

visions

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families

parents forever: hope for
families affected by
substance abuse

learning to swim
when my daughter
is drowning



visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental illness or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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*pseudonym

letters to the editor

I wish to congratulate you and thank you for the outstanding recent publication of *Visions on Wellness*. As a person who has struggled with depression, on and off, over a 35 year period, I am always on the lookout for more good information about wellness. The articles and the authors have provided very useful and positive information. I note that Dr. Martin Seligman's writings are mentioned in one or two articles, and I wanted to mention that I have found his books and thoughts to be very helpful. You may be aware that he is often referred to as the father of positive psychology. This is a concept that I find very helpful. Dr Seligman, in his book *Flourish*, describes how, after a long career of treating persons with a mental illness, that he became tired and concerned that the same people kept returning for more therapy after suffering a relapse. He decided to toss aside the term "mental illness" and, instead, focus on "mental wellness." So your recent journal is exactly the right topic at the right time. Many thanks for the good *Visions* journals.

—Roger, Vancouver

📖 footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 2.

editor's message

There are some themes we cover in *Visions* that don't really affect all our readers to the same degree. I think Families is one of those themes that will resonate with virtually every reader whether you're a loved one, a professional, an individual living with a mental health or substance use problem—or some or all of the above.

Right off the bat, I want to say we use a broad definition of 'family' here, and actually always do. Biological ties are just one piece of the puzzle. Who you live with is just one piece of the puzzle. If you care deeply about someone and don't have a professional responsibility over them, you're family. So close friends and supporters? Please count yourself included in these pages.

I'd like to share that in my own story, family support has at least two layers.

'Normal' looks different when there are largely-unrecognized mental health problems in your family (in my family's case, anxiety). Loving, well-meaning parents who have problem anxiety themselves may never see problem anxiety in their kids as, well, a problem. I wish they had encouraged me to get help then. But we only know what we know. So for my childhood anxiety, family wasn't my most helpful source of support.

But when I experienced severe depression in my late teens, my mom was really amazing. I was too ill to advocate for myself or to see any hope. She called doctors, pushed receptionists to move up appointments for me, came in to sessions with me to describe how I really was at home. (That was with my absolute blessing. I can "fake it" well. I don't think my doctors would have known how serious things were without her input). She handled all the paperwork. She gently encouraged me not to cry alone in my room. We went on walks. She asked me what I wanted to do about school, what I wanted to tell people. The rest of my family was pretty good too—my dad's silent hugs stand out—but Mom was the head of my care team. And given that I'm part of an Asian culture that has some extra taboos around mental illness and 'family shame,' her unconditional love was even more amazing. And my best medicine. And I've told her so.

It was almost 20 years ago but I still get choked up writing about it. I hope the perspectives in this issue similarly move and inspire you.



Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division

Putting the Family in the Picture

A BEST PRACTICE

Guest Editors Jane Duval and Nichola Malim Hall

As family members ourselves, we know first-hand the challenges that are faced when someone we love struggles with mental illness and/or substance abuse. And we know the strengths that we can bring to help and support those family members.

Families are often instrumental in helping someone with mental health and/or substance use issues to access treatment. Family members are usually the ones contacting counsellors and physicians, encouraging their relative to seek professional help, taking them to the hospital or clinic, sometimes dealing with the police, and advocating for appropriate levels of care and safety. At the same time, families desperately need help in finding those resources in the first place.

“Collateral information”—information from family members and friends about a person’s behaviour and symptoms—is crucial for the best possible assessment and diagnosis.¹

Family members who watch the individual’s illness develop see how their behaviour changes, and they know what the person was like before they were affected by their mental illness or addiction. Family members usually also have substantial knowledge of treatment history, such as which medications were used in the past, and what doses and treatments worked or didn’t work. When there is a concurrent disorder—as is often the case—the family can provide information about previous symptoms or self-medication with unprescribed drugs.¹

So families can be an important diagnostic resource, especially when critical information is not available

from previous treating professionals. And while professionals come and go, families are generally there for a lifetime.

Family as a therapeutic partner

Treatment for both people with mental illness and those with addictions (and especially for those with a concurrent disorder) varies enormously from individual to individual. In the case of substance abuse, treatment (either day or residential) may have to be repeated several times. In the case of mental illness, pharmaceutical prescriptions may take years to adjust to an effective dosage.

During treatment and in the subsequent period of stabilization and rehabilitation, however, families can also play a major role in continuity of care. They monitor and encourage the person to follow their treatment plan. They can play a key role in alerting professionals to early warning signs of relapse, calling for emergency outreach if things deteriorate, and helping get the person back on track or into hospital.

Families often arrange regular social contact, organize shared activities, and provide support of all kinds—physical, emotional, financial—for the person struggling with mental health or substance use issues. These are all major elements of rehabilitation. This regular interaction with family complements the work of mental health and addiction teams, whose heavy

Jane is Executive Director of the BC Schizophrenia Society. She has 18 years experience in mental health policy research, education and advocacy for families affected by serious and persistent mental illness. She has been involved with the creation and promotion of two education programs used by the national Schizophrenia Society: Reaching Out (early psychosis intervention) and Strengthening Families Together. Jane has an adult son with schizophrenia

Nichola is a founding member of From Grief to Action (FGTA). She has two sons who are in recovery from addiction to unprescribed drugs and are currently on the methadone program. Her work in raising awareness of addiction as a disease that knows no socio-economic or family boundaries won Nichola a YWCA Woman of Distinction Award in 2003. She represents FGTA on both the BC Alliance on Mental Health and Addictions and the Community Action Initiative



I strongly believe that if it were not for the real, practical, useful advice I received from other family members when I attended a BC Schizophrenia Society support group 15 years ago, my son would not be alive today. – Jane Duval

caseloads often allow only periodic contact.

If someone relapses, it's family members who most often are there to pick up the pieces and advocate to help the ill person regain their physical and mental health.

There is significant evidence that family involvement leads to lowered relapse rates and improved functioning.²

Unfortunately, the delivery of mental health and addiction services by professionals often bypasses the family.²

It is sometimes true that family dysfunction can be a contributing factor to the individual's problem. If this is indeed the case, clinicians must use their professional judgment as to whether or not the family should be involved. Given the importance of family support—when families are involved, prognosis is greatly improved—every effort should be made to determine whether the family can offer valuable natural support.

The client's right to privacy is also of paramount concern for professionals—and families understand the need for privacy. However, privacy issues do not mean that the family's knowledge and expertise cannot be tapped.³ In our experience, a separate interview with the family can fill in many gaps left (either intentionally or unintentionally)

by the individual, and can provide a wider context and perspective.

Regardless of the age of the individual with mental health or addiction issues, family involvement should be part of a specific treatment plan when it is possible. Family members should be actively approached and engaged as early as possible.

Supporting families

How families are treated and the way they are supported can contribute to the client's recovery. Involving families in the therapeutic process improves not only client outcomes, but also family well-being.²

Families need support, however—both for themselves and to assist their ill family member. When a loved one has a mental illness or an addiction, there are enormous stresses on the family. The chronic stress family members experience as primary caregivers often undermines their own health, financial resources and ability to cope.

We feel that there is great value in providing families with resources such as professional counselling, psychoeducation, stress management and coping skills. Peer support groups can be immensely helpful for family members. Many people receive support from their faith groups.

Through family support organizations and interaction with professionals, families can learn how best to respond when their relative is not doing well. Family members become empowered by learning how their local mental health and addiction system works and how to be effective advocates on behalf of their loved ones.

'Hopefulness'

*"Professionals . . . must help the ill person set realistic goals. I would entreat them not to be devastated by our illness and transmit this hopeless attitude to us. I urge them never to lose hope; for we will not strive if we believe the effort is futile."*⁴

– Esso Leete, who has had schizophrenia for 20 years

While it is important not to have false hopes or unrealistic expectations, research shows that maintaining a sense of "hopefulness" is also important for family members in coping with the impact of mental illness and addiction.⁵

Skilled professionals who engage families as therapeutic partners are keenly aware of their capacity to either sustain or diminish hope. Above all, they understand and respect the expertise of the family, as well as the important role of hope and time in the process of grief and acceptance.

When the real value of a therapeutic partnership is recognized between the client, treating professionals and the family, there is true hope for recovery. As mothers and members of that network called "family," we ourselves subscribe wholeheartedly to that hope. ▽

What Would a Family-Centred Mental Health and Substance Use Care System Look Like?

REPORTING ON A UNIQUE EVENT DESIGNED TO SUPPORT SYSTEM TRANSFORMATION

Jonny Morris

On November 5 and 6, 2012, a special gathering took place at the Wosk Centre for Dialogue in Vancouver. Over 150 people—including family members, government representatives, service providers and educators—came together with a particular focus in mind: moving toward a more family-friendly mental health and substance use care system.



Jonny is Director of Public Policy and Campus Mental Health Initiatives at the Canadian Mental Health Association's BC Division. Jonny's portfolio includes a broad cross-section of public policy priorities related to mental health and addictions including access to care, poverty reduction, housing, and justice

The event, convened as part of the Healthy Minds, Healthy People Knowledge Exchange Series, was designed to put the experiences of families front and centre. This event was hosted by the Healthy Minds/Healthy People Directorate, which sits within the BC Ministry of Health and includes participation by the BC Ministry of Children and Family Development. The dialogue generated at the knowledge exchange event will inform the development of a cross-sector family mental health and substance use action planning framework, led by the BC Ministry of Health and scheduled for release in summer 2013.

Listening to Family Expertise

Readers of *Visions* will be very familiar with the power of story and its potential for transporting an audience

into new worlds of understanding. Stories also have the potential to inspire system change, especially when they are based on the storytellers' up-close and first-hand experiences. Specifically, when combined with data, stories of lived experience can have a direct impact on policy-makers and the decisions they make.

In recognition of the power of story, the Canadian Mental Health Association's BC Division (CMHA BC), alongside a number of other agencies, designed two panel interviews for the day-long event. One panel was made up of four family members, each carrying diverse experiences of engaging with the mental health and substance use care systems. In addition to their personal experiences, each of the family member panelists also worked within family-centred community organizations.

The second panel featured five people who work within the mental health and substance use care systems. They represented various clinical and social service positions in the public and non-profit sectors, including perspectives from the Ministry of Children and Family Development and Aboriginal health.

With each of the panels assembled, I completed two distinct, yet connected, interviews of the panelists.¹ I intentionally interviewed the family panel first. Often, the knowledge of clinicians, researchers, or decision-makers can be elevated above the knowledge of family members or those with lived experience and is viewed as having more validity. Completing the interview this way provided a vivid set of family member experiences for the second panel to respond to, helping to ensure family experience was centred throughout the dialogue.

One of my starting questions for each of the panels was, “If our mental health and substance use care system had families at its centre, what would it look like?” This question, and the questions that followed (see sidebar), gave the panelists an opportunity to think out loud together and weigh in with their ideas about how to transform our system. I also invited audience members to share their reflections and become involved in the conversation.

Panelists and audience members demonstrated a remarkable generosity with their stories and ideas, all contributing to an important shift at the event: the distinction between “family member” and “service provider” started to collapse. Audience members were invited to share their responses to the following question: “As you listened

questions for change

- Can you catch us up about some of your ideas for action related to families and the mental health and substance use care systems?
- What would you say are some key areas of existing strength and capacity?
- Based on the conversation we have discovered so far, what’s possible here and who cares?²
- If our success in designing a mental health and substance use care system more responsive to families was completely guaranteed, what bold steps might we choose?³

to the lives of the people who were at the centre of these interviews, which expressions caught your attention or captured your imagination?”² Person after person responded to this question, readily identifying with the themes that emerged during the interviews: stigma; the difficulties linked to engaging with a complex, and at times uncoordinated system; and the experience of being excluded as a family member from a loved one’s care. Many of the audience members who responded prefaced their comments with a description of their job or role. As the dialogue progressed, however, the respondents spent less time describing their professional connection to mental health and substance use, moving quickly to sharing their own lived experience, individually or as a family member. It was no longer about *those* family members. It had become about *all of us* as family members.

So, what did we hear and learn?

Each of the panel interviews generated a number of guiding questions about how to design a more family-centred mental health and substance use care system:

- Tackling stigma and discrimination (e.g. How can the system better support service providers to trust family members, like parents, and better include them on the care team? What needs to happen to ensure that family members do not feel blamed as a result of their loved one’s need for treatment and support?)
- Creating a more coordinated system of care (e.g. How do we ensure every door is the right door, especially when mental illness and addiction are co-occurring? What needs to happen to streamline the requirements for multiple layers of consent to share information that do not necessarily transfer across systems?)
- Ensuring families have the opportunity to be active partners in the care of loved ones living with mental illness and/or substance use problems (e.g. How might the system better recognize that family members are often integral to the ongoing recovery of a loved one once they are back at home? What would things look like if family members were invited into conversations about ongoing care in more meaningful ways?)
- Examining how issues related to privacy, confidentiality and sharing personal health information might impact families’ experiences of the system. This issue was identified as a critical area for exploration and more consideration of this topic is provided below and in the graphic on the next page.

Privacy, confidentiality and sharing personal health information

Privacy is a fundamental right designed to give an individual some control over how their personal health information is shared and used. How to balance the individual's right to privacy with the needs of family members, who can make helpful contributions to their loved one's care, is a complex issue. Privacy and confidentiality have far-reaching impacts upon the relationships between individuals receiving care, their families and their service providers. One family member described feeling "judged" as a parent, and noted that confidentiality about their child's status was used as a way to keep them "off the team." Some described anxiety about not knowing the next steps of the care plan for their loved one, though others reported a good balance between respecting the privacy of the loved one receiving care while informing the family as much as possible.

Moving forward

The issue of privacy, confidentiality and sharing personal health information is an important one; it affects many people connected to the mental health and substance use care systems. To follow up on the dialogue that took place at the knowledge exchange event in November, CMHA BC Division is working on a project that looks at these issues as they unfold here in BC. This project will make recommendations for how the system, service providers, individuals accessing care, and their families can have a better experience when it comes to privacy and information sharing.



This is a graphic recording created by Lisa Arora. It visually captures a presentation delivered by Patrick Egan, Senior Investigator, Office of the Information and Privacy Commissioner. It juxtaposes some of the foundational legal and policy issues framing privacy, confidentiality and information-sharing alongside some of the experiences of family members engaging with the mental health and substance use care system.

The project, funded by the BC Ministry of Health, started in February 2013. Our work at CMHA will include an in-depth exploration of the research in this area, an examination of what is working and what is not working, and the development of guidelines to improve practice across the system. One of the guiding principles of this project is to engage with and consult individuals, their family members, service providers, policy-makers and a broad range of community organizations.

What do you think?

We invite *Visions* readers to become involved in CMHA BC's privacy/information-sharing project. If you are an individual or family member who has accessed the mental health or substance use care system, and you would like to share your story about the issues of privacy, confidentiality and sharing personal health information, email us at privacy.project@cmha.bc.ca. **V**

The Blame Game

IS IT MY FAULT? DID I CAUSE IT?

Angela Inglis, MSc, and Jehannine Austin, PhD

When someone develops a psychiatric disorder, one of the first things they and their loved ones wonder is: Did I cause this? Could I have prevented it? Is this somehow my fault?

Angela is a genetic counsellor who specializes in psychiatric disorders. She helps people understand the causes of mental illness, explaining in lay language what is known from research, and making that information relevant to each person. Angela provides this service to people who have mental illness and to their families*

Jehannine is an Associate Professor in the departments of Psychiatry and Medical Genetics at UBC, where she holds the Canada Research Chair in Translational Psychiatric Genomics. Jehannine led the development and implementation of the first and only specialist psychiatric genetic counselling service in the world, here in BC



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Those who have the psychiatric disorder often wonder whether they are somehow to blame for their illness—because, for example, they used street drugs, drank alcohol or didn't sleep properly.

Parents of people who have been diagnosed with psychiatric disorders can feel guilty for a lot of different reasons. The parents often wonder if their child developed a psychiatric disorder because, for example, they got divorced or because the mother had the flu while she was pregnant. And society, unfortunately, sometimes reinforces parental feelings of guilt. "I was told it was because I was a weak parent..." These sentiments imply to parents that if they had been more strict or a 'better' parent, perhaps their child wouldn't be ill. Also, if a parent has a family history of psychiatric illness,

they can feel guilty for causing mental illness by "passing on bad genes" to their affected child.

Siblings and children of people with psychiatric disorders can also feel guilty and wonder if it was their fault. Siblings may wonder, for instance: Is it because I teased him too much when we were growing up? Children might wonder if their parent developed mental illness because they were "difficult" children when they were young.

These feelings of guilt about whether or not mental illness is someone's "fault" are very common. They are also deeply uncomfortable. In fact, they are so uncomfortable that people often find it hard to talk about them. These are feelings that cause families much suffering.

So is it anyone's fault?

There is a lot of research data that clearly shows psychiatric disorders are caused by combinations of various experiential or "environmental" vulnerability factors (such as life events) and genetic vulnerability factors. None of the individual contributing factors are sufficient on their own to cause mental illness. In most cases, it is the combined effects of both these factors, with many different little contributions that ultimately lead to mental illness.¹

Feeling guilty about passing on "bad genes"

First, and most importantly, remember that genes alone don't usually cause mental illness—and so, typically, we do not inherit mental illness. We can inherit a vulnerability to mental illness, but this is an importantly different concept. Further, research is indicating that everyone has some genetic vulnerability to mental illness—not just those who have mental illness.¹ Second, we cannot control the genes that we pass on to our children.

If we consider all of this together, it's clear that even if a parent has a family history of mental illness, their child's mental illness cannot be attributed entirely to having received "bad genes" from a parent.

Feeling guilty about life experiences

It's very important to remember that any given life experience on its own typically doesn't *cause* mental illness. Often it's a combination of events that might contribute to the development of mental illness, usually together with an underlying genetic vulnerability.

It's also important to realize that experiences don't have to be dramatically negative—such as experiences of trauma—to contribute to the development of a mental illness. Some life events are not necessarily perceived as negative but can be stressful—planning a wedding or a vacation, for example. These kinds of stressful events may potentially contribute to vulnerability to mental illness.

One life experience people often feel guilty about is street drug use. While drug use can contribute to the development of mental illness, it is not typically the only *cause*. There are many people who use street drugs and don't develop a mental illness, and vice versa.

Parents often feel guilty about their child's mental illness and wonder if they could have prevented it by being "better" parents. We also know that even "perfect parenting" cannot prevent mental illness. It's important to recognize that we have limited control over many of the things that happen to us throughout our lives and that happen in our loved ones' lives.

So, do we have any control?

You need to know and feel that your family member's or your mental illness is not your fault. And while there can certainly be a sense of relief in letting go of blame, it can also make us feel frighteningly out of control or helpless. It can lead people to feel that everything is just a result of chance, and that perhaps there isn't anything we can do to help with recovery or protect mental health.

Because the development of mental illness is not all genetic, there are things we can do to try to protect our mental health and help with our recovery. Healthy habits to do with sleep, exercise, diet and social support can be very beneficial. It can be a challenge to keep up these healthy habits all of the time—no one is perfect at this.

But when we have periods where we are not taking care of ourselves as well as we'd like to, it's important to try to accept that we are doing the best we can, so as not to feel guilty. It's important, always, to be kind to ourselves. Family members and loved ones of individuals with mental illness can also try to encourage and model these healthy habits. ▽

*what is genetic counselling?

Genetic counsellors are health care professionals who complete a two-year master's degree program specializing in medical genetics and counselling. They are specially trained to help people understand, adapt to and manage conditions that have a genetic component, like mental illnesses. A genetic counsellor can provide you with personalized information to help you understand the development of your mental illness, the mental illness of your loved one, or what the chances are for others in the family to develop a similar condition.

To learn more about this service, to book an appointment or to refer a patient, contact Angela Inglis at 604-875-2726 or angela.inglis@cw.bc.ca.

Practitioners and Family Members

POINTS OF DISAGREEMENT

Simon Davis

There is increasing recognition in Canadian mental health settings that family members are an important stakeholder group.

Simon is a Manager in Mental Health and Addictions for Vancouver Coastal Health. He also teaches online mental health courses at UBC, Douglas College and the University of the Fraser Valley. The second edition of his text, Community Mental Health in Canada, will be published this year by UBC Press



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The Mental Health Commission of Canada concludes that, “The role of families in promoting well-being and providing care [should be] recognized, and their needs supported.”¹

However, a large body of evidence, accumulated through surveys, family accounts and the experience of administrators such as myself suggests that the family–practitioner relationship has, in many cases, been a strained one. Families haven’t always been given the support they need.

Three sources of tension in the family–practitioner relationship will be discussed in more detail: blaming families, information sharing and disagreements about the model of care. The reader is warned in advance that there are no easy answers here. There is, however, an obligation to try to appreciate the perspective of the other.

Blaming families

There is a legacy of psychiatric theories that implicitly or explicitly blame family members—the mother in particular—for contributing to the son or daughter’s mental disorder. While these ideas have been largely abandoned, research on communication styles continues: for example, the concept of expressed emotion predicts that in social settings and families where there is “emotional over-involvement” and excessive negative comments, people with schizophrenia

are more likely to relapse.² This, according to one author and advocate, is a perspective that “continues to blame families.”³

There are also particular schools of therapy that have been seen as having the potential to blame families. In her memoir,⁴ Vancouver writer and parent Susan Inman describes involvement with a counselling psychologist whose orientation was to see mental disorder in familial, rather than medical terms. After Inman’s daughter was finally hospitalized, the counsellor advised staff at the inpatient unit that the family was “dysfunctional” and “shouldn’t be around [the daughter] too much.” Later on, Inman was chastised by staff for “not encouraging [the daughter’s] independence”—this in the case of a 15-year-old girl certified to a psychiatric ward.

Parents naturally feel a sense of responsibility, and sometimes guilt, about their child, and if the child is disabled these feelings can be even stronger. Practitioners need to be mindful of this vulnerability, and the damaging effect of judgmental comments.

Information sharing

It’s important to understand that psychiatric treatment in English-speaking countries focuses on the individual. The person with the mental illness is considered the patient, not the family.

Further, what goes on between doctor and patient cannot be shared with the family on ethical and legal grounds. But, is this an accurate interpretation of the law?

Knowledge of the law is important, because the law permits a greater degree of information sharing than some clinicians believe to be the case.

In BC, information sharing with third parties is governed by the *Freedom of Information and Protection of Privacy Act* (FIPPA).⁵ This statute permits disclosure when the client consents. It also permits disclosure *without* consent in two situations: 1) to support continuity of care, or 2) when there are “compelling health and safety circumstances.”

Continuity of care applies between health care providers, such as when a hospital shares records with a family doctor concerning tests undergone by a patient, or when records are transferred between mental health teams. But what about family members of an adult mentally ill person?

The 2005 *Guide to the Mental Health Act*⁶ states that if the practitioner “believes it is in the best interests of the client to disclose personal information to the family so they can provide care to the client, the health care provider may do so,” adding that “only necessary information” should be released. Thus, sharing information without consent may fall under continuity of care if the family can be considered care providers. This becomes a weaker argument, however, when there is little contact between the family and client.

Concerning the “health and safety” provision, FIPPA doesn’t provide specific guidelines as to when this

would be used as an exception to confidentiality. It would be reasonable to assume that concerns about self-harm and harm to others could be shared with family members involved with the client.⁷

Ultimately, a decision about breaching confidentiality is more of an ethical one than a legal one. Worried family members may feel “shut out” by practitioners, but there is also the reality that long-term recovery hinges on trust between practitioner and client. Breaching confidentiality can seriously damage that trust.

Models of care

The model of care used by the clinician can be an area of tension for the family. To understand this, readers should be aware that public mental health services in Canada have been shifting their orientation away from what has been called a “medical model.” This model is one where the patient is the passive recipient of psychiatric expertise. The focus is more on symptom remission than on functional recovery, so activities such as employment or schooling may be seen as stressors to be avoided.

Now, health authorities are shifting toward a *recovery* vision, where self-management and appropriate risk-taking are promoted. Risk-taking, for instance, could take the form of facilitating a client’s employment goals through job-finding initiatives, while

reducing their medication dosage to support concentration on the job.

Family members may worry about risk-taking. In a family focus group I facilitate, one of the participants described her unending anxiety concerning her daughter: “There’s a constant feeling of vigilance, especially when the illness is more active—a feeling that if you let your guard down when they are ill, they’ll commit suicide.”

This mother’s fear is supported by data showing that seriously mentally ill people are, indeed, at higher risk for suicide, as well as financial and sexual exploitation, self-neglect and premature death from medical conditions.⁸ So, family members such as this mother may want clinicians to err on the side of caution—for example, by hospitalizing an ill relative sooner rather than later.

To minimize family–practitioner tensions, practitioners need to be as *transparent* as possible. They need to explain to clients, family members and other staff why they are using the approach they are using.

Ensuring client safety is paramount in importance, but it is not the only consideration when providing services. Crises must be managed when clients are in the acute phase of their illness, but at other times, recovery work—developing the skills to better self-manage a long-term illness—should be explored. ▼

It is important to begin with the assumption that families can play a potentially positive role in recovery and well-being.¹

Learning to Swim When My Daughter Is Drowning

Gail Windsor

Things came to a head on Mother's Day 2008, when my 19-year-old daughter Tracy wouldn't reply when I spoke to her. Her behaviour had been uncharacteristically odd for several months—laughing inappropriately and the next minute in tears; for days walking on tip-toes, stretched up as if floating; staying very close to me like she did as a child...

Gail is retired and lives in White Rock, BC. She volunteers in the mental health community and speaks publicly about her family's experience



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I thought my daughter was getting stoned, but she flatly denied any street drug use and agreed to go to the hospital for a drug test.

When the triage nurse asked her why she was at the hospital that day, Tracy replied that she had bipolar disorder. I looked at my daughter and the triage nurse incredulously. This was the first I'd heard of it.

Tracy tested negative for drugs. And Tracy had diagnosed herself from a pamphlet she'd read the previous summer.

I stayed with her overnight in emergency. In the morning a psychiatrist concluded Tracy was in a manic episode and committed her to hospital for 14 days.

Entrusting my child to this psychiatric ward was terrifying—people walking around with blank stares, many muttering illogically. One morning a nurse told me that Tracy had been combatant the night before and had to be physically restrained to give her a shot to calm her. Whenever I'd go to leave the ward, Tracy would grab my arm and plead with me not to leave her there. I was heartbroken for her, but

her condition was beyond my expertise. After that first hospital stay, Tracy's psychiatrist identified psychosis and said she should be back in hospital. Tracy didn't want to go back, and I was reluctant to involve the police to have her committed. And she definitely wasn't well enough to be out on her own in the world.

In June I left my job to care for Tracy. I tried to keep her safe and stay with her at all times. I barely slept; I made my bed on the floor in her room to keep watch so she wouldn't run away or harm herself.

Tracy did run away one evening. Luckily I saw her get on a bus; I pulled my car in front of the bus, brakes squealing, jumped out and ran on to the bus. I hollered at Tracy in front of stunned passengers, that if she didn't come with me I'd call the cops to get her. She co-operated and came home with me.

My actions could have easily backfired. Though if I'd called the police it would have been a good thing, as they'd have taken her to hospital, where she should have been.

It was a very steep learning curve. Everything I read about bipolar disorder was distressing—high suicide rate, medication non-compliance, lack of insight into their disorder, deep dark depressions and sky-scraping manias.

My fatigue and anxiety over my daughter's health were overwhelming.

By the end of June Tracy asked to go to St. Paul's Hospital to admit herself; she couldn't stand her distorted and paranoid thoughts anymore and felt she'd be safe there.

Her job was to get well. Mine was to get her to her medical team appointments, group sessions and therapy until she was well enough to travel herself.

From spending hours poring over mental health websites, I had just discovered a program for young people with psychosis. It would entail a long-term stay at UBC Hospital and eventual transfer to the Early Psychosis Intervention (EPI) outpatient program. At my request, a psychiatrist at St. Paul's followed up with UBC Hospital, and Tracy was transferred the next day. Some help. Hope.

I visited Tracy in hospital most days. I didn't want her to feel she had been abandoned. She was dealing with a serious and chronic illness, and spending her days in a psychiatric hospital. That's a lot for a young person to accept and adapt to.

Day after day, and there was no change in her condition. Much of the time her eyes were vacant, her face expressionless and her thoughts off in another world. It was agonizing to see her continue in this condition.

Mid-August, even though she still wasn't well, Tracy did get out of UBC Hospital and into the care of Early Psychosis Intervention. And back into my care at home. Her job was to get well. Mine was to get her to her medical team appointments, group sessions and therapy until she was well enough to travel herself.

After nearly four months off work, I was offered a job with a great company in the travel industry. Even though I was apprehensive about how Tracy would fare on her own, I was looking forward to the normality of being back at work.

But Tracy had a relapse mid-September, a few days before I was to start my new job, and my new employer and I decided it was best to sever ties. My daughter's recovery was not imminent, and I needed to be with her as her advocate and to provide support. Nothing would be 'normal' again until Tracy was well.

I had no idea that recovery would take such a long time. The nightmare was never-ending. To think of what Tracy was going through was gut-wrenching. Her life had imploded. She hadn't anticipated being diagnosed with a serious mental illness just when she expected to be free in the adult world—and neither had we.

After more than six months at home I needed work to avoid financial devastation. I was hired back by the firm I originally left. My employer was supportive, I had good friends there and the place was familiar. In early January 2009 I started at a couple of days a week, easing in to full-time.



They got her into an ambulance; I followed in a second ambulance, all sirens screaming. Was Tracy going to die? Would she have permanent brain and organ damage if she survived?

On Friday, January 16, after work, I found Tracy on her bedroom floor, convulsing, her eyes rolled back in her head so that only the whites were visible—an alarming sight. I called 911.

At first I thought it might be a reaction to her medication, but she had purposely overdosed.

Then Tracy stopped convulsing and became still. I couldn't tell, in my panic, if she was breathing—yes, she had very shallow breath. By the time the emergency responders arrived I was numb with shock.

They got her into an ambulance; I followed in a second ambulance, all sirens screaming. This was surreal. Was Tracy going to die? Would she have permanent brain and organ damage if she survived?

Stomach contents removed. Blood tests. I slept in the waiting room. Then over to intensive care, attached to many tubes and monitors. My daytime vigil was spent in a chair at the foot of her bed—it was standing room only next to her because of all the medical equipment.

I felt deep sadness that Tracy felt so miserable she had sought relief in death. I asked for a clergy person to pray for Tracy. She really needed help.

Whenever Tracy opened her eyes I whispered to her that she is very much loved and we'd get through this as a family. I told her everything positive that I could think of.

I was exhausted and overwhelmed with gratitude that Tracy had survived. Tracy was disappointed that she was alive.

After many weeks in hospital there was no shift in her stubborn, medication-resistant depression. The hospital psychiatrist, in collaboration with her mental health team psychiatrist, suggested electroconvulsive therapy (ECT). After arming myself with information, I concurred that this was a good option, and Tracy agreed to ECT. After several treatments, her depression slowly lifted—enough for her to be released from the hospital in April and continue her treatments and therapies under the EPI team.

Anguish over Tracy's struggle with mental illness and her suicide attempt

took its toll on me. No matter how hard I tried, I couldn't focus to work at my former capacity and was let go from my job. This was a painful blow to my psyche, but I was emotionally spent and didn't resist the opportunity to catch up on much needed rest.

It's been two years since Tracy was hospitalized for a relapse. But she is now in recovery, managing her symptoms, living in her own apartment, taking university courses, speaking to the public about mental illness, doing peer support work, going to the gym, taking her medications, and living a healthy lifestyle. Her illness is chronic, and she will have symptoms flare up in the future, but she now has many supports and strategies to deal with these episodes. Tracy considers me to be one of her main supports.

I'm finally able to relax with the knowledge that Tracy is successfully independent. I now get a reasonable amount of rest, read novels, go to aerobic, hip-hop, urban dance and zumba classes, and walk my dogs.

I continue to research mental health issues and am on many research/advocacy email lists. Recently I talked to a parent group about my experience, and Tracy and I gave a well-received presentation in tandem on a family panel at the 8th Annual Family Conference at Vancouver General Hospital. ▼

Autumn Leaves on the Family Tree

Winter Hammell

Family trees are not only one tree, but a forest of trees connected by the roots in the ground they share. Some blossom, and bear fruit. Others produce only autumn leaves.

The twisted, knotted roots—nameless, faceless ancestors—exist below my life’s horizon.

Nothing is known about my dad’s family, except there were many brothers, all in eastern Canada.

My mother’s family tree is well documented. Grandpa fought in World War I. He and Grandma had a son and two daughters. I remember that he was a stern man when he was very old. Grandma, though, was always smiling—a façade? I wonder. While I was growing up, there were whispers that hinted of mental illness among Grandpa’s siblings—he had eight sisters.

Mom and Dad had four children. My aunt and her husband had three. My uncle had no children.

We are now a family of only 16: I have two surviving siblings, three cousins, four nieces, two nephews, three great-nieces and one great-nephew. It’s very unlikely the number will increase in my lifetime, but it will likely decrease.

I’m the only one among the 16 who has been committed to the psychiatric wards of St. Paul’s Hospital in Vancouver.

My uncle, Danny, lived his short, troubled alcoholic life in the beer halls of Vancouver’s Main and Hastings streets in the 1960s and early ’70s. He would drift through family dinners and picnics in Stanley Park on the fumes of the beer he was always drinking.

Almost totally inaccessible, he—like me—had a very bad temper. I never had much chance to talk with him, and my memories of him are sketchy.

With his “un-named” mental illness, Uncle Danny was committed to Riverview Hospital in Coquitlam on many occasions. He was married once, but his First Nation wife died young, of alcoholism. How her death must have affected his mental illness! He only lived to be 45 years old.

I’ve seen pictures of my uncle when he was a child, back in the mid 1930s. In photos my uncle and I look very much alike. Did we the same “shadows” in our eyes as children? Does the same “tree sap” of mental illness and alcoholism flow in my veins? Is that what really connects us on the family tree? Genetics? Faulty “wiring”? Or, circumstances?

In junior high school, feeling incomplete, like a false person—I started drinking. There were big chunks of “me” missing. Hollow, I filled myself with gin. Later in life I filled myself with physical pain, cutting my wrists and arms to make up for the emotional emptiness. My own “un-named” mental illness—the grinding, never-ending darkness of depression—was crushing me.

Winter has been a mental health services consumer since 1987, and has been writing fiction and non-fiction since high school. His fantasy short stories and mental health articles have been published both locally and nationally, online and in print



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Looking back, it's easy to see why I started drinking. My family moved midway through my seventh grade. New school. No friends. And I was really struggling with my identity, and the depression.

Even now I feel I need a drink every day. But I refuse to have alcohol of any kind in the house—not even wine for visitors.

After a suicide attempt in 1987, when I was 29, my mental illness was finally “named”: borderline personality disorder. For a 10-year period I was hospitalized almost three times a year, every year—it was the worst decade of my adult life. I was drinking wine coolers, overdosing on prescription drugs and cutting to commit suicide. I still felt so empty and couldn't “help” myself.

I'm now 55 years old, 10 years older than my uncle was when he died. He wasn't helped with psychiatric drugs, or electroconvulsive therapy, or counselling, or cognitive therapy. But I have been.

My grandparents, parents, uncle and eldest brother are long gone. The family tree seems more and more lifeless. The boughs and branches are losing vitality. Memories of green...

My family hasn't knowingly helped or hindered my progress toward wellness—only three people know or have known specific details of what my life has been like: my wife, one of my cousins and my late aunt. Why do I still keep my secret from the rest of the family? Shame.

I'm not a parent. This was a conscious choice on my and my wife's part. I was

afraid any child of mine would also experience the pain. I would not have been a good father—I was too unstable during the child-bearing years of my marriage.

Of my three siblings, only two have had children. Only one of my three cousins has had children.

Is one of these children going to become ill? Will there be “shadows” in his eyes? Will she get the help she needs?

Do my nephews, nieces, great-nephews and great-nieces see me as I used to see Uncle Danny? As mentally ill? Unstable? A drunk, even though I'm not drinking now?

Are their own family trees—sons and daughters yet to be born—going to blossom and produce fruit, or will they bear only autumn leaves? ▾

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Matt's story bit.ly/PSRMatt

13012

The Mom I Never Knew

Debbie P

In August 2011, my mother passed away at the age of 80. It was sad for me to lay to rest this woman who had caused the family so much pain—it seemed I would never get an explanation for all the years of her strange behaviour, paranoia and rages.

It had been clear that Mom suffered from mental illness. Even at the age of six, I knew that a lot of what she said didn't make sense—stories about people following her, poisoned tap water, coworkers slipping drugs into her coffee... And then there was the time she told me she had leukemia; she didn't. I was often not aware of the 'events' causing her distress, but I couldn't help but see the repercussions, like the crazed look on her face and the hysterical crying. As an adult, I visited her on psychiatric wards time and time again.

In Mom's home, after her death, I found journals dating back 34 years—thousands of pages of journal entries, starting when my brother, the youngest of we four siblings, left home. From that time on she apparently wrote obsessively.

I wanted to keep the writings, but my siblings—I was the middle of three daughters—wanted them destroyed. We already had a collection of "the evidence"—letters Mom had sent us over the years, many of them that remained unopened. We knew it was 'crazy' stuff and didn't talk about it. They just wanted to move on, but luckily, I won out. I told them everyone has their own way of dealing with things and that I needed to read through them in search of some answers. They knew Mom had disliked me most, so gave their permission.

I was excited, yet nervous, to delve into the journal pages. And finally I got to see her world; before that I only got to see snippets. As I read through the journals, I was shocked to discover how ill she really was. It wasn't something that flared up once in a while like a trick knee—it was her life.

The journal pages were filled with horrific tales of the torment inflicted on her by her lifelong fictitious adversaries, the ones she called the "TIN GODS." Sadly, I remember often being accused, when I was a child, of being a tin god. "You're one of THEM," she'd cry. "They got to you, didn't they?" I'd stand quietly, afraid to speak. I knew not to rock the boat.

In the 1970s mom spoke of "THEM" and "THE POWERS THAT BE." By the late 1980s, they were the TIN GODS, whose singular objective was to ruin her life. They were everywhere. They used the "method" to influence people into wearing certain colours, say certain words and act in certain ways while in Mom's company—to make sure mom knew THEY were there. Once I wore a

Debbie is an instructor of business and entrepreneurial courses in Vancouver, BC. She has also been a mental health advocate since the passing of her mentally ill mother in 2011



If I could go back and change things, I would simply have been an understanding friend who listened without judgments or opposition—like pen on paper.

yellow blouse—this was a sign from the TIN GODS. *Knock, knock, WE are here.*

The most surprising thing was that Mom never acknowledged having a mental illness. I had always thought she knew. After 60 years of hospitalizations, medications and psychiatric treatment, how could she not! But the reality she lived, as strange as it was, was 100% real to her. She writes how she knew no one believed the TIN GODS were stalking, tormenting and manipulating her. She wrote that these journals were to be written proof to all the disbelievers, so they would finally know she had been telling the truth all along. Mom writes that she felt ashamed and embarrassed, knowing what others thought of her, and she consistently referred to herself as the “VILLAGE IDIOT.”

Mom lived within her own delusions. These delusions haunted her and made her daily life unbearable and her thoughts suicidal. She wrote: “In wartime it’s called ‘Torture’—in my life it’s called ‘Treatment.’” Her journals tell of her wish to die, but her fear of God kept her from committing this sin.

All these years—I am now 57 years old—I thought Mom was a mean and uncaring woman. But from her writings, I learned that what I saw outwardly was nothing compared to what was really going on inside. Inside she was barely hanging on. She was fighting a fight. She thought her fight was with the TIN GODS, but it went much deeper than that. Her fight was with mental illness.

I didn’t know how desperately lonely she was. Mom claimed in her journal that her only two friends were the crisis line and “pen on paper.” I thought

she chose to be isolated. When, as an adult, I’d try to visit her at her home, her curtains would be closed and she wouldn’t answer the door, though she was there. I thought it was because she didn’t like me. But her fears were legion. And little did I know that she stayed away from people to protect them. Mom wrote of a friend she had in the 1980s and how she had to end the friendship when she noticed a sign that the TIN GODS had “got to her” and were using her to get to Mom. Mom wrote that she couldn’t let her friend be mistreated by the TIN GODS and so sent her friend a letter saying good-bye.

Knowing what I know now, I wish I had done things differently. I wish I hadn’t tried to ‘fix’ her. As an adult, I occasionally confronted mom, suggesting reasons why her tales couldn’t be true. For instance, there was no evidence or reason that her neighbours were breaking into her home while she was out and moving things around. I naively thought that if I tried to reason with her she might snap out of it—after all, she seemed to be an intelligent woman. Unfortunately, it never worked. Mom would fly into a rage. If you confronted her, you were accused of being “one of THEM.”

I wish I had been given better informa-

tion to help me understand and make allowances for her behaviour. No one ever wanted to tell us anything. My mom was a single parent from the time I was six on, and I suppose the doctors wanted to protect us from the hard truth—“she’s tired, she’s working too hard.” Then as an adult, I had no privy to information from her health care providers; only hypothetical discussions with my own doctor. Mom’s siblings, too, right to the end espoused “just think about the good things.”

If I could go back and change things, I would simply have been an understanding friend who listened without judgments or opposition—like pen on paper. I think that’s what the crisis line workers did. I know that now.

I promised my siblings that I’d destroy the journals once I’d read them all—so some pages remain unread. I didn’t get all the answers I wanted, but reading my mother’s journals has been a big eye opener. I’m trying to make sense of it all. I want to use my mother’s story for greater good—she says in her journal she was hoping to write a book. I continue to sift and digest...

Toward the end of her life, Mom wrote the following poem. (see below) For me...this says it all. ▼

BEYOND
THE REAL TRUTH
LIES ONLY IN THE AFTER-DEATH.
IT IS THERE THAT THE MISJUDGED
ARE VINDICATED - - -
AND THOSE WHO LENIENTLY JUDGED
(WRONGLY SO!)
ARE FORGIVEN.

(ALIAS THE VILLAGE IDIOT!)
STILL !!

A poem by Debbie’s mother.

A Tainted Son

AND THE REDEEMING POWER OF A GRANDMOTHER'S LOVE

Ganesh*

My journey with addiction and mental health started in my early childhood. My mother and I fled Sri Lanka in 1983 after my father was murdered by the Sinhalese army during the onset of civil war there. We arrived in Toronto as refugees, with very little money. I was just shy of two years old.



Ganesh is completing his certificate in community counselling and plans to study Child and Youth Care at Douglas College. He has volunteered with the Mood Disorders Association of BC speakers bureau and currently volunteers with SpeakBOX, a new peer support organization, advocating for youth mental and physical well-being

*pseudonym

We lived in battered women's shelters for a number of months until we were placed in low-income government housing. My mother struggled to get by, working a few jobs to make ends meet while also studying for her nursing degree. I was a latch-key child and had to fend for myself.

The fact is, my mother didn't want a babysitter to watch me while she was working or going to school. You see, she was worried that a nurturing bond with a caregiver might make it possible for me to reveal what was going on behind our closed doors.

She had been abusing me from as early as I could remember. Unless we

had extended family over—I had an uncle in Toronto, a cousin in Ottawa and relatives from other countries visited—I slept in the same bed as my mom and she would fondle and kiss me provocatively. It wasn't until I was eight or nine that I realized—from watching TV when my mother was at work—this wasn't normal behaviour between a mother and child.

Physically, she beat on me with her fists, whipped me with a belt and forced me to hold painful crouching positions for long periods. These were punishments. In Tamil culture, academics are revered, but I didn't care about school and didn't do well. I hated being at home. Out in



Since I felt I couldn't reach out for help, I turned to alcohol and drugs to numb what I was feeling inside. I was now a drug-addicted homeless youth.

the neighbourhood I got into risky behaviours like shoplifting.

When I started grade school, I was bullied by other kids. Sometimes it was racially motivated; other times it was because I was the "weird kid" that rarely spoke. The name calling, the mean comments, the dog poop smear-threat and such often ended up in fights and trouble at school.

It was the happiest day of my life when my maternal grandmother was sponsored to come live with us in Toronto. This also happened when I was about eight and a half. My "Grams" became my best friend. A kind of resonating light shone from her. I loved to sit and listen to her stories about when she was a little girl in Sri Lanka. Grams lived with us for

a couple of years before moving into a retirement home.

When I was nearing 10, perhaps fortified by my grandmother's presence, I decided to confront my mother about the sexual behaviour and how I was feeling. She threatened to kill me, herself and Grams. I didn't care if she killed herself or me, but I didn't want her to kill my Grams. So I continued to keep the abuse secret.

I was sad all the time and blamed myself for what was going on. Much as I knew it was wrong, I had become attracted to my mother and got sexually aroused. I thought I was provoking the abusive behaviour. I felt ashamed and disgusted with myself. I suffered a lot of dissociation and withdrew from the outside world.

Emotional abuse intensified as I got older and rebelled more against my mom. She called me worthless over and over. She suffocated me, trying to control what I did, where I went and who I spent time with—way beyond reasonable care.

When I was 12, she and I moved to Houston, Texas, where she'd been offered a full-time nursing job. At age 13, I was still sleeping in my mother's bed. Finally, at the age of 14, I could no longer stand the pain consuming me—I jumped off the fourth-floor balcony of our apartment. Trees broke my fall, and I survived. Everyone thought my suicide attempt was an accident.

I finally phoned Grams and told her what was going on. She told me she understood. Her father had inflicted abuse on her and her brothers. Her husband had inflicted abuse on her and my mom.

Grams confronted my mother, and for a couple of years they battled back and forth. Grams told my mom she needed to stop what she was doing, and that I needed to get help. (I made two more attempts to end my life by not eating.). Finally, my mother—afraid the uncles would find out, afraid she might get charged—bought me a Greyhound bus ticket to Toronto. I was 16.

When I first arrived in Toronto, I stayed with my Grams. She loved me, but because she was on a fixed pension and lived in a retirement residence, she couldn't help me all that much.

When I went to my extended family about getting help for what happened to me and how I was feeling, my uncles

told me to keep those things to myself. Toronto has the largest Tamil community outside Sri Lanka, and no one wanted shame brought on the family. I was told to “just tough it out.”

Since I felt I couldn't reach out for help, I turned to alcohol and drugs to numb what I was feeling inside. Alcohol, cocaine and OxyContin were my drugs of choice. I also mixed them with hallucinogens like acid, PCP, ecstasy and mushrooms, to name a few. I was now a drug-addicted homeless youth.

Instead of having compassion and understanding for why I turned to alcohol and drugs, my uncles told me I was a loser and would never amount to anything—the same things my mother had told me over and over.

I spent the better part of eight years, from age 17 to 24, couch surfing, living in shelters, squatting with other street kids, and sharing crappy apartments in shady areas with other users. I supported myself by prostituting myself to middle-aged and older men who had wedding rings on their fingers. And by dealing drugs.

But through all this, Grams was my touchstone.

Once a week, I'd clean up and show up at her place for dinner. I told her I had my own apartment, that I was working at retail jobs, Chapters, Second Cup, and so on. I thought I had fooled her, disguising my life. But over time my physical appearance changed—I went from having judo and wrestling muscle mass to being gaunt and emaciated. Grams knew something was wrong and finally confronted me about my

But after Grams passed away in October 2009, I lapsed into depression and agoraphobia. I had lost the one person I cared about and who had cared about me.

addiction and lifestyle. I broke down and cried. And finally decided to get help for my addiction.

After that talk with my Grams, I reached out to a support worker at one of the shelters I frequented, and she got me into detox and treatment. The care providers in those programs realized I had symptoms of mental illness. I was diagnosed with major depressive disorder and, based on what I'd been through, post-traumatic stress disorder.

Over the next three years I was in a pretty healthy space—became a support for my Grams, who battled cancer that whole time. But after she passed away in October 2009, I lapsed into depression and agoraphobia. I had lost the one person I cared about and who had cared about me.

In spring of 2010, I moved to Vancouver, thinking a change of scenery might help. Ran away from my past.

In December 2012, I was diagnosed with bipolar disorder Type 1, when

it became clear that the auditory and visual hallucinations and the delusional thoughts I'd experienced over the years weren't caused by drug use. And when I told the mental health care providers about the mania I'd experienced.

In February of this year I was diagnosed with borderline personality disorder. This explained the severity of self-harm incidents—from about 12 on I would smash my head into hard surfaces, like bullies did to me—and the number of suicide attempts (six) in my life. I'm waiting for access to dialectical behavioural therapy.

I have now been clean and sober for over six years. I attend AA meetings regularly and have an excellent psychiatrist and other mental health professionals in my life. I've found a great combination of medications that have been vital in my recovery. I share an apartment with a roommate, have started to eat more healthily and have become active again—physical fitness is crucial to mental health recovery.

I advocate for the youth and young adult mental health community, and work in Vancouver's Downtown Eastside, helping marginalized people who struggle with challenges similar to those I once faced.

I've never reconciled things with my mother. And I miss my Grams. But I've made strides in overcoming my asocial behaviour and have found some great friends who accept me for who I am.

I also have a 'secret weapon' I didn't have before...I have hope! ♡

Resilient Kids—How Can Parents Help?

Dan Reist

Resilience is a critical capacity for health and well-being. It represents the ability to cope with challenges, rise above negative feelings, bounce back from bad experiences, and move forward in the face of adversity. It is what allows people to look after themselves when life just isn't going their way.

Dan is Assistant Director (Knowledge Exchange) at the Centre for Addictions Research of BC, University of Victoria. Dan leads a team that communicates evidence related to substance use in a way that supports effective policy and practice. This involves advising government departments and regional authorities, and creating materials that respond to real-world contexts



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Although some aspects of resilience are inborn, others aspects can be learned and practised. As parents, we can help prepare our children for the challenges they will face throughout their lives. According to psychologist Albert Bandura,¹ this can be done by developing *self-efficacy*, the essential building block of resilience.

Fostering self-efficacy

Self-efficacy involves believing in one's own abilities to face a task and succeed. Its development is affected by how we interpret the input we receive from the following four sources.

1. From our own experiences of mastery
How we take the results of our performance on any given task is the most

influential source of our self-efficacy beliefs.

As parents, we can help our kids develop self-efficacy by structuring situations for them in ways that bring success. And, we can avoid prematurely putting our kids in situations where they are likely to fail often. On the other hand, kids need to be allowed to experience some failures. If they experience only easy successes, they come to expect quick results and are easily discouraged by failure.

Parents can also help by asking kids to evaluate their own performance before giving them feedback. Most importantly, kids can practise identifying what they did well, what kind of effort

they put into the task, and what they learned.

2. By observing others

Children will learn from parents, teachers and other role models, for better or for worse. A good mentor can model a better way of doing a task, whether the task is learning how to resolve conflict, how to ask good questions, how to refuse a drink, or how to learn from mistakes.

As parents, we can reinforce positive modelling, not only through our own behaviour, but by asking kids what they observed another child doing well. Adults can also practise healthy self-reflection, sharing with their kids what they liked about their own behaviour and what they might improve with practice or effort.

3. From what others say about us and to us

An interesting finding is that repeated negative appraisals by others can and will weaken self-efficacy even more than positive appraisals will strengthen it. In other words, lots of praise is not going to make up for lots of criticism and negative judgments.

As parents, we can teach our kids (and ourselves) that failure is a necessary part of learning, and that mastery of any difficult task takes repeated, concentrated practice for everyone. When giving feedback on areas that need improvement, we can give our children information about what they *can* do to succeed at the task, rather than telling them what they did not do.

We should practise measuring success in terms of self-improvement rather than by triumphs over other people.



A good mentor can model a better way of doing a task, whether the task is learning how to resolve conflict, how to ask good questions, how to refuse a drink, or how to learn from mistakes.

4. From the signals we get from our bodies and our emotions

In stressful situations, most people experience common signs of distress. We may feel shaky, suffer an upset stomach, have cold hands, sweat more than normal, or feel anxious or afraid. Each of us assesses how confident we feel by how we interpret our emotional and physical state when we think about whatever task is at hand (e.g., a test, a game, a speech, a job interview).

Parents can help kids tune in to their bodies. We can explain how the physiological signs of stress are actually healthy mechanisms that get our bodies ready for action, rather than being signs of imminent failure. We can teach our kids how to take slow deep breaths and

to feel the difference between tension and relaxation. We can have them imagine feeling good about themselves while they mentally practise the feared task.

Persevere!

Some kids, teens and young adults have challenges or personalities that make it harder for parents to keep practising the self-efficacy-building exercises noted above. If positive parenting is wearing you out, take a moment to practise building your own resilience. Don't give up when it gets hard or when you fail at some aspect of parenting. Don't tell yourself you can't do it or it'll never get better. Parenting requires patience, practice and perspective—and a lot of humour. ▼

related resource

Masten, A. & Gewirtz, A. (2006). Resilience in development: The importance of early childhood. In *Encyclopedia on early childhood development*. Montreal: Centre of Excellence for Early Childhood Development.

www.child-encyclopedia.com/documents/Masten-GewirtzANGxp.pdf

Is It Ever Too Early to Talk About Disordered Eating?

Mimi Hudson, MA, RCC, and Dawn Livera, BSc

Last winter, a parent commented to us that her daughter refused to wear a warm coat. She said it made her look fat. The mom laughed and said, “Appearance is so important to kids this age.” Her daughter is six.

Mimi is the Director of Community & Provincial Programs at Family Services of the North Shore. She supervises a number of early childhood development programs and the provincial Jessie’s Legacy eating disorders prevention program

Dawn Livera is the Family FUNdamentals Program Coordinator at Jessie’s Legacy and a writer. She has published a story, “Lessons in Parenting,” about how she and her husband learned to be parents from a stray cat they took in before they had children of their own



“Can I try your pizza?”

*The photos on the next two pages are from the Family FUNdamentals program that took place at the I hope family centre in North Vancouver, Fall 2012

From a very early age, children are exposed to messages that emphasize the importance of being thin and looking fit. There is a growing body of literature to suggest that children as young as three are not only aware of weight and body size, but commonly express a desire to be thinner regardless of body mass index.¹ Children learn more in their first five years of life than at any other time. This is when they form the attitudes and behaviours that shape the rest of their lives. It was with this in mind that the Jessie’s Legacy eating disorders prevention program developed Family FUNdamentals for families with children aged two to four.

Family FUNdamentals is an early childhood development program that

helps families foster a joyful (FUN!) and competent parent-child relationship around food and activity.

The program is intended to promote healthy eating, healthy weights and positive body image, and to prevent disordered eating, including eating disorders and obesity. It aims to enhance connectedness to family and community, as well as parental support and acceptance of body size diversity. These are protective factors in the development of disordered eating.

This six-session program helps parents/caregivers give their children a strong start in life. The program covers parenting topics that help build confidence and self-esteem, promote positive eating and feeding



Dancing with ribbons – Creative Activity & Movement Module 4

relationships, and engage families in fun and mastery of physical activities. In Family FUNdamentals a key message is that that meals and activity should be fun and enjoyed by the whole family. Power struggles over food, “bribing” with food or denying food (if parents think their children are too “chubby”) are strategies to be avoided.

Parents are their children’s first teachers. Young children learn by watching and copying the people around them. Family FUNdamentals is a family-centred program, as parents/ caregivers and their children attend together. Through songs, stories,

games, healthy snacks and lots of positive role modelling, parents/caregivers learn how they can support the healthy growth and development of their children—and have fun together in the process!

The Family FUNdamentals key messages can be summed up nicely in the program song that is sung each week (to the tune of “Frère Jacques” [Brother John]):

*I am special, I am special
You are too, you are too
All of us are special, all of us are special
Yes it’s true, yes, it’s true ▼*

FUNdamental questions

- Do you enjoy spending time with your children?
- Are you able to help your children cope with day-to-day routines or the unexpected?
- How many times a week do you eat together as a family?
- What physical activities does your family like to do together?
- Is it okay to make mistakes, or is it important to be perfect?
- Do you accept yourself as you are, or are there things you would like to change?
- Do your children hear you making comments about your own or other people’s weight, shape or size?

To find out why these questions are important, look for a Family FUNdamentals program near you. The program has already been piloted in nine communities around the province.

Visit jessieslegacy.com or email fundamentals@familyservices.bc.ca.



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The FORCE Society: Empowering families

Karen Copeland

I work for an organization called the FORCE Society for Kids' Mental Health. FORCE stands for Families Organized for Recognition and Care Equality. It's a non-profit organization that was co-founded in 2000 under the leadership of Keli Anderson and Donna Murphy.

Karen lives in Abbotsford and is the parent of two children, one of whom experiences mental health challenges. Karen works as Parent in Residence for the FORCE Society for Kids' Mental Health. She hopes to create a difference in how we think and view mental health issues in families and communities



Now, 13 years later, with 36 staff and contractors, the organization has evolved into quite the “force” for child and youth mental health within BC.

The mandate of the FORCE is to support and empower families, and to work collaboratively with health care professionals, toward seeing that the mental health needs of families are met. The FORCE is committed to promoting engagement of families in the systems that service child and youth mental health—the Ministry of Child and Family Development, for example. We believe it's important for family members to be valued partners in planning for, and services to, their child or youth with mental health challenges.

Parents in Residence

The Parent in Residence (PiR) program and the Youth in Residence (YiR) program were launched in July 2011.

The Parent in Residence role has been established in four regions of BC: Vancouver Coastal, Fraser, Vancouver Island and the Interior. The Youth in Residence role has been established at BC Children's Hospital. We currently have 15 PiRs and two YiRs supporting families and youth across BC. I work as a Parent in Residence in the community of Abbotsford.

You might be asking yourself, “What is a Parent in Residence?” A lot of people do! Simply put, a PiR is a parent who has lived experience with a child or youth with mental health issues, and who acts as a navigator, educator and mentor to assist families to develop respectful and collaborative relationships with professionals.

In my role as PiR, I provide parent peer support. I am not a professional counsellor or a clinician; I am a parent

I listen to the parent, hear about their journey, and let them know they are not alone.

of a beautiful boy who experiences mental health challenges. I draw from my own experiences of navigating the health care systems to try to get the support my son and my family needs and deserves.

First and foremost, I listen to the parent, hear about their journey, and let them know they are not alone. We all know how isolating this journey can be, and many families find new strength knowing that someone out there “gets it.” I can then provide parents with information and knowledge about the systems they are working with: for example, what to expect, some of the limitations of the systems, and good questions to ask.

I also assist parents to prepare for meetings, helping them focus on their main goals and outcomes, and on ways to work toward achieving these outcomes. I believe the more prepared a parent (or youth) is, the better they are able to let the professionals supporting them know what they need.

Often, we are described as advocates, but this is a misnomer. As PiRs, we walk alongside our families, guiding them through the myriad of services and systems. We don’t speak for the families we connect with; we teach and empower them to speak for themselves. We mentor family members to become their own advocates.

The flip side of supporting parents is creating relationships with professional

service providers in my community. It’s very important for me to have a good understanding of the services that are available, so that I’m providing accurate information to families about the services they can access in their community.

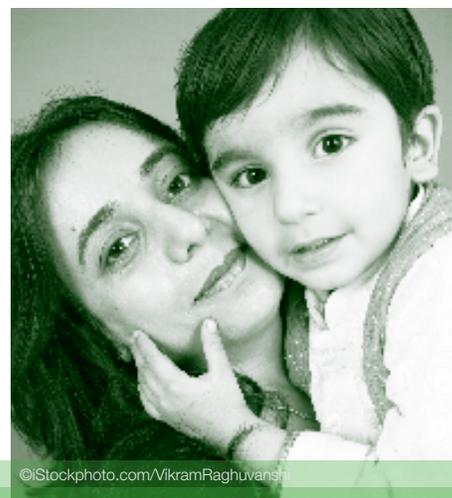
Good relationships with service providers are also critical to ensure that positive bridging happens between the service system and the family. If the professional or the family doesn’t understand my role as a PiR, this can impact how everybody thinks about each other. I also have to be mindful of how I advocate for my own son within the same service systems. Becoming overly emotional can damage a relationship, not only for our family, but for other families I am supporting.

As a parent, I’ve had many types of experiences with service systems. However, when I feel the professional is really listening and values the knowledge I have about my son, there is a strong feeling of trust that develops. When a professional demonstrates empathy and works with me to find solutions, I feel a strong sense of hope for our son and our family.

FORCE full

The FORCE has had a huge impact on my own life, and by extension, my family. I have learned that celebrating when things are going well is incredibly important. It’s so easy to get caught up in the difficulties—the road blocks that seem to pop up regularly. For instance, our family struggles regularly with school refusal, which causes a lot of anxious moments, tension and sadness. But I savour the days that go well. It’s empowering to take a moment to just breathe, and to bring to mind the good things our journey has created.

I’ve learned about the power of collaboration. Working together with people within systems is not always comfortable, but it can lead to great things if we are mindful of the mutual outcome we are looking to achieve, opening our minds to possibilities. My son is currently transitioning from elementary to middle school. This is a daunting proposition, as it will involve working



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I have learned that celebrating when things are going well is incredibly important. It’s so easy to get caught up in the difficulties.

with new professionals to ensure our son gets the support he needs. At one of the first planning meetings, our elementary school principal started by saying she was interested in where we, our son's parents, hoped to see him at the age of 22, and what we felt needed to happen to make sure he got there. This broader question set the stage for a great conversation, without judgment about our concerns and worries, and gave the professionals at the table a deeper understanding of our family.

My favourite saying is: "We need to come from a place of curiosity, not a place of judgment or assumption." I practise this, and try to teach this not only to other families and professionals, but also to my children.

We have two choices when we are facing challenges: we can choose to let the challenge defeat us, or we can choose to embrace the challenge. By embracing the challenge, we explore opportunities and create things that perhaps never existed before. Our best learning comes when we are struggling—although I sometimes wonder what it is that makes us have to struggle so darned much!

And here's what the power of knowing someone who "gets it" means to me. The knowledge that I am not alone keeps me from slipping into a dark hole where words, behaviours, endless meetings and appointments, and ongoing advocacy can consume a person. Being able to connect with other parents who are on this journey brings me incredible strength and courage to continue on mine. I am so very thankful. ▾



parent in residence program

The FORCE Society for Kids Mental Health provides support to families through its Parents in Residence (PiR) program.

Parents and families can connect with the FORCE by calling 1-855-887-8004 and leaving a message with their name and the name of the community they're calling from. There is no charge to access our service. Our criterion is simply that you are a parent or caregiver who has a child or youth who may be experiencing a mental health challenge.

PiRs connect with parents through telephone conversations and meeting up in coffee shops in the community. The amount of time spent with a PiR is up to the parent. Some parents connect with us briefly, moving on when they feel confident they have developed a plan. Other parents need more guidance and support, and they continue to connect with us when they need to.

Regional PiRs are available in the following BC communities:

Abbotsford	Courtenay	New Westminister	Sooke
Boston Bar	Delta	Penticton	Squamish
Burnaby	Hope	Pitt Meadows	Sunshine Coast
Campbell River	Kelowna	Port Coquitlam	Surrey
Chilliwack	Langley	Port Moody	Vancouver
Comox	Maple Ridge	Richmond	Victoria
Coquitlam	Mission	Sidney	White Rock

If your community is not on this list, you can still connect with a PiR or YiR by phone. Call the Kelty Mental Health Centre at BC Children's Hospital at 1-800-665-1822 and ask to speak with the Parent in Residence or Youth in Residence.

For further information about The FORCE, visit www.forcesociety.com

Mental Wellness Parenting Program

Karin Rai, MA

For over 40 years, the Family Education and Support Centre of Maple Ridge has been offering educational and support programs in the area of mental health and parenting.

In the fall of 2011, the Centre's Adult Mental Health Program organized a workshop for parents with a mental illness who had an interest in learning more about issues related to actively parenting with a mental illness. The presentation and ensuing discussion was coupled with feedback from parents who were using our adult mental health services, and from workers at our local Ministry of Children and Family Development (MCFD) offices.

Some of the issues and concerns identified by parents and service providers included:

- how much a parent should tell children about the parent's mental illness, and how to tell children in a way that is appropriate and doesn't provoke anxiety
- children mimicking behaviours that are associated with a parent's mental illness
- preventative strategies to support parents' own mental wellness and their families' wellness

With this information, we were able to identify a specific gap in services: a service that would bring together a parenting program with a mental health education program.

Our Mental Health and our Parenting departments collaborated to develop the Mental Wellness Parenting sessions. Since October of 2011, we have been offering eight-week sessions, facilitated

by one mental health facilitator and one parenting support facilitator. Free child-minding is provided.

The Mental Wellness Parenting program integrates cognitive-behavioural therapy with parenting support group components. This is a highly effective approach to building skills to lower depression, anxiety and isolation and boost wellness.

Our goals for the parents taking the program include:

- learning about the physical and emotional symptoms of mental health concerns
- understanding patterns of stress and how stress manifests in their parenting style and behaviour with their children
- developing strategies for self-care
- identifying early warning signs of not feeling well and developing preventative and coping strategies
- learning strategies for communicating with family members about their mental illness
- feeling less isolated by sharing and learning from other parents

Parents who took the group reported the following benefits:

- no longer felt alone with their feelings; were glad to know that other people felt depressed and anxious while parenting

Karin is the Coordinator of the Adult Mental Health Program at the Family Education and Support Centre in Maple Ridge. She and her colleague Jenny Early, Coordinator of the Families Supporting Families program, are co-facilitators of the Mental Wellness Parenting Program



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Parents Forever

HOPE FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

Frances Kenny

I'm the mom of two wonderful sons, ages 35 and 38. When my youngest was 14, he began acting out: lying, stealing, skipping school, running away. We felt totally helpless and didn't know where to turn for help.

Frances is the founder/facilitator of Parents Forever, a mutual support group for parents and family members of adult children who struggle with substance abuse issues. She is a member of the Mental Health and Addictions Family Advisory Committee in both Vancouver and Hope



After he ran away a second time, the RCMP referred us to a mutual support program called Parents Together.

Parents Together is a province-wide program managed by the Boys and Girls Clubs of South Coast BC. It has been helping families for over 20 years.

I spent four years in the Vancouver group, where I learned new strategies for dealing with my son's behaviour. And most importantly, I learned how to take care of myself and still maintain a relationship with my son. Parents Together literally saved my life—and my marriage!

The one item that I was terrified would end up on the list of acting-out behaviours was "involvement with drugs," and unfortunately my worst fears came

true. When my son reached his late teens, he became seriously addicted to heroin. By that time I had "graduated" from Parents Together as it was a program for parents of teens and my son had turned 18. After a year of trying to cope on my own, it occurred to me that the same model of support offered by Parents Together would work for parents and family members who struggle with their adult children's substance abuse issues. In 2000, with the endorsement of the Boys and Girls Clubs of South Coast BC, I founded Parents Forever.

I'm proud to say that 13 years later, Parents Forever continues to provide comfort, support, strategies and coping skills to families affected by substance use. The current membership stands at close to 200, and everyone receives

regular communication via email informing them about resources, events and speakers.

So how does Parents Forever work? It provides a safe and confidential place for parents and family members to come together to share their experiences, their wisdom and their courage. Folks come from all walks of life and from all socio-economic and cultural backgrounds. From the moment they arrive at the group, they are surrounded by people who:

- truly understand what they are going through
- don't judge or blame them
- offer hugs and shoulders to cry on
- give hope and encouragement for change

The ongoing support group meets every other Friday, with average

attendance between 15 and 20 people. Parents and family members find us via our website or by referral from doctors, hospitals, social service agencies, psychiatrists and victim services.

The following is an excerpt from an article posted on the From Grief to Action website (www.fgta.ca) by a long-time member (mom) of Parents Forever:

"I began to realize that I needed to recover from S's addiction, that his illness had affected my thinking, behaviour and feelings, and had indeed affected my sense of well-being as well as my relationships with others. Around this time we started attending Parents Forever. What an amazing group! We learned valuable lessons and coping strategies, and gained strength from the folks at the group. We rarely missed a meeting in seven years."

After 20 years of involvement in Parents Together and Parents Forever, I can credit the wonderful support I received for keeping the relationship with my son alive—even during the dark years of his addiction. For the past seven years, my son has been living a sober life, and today our relationship is stronger than ever. There were times I believed we'd never get to this point, but as we say in Parents Forever: "Ever hopeful, no expectations."

Parents Forever is supported by Vancouver Coastal Health, Boys and Girls Clubs of South Coast BC and From Grief to Action. For more information, visit parentsforever.ca. ▼

CONTINUED FROM PAGE 31

- mothers with infant children shared that this was the first time they felt comfortable leaving their child in someone else's care (and we observed that both the mothers and their children experienced less separation anxiety and increased trust with our child-minding staff over the course of the group)
- increased success at setting and achieving realistic personal goals
- new parenting skills
- felt less isolated and more connected with resources in the community (several parents bridged to other programs at the Family Education and Support Centre)
- felt less guilty about asking for help

- some reported wanting to repeat the Mental Wellness Parenting program
- felt supported to work on their own mental wellness
- felt more able to identify early warning signs of not feeling well
- one mother realized the importance of seeing her doctor and resumed taking her medication

As facilitators of the Mental Wellness Parenting program, my colleague Jenny and I have observed that supporting parents with mental illness benefits the entire family unit. It improves parent/child relationships, personal relationships with partners, and relationships with extended family members.

Referrals for the program are accepted from a variety of sources, including health care professionals, MCFD, community agencies, friends, family and self.

For further information, call us at the Family Education and Support Centre at 604-467-6055 or visit www.familyed.bc.ca. ▼

BC Schizophrenia Society— Strengthening Families Together

Sharon Evans, RPN, ADPN, BSPN

When I was asked to write about Strengthening Families Together—a course offered by the BC Schizophrenia Society (BCSS)—I was surprised. There are certainly other people in the BCSS who are more experienced at teaching the course. Nevertheless, as I thought about what to write, I realized I have a special view of the importance of helping family and friends understand how a loved one lives with a mental illness of any kind.

Sharon is a retired psychiatric nurse and President of the Penticton Branch of the BC Schizophrenia Society



I am a retired registered psychiatric nurse who practised for over 40 years in acute inpatient care and in a day hospital program. I am the mother of an adult who has recovered from a severe depression and I learned first-hand that making time for myself helped my child feel less of a burden. In addition to teaching the Strengthening Families Together course, I volunteer for the BCSS's Penticton Branch in the role of president and am actively involved in the day-to-day operations of the branch. And I am a person who had polio in 1953 and who learned to adapt to my limitations, thanks to the

support and encouragement of my parents.

In the mid-1990s, as clinical resource coordinator for the Penticton Regional Hospital's psychiatric day hospital program (closed in 2005), I worked with the local BCSS branch to bring family support to the Department of Psychiatry. The purpose of the BCSS branch was to bring hope and coping skills to family members toward alleviating the burden of mental illness.

We held weekly family support sessions at the day hospital program.

Our clients, and some of our inpatients who would be graduating to the day program, were encouraged to invite family members to come to the optional weekly sessions and meet with BCSS volunteers.

Clients did invite their family members or other support people because we made a strong case for how it would help the person in their recovery. Family is part of any mental health consumer's recovery. So it's important that the family understands how best to help their family member. The fact that we served a meal also helped draw family members to the sessions!

The sessions weren't facilitated. They were very informal gatherings, defined by the people who came. Activities that took place were voluntary and often very client-specific. One client family used the time to sort family pictures. For another family, the parent (client) and teenager played chess and practised focusing on the game rather than on the parent's concerns about the child.

For our families, it was an opportunity to socialize without being concerned about illness or illness-related

behaviours—for some it was the first time in months, or years. For some

strengthening families together

Strengthening Families Together is a 10-session education program developed by the Schizophrenia Society of Canada for family members and friends of individuals with serious and persistent mental illnesses such as schizophrenia and other related disorders. The program provides information on living daily with a mental illness.

Topics presented include:

- schizophrenia and mood disorders
- mental illness, addictions and the criminal justice system
- treatment options
- living with mental illness
- understanding the mental health system
- coping as a family
- advocacy and support

The course is offered across BC. To find out about a Strengthening Families Together program in your area, visit the BC Schizophrenia Society website at www.bcscs.org.

people, it was the very first time they were able to acknowledge their family member's illness. Some family members began to have hope and become aware of new ways to cope.

Our client's family members attended the regular BCSS support groups and many chose to take the Strengthening

Families Together course when it was offered by the BCSS branch.

When our clients completed surveys, on discharge from the day hospital program, many commented on the high value of having family members come to the weekly family sessions. For example: "They understand my illness better"; "They have started calling me more often and visiting." ▾

The sessions weren't facilitated. They were very informal gatherings, defined by the people who came. Activities that took place were voluntary and often very client-specific. One client family used the time to sort family pictures.

Family Toolkit from HeretoHelp

www.heretohelp.bc.ca/workbook/family-toolkit

A guide for family members and loved ones. Learn more about mental illnesses, strategies to support someone's recovery, skills to help you and your loved one communicate and solve problems effectively and self-care strategies to support your own health.

Resources from the BC Schizophrenia Society

- **Family Support and Education Events Calendar:**

www.bcscs.org/events-calendar-page/

A province-wide list of family support groups and family education opportunities.

- **Online Support Groups for Family and Friends:**

www.reachingfamiliesproject.org

An online forum for family members and friends. Connect with others, seek support and share your experiences.

Fact Sheets

- **Hospital Discharge Checklist:**

www.bcscs.org/resources/topics-by-audience/family-friends/2007/05/hospital-discharge-checklist/

- **Understanding and Coping with Mental Illness...**

- 14 Principles for Family Members:**

www.bcscs.org/wp-content/uploads/14-Principles-for-Families.pdf

- **Advocating for your relative (and yourself)—Do's and**

Don'ts: www.bcscs.org/resources/topics-by-audience/family-friends/2005/05/dos-and-donts/

 This list is not comprehensive and does not imply endorsement of resources.

FORCE Society for Kids' Mental Health's *Families Matter: A Framework for Family Mental Health in British Columbia*
www.forcesociety.org/sites/default/files/23154_FAM_Framework-3.6-LR.pdf

A planning resource for policy makers, service providers, advocates, and families in BC. Families Matter looks at mental health from a health promotion perspective and advocates for services that support the whole family.

Coping Kit from From Grief to Action

www.heretohelp.bc.ca/workbook/fgta-coping-kit

A toolkit for parents or caregivers who are dealing with a son or daughter's substance use. Find information and useful tips and strategies from parents who have been there.

Kelty Mental Health

www.keltymentalhealth.ca or call 1-800-665-1822 (toll-free) or 604-875-2084 (in the Lower Mainland).

BC resources for parents and caregivers of children and youth. The Help Finder describes different people in the mental health system and how they can help. Some resources in French, Farsi, Punjabi, Chinese (Simplified and Traditional), and Korean.

Rethink Mental Illness: Siblings Network

www.rethink.org/siblings

A UK-based support network specifically for brothers and sisters. You'll find fact sheets, videos, toolkits, and personal stories. They also have information for young siblings and adult siblings.

Children of Parents with Mental Illness (COPMI)

www.copmi.net.au

An Australian resource for children, youth and family members of parents who experience a mental illness. Parents who experience a mental illness can also learn more on talking about mental illness with their family. Policy-makers and services providers may also be interesting in a BC resource, Parental Mental Illness, at www.parentalmentalillness.org.



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