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SHARE&CARE

THE RECOVERY OF HOPE ~ THE HOPE OF RECOVERY

HARD FACT OR ROMANTIC MYTH?

The possible connection between creativity and mental illness never fails to intrigue. Get the fascinating story next month at our 2012 Low-Beer Lecture

Michelangelo, Beethoven, Strindberg — were they or weren't they? The Greek philosopher and scientist Aristotle claimed that "no great genius has ever existed without a strain of madness." That was over 2,000 years ago. Yet despite all the studies and theories accumulated since then, a definitive answer still eludes.

If anyone can bring a sharp focus to the subject, it's Dr. David S. Goldbloom, this year's Low-Beer Lecture speaker. A well-known psychiatrist, he is senior medical advisor at Toronto's Centre for Addiction and Mental Health (he was the founding physician-in-chief) and a professor of psychiatry at the University of Toronto. A Rhodes scholar, he has more than 100 scientific articles and book chapters to his credit and has edited two clinical textbooks. He recently succeeded Senator Michael Kirby as Chair of the Mental Health Commission of Canada.

Goldbloom also chairs the board of governors of the Stratford Shakespeare Festival. By any chance, does he place the Bard in the art-madness nexus? Don't miss Goldbloom's address, **Where madness meets art — mental illness and the creative mind**. You'll go home with a new perspective on one of the world's age-old mysteries.

The Edith and John Hans Low-Beer Memorial Lecture will be held **Wednesday, October 24, 7:00pm at Oscar Peterson Concert Hall, 7141 Sherbrooke St. W.** The event is co-sponsored by AMI and Concordia University's department of psychology. Free admission. Presentation in English. ❐

Now you can donate online

Donate, renew your membership, buy tickets to events — now it's all possible online at our newly designed website.

You can pay by Visa or MasterCard and you'll receive a tax receipt for your donation instantly by email. Telephone transactions still apply for those who prefer, but many people find they like online convenience.

One of the best ways to support AMI's work in helping families cope with a mental illness is by becoming a monthly donor. The amount you choose will be deducted from your credit card each month and you'll receive a year-end tax receipt for your contribution total. This ensures us regular revenue and reduces our administrative costs.

Use the form provided in this newsletter, call us at 514-486-1448 or visit **www.amiquebec.org** to donate today. ❐

Wisdom for caregivers

Goals and how you adjust them when caring for a mentally-ill loved one can have a positive impact on your quality of life. The previous issue of *Share&Care* carried a summary of a research study on the subject conducted by executive director Ella Amir. Her conclusions translate into help that allows you to be both an effective, loving caregiver and an individual with a rewarding life of your own.

Three types of goals

Personal goals are the kinds most people have: plans for careers, relationships, interests and projects worth pursuing. Parents often also have expectations for their adult children, goals that the children may or may not subscribe to. A diagnosis of a serious mental illness can shatter everyone's expectations. If dreams for a certain career are no longer feasible, the old goals need to be replaced with new, attainable ones. Your son, for instance, may not be able to practice medicine with

continued on page 2

Four ways to get the upper hand when stress threatens

As AMI families know only too well, caregiving plus mental illness is one of the most stressful combinations going. Confusion, obstacles, conflicts — it can all quickly add up and overwhelm.

There are ways for caregivers to cope, however. Francine Waters, program co-ordinator and SOS-*Famille* counselor, offers her top four ways you can learn to de-stress.

1. Breathe deep. This is a technique recommended by both doctors and fitness trainers. Here's how: Take a deep breath to fill your stomach and chest area with air. At the same time, tense all your muscles. Then breathe out slowly as you consciously relax every limb of your body. Repeat several times.

2. Live in the here-and-now. Worrying about what might happen is often a surefire way to create stress. The future is beyond anyone's control, so remind yourself to live in the present. Agonizing about the unknown is pointless, even harmful.

3. Let go. Control just what you can and nothing else is an important strategy for caregivers. For instance, if your son or daughter is suddenly unemployed, be a positive guide by helping to correct obvious mistakes, perhaps, then giving your loved one the encouragement and confidence to look for another job. Understand that this is as much as you can do. Do it well and you both can start living your own lives.

4. Educate yourself. There's still much stigma and shame surrounding mental illness. You can't control what society thinks, but learning the facts is the best way to understand that a mental illness is just that — an illness like any other. It deserves neither apologies, shame nor blame. ❐

Wisdom ... *continued from page 1*

a diagnosis of schizophrenia; there are other professions to investigate that better suit the ebbs and flows of his illness.

Caregiving involves daily domestic goals. Parents of adult children can sometimes become overzealous of these.

For example, a mother who cleans, cooks and provides her daughter with medication three times a day can easily become swamped with her responsibilities. She may think she's helping her child, whereas in fact she may well be a hindrance. Her zeal may infantilize her daughter or encourage her to become complacent. In the long run, she's nurturing a dependency rather than contributing to building strength and capacity.

Motivated by goodwill and a genuine desire to help, overzealous caregivers take on more than necessary. These are the important questions to ask: Why am I doing this? What am I accomplishing? Is this the best way to instill independence and fuel motivation in my child?

Be honest with yourself: do you derive a sense of comfort and/or control from your excessive caregiving? Are your actions ultimately selfless or selfish?

Repeat often: a diagnosis is not a death sentence. Rather, recovery allows people to maximize their potential and family members can play an important role in facilitating that recovery.

Who gets the blame?

Amir's study confirmed that caregiving in mental illness gives rise to significantly high levels of burden. This is made worse by the typical long-term and cyclical nature of mental illness, with its pattern of relapse and remission. In addition, social stigma is often internalized and becomes self-stigma. Caregivers commonly blame themselves for their relative's illness or for failing to effectively care for it.

There's a connection between self-blame and the ability to adjust one's goals.

Caregivers who experience higher levels of guilt also have difficulty disengaging from goals that have become unattainable. They experience more depressive symptoms and higher burden. Compare that to caregivers who can relinquish goals that have become impractical. They experience less guilt, fewer depressive symptoms, feel less burdened and more satisfied with life.

If you give up your old goals, developing new, more appropriate interests and commitments will reward you with a higher sense of purpose in life. Just be careful you don't overdo it. Take on too much and you may feel you don't have the time or resources to fulfill your caregiving responsibilities. This will only promote higher burden. The ideal is to reframe the stress of caregiving in a balanced and positive light.

Amir's study offers real-life benefits

The trick is knowing how. Your first new goal should be to take advantage of the tried-and-true formula of support and education — and do it as early as possible. Caregivers don't cause mental illness. They can't control or cure it either, but they can learn to understand it. When knowledge replaces shame and guilt, the way is cleared for acceptance, active coping and a better life for you as a caregiver. ❐

THE MAN BEHIND THE DR.

To many AMI members, Dr. Warren Steiner is a familiar name and face. He's been a source of help to us since the early '90s and now sits on our advisory board.

Until the end of August, Steiner held the position of psychiatrist-in-chief at the MUHC. Now he's left administrative work and is once again a full-time clinical psychiatrist.

The recent years have seen seminal changes in the mental healthcare sector and during his 30 years at the Montreal General Steiner has absorbed them all as both witness and participant. His recollections and views breathe life into the title Dr. They made for an engrossing interview, as well.

S&C: Is there something about clinical work that lured you back?

WS: It's where I began, in inpatient psychiatry. I like to change jobs every eight or nine years. That's the nice thing about psychiatry — it has so many aspects you can really reinvent yourself clinically.

S&C: Had you always wanted to be a psychiatrist?

WS: No. Very few people start medical school saying, "I want to be a psychiatrist." I was interested in cardiology, but studying cardiac physiology I became fascinated with neurochemicals and biochemical processes. When I did a rotation at the General in psychiatry I absolutely fell in love with it.

S&C: So you and this hospital go back a long way.

WS: I entered McGill med school in '79, first worked here in psychiatry as a student in '82, then joined the General staff in '88. So I know it quite well. When the MUHC merger took place in 2003, I also got to know the Allan, because I was involved on both sides.

S&C: How has this department changed since the '80s?

WS: When I started, psychiatry really was physician-centric. Inpatient psychiatry had 120 beds and was the heart of the department. Outpatients were seeing their doctor mostly. There wasn't a lot of nursing care, occupational therapy or psychology involved.

Then in '95, with *virage ambulatoire*, government money went to outpatient services for all specialties. We reduced our beds to 70 and the emphasis became: how do we provide really extensive service on the outpatient side in order to best prevent people from needing to come into the hospital? It was a very dramatic shift.

We began creating teams. A physician, a psychologist, an occupational therapist, a social worker and a nurse all worked together. Patients at highest risk for frequent relapses were assigned to case managers. This was all brand new. We survived with fewer beds because we could give better service in the outpatient department. Now we've cut beds again. We're down to 59 and dropping.

Steiner's been our good friend for some 20 years

S&C: You'd call the change beneficial, then?

WS: Absolutely. It's an easy out to rely on beds instead of preventing relapse. Being admitted is very disruptive to a person's life. We should do everything we can to help people stay healthy rather than treat them once they become sick.

S&C: As psychiatrist-in-chief you were responsible for overseeing the merger of psychiatry departments at the General and the Allan. That must have been quite the challenge.

WS: We needed to create a single MUHC department but also respect the cultures at both hospitals. The philosophy of care was quite different.

S&C: How so?

WS: The Allan had a psychoanalytic tradition and a history that focused mostly on biological psychiatry. At the General it was much more a recovery model — less pharmacology, more psychosocial. As psychiatrist-in-chief, merging the two was my toughest challenge. And an opportunity, too. The first two years were difficult, but now it's working very well.

Today our external services are at the Allan. All our outpatient clinics are there. The General is the acute-care site. The major emergency room, inpatient services, the post-hospitalization day hospital — they're here. In fact, we just recently finished the transformation.

S&C: How does the hospital view patients' families?

WS: I'm glad to say we've undergone an attitudinal shift in that regard. Families are now invited to be part of the treatment, which didn't happen 20 years ago. Every patient who's admitted, there's at least one family meeting. We inform outpatients that we'd like their family involved and it's rare that they say no. One of AMI's projects was putting a volunteer on the inpatient service. For a variety of reasons, that didn't work out very well. But now that there's a single inpatient service here and our staff is more aware of the benefits of having families involved, maybe it's time to revisit the idea.

S&C: How did you first connect with AMI?

WS: Residents had to do six-month rotations in various areas. One of them was what's called chronic care, long-term treatment for severe and persistent mental illness. I got special permission to spend a day and an evening each week at Forward House, where I worked with community workers. That really turned me on to community psychiatry and organizations. I also got involved with Tracom and ARC and that eventually led me to AMI.

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With all this good help available, why go it alone?

If there's anything you can do to counter the difficulties of dealing with a mental illness, it's having the right information, understanding and support from professionals who know the ropes. Whether you're a caregiver, a relative or someone living with a mental illness, our 2012-13 lineup of education, information and support programs has something you can use. It's help designed to build your confidence and put you in control. Call the office, 514-486-1448, for more information or to register.

ROUNDTABLE DISCUSSIONS

Learn a lot in two hours. Professional presentations are followed by questions and answers. Open to families and consumers. Free but advance registration is necessary. At **AMI, 7:00-9:00pm**. Outside Montreal, participation via interactive videoconference. Contact your **Community Learning Centre** or call us at **1-877-303-0264** for more information.

October 10. Personality disorders: more common than you think. Dr. Suzane Renaud, psychiatrist.

November 14. Resiliency: using strengths to overcome life challenges. Moira Edwards, nurse.

February 13. The hoarding life: what happens when "stuff" starts to control you. Dr. Kieron O'Connor, psychologist.

March 13. Nutrition: a key to well-being. Véronique Ménard, dietician.

May 8. Helping a family member who is suicidal. Sharon Casey, trainer-consultant.

TELEWORKSHOPS AND INDIVIDUAL COUNSELING

Join a group discussion with professional guidance via telephone. One-family counseling by request. Ideal if you're housebound, living in a remote area or where English-language services are scarce. **7:00-8:00pm**. Registration necessary. Call **1-866-396-2433** or go to **www.careringvoice.com**.

September 19. Understanding private and public curatorship. Ura Greenbaum, jurist.

October 17. Wills, trusts and other techniques for protecting the future of your ill relative. Nathan Liebowitz, financial advisor.

November 21. More harm than good? Mental illness in the media. Loreen Pindera, journalist.

January 16. What caregivers need to know about avoiding burnout. Moira Edwards, nurse.

February 20. I get these urges and I can't stop them: the strange world of obsessions. Dr. Kieron O'Connor, psychologist.

March 20. Your pharmacist knows: the straight facts about medications. Dr. David Bloom, psychiatrist.

April 17. Understanding court orders and how the police can help. Michael Arruda, police officer.

May 15. Betrayal of trust: the shame of elder abuse. Katie Fagen, social worker.

EDUCATION PROGRAMS

Open to relatives, friends and consumers. All are six-week programs with different start dates. Free for AMI members. At **AMI, 7:00-9:00pm**. Register in advance to reserve your place.

Mood and Thought Disorders. Group 1 begins **October 9**; group 2, **November 1**; group 3, **April 9**; group 4, **May 2**.

Obsessive Compulsive Disorder. One session only, March 20.

SUPPORT GROUPS

Open-agenda sessions led mostly by family members. No registration necessary, come and go any time. Starting September, groups held at the Jewish General Hospital start a half-hour earlier at **7:00pm**. See **Calendar**, page 7 for dates and locations. There's an update on Kaleidoscope also on page 7.

One more good reason to walk for mental health next month

Back for the fourth time, **Montreal Walks for Mental Health** is becoming one of fall's must-attend events. It's a healthy, fun way to spend a Sunday with family or friends, an easy 5K walk that will take place on **October 14**. And this year a new fundraising formula assures that all organizations participating in the event will get a financial boost.

What that means to you is, 60 percent of your team's donations will be turned over to AMI. The financial gain is in addition to the walk's other benefits of helping to increase awareness of mental illness, reduce stigma and raise funds for improved mental health services.

Now's the time to organize your team. Walking begins at 11am rain or shine at **Phillips Square** (across from The Bay on Ste. Catherine St.). Pre-registration at 10am. You may also pre-register or donate by phone, **514-935-5770**, or go to **www.mtlwalksformentalhealth.com**. ❒

WOMEN AND DEPRESSION

When you need help, being told "it's just your hormones" is not the answer. It's the problem

Windows of risk. That's the term often used for the significant changes in a woman's life — puberty and menstruation, pregnancy and motherhood and, finally, menopause — that are now recognized as being influenced by abrupt and sometimes chaotic changes in female reproductive hormones. These fluctuations affect neurochemical pathways that are linked to depression.

Before puberty, girls and boys have about the same risk of depression. Once puberty hits, the risk for girls roughly doubles. Studies have found that, as adults, women are 1.5 to three times likelier than men to suffer from major depressive disorder. The risk approximately triples with perimenopause. And during the transition to menopause, women with a previous history of depression are nearly five times more likely to be diagnosed with major depression.

All women have monthly hormonal fluctuations, but not everyone gets depressed or anxious. There's a complex interplay between genetics, hormones, other biological goings-on and lifesyle.

Margot's story

In her teens Margot would begin to feel a sense of gloom and hopelessness three or four days before her period, a pattern of depression that continued for two decades. She now points to the psychological impact of premenstrual syndrome (PMS) as a major cause of her clinical depression, noting the absence of any family history or triggering events.

"No one ever asked questions or talked to me about it," she says. She finally met a therapist who stressed that she didn't have to pay rapt attention to every thought, especially negative ones. "My therapist helped me to stop investing energy into looking for meaning in them." She also credits her medication with quieting her mind, enabling her to observe her thoughts without getting upset.

PMS-related depression is increasingly being accepted as a biological condition that can be helped. There is also growing recognition that postpartum depression is a legitimate disorder that benefits from treatment.

Research shows that 14 to 23 percent of pregnant and postpartum women are affected by depressive disorders; anxiety disorders affect 10-12 percent. Yet in many cases postpartum depression gets written off as "baby blues," an inevitable part of giving birth.

Public awareness campaigns to spotlight postpartum depression have brought the condition out of the shadows. According to Ruta Nonacs, a psychiatrist at Massachusetts General Hospital, the same needs to be done for the physiological downside of perimenopause. The years when menstruation is winding down can be marked by hot flashes, sleep disturbances, mood swings and other symptoms caused by widely fluctuating estrogen levels. It is increasingly recognized as a high-risk period for depression, whether or not there's a previous history of the illness.

"What frustrates me the most," Nonacs says, "is when women who have endured symptoms for several years mention that everybody told them it was normal."

Every reason but

As a teenager, Maureen had two gynecologists dismiss the idea that her monthly cycle had anything to do with her sadness and fatigue. They blamed midterms and other adolescent-related stressors instead.

Hospitalized with clinical depression in her early 20s, she experienced postpartum depression after the birth of her daughter. Her therapist counseled, "You'll be fine. You probably really wanted a boy." At her husband's insistence, she found a psychiatrist, began medication and joined a self-help group for support. Now that she's reached perimenopause, she's more aware of the reason for her current mood swings. "I used to think I was doing something wrong," she says. "Now I just ride it out and know things will probably get better in a couple of days. I don't blame myself any more."

There's still more research needed to better understand the relationship between female hormones, mood and what's behind women's increased vulnerability to poor mental health. But things are improving. And anything's better than such cliché advice as, "Just buy yourself some flowers or a new pair of shoes." ❐

Text adapted from an article by Robin L. Flanigan, *Esperanza Magazine*.

Simple coping strategies

Lean on your girlfriends. Female relationships are of prime importance to your well-being. Make the effort to sustain them.

Map out your monthly cycle. Charting symptoms daily over at least two cycles is helpful to arrive at a more precise diagnosis.

Ask for help. Be proactive about possible postpartum depression while you're still pregnant. Line up family and friends or pay someone to help with household chores for a few weeks after your baby is born. It's easier to deal with postpartum depression without the added stress of cleaning and cooking. Enlist trusted adults as daytime sitters so you can get some sleep.

Be self-aware. Take time to reflect on your emotions and behavior. Do you react to triggers? Do you find yourself overwhelmed by negative thoughts? You may want to consult a mental health professional to help you achieve clarity and confidence.

Computer game to the rescue

From New Zealand comes SPARX, developed to help depressed teens help themselves

Researchers call it a “computerized self-help intervention for adolescents with mild to moderate depression.” Teens would more likely describe it as a 3D fantasy game.

SPARX is an acronym for Smart, Positive, Active, Realistic, X-factor thoughts. The on-line game lets players choose an avatar, or character, which roams around a virtual world and interacts with other virtual characters. It also helps teens take on challenges based on cognitive behavior therapies to change their depressive thoughts and reactions.

SPARX has seven levels that need to be completed sequentially. The lowest is Cave province (finding hope). Next comes Ice province (being active), then Volcano province (dealing with emotions), Mountain province (overcoming problems), Swamp province (recognizing unhelpful thoughts), Bridgeland province (challenging unhelpful thoughts) and finally Canyon province (bringing it all together).

As defined, each level presents different core skills and exposes players to a new behavior therapy. At level 1 they’re introduced to a fantasy world dominated by GNATS (Gloomy Negative Automatic Thoughts). With the help of an instructor-guide and their avatar, players undertake a series of challenges to restore that lop-

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***The Man** ... continued from page 3*

S&C: How involved with AMI are you these days?

WS: Now I’m on the advisory board, but for many years I attended all the board meetings. Ella [Amir, executive director] and I would often discuss issues and questions between meetings.

S&C: Do you see opportunities for AMI to grow its influence and effectiveness in the community?

WS: AMI has been really good at education and getting involved politically. It’s difficult in Quebec for an English-language organization to develop influence. Nationally I think AMI is a leader. Their work with the Mental Health Commission has been great.

I believe continuing to work with McGill hospitals to develop more direct services for families would be very helpful. CLSCs are also worth exploring. It looks like more and more mental health services will be moving there over time.

AMI might also look into helping families with children in psychiatric services. I spent time as interim head of the Children’s and I can tell you there’s a huge need. Those families are truly lost.

S&C: Has psychiatry lived up to the expectations you had as a resident?

WS: Yes and no. I’ve had a very good leadership team here and I think things are generally moving in the right direction. We all share a similar philosophy, which is not unlike AMI’s, in fact.

S&C: That being…

WS: Patient-centered, recovery-based care. Moving people in from the margins so they can lead fulfilling, active lives.

S&C: Who will be taking your place as psychiatrist-in-chief?

WS: That’s still being worked on [as of the end of July].

S&C: Are you looking forward to going back to your roots?

WS: It’s the right time for me to move on. I think I’ve done a good job, but it will invigorate the department to have a new leader step in. There’s a whole generation just behind me with some really great people. ❐

TRIBUTES & MEMORIALS

In honor of Naomi and Jack Richer
Pat and Paul Rubin

In honor of Blanche Moskovici
David Donath

In honor of Bernard Pollock
Marcy Bruck

In memory of John Simpson
Kay Simpson

In memory of Roch-Peter Piper
Muriel Morris Bérubé

In memory of Jason Bassilios
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In memory of Mrs. Takahashi
Lynn and Andy Nulman

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Anonymous
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Alain Amzallag

In memory of Vicki Drudi
Leonard Drudi

In memory of Guus Boudens
Beppie Boudens

AMI-Québec extends sympathy to the bereaved and appreciation to all donors for their generosity. For information, please phone 514-486-1448.

FREE TO BE YOURSELF

Kaleidoscope provides a safe haven for people living with a mental illness

Of all AMI's many support groups, Kaleidoscope is different. No family members, no healthcare support workers, not even friends are allowed. The welcome mat is out strictly for those with a mental illness. A mental illness of any sort.

Kaleidoscope offers strength in numbers and an important space, says Zidulka

This month Marty Zidulka takes over as Kaleidoscope's facilitator. He has what it takes, being a long-time facilitator of other AMI support groups, namely depression and bipolar disorder. And living with depression, he also knows what's what.

"Kaleidoscope gives us a chance to be in a space of shared experiences," he says. "It's a place where we don't have to hide our sickness, where we can finally let our hair down, speak freely and be understood. That's something we can't do with just anyone or just anywhere."

As with all support groups, people come and go as they please at Kaleidoscope and there's no set agenda for discussion. Conversations change to suit the mood of the evening. It could be complaints about the medical system, anxiety over family or trouble finding a job; or it might be a serious debate on planning the next social outing and where's the best place for coffee.

Zidulka, a member of Donald Berman UP House, calls grieving the loss of health and function one of the worst things that happen when a mental illness strikes. Loneliness is another. "Your illness is part of who you are. When you live hiding that big part of yourself because you're unable to share it with the people around you, you end up feeling quite lonely. Kaleidoscope lets you connect with your full self. You're among friends so you make friends. You relax, you speak up. You can also learn a lot about resources and supports from those who've dealt with their mental illness longer than you."

Call the office for more information about Kaleidoscope and why not make an effort to attend a session. As Zidulka says, "We're not meant to travel the earth alone. People give each other strength, we're stronger together." ❐

FALL 2012

October 24: Low-Beer Memorial Lecture. *Where madness meets art — mental illness and the creative mind.* David S. Goldbloom. Oscar Peterson Concert Hall, Concordia University, 7141 Sherbrooke St. West, 7:00pm.

SUPPORT GROUPS
Mondays 7:00pm 4333 Côte Ste-Catherine Road unless otherwise indicated. No registration necessary.

FAMILY for relatives
Sept. 10, 24; Oct. 1, 15, 22; Nov. 5, 12, 19; Dec. 3, 10, 17

SIBLINGS AND ADULT CHILDREN for relatives
September 24; October 15; November 12; December 10

BIPOLAR DISORDER for consumers and relatives
September 24; October 22; November 19; December 17

DEPRESSION for consumers and relatives
September 10; October 1; November 5; December 3

OBSESSIVE COMPULSIVE DISORDER for consumers and relatives
September 24; October 15; November 12; December 10

HOARDING GROUP (in collaboration with Quebec OCD Foundation) for consumers and relatives
September 10; October 22; November 19; December 17

KALEIDOSCOPE for consumers
September 24; October 15; November 12; December 10

ANXIETY for consumers and relatives
September 10; October 1; November 5; December 3

PAC Parents of Adult Children
7:00pm at AMI
September 11; October 11; November 20; December 11

SOUTH SHORE for relatives
Wednesdays 6:30pm Greenfield Park Baptist Church, 598 Bellevue North, Greenfield Park
Sept. 5, 19; Oct. 3, 17, 31; Nov. 14, 28; Dec. 12, 26

LIFELINE for consumers
Last Tuesday of the month 1:30–2:30pm
Alternative Centregens, 5770 Auteuil, Brossard

Registration required for programs below (Call 514-486-1448 for details or to register)

Mood and Thought Disorders
6-session programs begin October 9; November 1

Roundtable Discussions
October 10; November 14

Teleworkshops
September 19; October 17; November 21

Volunteer appreciation
November 27

BOARD MEETINGS
Tuesdays 7:00pm at AMI
September 4; October 2; November 6; December 4

AMI-Québec Donation & Membership Form

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Monthly donations will be deducted from your credit card the 15th of every month. You can change or cancel your monthly donation by calling 514-486-1448.

New Membership

Membership includes the quarterly *Share&Care*, other mailings and lecture announcements, access to the AMI library and all other activities. Complimentary membership is available for people with limited incomes.

Existing members receive their renewal notices in the mail

Membership ($25 annual): $_______________

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Payment may be made by cheque, VISA, MASTERCARD or by phoning 514-486-1448

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We never share, trade or sell donor information.

Computer *... continued from page 6*

sided imbalance. If they succeed, by level 7 the bad-guy GNATS are defeated by SPARX, the good guys.

Players are prompted by their instructor-guide to choose some of the techniques they've practiced in the SPARX world, apply them to situations in real life and then report back on their success. They're also urged to seek professional help if their mood is not improving or worsening.

New Zealand statistics reveal that as many as a quarter of its youth population will experience a depressive disorder by age 19. Although effective therapies for mild to moderate depression are available (notably cognitive behavioral therapy), fewer than 20 percent of young people receive treatment. This is seen as partly due to workforce shortages and partly because teens generally prefer informal help and are known to be reluctant to go the traditional route.

Sally Merry, an associate professor of psychology at Auckland University who helped develop the game, says SPARX is a tool that's not intended to replace face-to-face counseling. "We aimed to design an intervention that would have wide appeal to young people in New Zealand and elsewhere and that would be enjoyable, so players would stay with it. We're hoping that we can make this downloadable from the [university's] website and thus very readily available." ❐

For more about SPARX, go to
http://www.stuff.co.nz/technology/digital-living/3662366/Gnats

amiquébec

Agir contre la maladie mentale
Action on mental illness

AMI-Québec, a grassroots organization, is committed to helping families manage the effects of mental illness through support, education, guidance and advocacy. By promoting understanding, we work to dispel the stigma still surrounding mental illness, thereby helping to create communities that offer new hope for meaningful lives.

Mental illnesses, widely viewed as biologically-based brain disorders, can profoundly disrupt a person's ability to think, feel and relate to others. Mental illness affects not only individuals, but also their families, friends and everyone around them.

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