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SHARE & CARE

THE RECOVERY OF HOPE ~ THE HOPE OF RECOVERY

REACHING YOUNG MINDS

A new school-based program called FRIENDS for Life is giving kids the skills they need to deal with their very difficult world

General Vanier kindergartners with (l-r) school principals Evelyne Alfonsi of Gerald McShane, and Pina Rizzi from Vanier. Woman on right not identified

Forget those notions about the carefree years of childhood. Educators such as Dora Cesta, assistant director of Student Services at the English Montreal School Board (EMSB), will tell you that storybook life is in short supply.

One news item speaks volumes: Results of a six-year study carried out by university teams with mothers of Quebec-born children showed that close to 15 percent of preschoolers had high levels of depression and anxiety. The children ranged from five months to 50 months in age.

"It's a different world out there," says Cesta. "Home life and families have changed, computers have been a force for bad as well as good. The problems children have are a reflection of our society's problems in general because they're part of our world." Those problems include stress, lack of confidence and feelings of fear, worry and sadness.

FRIENDS For Life is a program for the prevention of anxiety and depression. It helps children and teenagers by building the resiliency they need to deal with their emotions. Developed some 10 years ago in Australia and used today in schools throughout the world, it's the only program of its kind acknowledged by the World Health Organization. There's a FRIENDS for Children program for ages 7-11 and another, FRIENDS for Youth, for students 12-16 years. The latest addition is Fun FRIENDS, designed for ages four to seven.

Good timing

AMI's executive director Ella Amir was aware of the FRIENDS concept and knew that it was being used in B.C. schools. We've been reaching out to students through our high school program. Putting two and two together, a light flashed: schools in Quebec could surely also benefit from FRIENDS and AMI could help.

She proposed the idea of a pilot project, which we would help launch, last September at a meeting of REISA, the East Island Network for English Language Services. Both AMI and the EMSB are members of the group. REISA has identified mental health as a priority and funds were made available. "Everyone was excited," Amir says. "The school board jumped on it immediately. All that was left to do was work out the details." It didn't take long. A decision was made that Fun FRIENDS would be introduced February 1 into kindergarten and grade one classes in two EMSB schools. A teachers' training workshop and two information evenings for parents would be held before then, in late January.

AMI did the initiating, but responsibility for shepherding the project into the classroom fell to Cesta and two associates, Lino Buttino, Healthy Schools consultant, and Irene Miller, consultant for Student Services. General Vanier in St-Léonard and Gerald McShane in Montreal North were the two first schools they chose for the pilot.

Fun FRIENDS is being given an hour a week for 12 weeks. On February 25, training began for teachers in grades two, three and four in both schools. Next fall, it's expected that grades five and six will get their turn and Cesta is optimistic FRIENDS will be introduced into EMSB schools in other regions at the same time. AMI hopes that before too long the EMSB will make the FRIENDS programs part of the school curriculum.

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Pilots of the project, l-r: REISA coordinator Fatiha Gatre-Guemiri, Dora Cesta, Ella Amir

Reaching Young Minds *... continued from page 1*

Not the 3 Rs

This is a different sort of teaching. How do you help very young children cope with their nervousness, anxiety or worry about conditions at home? Building their emotional resilience is one way. Improving their self-image and social skills is another. And so is helping them find the words they need to express their emotions. These changes are harder to effect as people grow older, which explains the strategy of starting with the youngest grades.

Teachers, a social worker, speech therapists and spiritual animators — 15 people in all — attended the teachers' training workshop last January to learn the rationale and teaching approach of the program. Cesta, Buttino and Miller were all there and they acted out that approach through some unusual creative activities.

Enthusiasm reigned at the teachers' workshops

Lino Buttino and Irene Miller

"It was fascinating," says Buttino. "At one time we were told to pretend we were kids and we were led through a typical lesson. For instance, many situations in class, like being called upon by the teacher, can be frightening to children. We divided into teams and each group had to draw a silhouette of a body and identify on the outline everything that happens to us when we get a case of nerves. Like sweaty palms or headaches or stomach pains. Then the teams compared their work. Sharing the results made the point that everyone has the same fears and that nobody needs to feel alone. In a real class, the teacher would then give the kids tips for dealing with their nervousness."

Teachers were so keen on the program that some couldn't wait for the official start date and jumped the gun to begin working.

Home work

At the training sessions for parents, workbooks were handed out and guidance given for implementing the Fun FRIENDS philosophy at home. The goal is to open lines of communication and build a stronger bond between child and parent. "This is an essential part of the program," Cesta notes, "because family life affects everything in a child's world."

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WHAT'S THE MATTER WITH KIDS TODAY?

Computers, activity overload and our more-is-better way of life stir up a perfect brew for trouble

Youngsters who make headlines too often do so because of a crime or other alarming behavior. But many more are going through their days worried and stressed, below the media radar and beyond their parents' perception.

There's more than one reason why, in a time and place of enviable abundance, so many children are growing up unhappy.

Digital dilemma

Indispensable as computers are for learning and communicating, there's a downside. The family used to be the fulcrum in a youngster's life. Now it's friends who can be texted or called at any minute. To the growing disconnect you can add games, chat rooms and the Net, where kids know anything goes. Do-all cell phones have heightened our obsession with the pop music scene and the cast of characters who inhabit it. Cesta reports that phones and pink purses à la Lady Gaga have shown up in kindergarten.

Instead of expanding a young understanding, over-exposure to so many fads, thoughts and ideas can have a negative effect. It's all too much too fast.

Great expectations

No matter how successful a family becomes, or how much well-meaning parents do, the injunction is always there for the younger generation to move up, be more, do better.

"The push starts early," says Buttino. "The first thing parents ask at a daycare is, 'What's your education system like?' It's no longer just about having children play and enjoy being kids. My daycare has a curriculum that includes reading and writing and I'm sure others do, too. When they're under constant pressure to succeed, sooner or later young people risk becoming anxious and depressed."

Two working parents who need to relax at night are increasingly the norm and there's precious little time to be together as a family. Children's leisure hours are often also at a premium. If it's not school and homework, it's hockey, soccer, ballet, skating, whatever. They're being pushed to go, go, go and the burnout plays havoc with their peace of mind.

Children who are confident and resilient do better in school and have an edge when it comes to facing challenges at any stage of life. Parents are the key to helping their children regain better balance, but many don't know where to start. "First off, they need to be sensitive to their children's feelings," says Miller. "Without that awareness communication isn't possible."

Awareness was just one of the issues discussed at the Fun FRIENDS information sessions for parents. Learning to communicate and having quality time together is what Buttino, Miller and Cesta hope families will learn to do. "If that's the only outcome, we'll consider Fun FRIENDS a success," Cesta says. ❐

SPRING 2010

SUPPORT GROUPS
Mondays 7:30pm 4333 Côte Ste-Catherine Road unless otherwise indicated. No registration necessary.

FAMILY for relatives
April 12, 19, 26; May 3, 10, 17; June 14, 21, 28

PAC Parents of Adult Children
7:00pm at AMI
April 13; May 11; June 15

SOUTH SHORE for relatives
Wednesdays 6:30pm
10 Churchill, Suite 205, Greenfield Park
April 7, 21; May 5, 19; June 2, 16, 30

SIBLINGS AND ADULT CHILDREN
April 19; May 10; June 21

BIPOLAR DISORDER for consumers and relatives
April 12; May 3; June 14

DEPRESSION for consumers and relatives
April 26; May 17; June 28

OBSESSIVE COMPULSIVE DISORDER for consumers and relatives
April 26; May 17; June 28

HOARDING GROUP (in collaboration with Quebec OCD Foundation) for consumers and relatives
April 12; May 3; June 14

KALEIDOSCOPE for consumers
April 19; May 10; June 21

LIFELINE for consumers
1 Tuesday every month 1:00-3:00pm
Call 450-445-5427 for dates
Alternative Centregens
5770 Auteuil, Brossard

Registration required

MOOD AND THOUGHT DISORDERS
Call AMI for details
6-session program begins April 22

ANNUAL GENERAL MEETING
June 14 (details to come)

BOARD MEETINGS
Tuesdays 7:00pm at AMI
April 6; May 4; June 1

PIETER BOUDENS

AMI mourns the passing in March of longtime member and friend Pieter Boudens. Pieter served on our board and executive committee from 1999-2005. He was also a founding member of our South Shore group and represented the Anglophone community on FFAPAMM's board for four years. Pieter's unwavering dedication of his time, energy and heart to his work and to AMI's goals was an inspiration to us all. We shall miss him.

FAMILY SUPPORT IN THE ER

In Northern Ontario they're successfully running a program like the one AMI would like to start here

Grey Bruce is a sparsely populated rural area with a shortage of doctors, limited psychiatry resources and one of Ontario's lowest medical specialist ratios. Because of — or despite — those lacks, the healthcare professionals there have found a way to compensate. Since the groups that do exist rely so heavily on each other, they simply work as a team and collaborate for the greater good of the public.

The Family Crisis Support Program is one shining example. It's a joint venture of Grey Bruce Health Services, which operates five hospital sites in the area, and the Grey Bruce Community Health Corporation, a local agency that provides community-based mental health and addiction services.

The goal of the program is to provide support, education and advocacy for family members who come to the ER with a relative or friend in psychiatric crisis. While the patients are being attended to, a family support worker meets with those who are waiting to explain what's happening and help them navigate the hospital and mental health systems. Among the topics they discuss: the routine in the ER, what the family can expect, what they can and should ask for, even an explanation of privacy laws and legal rights. If it's the family's first experience with mental illness, they'll be introduced to other ER staff members. They'll learn about their loved one's problem, what will happen should there be a hospital admission and the various family support programs that exist in the community.

This assistance is time-limited in nature. The crisis worker is there to help families weather their initial panic. They're encouraged to become involved with family organizations for longer-term support and education.

Does this sound familiar?

In a research study, Grey Bruce families typically complained that they lacked information about mental illness; that they were ignored by mental health professionals; that they felt left out and uninvolved in the treatment process of their relative; that they were dissatisfied with the frequency of contact and quality of communication with professionals.

Families venting their frustration to the hospital about the lack of information and support was the catalyst behind the development of the Family Crisis Support Project.

The two partner organizations, which already had a strong history of collaborative projects to their credit, sat down to determine how best to improve the crisis service. A family crisis worker, they decided, was what they needed. The individual would be a veteran family caregiver provided by the Community Health Corporation, but integrated into the hospital's mental health team. (The idea of having a non-health professional in the ER was in itself a bit of a shocker that required changing habits and creating new systems.) The service was launched in 2006 as a low-budget pilot project. It still is low-budget but the impact is definitely high.

Less than half-way through their 2009-2010 year alone, the crisis worker had received 251 referrals and met with over 550 face-to-face contacts, more than in any other complete year since the launch. And this in an area of some 160,000 inhabitants.

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FACING UP TO THE FEAR

Psychiatrist E. Fuller Torrey has attacked stigma – and ruffled feathers – by frankly linking violence and schizophrenia

Are people afflicted with schizophrenia dangerous? The negative stereotype persists, reinforced by lurid newspaper headlines of tragic events and popular Hollywood movies, "The Dark Knight" with Heath Ledger's portrayal of The Joker being just one in a long list.

A British survey done in 2009 found that 49 percent of the 1,989 respondents had seen people with mental illness acting violently on the screen. Forty-four percent of those asked said they believe those with mental illness are more prone to violence. Myth or truth?

A recent University of Pennsylvania study found that individuals with serious mental illnesses are responsible for 10 percent of all homicides in Indiana. Is that figure typical or not?

Many people with an interest in or connection to mental illness deny the schizophrenia-violence link. They insist that such accusations are blown out of proportion and that those who suffer from mental illness are being unfairly vilified.

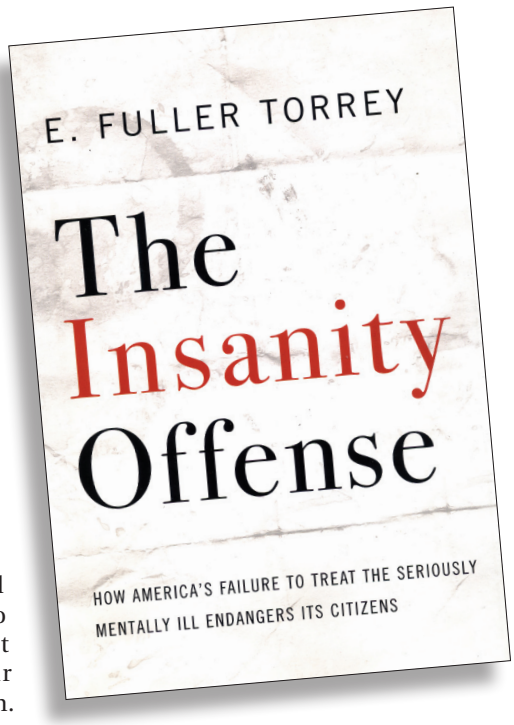
Well-known psychiatrist and author E. Fuller Torrey believes the media give more ink to crimes committed by people with schizophrenia (homicides in particular) because their acts are more bizarre and harder for the general public to comprehend. "Most people understand when a drug dealer is killed by another dealer trying to take over his territory," he says, "but nobody understands when a young mother with schizophrenia drowns her two small children."

Yes, but

Torrey confronts the violence and offers an approach to countering stigma with a single word: treatment. "We all want to reduce stigma, but until we reduce the high-profile homicides, it will be impossible to do so. Individuals with schizophrenia who are being treated are no more dangerous than the general population. However, if they are not being treated, a small percentage are definitely more dangerous, especially if they are also substance abusers. If an individual with schizophrenia who is not being treated and is abusing drugs moves in next door, then yes, people have a legitimate reason to fear that person."

Torrey collected newspaper clippings of stories about violent acts committed by people with mental illnesses since 1980 and reproduced them in detail in his book, *The Insanity Offense* (W.W. Norton). He reasoned the evidence would help quell discrimination by reinforcing his point that those with schizophrenia who commit criminal acts have the potential to be dangerous only if they're not being treated with antipsychotics.

At the same time, he hoped the book would encourage those with the illness to get help and spur government bodies to realize the urgent need to treat the mentally ill.



Families are vulnerable

Torrey's research shows that most severely mentally ill individuals who become violent don't select their victims at random. "Multiple studies have confirmed that between 50 and 60 percent of the victims are family members. By contrast, among homicides committed by non-mentally ill individuals, only 16 percent of the victims are family members," he writes.

A 2002 investigation into mental illness in Canada by the *Windsor Star* estimated that by 2020, more than 60 percent of people with schizophrenia will have a criminal record. Family peril was a key finding, particularly when schizophrenia or bipolar disorder was involved. According to the investigation, many of those who committed homicide were defying court orders to take their medications, often believing that because their symptoms had subsided they were cured. "Family members are seen as the enemy because they enforce difficult rules," says Dr. James Young, Ontario's chief coroner. "They're the ones who call the police or seek a court-ordered hospital admission."

Torrey has an ally in Barry Jones, a Canadian psychiatrist who specializes in schizophrenia. He agrees that most suicides and homicides are preventable if the illness is treated.

Another ally is Sathnam Sanghera, a British journalist whose father and sister both have schizophrenia. He applauds Torrey for highlighting the link between violence and severe mental illness and takes issue with critics who have pronounced Torrey's data dubious. The critics charge that Torrey ignores studies that suggest the proportion of violent acts committed by people who are mentally ill account for just five percent or less. They say he risks setting off unnecessary panic about anyone with schizophrenia. Sanghera calls Torrey's argument "more intelligent and realistic than those of the mental health establishment" that often diminish the likelihood of violent mentally ill predators.

Educating the public

Remember Cho Seung-Hui? He was the 23-year-old senior at Virginia Tech who went on a rampage in 2007, killing 32 students and teachers. He was later identified as suffering from a mental illness.

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Facing Up To the Fear *... continued from page 4*

In *The Insanity Offense* Torrey details some of what went wrong: "Cho was court-mandated to be psychiatrically evaluated; he was held overnight in a local hospital, but apparently not treated. He was ordered to get treatment as an outpatient, but did not do so. The counseling center at Virginia Tech received a copy of his court order mandating treatment, but apparently did nothing." More, much more went off the rails in a state that has, according to Torrey, "one of the most stringent state commitment statutes in the U.S."

So the fundamental question remains: how to safely and effectively proceed when it comes to violence and mental illness?

"The solution lies in the area of public education," says coroner Young. "I have seen media reports of violent acts carried out by someone with mental illness that constantly miss the point. They focus on gun control issues or school violence instead of the lack of services for the severely mentally ill.

"There should be more education about mental illness in schools and early detection. The legal system needs to find a way to deal more effectively with treatment orders for the mentally ill before the potential for violence has emerged. Stigma will always be present, but rational management of mental illness can exist even in its presence." ❐

The Insanity Offense by E. Fuller Torrey is available in our Monty Berger library.

Text adapted from *Violence and Schizophrenia: Taming the criminal myths* by Peggy Thomson, SZ Magazine, Winter, 2010.

You live a distance away?
Our new toll-free service is for you

Now you can call AMI toll-free from locations anywhere in Quebec and Canada. Note the number:

1-877-303-0264. We're always glad to hear from you, but understand that we've installed this toll-free service specifically to help families living in remote areas. If you live in or close to Montreal, please continue to dial our local number as you always have: 514-486-1448.

WHEN YOU NEED A COURT ORDER

How you can make a trying situation easier on everyone

It's a step nobody wants to have to take, but if there are signs your ill relative is losing control and close to a crisis, if physical danger is a distinct possibility and you know that voluntarily checking into a hospital just won't happen, the time has come for a court order.

With a court order your relative will be taken to hospital for a maximum 72 hour-stay to undergo a psychiatric assessment. Two psychiatrists will conduct the evaluation and decide whether or not their patient is fit to be released. If not, the hospital must obtain its own court order, which gives them legal permission to keep your relative as an in-patient for up to 21 days.

How to proceed

Court orders accelerate emergency help, but they're not a quick fix and not always the right course of action. If you're uncertain, AMI can help you assess your situation and make a decision.

Once you've decided on a court order, you first must obtain a court order form. AMI always has a supply of these and they're also available at your local CLSC. The form needs to be completed by you and a witness attesting to your relative's disturbed behavior or thinking. We can also help you with this if you wish.

You then go to the *Palais de Justice* (make an appointment beforehand) to have the order granted and signed. Finally, you have to take the order to the police station closest to where your relative is living. The police will visit the premises and call an ambulance to provide transport to the designated hospital. If there's resistance, they're allowed to use force. Should your relative not be found at home, the court order remains in effect until he or she is located.

A stressful decision

This is an emotional time. You need to stash the excuses and denial and act quickly. Some family members are beset with guilt at causing their loved one to be hospitalized. And your relative may well be livid at everyone involved, particularly you. Fortunately there are steps you can take to minimize the acrimony and keep things on as even a keel as possible. Short-term pain for long-term gain was never truer.

Techniques to remember

1. **Be candid.** The message you need to get across is that you're sorry things had to turn out the way they did, but you couldn't live with the consequences if something happened to yourself, your relative or anyone else.

2. **Be brief.** With some people, anger inevitably gives way to acceptance of the situation as being necessary. If your relative is still angry when you visit, don't prolong your stay. Ask if you can bring or do anything to help, say you'll be back soon and leave.

3. **Listen first.** Let your relative vent, then you can both talk about the situation. It's important that you don't apologize for initiating the court order, only for any unhappiness that it caused.

In his book, *I'm Not Sick, I Don't Need Help* (Vida Press), which you can borrow from our library, Dr. Xavier Amador expands on these ideas and adds a list of don'ts.

Do not deny your relative's feelings of betrayal.
Do not expect to be forgiven.
Do not blame your loved one for what you felt you had to do.
Do not be misleading about what you would do in the future.

Under the best of circumstances, when the crisis is history, the court order episode will be seen in a positive light as a first step towards recovery. Your relative may even thank you for what you did.

Note: if you're in a situation where the danger has escalated from potential to critical, a court order is no longer appropriate. Call 911 immediately. ❐

Parts of this text adapted from "What Happens After the Request for Psychiatric Evaluation" by Sheryl Bruce, *Friendly Link*, Vol. 27, Issue 3.

TRIBUTES & MEMORIALS

In honor of Sylvie Stelcner
Susan Stelcner

In honor of Sharleen Young
Nina Silverstone

In honor of Annie Young
Randy Zittrer

In honor of Francine Waters
Janet and John Cheffins

In honor of Kiki and Jim Tremain
Frances Sault

In honor of Abe Weiss
T.G. Gould

In honor of Frances Wesley and Fred Bird
Anonymous

In honor of Shirley and Brian
Anonymous

In honor of Judith Anna Phillipson
Bernadette Laroche

In honor of Betty and Mort Saxe
Marylin and Jeff Block

In honor of Mr. and Mrs. Jack Cherry
Donald Cherry

In honor of Pat and Paul Rubin
Mona and David Saltzman

In honor of Esther and Matt Preiss
Marylin Block

In honor of Neil Dworkin
Ruthie and Ricky Sherman

In memory of Debbie Richardson
Charlotte and Eric Bracegirdle

In memory of Rose Braseliten
Lynn and Andy Nulman

In memory of Cynthia and Asher Adler's mother
Lynn and Andy Nulman

In memory of Heather Gordon
Sharleen Young
Shirley and Bob Smith

In memory of Leonard Mariano
Barbara Green-Mariano

In memory of Lynda Percival
Martin Done

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St. George's School

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Thelma McDonald

In memory of Ted Outram
Heather Geary

In memory of Gary Banks
Shirley and Bob Smith

In memory of Joan, Stuart and Watson Gall
John Gall

In memory of Fanny and Abraham Greenbaum
Ura Greenbaum

In memory of Gino Motafferi
Helena Casey

In memory of Leatrice and Doris
William Maurice

In memory of Regina Goldin
Rena and Eddy Entus

In memory of Gordon Calderhead
Kay Simpson

In memory of Pieter Boudens
Pat and Paul Rubin

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

Family Support in the ER *... continued from page 3*

Why not in Montreal?

A few years ago, AMI proposed a pilot project that was similar to the one existing in Grey Bruce now. We would provide a staff member whose job it would be to assist families with early intervention, offering them support and information.

What seemed to us like an excellent idea didn't last beyond a year. There was more than one reason why it didn't fly, says executive director Ella Amir.

"We saw this as help for families at the start of their crisis, which meant reaching them the same day they arrived in the ER. It was clear to us that they needed someone right then and there to listen and answer their questions. At the same time, our staff member could explain our education and support programs as resources that families might find useful on an ongoing basis. The hospitals liked the concept, but saw our help more as liaison with in-patients. Unfortunately, families don't often visit the in-patient ward, particularly when it's a repeat hospitalization."

There was also the perpetual issue of priorities. Many front-line healthcare professionals see patients as their first responsibility and still don't consider families and their problems critical enough to merit extra time and attention. We could have been a big help by providing precisely that.

Finally, the close-knit cooperation that binds hospitals and community resources in a sparsely populated area like Grey Bruce doesn't play out the same way in a metropolitan centre like ours. There, a few key people with steely determination overcame the obstacles and made all the difference. Their success is unlikely to be duplicated as quickly or easily here, where there are many more stakeholders in a complex system.

Still, because the Family Crisis Support Program has proven so effective, AMI is encouraged to give it another try.

"We now realize that for the idea to succeed there needs to be a true partnership between ourselves and the hospital, with objectives clearly spelled out," says Amir. "We're sure that our being there for families at the crisis stage can help defuse much of the tension and conflict that inevitably arise. The more they understand, the better able they'll be to provide their relatives with meaningful, effective help down the road."

We've learned something else in our 33 years: families are not the natural adversaries of consumers. And we're not taking sides when we help. On the contrary. "Giving families the knowledge they need to cope with mental illness is in the best interest of everyone — their loved ones, themselves and the healthcare system," adds Amir. ❐

THEIR OWN WORST ENEMY

Some people hate their looks so much they make themselves sick

It's called Body Dysmorphic Disorder (BDD) and despite its somewhat cosmetic-sounding name it's an all-too-real form of anxiety, listed in the psychiatric diagnostic manual since 1987.

BDD causes people to obsess about a perceived flaw in their appearance until it distorts their life. They think they're ugly and develop an unhealthy fixation on one or more of their features — skin, hair, nose, weight, eyes, legs, chest, breasts, teeth, the list goes on.

"They're ashamed," explains Dr. Richard Swinton, medical director of the Anxiety Treatment and Research Centre in Hamilton, Ontario. "There's a feeling of distress, a preoccupation with the idea that their appearance doesn't match the internal and even external ideal."

No single explanation

BDD affects both males and females, usually in their teens, twenties or thirties. It's unclear why it happens, although Swinton points a finger at the same mix of causes usually cited in psychiatric disorders: genetics, experience and circumstances. The disorder can be misdiagnosed or confused with other disorders. Many people with BDD have relatives suffering from depression or obsessive behavior. It also afflicts some people who have developed anorexia or bulimia.

One extreme to the other

BDD sufferers try to rearrange their lives and can go to great lengths to hide their perceived flaws. Some comb their hair so as to hide their skin or ears, pick at their skin or pluck beard hairs. They often compare their body to others or scrutinize other people. They might either seek reassurance from others or try to convince them how truly unattractive the perceived defect is. They may diet or exercise excessively.

Some people keep far away from mirrors, as their imagined ugliness will only look back and taunt them. Yet in private, they may endlessly study their flawed feature with a magnified mirror or magnifying glass.

Others can't pass a mirrored surface without stopping to check themselves out. Their distorted self-image then takes over and dominates their thoughts and lives. They worry that everyone else can see what they see and may consequently withdraw into isolation for fear of being stared at and judged. The result can be lost school days, absence from work or missing out on social events. Marriages have broken down because the asocial situation becomes intolerable.

"The trouble with BDD is that people don't talk about it," says Swinton. "They won't reveal their problems." So rather than confide in their family doctor, they're more likely to seek out a plastic or cosmetic surgeon to eradicate what they hate. Our culture's obsession with celebrity, beauty and weight has contributed to an increased acceptance of cosmetic surgery as a solution for physical flaws. Despite presenting a perfectly acceptable, even attractive appearance, some BDD sufferers undergo repeated cosmetic procedures. There are even cases of people using sharp objects in an attempt at do-it-yourself surgery. The consequences can be critical or they become very skillful at disguising the mess they've made.

Treatments that help

Medication and cognitive behavior therapy are the choices of treating psychiatrists and psychologists.

Although currently there aren't any approved drug treatments specifically for BDD, antidepressants prescribed for OCD and other anxiety and mood disorders can be helpful. The antidepressants include both main types of serotonin reuptake blocking agents, namely serotonin selective reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs). Atypical antipsychotics added to the antidepressants are effective.

While acknowledging that medication can help, Dr. Christine Courbasson, head of the Eating Disorders and Addiction Clinic at Toronto's Centre for Addiction and Mental Health, believes it's also important to challenge BDD sufferers' thoughts and help them back to reality.

Mindfulness-based treatments aim to sensitize patients to how they feel, their sensations and emotions, so they can notice the reality of what's there and view themselves as they truly are. "The treatment uses a lot of acceptance strategy," she says. "Patients need to accept that the way they see themselves is grossly overestimated."

Online support and OCD support groups can also help with the emotional anxiety and self-imposed limits that BDD sufferers experience. A good course of action is to speak to a family physician for a referral to a mental health professional. Even friends, family and colleagues can do their part by assuring the BDD sufferer that what appears to be a horrible flaw is a fiction of their own imagining and matters very little, if at all, to anybody else. ❐

Text edited from "Body Dysmorphic Disorder" by Heather Beaumont, *Moods magazine*, Winter, 2010.

AMI-Québec Membership & Donation Form

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5253 Décarie, Suite 200, Montréal, Québec H3W 3C3

Reaching Young Minds *... continued from page 2*

At the start of the program, parents and teachers all filled out a one-page questionnaire designed to provide information about a child's behavior and personality. They'll fill out another one when the program ends. The profiles of strengths and difficulties will then be compared to evaluate the efficacy of the program. While the program is underway, teachers are sending the children home with a variety of activities that the parents need to complete.

Closeness grows when experiences are shared. One mother told Cesta that at school her daughter had to draw how she saw the family. She, in turn, had to draw her impression of her family when she was her daughter's age. "When we compared our work, I found it easy to tell her how my childhood was," the mother reported.

FRIENDS is a totally flexible program, meaning it doesn't need to be locked into a rigid time slot of its own. A teacher can be creative and reinforce its message by integrating it into any other subject being taught, from math to music. "We call it cross-curricular," says Miller. "I even see how it could work at lunchtime or in the schoolyard. Ultimately it can become the character of the school itself."

Which is why Cesta sees FRIENDS as more than just a subject. "That's theory," she explains, "but behavior, expression, communication, social skills — they're a school's way of life and a student's, too. And that's what we want FRIENDS to do — bring about a change for the better in both." ❐

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, known to be 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.

SHARE&CARE

Share&Care is published quarterly for members of AMI-Québec and mental health professionals.

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Articles and comments are invited. Anonymity will be respected if requested. Guest articles reflect the opinions of the authors and do not necessarily reflect the views of AMI-Québec.
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