoretical frameworks that have arguably been better validated in the addiction literature. Given that not all professionals can agree on one approach to addiction treatment, the idea that one model or concept is shared with a child who appears innocent and impressionable is worrisome. Also, although Janey was given accurate and simple information about her mother, it was

curious how Janey woke up to the surprise of her mother missing. I would encourage families to discuss the plan of treatment with their children so they can prepare for the event and ask questions.

It is important to publish literature that helps children understand the complexities of what it means when a family member has an addiction or mental health concern. However, it is challenging to find a balance of the right message because of the many theories and debated causes of addiction. Crosson has made a valiant effort in attempting to approach this topic. However, I would encourage readers to consider the story of Janey to be one circumstance, for one family, that has its own cultural beliefs, and that there are other perspectives to consider in understanding addiction. ■

Mommy’s Gone to Treatment and *Mommy’s Coming Home from Treatment*. Denise Crosson. Central Recovery Press, Las Vegas, 2008, 44 pp. each, \$14.95US, each.

Kirstin Bindseil is an advanced practice clinician in the Addiction Program at the Centre for Addiction and Mental Health.

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SHEILA LACROIX

The anti-stigma movement: Branching out

Government agencies, regional health services and professional associations have joined consumer advocacy groups in addressing the stigma and exclusion experienced by people with mental illness.

New Zealand: Like Minds, Like Mine www.likeminds.org.nz

An enquiry into mental health services in the late 1990s paved the way for the **Like Mine, Like Minds** public education campaign, named to focus on similarities, rather than differences. This core funded government public health program offers a research component that includes surveys and campaign evaluations.

United States: ADS Center www.stopstigma.samhsa.gov

In 1996, the WPA introduced a global program to combat stigma around schizophrenia.

The program web site provides information for professionals and families. One core resource is a periodically updated annotated bibliography of resources on stigma. Alberta was the first site in Canada to introduce Open the Doors by Canadian psychiatrists in co-operation with the regional Schizophrenia Society and its speakers’ bureau. Guidelines for reducing stigma directed at ER patients with acute psychosis were developed and have since been adopted across Canada.

Canadian Psychiatric Association: Part of the Solution

It should be noted that within disciplines mental health specialists may also be affected by stigma that can affect recruitment and image. At the 2008 CPA annual general meeting, “Proud to be a Psychiatrist – Part of the Solution” t-shirts were distributed. Read Dr. Patrick White’s presidential address in the October 2008 issue of *Canadian Psychiatrist Aujourd’hui* at www.cpa-apc.org under Publications.

Psychiatrists fighting stigma: Doing more harm than good?

BY DR. JAN WALLCRAFT

Madness has been stigmatized for centuries. The madhouses and asylums of yore simply removed the “mad” from society, often permanently. Nathaniel Lee, a 17th-century English playwright who spent five years in the notorious Bedlam asylum, said: “They called me mad, and I called them mad, and damn them, they outvoted me.”

Lee was one of the few whose voice was heard. For most, their exclusion was complete. The French philosopher Michel Foucault described the emergence of psychiatry at the end of the 18th century, silencing the voices of the mad and ending dialogue between “reason” and “madness,” and establishing the language of psychiatry as a “monologue of reason about madness.”

The tide turned, and asylums began to close in the mid-20th century. But stigma and social exclusion remained. Sociologist Irving Goffman wrote his seminal work on stigma, based on research with asylum inmates. Since then, many studies have shown that the public and even mental health professionals hold stigmatizing attitudes towards people with mental illness. These studies have led to calls to eliminate stigma.

Answering the call recently have been psychiatric organizations that have launched high-profile anti-stigma campaigns. Their logic is that if mental illnesses are seen as “brain diseases,” for which people with mental illness cannot be blamed, stigma will reduce. But the stigma remains. People deemed mentally ill are still disadvantaged in employment and health care, and die younger. Schizophrenia is the most stigmatized, due to fears of violence, but depression, anorexia nervosa and suicidal behaviour are also targets – as is addiction.

Psychiatrists claim that diagnoses are scientific descriptions of diseases, necessary to ensure correct treatment. Many professionals, including some psychiatrists, disagree, arguing that diagnoses are concepts, not diseases, which have acquired spurious solidity. In physical medicine, a disease is identified by physical signs as well as reported symptoms. In psychiatry, there are no physical signs, and the patient’s own view is marginalized. Psychiatric diagnoses

are simply labels for types of behaviour, adding nothing to the understanding of experience, cause or cure.

Psychiatric diagnosis may in fact itself be to blame for the stigma of mental illness. Sociologists developed labeling theory, stating that negative cultural definitions of mental illness affect treatment outcomes. In their 1991 book *From Mental Patient to Person*, Peter Barham and Robert Hayward quote one person with mental illness, illustrating the negative effect of labeling: “You wake up every morning and you think, ‘Oh God, I’m a schizophrenic!’ If the doctor hadn’t told me, I’d just have woken up and thought, ‘Well, I’m just going through some sort of illness and I’ll probably get over it.’ But once you get diagnosed you start thinking all sorts from different corners about the illness and it just gets worse and worse.”

Negative assumptions are found inside hospitals too. One woman, Kate, shares her experience on the web site of Time to Change, a UK-wide initiative to fight the stigma of mental illness: “My main experience of Mental Health discrimination was actually within the mental health system itself! Nurses and psychiatrists assumed anything I said was not real (because I was mad), expected everyone to conform to the established routine ... and expected to solve people’s problems by giving them drugs and labelling them as insane... I have always upheld that if you put ANY human being through enough stress, contradictions and devaluing, they will develop ‘symptoms.’”

In a recent *New York Times* article adapted from his new book *Crazy Like Us: The Globalization of the American Psyche*, Ethan Watters suggests that “we treat people more harshly when their problem is described in disease terms” and that “a brain made ill through biomedical or genetic abnormalities is more thoroughly broken and permanently abnormal than one made ill through life events.”

The Royal College of Psychiatry in the United Kingdom ran the Changing Minds campaign from 1998 to 2003, aimed to reduce stigma by increasing awareness about mental illness and offering modern understandings of anxiety, depression, anorexia,



schizophrenia and personality disorders. But critics saw the campaign as an attempt to increase public take-up of psychiatry, saying the College had ignored evidence that labeling itself causes damage. Similarly, in the United States, psychiatrists have been criticized for campaigning to convince the public that millions more people, even babies and children, are in need of psychiatric help. Removing the stigma of mental illness, they argue, will simply help psychiatrists and drug companies to widen their empire.

Recently, the World Psychiatric Association began to campaign against the stigmatization of psychiatry and psychiatrists. Dr. Norman Sartorius has admitted that diagnoses are problematic, calling for more care in the use of labeling. He argues that diagnoses can be misunderstood by non-medical professionals and especially by the public, where they feed into negative stereotypes.

However, if we take the psychosocial medicine route, currently eclipsed by biomedicine, we move away from categorical diagnoses and start to see each person’s unique problems, life history and needs and wishes, and can build solutions around these. People can regain the capacity to help themselves and one another. Those in the best position to re-educate the public and the professionals are the patients and former patients themselves.

Dr. Jan Wallcraft is a Visiting Fellow at the Universities of Hertfordshire and Birmingham in the United Kingdom.

CANADA

National Association for the Dually Diagnosed International Congress

April 14–16, Toronto, Ontario
Contact: NADD, 132 Fair St., Kingston, NY 12401 USA
tel 845 331-4336
toll-free 800 331-5362
fax 845 331-4569
e-mail info@thenadd.org
www.thenadd.org

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
toll-free tel 877 328-7744
e-mail ipconf@interchange.ubc.ca
www.interprofessional.ubc.ca/Adults.html

2010 Conference of the Canadian Society for the Investigation of Child Abuse

May 3–5, Calgary, Alberta
Contact: CSICA, P.O. Box 42066, Calgary, AB, T2J 7A6
tel 403 289-8385
e-mail csica@shaw.ca
www.csicainfo.com

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

Collaborative Mental Health Care: Practical Approaches to Mental Health Promotion

May 13–15, Winnipeg, Manitoba
Contact: Planners Plus, 475 Provencher Blvd., Ste. 106, Winnipeg, MB R2J 4A7
tel 204 257-5205
fax 204 255-2523
e-mail carmen@plannersplus.ca
www.shared-care.ca

International Association of Forensic Mental Health Services 10th Annual Conference

May 25–27, Vancouver, British Columbia
Contact: IAFMHS, 718 – 333 Brooksbank Ave., Ste. 617, North Vancouver, BC V7J 3V8
tel 604 924-5026
fax 604 924-5027
e-mail info@iafmhs.org
www.iafmhs.org

Congress 2010 of the Humanities & Social Sciences

May 28–June 2, Montreal, Quebec
e-mail congressinfo@fedcan.ca
www.congress2010.ca

42nd Annual Addictions Conference

May 30–June 1, Toronto, Ontario
Contact: Addictions Ontario
toll-free tel 800 965-3307
e-mail info@addictionsontario.ca
www.addictionsontario.ca

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/

Pathways to Resilience II Conference: The Social Ecology of Resilience

June 7–10, Halifax, Nova Scotia
Contact: Amber Raja, Resilience Research Centre, School of Social Work, Dalhousie University, 6414 Coburg Rd., Halifax, NS B3H 2A7
tel 902 494-3050
fax 902 494-1653
e-mail rrc@dal.ca
www.resilienceresearch.org

Canadian Public Health Association Centennial Conference

June 13–16, Toronto, Ontario
Contact: CPHA, 1565 Carling Ave., Ste. 400, Ottawa ON K1Z 8R1
tel 613 725-3769, ext. 167
fax 613 725-9826
e-mail conference@cpa.ca
www.cpha.ca/en/conferences/conf2010.aspx

Grounding Trauma Conference

June 14–15, London, Ontario
tel 905 877-6547
e-mail gt@cast-canada.ca
<http://cast-canada.ca/GroundingTrauma>
2010.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 iaspdesk@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

Canadian Coalition for Seniors' Mental Health 4th National Conference

September 27–28, Halifax, Nova Scotia
Contact: CCSMH, c/o Baycrest, 3560 Bathurst St., Room 311, West Wing, Old Hospital, Toronto, ON M6A 2E1
tel 416 785-2500, ext. 6331
fax 416 785-2492
e-mail kwilson@baycrest.org
www.ccsmhvents.ca/2010conference

Canadian Society of Addiction Medicine Annual Conference

October 19–23, Charlottetown, Prince Edward Island
Contact: CSAM, 47 Tuscany Ridge Terrace N.W., Calgary, AB T3L 3A5
tel 403 813-7217
e-mail admin@csam.org
www.csam.org

Thriving in 2010 and Beyond National Mental Health Conference

October 21–23, London, Ontario
Contact: Thriving in 2010 and Beyond, c/o Canadian Mental Health Association, 648 Huron St., London, ON N5Y 4J8
tel 519 434-9191
e-mail info@thrivingin2010.ca
www.thrivingin2010.ca

UNITED STATES

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
e-mail lwatson@asam.org
www.asam.org/annualmeeting.html

Holistic Treatment: Changing the Way We Look At Recovery-Body, Mind, and Spirit

April 28–30, Las Vegas, Nevada
toll-free tel 877 345-3360
e-mail events@frnmail.com
www.foundationsrecoverynetwork.com

6th International Conference on Clinical Ethics Consultation

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

National Association of Addiction Treatment Providers Annual Conference

May 22–25, San Antonio, Texas
Contact: NAATP, 313 West Liberty St., Ste. 129, Lancaster, PA 17603-2748
tel 717 392-8480
e-mail sanderson@naatp.org
www.naatp.org

American Psychiatric Association 163rd Annual Meeting

May 22–26, New Orleans, Louisiana
Contact: APA, 1220 Wilson Blvd., Ste. 1825, Arlington, VA 22209-3901
tel 703 907-7300
e-mail apa@psych.org
www.psych.org

College on Problems of Drug Dependence Annual Meeting

June 12–17, Scottsdale, Arizona
e-mail ebgeller@temple.edu
www.cpdd.vcu.edu/

Translational Research in Methamphetamine Addiction Conference

July 19–21, Pray, Montana
www.cpdd.vcu.edu/Pages/Index/Index_PDFs/MethConferenceFlyer.pdf

118th Annual Convention of the American Psychological Association

August 12–15, San Diego, California
Contact: APA, 750 First St. N.E., Washington, DC 20002-4242
toll-free tel 800 374-2721
fax 202 336-5500
e-mail convention@apa.org
www.apa.org

American Association for the Treatment of Opioid Dependence National Conference

October 23–27 Chicago, Illinois
Contact: AATOD 225 Varick St., 4th flr, New York, NY 10014
tel 212 566-5555
fax 212 36604647
e-mail info@aatod.org
www.AATOD.org

ABROAD

Europad 2010

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

Club Health 2010: 6th International Conference on Nightlife, Substance Use and Related Health Issues

June 7–9, Zurich, Switzerland
Contact: Karen Hughes, Centre for Public Health, Liverpool John Moores University, 5th flr., Kingsway House, Liverpool, L3 2AJ UK
tel 44 0 151 231 8723
fax 44 0151 231 8020
e-mail k.e.hughes@ljmu.ac.uk
www.clubhealth.org.uk/conference

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/

International Society of Addiction Medicine Annual Meeting

October 4–7, Milan, Italy
e-mail dntb@unimib.it
www.isam2010.medicina.unimib.it

53rd International ICAA Conference on Dependencies

November 7–12, Cancun, Mexico
e-mail icaa2010@icaa.ch
www.icaa.ch/mexico2010.html

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