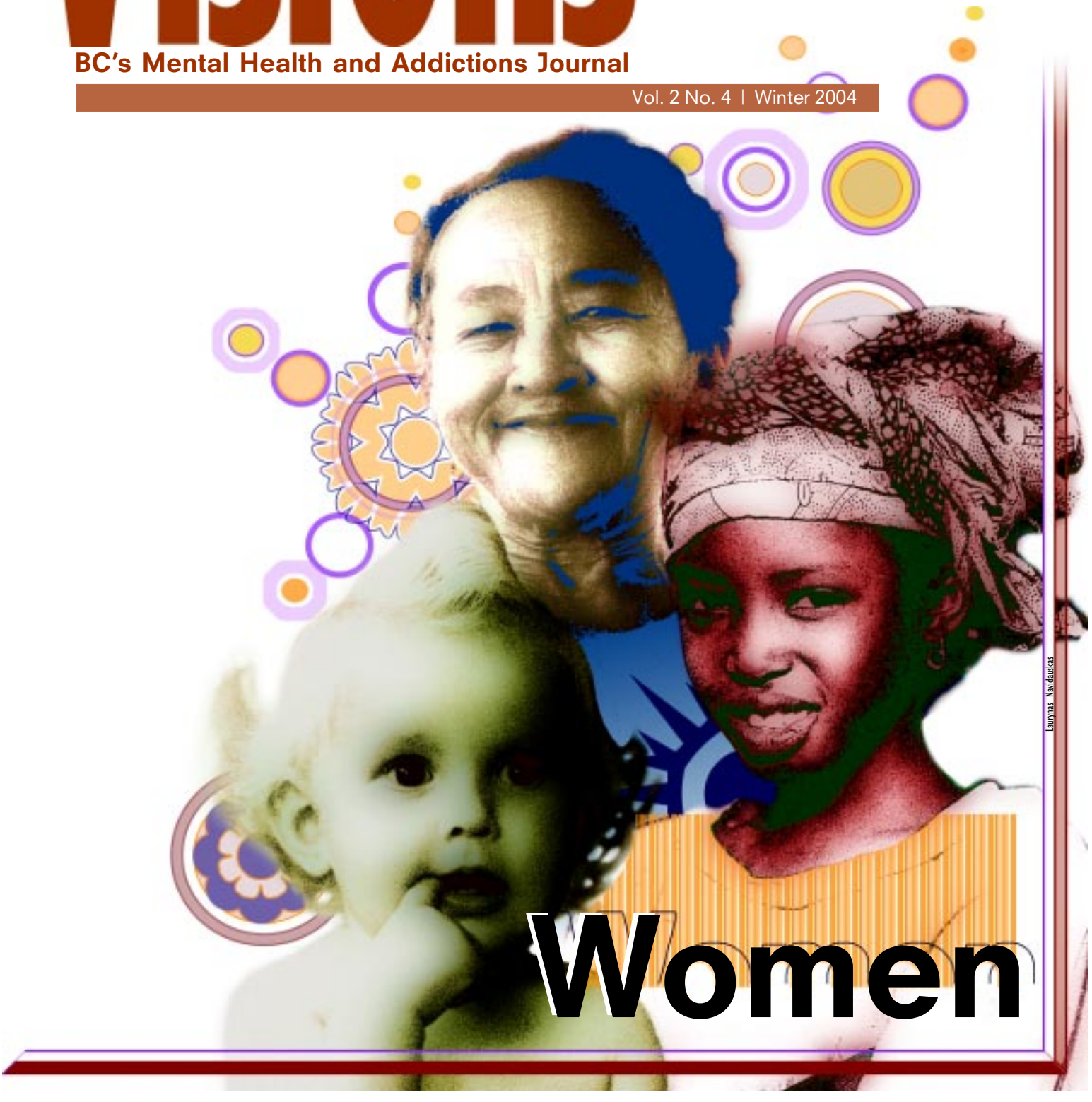
BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

Vol. 2 No. 4 | Winter 2004



Laurynas Navidauskas

Women

background

3 Editor's Message Christina Martens
4 Measured Steps...Toward Big Leaps? [guest editorial] Nancy Poole
6 Mental Health and Substance Use: Why women? Marina Morrow
7 Embodying Beauty: The time has come Tannis Hugill
8 Women and Benzodiazepines Frances Kirson
12 Depression and Anxiety Barriers for One in Five Working Women
13 Women Bear the Brunt of Role Overload
13 Painful Pasts: Post-Traumatic Stress in Women Survivors of Canada's Indian Residential Schools Ingrid Söchting
15 Violence Against Women and Substance Use in a Rural Context Sheila Dick and Colleen Varcoe
16 How Widespread are Eating Disorders? Misconceptions and realities Erin C. Dunn and Josie Geller
18 Anxiety in Pregnancy and Postpartum Nichole Fairbrother
19 Breastfeeding: Cautions and concerns Anne Price

experiences & perspectives

21 You Are Mother Dawn-Marie Tytherleigh
22 Women Need Community Support to Survive Laraine Michalson
23 Post-Traumatic Stress and Substance Use Sally Gose
25 Continuing the Journey: A way back from trauma and substance use Katherine B. Oxner and Veronica Brown
26 My Fall From Grace: Exercise, well-being and medication side effects Cynthia Row
27 On the Road Again S. Linda Walker
28 Bingeing and the Blues Victoria Maxwell
29 My Eating Disorder Caitlin M.

alternatives & approaches

30 Moving Forward with Women's Addiction Treatment in BC Carol Savage
31 Good Drugs, Bad Drugs: Pregnancy, substances and social attitudes Susan Boyd
32 Substance Use and Indo-Canadian Women Kalyani Vittala and Nancy Poole
34 The 16 Steps for Discovery and Empowerment: An alternative to 12 Step programs Candace Plattor
36 Finding—and Sticking with—Medication that Works Linda Pook
37 Body Image and Physical Activity: New perspectives for self-care Kate Maliha
38 Focusing on Healing: Disordered eating, trauma, addictions Judy Lyon

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, Awareness and Networking around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to the Provincial Health Services Authority for providing financial support for the production of Visions

regional programs

39 Changes in Substance Use, Violence and Stress Among Women in Transition Houses in Rural Areas Lucy McCullough, Natasha Jategaonkar, Lorraine Greaves, Cathy Chabot, and Nancy Poole
40 Structured for Success: Working with adults affected by FASD Jeanette Turpin
41 Harm Reduction and Housing: YWCA Crabtree Corner Wendy Lund
42 Fir Square at BC Women's Hospital: Maternity care and substance misuse Yalile Seaman
43 Effective Treatment for Women with Substance Use Problems: Aurora Centre's approach Gail Malmo
45 Seeking Solace and Safety: Trauma-informed training at Riverview Kathleen Whipp
47 Pregnancy Outreach Programs Maria Burglehaus
48 Resources

promotions & advertisements

24 Provincial Health Services Authority
33 Jack Hirose and Associates
35 Release of the BC Partners' Family Toolkit: A new resource for family members

This edition of *Visions* marks a fairly dramatic change in the way the magazine is created. Eric Macnaughton, *Visions*' long-time researcher and editor, has gone on to pursue his PhD. His contributions have been immense and his will be a difficult role to follow. I am filling in one part of his work by taking on the challenging role of policy/issues editor. We have, as in the past, a guest editor. Many thanks also to our new structural editor, Vicki McCullough, as well as Cynthia Row, Sarah Hamid-Balma and the entire story line committee for pulling all the ideas together.

This edition focuses on the issues and experiences of women and girls with mental health and or addiction issues. Some of the work is controversial, some is technical, all are meant to make us think through our long-held assumptions about what living with mental illness or addiction mean to women and girls and the relevance of using a gender lens in designing policies and services. Gender plays a key role in diagnosis, treatment, stigma, and recovery. And not just for women. Our next issue of *Visions* looks at the issues that men and boys face. The differences may astound you, or they may simply reaffirm that while we have come a long way in the diagnosis, treatment, and support for persons living with these conditions, we still have a long way to go.

We present to you articles that cover a range of issues: eating disorders; illness/addiction and mothering, differing services that work with women who have mental illness and/or addictions, rural issues, benzodiazepines and workplaces. What we have been unable to do is to include articles on all possible issues. Notable by their absence are articles on women and poverty/homelessness or women in the sex trade; what happens when a physical problem is also present; more examples of how culture and social role play a part in women seeking treatment and how services can adapt for them; the diagnosis, treatment, and service for women with personality disorders; other reproductive mental health issues beyond postpartum and pregnancy such as menopause or premenstrual dysphoric disorder; and more articles featuring girls and young women, just to name a few.

Christina Martens

Christina is Executive Director of the Canadian Mental Health Association's Mid-Island Branch. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria

subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge. You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website at www.heretohelp.bc.ca/publications. Contact us via any of the means listed below to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online.

contact us

Mail: Visions Editor
c/o 1200-1111 Melville Street
Vancouver, BC V6E 3V6
Tel: 1-800-661-2121 or (604) 669-7600
Fax: (604) 688-3236
Email: bcpartners@heretohelp.bc.ca
Web: www.heretohelp.bc.ca

editorial board | Nan Dickie, Dr. Raymond Lam, Victoria Schuckel, plus representatives from each BC Partners member agency
policy/issues editor | Christina Martens
structural editor | Vicki McCullough
editorial assistant | Cynthia Row
production editor/design | Sarah Hamid-Balma
printing | Advantage Graphix

Measured Steps...Toward Big Leaps?

Nancy Poole, MA

Nancy has over 20 years experience in knowledge translation, research, policy and practice relating to women and substance use issues. She currently works as Provincial Research Consultant on women's substance use issues, based at the Aurora Centre at BC Women's Hospital, a role which involves evaluative research and knowledge translation efforts on the provincial and national levels on women's substance use and its treatment. Nancy also works with the BC Centre of Excellence for Women's Health on research related to women's health and substance use that is designed to inform policy and service provision. She also teaches on substance use issues through the Justice Institute of BC

It is a pleasure to introduce this issue of *Visions*, with its focus on women's mental health and substance use concerns. This issue is a testament to the many steps we have taken toward understanding the connections between these issues, and to the big leaps still needed to provide integrated, women-centred prevention, harm reduction and treatment.

Since 1993, I have worked on substance use programming, evaluation and research in British Columbia. In that time period, much progress has been made, but at the same time, we continue to learn more about the complexities of the links between women's mental health, substance use and other health concerns.

I have had the opportunity to collaborate with many of the contributors to this issue of *Visions* through my involvement with BC Women's Hospital and Health Centre and the Vancouver and Area Women's Addictions Services Providers Network. Others I have met on collaborative research teams on substance use, fetal alcohol spectrum disorder, disordered eating, and mental health and violence issues, with the British Columbia Centre of Excellence for Women's Health.

Many of the articles and narratives here illustrate just how difficult the lives of many women are. So often, our addictions and mental health systems have forced women to focus on only one, or more recently two, problems at a time—at great cost to the women who need to understand their experience of multiple burdens and to receive more holistic support.

Bringing in the voices of women who are consumers of mental health services, survivors of trauma and/or who are reducing harm from substance misuse or are in recovery helps us see the ways we can be compassionate to women carrying multiple burdens, and see how to make our programs and policies much more flexible and comprehensive. These stories also remind us of how, within our experiences as women, there is so much difference. The challenge is to recognize both our oneness and our diversity.

The evidence of need for a women-centred health care response continues to mount. Marina Morrow's article discusses the benefits of research that investigates how sex and gender interact to produce conditions that are unique to, more prevalent among, or more serious for a particular sex, or that have different risk factors or interventions for women and men.[1,2] And in November 2004 alone, news of new research poured in: on associations between marital quality, social support and depressive symptoms in women;[3] on increase in date rape drugging;[4] on the connection between women's work stress and greater vulnerability

to anxiety (see p. 12); and increased alcohol consumption after the terrorist events of September 11.[5]

It is striking how often violence and sexual assault is mentioned as linked to mental health and substance use. The Canadian Research Institute for the Advancement of Women reports that half of Canadian women have survived at least one incident of sexual or physical violence, that over a quarter of Canadian women have been assaulted by a spouse, and that girls, more so than boys, are targets of abuse within the family (79% of family-related sexual assaults are on girls).[6] Thus it is very encouraging to see the articles here from BC-based services that have been able to integrate 'trauma-informed' care.[7] Integrated services for women with co-occurring disorders and trauma histories are being developed in other countries as well.[8] This integration of issues is definitely an important and long-overdue direction in responding to women's mental health and substance use issues.

Women's experience of substance use, mental health and violence in pregnancy is another theme in the articles here. Nichole Fairbrother illustrates how far we have yet to go to provide care for pregnant and postpartum women with mental health problems. Other articles, however, describe the hopeful programming being developed by BC Women's Hospital, Sheway, the Northern Family Health Society and the 40-plus Pregnancy Outreach Programs across BC. These service providers all recognize and address the multiple connections between women's physical health, nutrition, mental health, income security, roles as mothers, discrimination, experience of isolation, and violence and substance use. They also continue to explore how we can best provide harm reduction-oriented and holistic care in this critical period of women's lives, in a way that focuses equally on women's and fetal health—honouring their inextricable nature. These are important steps toward creating a welcoming treatment system for pregnant women.

Many contributors have been long-term advocates of women's health, and, like Carol Savage, are concerned about maintaining and expanding a focus on women's addictions and mental health services. Two recently released provincial frameworks support system-wide change in this direction. *Every Door is the Right Door*, a provincial strategic planning framework on addiction, advocates a more comprehensive, gender- and diversity-sensitive service system, built on the foundations of population health, health promotion, harm reduction and community involvement.[9] *Advancing the Health of Girls and Women*, the recently released women's health strategy for British Columbia, identifies "supporting women-centred approaches to mental health and problem substance use and addiction for girls and women" as one of three initial priorities.[10]

Now our interdependent work as researchers, policy makers, program providers and women's health advocates becomes even more crucial in order to realize these visions in policy and service system design. As this edition of *Visions* reveals, much has been accomplished in improving our research, programs and policy regarding women's mental health and substance use issues, but there remains a giant leap to be taken to truly provide a comprehensive and positive response to women.

footnotes

1 Greaves, L., Hankivsky, O., Amaratunga, C. et al. (2000). *CIHR 2000: Sex, gender and women's health.* Vancouver, BC: BC Centre of Excellence in Women's Health.

2 Pinn, V. & La Rosa, J. (1992). *Overview: Office of Research on Women's Health.* Bethseda, MD: National Institutes of Health.

3 Spotts, E., Neiderhiser, J., Ganiban, J. et al. (2004). Accounting for depressive symptoms in women: A twin study of associations with interpersonal relationships. *Journal of Affective Disorders, 82*(1), 101-111.

4 Picard, A. (2004, November 5). 'Date-rape drugging' increases dramatically. *Globe and Mail*, p. A13.

5 Richman, J.A., Wislar, J.S., Flaherty, J.A. et al. (2004). Effects on alcohol use and anxiety of the September 11, 2001, attacks and chronic work stressors: A longitudinal cohort study. *American Journal of Public Health, 94*, 2010-2015.

6 Morris, M. (2002). *Violence Against Women and Girls.* Retrieved November 8, 2004, from www.criaw-icref.ca

7 Harris, M. & Fallot, R.D. (2001). *Using Trauma Theory to Design Service Systems.* San Francisco, CA: Jossey-Bass.

8 Moses, D.J., Huntington, N. & D'Ambrosio, B. (2004). *Developing Integrated Services for Women with Co-occurring Disorders and Trauma Histories*. Retrieved November 15, 2004, from www.wcdvs.com/pdfs/LessonsFinal.pdf.

9 BC Ministry of Health Services. (2004). *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction.* Victoria, BC: Author.

10 BC Women's Hospital and Health Centre and BC Centre of Excellence for Women's Health. (2004). *Advancing the Health of Girls and Women: A Women's Health Strategy for British Columbia.* Vancouver, BC: Authors.

The Summer 2004 issue of *Visions* included many valuable articles on mental health and the variety of sources of help available to families. One source of help was overlooked: school-based peer support programs. These programs provide trained and supervised young people who can and do provide friendly and nurturing support to their peers and who, in some cases, know what it's like to be in recovery from mental illness. While peer pressure has a notorious reputation as a source of negative or problem behaviour or may be seen as creating mental health problems through bullying, harassment, taunting, ridiculing, name-calling, and cruelty, schools that have peer support programs provide a healthy environment for students struggling with mental illness. Peer helpers are not a substitute for professional assistance, but they can often act as a referral source, and, as recent studies have shown, provide the support necessary for students to seek professional help for what is troubling them. From a parent's perspective, the awareness that a school provides such a program and that their son or daughter is likely to have contact with supportive, positive-influence peers, can be a great relief and source of hope for healthy recovery. For more information about peer support, visit www.peer.ca/peer.html or call toll-free 1-800-567-3700.

Rey A. Carr, PhD, Peer Resources, Victoria, BC

I have been forwarded your website and the link to the *Visions* publication via the Executive Director of Children's, Women's and Senior's Health at the Ministry of Health Services. I have been aware of *Visions* for some time and have continued to find the articles informative, useful and engaging. Of particular relevance to our area of work is the information around women's, mothers' and children's mental health and/or addiction issues. I was glad to see the article "When Bliss Turns into Blues," by D. Ryan and D. Bodnar, in the Spring 2004 issue. Considering that postpartum depression affects anywhere from 12 to 16% of women in the first year after they give birth, it is important that we educate all members of our community as well as we can. We appreciate all the support and education you provide in the mental health and addictions area and encourage you to continue. I look forward to your next edition of *Visions* and will advise others that I work with of this useful resource.

Joan Geber, RN, BN, MPA
Director, Maternal and Women's Health
Ministry of Health Services, Population Health and Wellness

we want your feedback!

If you have a comment about something you've read in Visions that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3.

Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence.

All letters are read. Your likelihood of being published will depend on the number of submissions we receive.

Mental Health and Substance Use
Why women?

Marina Morrow, PhD

Marina is Research Associate with the BC Centre of Excellence for Women's Health where she heads a program of research on women and mental health. Marina also teaches women's studies at UBC

Those of us who have spent much of our careers championing the concerns of women with mental health and substance use problems are often asked: "Why the focus on women? Don't men have these problems too?" The simple answer is that, yes, both men and women suffer from mental health and substance use problems.

Men and women are products of their differing social environments. Attention to gender is necessary for understanding how mental health and substance use problems are expressed and experienced differently by women and by men.

Historically, most medical scientists have been men who studied men and we therefore have a body of knowledge that reflects this bias. Also, the current biomedical focus in mental health and substance use research has pushed examination of the social determinants of health into the background. Biological and genetic factors are critically important components of research in the mental health and addictions fields; however, integrative approaches—those which take into account the biological, psychological and social determinants of mental health and substance use problems—make for good scientific practice.

In order to counter these biases in scientific research and practice, researchers concerned with women's lives have had to build a new body of knowledge addressing the problems specific to women. The work of building this body of scientific knowledge has begun; however, what is known is not always integrated into policy and practice on mental health and substance use.

It remains an important task to not only highlight what is known about women, but to advocate for research—and practice—that applies a 'gender lens.' Research and practice must recognize that gender shapes our lived experiences, our expressions of distress, and the ways in which the helping professions respond to us.

In applying a gender lens, it is extremely important that we also recognize the differences among women. Women are not all the same. Their lives and experiences are shaped by their race, ethnicity, culture, sexual orientation, gender identity, social class and physical abilities. And their lives may be variously marked by inferior social status, impaired self-esteem, sexual abuse, sexual discrimination, economic inequities, restricted education and employment opportunities, and the greater burden of family caregiving.

Psychosocial explanations of mental health and substance use problems consider how socialization into the female gender role makes women more vulnerable to poor mental health. A psychosocial approach would look at how the socialization may result in lower self-esteem and greater vulnerability to depression, and the ways in which particular social roles and experiences may be associated with poorer mental health and substance use.

Understanding women's lives and their unique mental health and addictions—and incorporating that understanding into policy and practice—is an important goal for researchers, policy makers and practitioners. In support of this goal, the articles in this edition of *Visions* provide a window into specific aspects of the lives of diverse women who suffer from mental health and substance use problems.

Applying a gender lens in the field of mental health and addictions promotes better scientific research, enhances mental health outcomes, and strengthens mental health care and policy.

Let us hope that soon the commonly asked question will no longer be "why women?" but rather, "how can we design research, practice and policy to help us better understand and respond to the similarities and differences between women and men and their experiences of mental health and substance use problems?"

did you know that...

- Women are about twice as likely as men to experience depression and anxiety, while men are about four times more likely than women to have substance use problems or antisocial behaviours.
- There is an established association between poverty, mental illness and substance use problems. Women, especially elderly women, Aboriginal women and single mothers tend to be much poorer than men.
- Learning to adapt to a new culture may place unique stresses on the mental health of immigrant women.
- Experiences of racism worsen the mental health and substance use problems of women of colour.
- Women more often than men are the victims of intimate violence and sexual abuse, both of which are associated with mental health and substance use problems.
- For women with mental health and substance use problems, reactions to experiences of violence, and symptoms related to anxiety and depression, are common.

Embodying Beauty
The time has come


Laurynas Navidauskas

Ideals of beauty are a part of every culture. If we look at images throughout Western history alone, we can see how these ideals change according to what is valued and needed by the culture. Historically, women's bodies have been the primary images of human beauty. Women have long been valued mainly for pleasure, adornment, and birthing children.

Often a culture's ideals oppress the body. This is true today; the oppression of women and the 'cult of thinness' are linked to a view that sees all living bodies as objects. We live in a society that emphasizes the surface, not the substance, of the human being. After over 25 years of feminism, a woman's self-image, as well as her social and economic success, is still largely determined by her looks.

Standards of beauty are often intertwined with fashion. How we choose to dress is a complex cultural phenomenon—it's a way we create ourselves, participating in cultural norms of acceptance and self-expression. This helps us to connect, while affirming our differences.

Slenderness came into fashion in North America and Europe at the turn of the 20th century. It came to be the aesthetic of modern mechanization and coincided with the increasing freedom of women.

Fat phobia began after World War II, when the health industry and insurance companies began to persuade Americans to lose weight, and this phobia intensified throughout the 20th century. Weight loss techniques proliferated, the fitness craze developed and plastic surgery expanded. The bare-boned adolescent image of Twiggy appeared in the 1960s. In 1950s, models weighed 4% less than the average woman. Now, fashion models weigh 25% less than the average woman—a diagnostic criterion of anorexia nervosa.

The current fascination with altering the body is poignantly demonstrated by the popularity of 'reality' TV shows, such as *Extreme Makeover* and *The Swan,* in which people undergo plastic surgery in the quest for a more desirable look.

Weight prejudice in this culture is rampant and not significantly challenged. 'Fatism' is as damaging as sexism or racism. The corporate, advertising and cosmetic worlds, and the diet and cosmetic surgery industries, have huge amounts of money invested in deluding us into starving, cutting and mutilating our bodies. In this social environment, where normal-weight women are considered overweight or 'fat,' it's no wonder that so many women and girls have the negative body image and chronic low self-esteem that lead to eating disorders. At the same time, more and more people are poorly nourished from eating fast foods, and obesity is on the rise, causing a new wave of fat phobia. The pressure to be thin is now affecting men; one in 10 people with eating disorders now are men and boys. These are life-denying standards of beauty.

The mandate to be ultra thin is everywhere—magazines, newspapers, billboards, movies, television, stores, and so on. The cult of thinness promises that if we fit this image, we will be successful and happy. We are brainwashed at a subconscious level, so we cannot see that the promise is false. We live in stressful times and we displace anxiety to things we imagine we can control—how our bodies look, for instance. Driven by guilt and shame, many people punish themselves, diet, limit their self-images, disable their imaginations, and find themselves in a spiral of sado-masochistic self-hate.

We must break this addictive pattern. Cultures are made up of individuals. If we become media literate, develop a healthy relationship to food, nourish our self-esteem by loving the bodies that we have, and focus on what really fulfills us, we can challenge the collective obsession with distorted ideals of perfection. We can discover the true beauty that is our birthright. We can talk to each other and validate the ways each of us is beautiful—inside and out.

By joining together, speaking up and stepping out, we can create and celebrate new images of beauty that reflect the diversity and humanity of all. i

Tannis Hugill, MA, RCC, RDT, ADTR

Tannis has over 20 years experience in healing through the arts. This includes directing a hospital eating disorder program and teaching somatic approaches to the treatment of eating disorders. She is a registered clinical counsellor, dance and drama therapist, creator of ritual performance, and teaches Authentic Movement. Please contact Tannis at (604) 267-9951 or tannisis@shaw.ca

Women and Benzodiazepines

Frances Kirson, MA

Frances is a certified personal and executive coach, educator and community researcher. She has over 20 years experience working with women on lifestyle management, gender and development, and social justice issues

Frances prepared this article in 2002 based on the results of a community-based research project developed by principal investigator Nancy Hall, PhD, and funded by the BC Health Research Foundation and supported by the BC Division of the Canadian Mental Health Association and the BC Women's Hospital and Health Centre. Reprinted with permission from the Women's Addiction Foundation

What are benzodiazepines?

Benzodiazepines are a family of prescription drugs commonly known as tranquillizers and sleeping pills. These medications were originally designed for short-term relief of anxiety and/or sleeping problems. They are also used to ease withdrawal from other drugs.

About 16 different benzodiazepines are available in Canada today. In the 1960s when benzodiazepines were first prescribed, Valium (diazepam) and Librium (chlordiazepoxide) were the most common kinds. (The first word is the brand name; the second word is the generic name). Both drugs are still in use today. Other benzodiazepines prescribed by Canadian doctors are:

- Ativan (lorazepam)
- Restoril (temazepam)
- Halcion (triazolam)
- Rivotril (clorazepam)
- Xanax (alprazolam)
- Tranxene (clorazepate)
- Serax (oxazepam)
- Mogadon (nitrazepam)
- Somnal/Dalmane (flurazepam)
- Klonopin (clonazepam)
- Imovane (zopiclone), a hypnotic similar to a benzodiazepine

Women and benzodiazepine use

Many women are prescribed benzodiazepines when they tell their doctor about being anxious or having panic attacks. Other women are given benzodiazepines because they are in emotional pain or grieving a loss. Others are given the drug because they are experiencing trauma, chronic illness, physical pain and/or sleep problems. It is also common for women to be offered benzodiazepines if they are going through a divorce or are in a period of physical change, such as adjusting to a new baby or menopause. Still other women use benzodiazepines to deal with long work hours or a stressful job.

More women than men are prescribed benzodiazepines. Indeed, women in British Columbia are prescribed benzodiazepines at a rate two times higher than men. This discrepancy is a sign of a serious social problem. Many people believe that women are over-prescribed benzodiazepines: offered a mood-altering drug rather than the human support they need to cope with difficult life circumstances.

Many women do have too much stress and anxiety in their lives. They may be taking care of children, elderly parents, husbands and jobs with very little assistance. Women often have no time to look after themselves, physically or emotionally. They are more likely than men to be living in poverty as single parents or as seniors. Yet these are social and economic problems that will not be solved by giving pills to women. The real solution is to provide women with services and community support.

How benzodiazepines are prescribed

Benzodiazepines were originally intended for short-term use only, seven to 10 days at most. However, many women are given prescriptions for much longer periods. A doctor will often prescribe benzodiazepines month after month without a follow-up visit to discuss the woman's progress. Some doctors prescribe more than one type of benzodiazepine at the same time. Other doctors switch a woman from pill to pill if the old prescription stops being effective. A woman may be given a second benzodiazepine if she has negative side effects from the first.

Today, benzodiazepines are typically prescribed in four ways:

- in a single dose to cope with a specific event (e.g., surgery, plane ride)
- for short-term use up to four weeks (e.g., after a death in the family)
- for a set period exceeding one month (e.g., during a stressful divorce)
- for long-term use, with no end date

Many women slip from short-term use into long-term use. This often happens when the doctor fails to do any follow-up, or when the woman is not offered any community support or counselling.

The problem with benzodiazepines

Are benzodiazepines addictive? The answer is yes, if we listen to women's stories. Prolonged use of tranquillizers and sleeping pills can result in physical and mental dependency. Some doctors and scientists disagree about the risk, claiming that benzodiazepine addiction is not a real possibility. The fact remains: many women find themselves hooked on benzodiazepines.

Every woman is vulnerable to addiction, regardless of her background, income, education and age. Some women find themselves dependent on benzodiazepines after their trusted family doctor prescribed the drug. As a result, they can feel angry,

confused, afraid, isolated, betrayed or ashamed. Other women get benzodiazepines 'on the street' to manage the pain in their lives or to deal with withdrawal from illicit drugs. They too may find themselves feeling trapped and ashamed.

Every woman must evaluate the benefits of using benzodiazepines against the dangers of becoming addicted.

The signs of dependency

The signs of benzodiazepine dependency include:

- feeling unable to cope without the drug
- making unsuccessful attempts to quit or cut down on the number of pills you take
- craving the drug
- feeling extreme discomfort (mental or physical) if you miss a pill
- going to great lengths to ensure your pills are always close by
- monitoring your supply to make sure you don't run out
- taking 'extra' pills when a situation is stressful
- taking more pills or trying different brands because the effects are wearing off
- increasing your dose over time
- noticing that the drug's effects are wearing off

Benzodiazepine use is also associated with accidents. Women are advised not to drive when taking the drug. The risk of falling due to benzodiazepine use is a serious concern for seniors and people with certain medical conditions. For example, women with low bone density can easily break a hip during a fall.

Masking the real problem

The short-term use of tranquillizers and sleeping pills can be a helpful part of an overall plan to deal with anxiety or sleeplessness. But the drugs take care of symptoms only, not with the underlying problem. For true relief, a woman needs to get at the root cause of her distress.

It is easy to become dependent on benzodiazepines. For one thing, the pills 'work well' at the beginning. Many women find it easier to take pills for 'just one more day' rather than to tackle the root problems. This is very understandable given how little social support there is for women in crisis or emotional pain.

Tackling the problem

Many women reach the point where the negative effects of taking benzodiazepines outweigh the original benefits. They no longer want to cover up the reasons for their anxiety or sleeplessness. This is an important, life-altering stage, but any changes in benzodiazepine use must be made slowly and in consultation with medical professionals.

▶ Do not suddenly stop taking benzodiazepines. 'Cold turkey' withdrawal is extremely dangerous and can cause lifelong, negative side effects.

▶ If you have decided to cut back or stop using benzodiazepines, try to find a supportive doctor and other health care providers who are knowledgeable about the issue.

The process of withdrawal is different for each woman depending on how long she has used the drug, the amount she uses, and her personal circumstances. The process can be difficult if she has used benzodiazepines for a long time. Withdrawal must go very slowly and gradually. Women should be under informed medical supervision during this process.

The recovery process

The recovery process includes withdrawal, healing, finding personal supports and learning new coping mechanisms.

Recovery begins when a woman makes a commitment to herself to stop using benzodiazepines. Her goal is often to replace them with more positive coping skills.

Although each person's experience of withdrawal from benzodiazepines is unique, women also have many common experiences. Support is an essential part of recovery. Every woman benefits from having a safe, confidential place to talk and listen. This basic support makes a world of difference to day-to-day survival and long-term success. By learning positive coping skills and seeking support, women find it easier to deal with life's many difficulties, from grief, pain, chronic illness, insomnia, cultural changes and divorce, to aging and death.

withdrawal symptoms

Benzodiazepine withdrawal has many symptoms. Some lucky people do not feel any negative effects. But most women will experience some, or all, of the following symptoms (the list is partial):

Common symptoms

- increased anxiety and panic attacks
- flu-like symptoms
- hypersensitivity to light
- depression or "the blues"
- excitability, jumpiness, restlessness
- poor memory and concentration
- dizziness and light-headedness
- weakness, tremours or shaking
- heart palpitations, sweating
- nausea, indigestion, bodily pains
- changes in sight, hearing and other perceptions

Less common symptoms

- tightness, like a band around the head
- feelings of depersonalization (the loss of one's sense of identity)
- suicidal thoughts, paranoia
- tingling, numbness
- hallucinations
- outbursts of rage and aggression
- pins and needles, other skin sensations
- hypersensitivity to sound or touch
- increased saliva, difficulty swallowing

benzodiazepines: rates and trends

this sidebar is contributed by the BC Partners for Mental Health and Addictions Information, 2004, and did not originally appear with the preceding article on benzodiazepines

Specific Populations

Although the benefits and risk of benzodiazepine use should be carefully measured in all populations, the biological, psychological, and social factors in certain populations call for further special considerations when using benzodiazepines.

Gender

Women make up to 65% of all adults who are taking benzodiazepines. Some studies suggest that women are prescribed benzodiazepines at twice the rate of men[1,2] and for longer periods of time than men.[1,3] Several factors may contribute to this phenomenon, including the higher incidence of anxiety and mood disorders in women[4,5] and the possibility of increased anxiety and sleep problems related to the reproductive processes of menstrual cycles, pregnancy, postpartum and menopause. Other conditions that affect women more commonly than men like sexual assault, domestic violence, poverty, and single parenting may increase their vulnerability to anxiety, panic, mood, and sleep disorders. All of these factors can result in significant stress, but not all will lead to a clinical syndrome warranting a medication. Thus, a careful diagnostic assessment is essential and non-pharmacological solutions and interventions should first be utilized in women presenting with some of the above factors.

Pregnancy and Lactation: benzodiazepines and their metabolites freely cross the placenta and are excreted into breast milk.[6] Prolonged use of benzodiazepines is not recommended in breastfeeding and in pregnancy.[7] As the newborn's ability to metabolize benzodiazepines is limited, they may accumulate in the baby's blood when breastfed. If given in the first trimester, there is an increased risk of congenital malformation (the most common being a 0.4% risk of cleft palate with the use of diazepam[7]). In addition, ongoing use of benzodiazepines in pregnancy can result in withdrawal symptoms in the newborn.

Youth

In general, the developing brain of childhood and adolescence is more sensitive to the central nervous system effects of most medications. Younger individuals on benzodiazepines often encounter enhanced sedation, cognitive and motor effects. In addition, benzodiazepine side effects of agitation and irritability are more common in children—particularly those who are mentally challenged. ▶

Barriers to getting help

The stigma of drug addiction

For most women, the biggest barrier to getting help is the stigma of drug addiction. Women often suffer in silence and isolation because they feel ashamed of their dependency on benzodiazepines. This is particularly true for a woman who trusted her family doctor and unknowingly became addicted to a prescription drug. She may fear the judgement of friends and family who discover she is hooked on a pill that was supposed to help her.

Lack of treatment programs

Another barrier is the lack of treatment programs specifically designed for women. For example, women with children or other dependants need programs that take account of their caregiving responsibilities. There are also very few programs that understand the particular features of benzodiazepine addiction and withdrawal.

What works?

Self-help options

New options are gradually becoming available to women who want to deal with their benzodiazepine use. Among the most promising are self-help circles: groups in which women can tell their story and get support from women in similar situations. In the circle, women share information about what helped them to recover and where they got stuck. The circles are a safe place for women to talk without being judged, go at their own pace, and just listen if they wish.

Awareness

An increasing number of organizations that provide health services to women are becoming better informed about benzodiazepine use. They are learning to provide specialized services to women with benzodiazepine problems; some are offering recovery services to addicted women.

Outpatient withdrawal

Outpatient withdrawal management options are also being developed. These programs provide a woman with a safe withdrawal process adapted to her individual medical and personal needs, without requiring that she stay in a hospital or treatment facility. Unfortunately, these programs are scarce and often underfunded.

Internet Support

Some women are using personal computers to connect with other women in recovery. They can email each other about their histories of using and withdrawing from benzodiazepines. Women can find this a safe, comfortable way to get information and support because they need not identify themselves. There are also a growing number of websites with up-to-date information on benzodiazepines. i

For a list of print, online and community resources, please see the Internet version of this article at www.womenfdn.org/Resources/info/benzolng.htm or call the BC Mental Health Information Line at 1-800-661-2121 for resources in your area

Elderly

The elderly commonly experience health problems such as insomnia, anxiety, and depression that can lead to prescription benzodiazepine use. Some factors that may result in increased benzodiazepine side effects and toxicity in the elderly include:

a) benzodiazepine accumulation as liver metabolism slows down with age
b) increased brain sensitivity to adverse effects
c) increase in general medical problems
d) increased likelihood of being on more than one medication, with certain medication combinations possibly interfering with metabolism and/or enhancing central nervous system effects.

The cumulative result of the above factors may include more sedation, confusion, behaviour problems, and impairment in memory, balance and coordination in the elderly. There is a higher risk of motor vehicle accidents and falls in the elderly.[6] Some current data suggest that the use of benzodiazepines by older persons increases their risk of hip fracture by at least 50%.[2] Those using higher doses and/or those who had recently started benzodiazepines were at the highest risk of hip fracture.[2]

Some people can experience extreme side effects, regardless of their age. However, as the body ages, it becomes more sensitive to medication. Illness and disease further increase the body's sensitivity. Seniors, then, are particularly vulnerable to side effects from benzodiazepines.

~ Women's Well-Being Group project. (1999). *Tranquility without tranquilizers.*

Are prescriptions increasing?

Here is a look at the issue in context.

British Columbia context

BC is well below the average Canadian rate for benzodiazepine tablet dispensing per capita.[8] The Mental Health and Addictions Branch of the BC Ministry of Health Services recently reviewed the Pharmanet database for benzodiazepine utilization in BC from the fiscal years 2000-2003. Their analysis showed no significant change in the number of persons receiving benzodiazepine over those three years and benzodiazepine use was less than the prevalence of anxiety disorders (7.5% vs. 10%). BC psychiatrists prescribe more benzodiazepines than general practitioners (GPs), but GPs on average prescribe to a larger number of patients. The vast majority of benzodiazepine users (>80%) receive only one type of benzodiazepine, however about 30% receive prescriptions that would last six months in duration, indicating long-term use. The elderly are particularly vulnerable to longer-term benzodiazepine use, more so than younger populations in BC.[1]

Canadian context

Benzodiazepines are widely used in Canada. Information from the Centre for Addiction and Mental Health indicates that about 10% of Canadians report using a benzodiazepine at least once a year, and continue using them for at least a year. Since each province is responsible for monitoring its own use of prescription medications, there is limited data on national trends for benzodiazepine use. Based on data from Canadian retail pharmacies on the number of benzodiazepine tablets dispensed per capita per province, there is not an overall increase in the use of benzodiazepines per capita from the years 1997–2001. The Eastern provinces of New Brunswick, Nova Scotia, and Quebec have the highest rates compared to the western provinces of BC, Alberta, and Saskatchewan with the lowest rates.[8]

footnotes

1 Anderson, J.F. & Scott, D. (2004). *Overview of Pharmanet Benzodiazepine Utilization Data to Inform Decision-Making Regarding Interventions Targeting Long-term Utilization of Benzodiazepines.* Victoria, BC: BC Ministry of Health Services, Mental Health and Addictions.

2 Cumming, R.G. & Le Couteur, D.G. (2003). Benzodiazepines and risk of hip fractures in older people: A review of the evidence. *CNS Drugs, 17*(11),825-837.

3 Jorm, A.F., Grayson, D., Creasey, H. et al. (2000). Long-term benzodiazepine use by elderly people living in the community. *Australian and New Zealand Journal of Public Health, 24*(1), 7-10.

4 American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: APA.

5 National Institute of Mental Health. (2001). *The Numbers Count: Mental Disorders in America.* Retrieved November 15, 2004, from www.nimh.nih.gov/publicat/numbers.cfm

6 Bezchilibnyk-Butler, K.Z. & Jeffries, J.J. (1998). *Clinical Handbook of Psychotropic Drugs.* Toronto, ON: Hogrefe & Huber Publishers.

7 Canadian Pharmacists Association. (2002). *Compendium of Pharmaceuticals and Specialties: The Canadian Drug Reference for Health Professionals.* Toronto, ON: Webcom Ltd.

8 IMS Health Canada. (2002). *Canadian Compuscript Audit: Estimated Number of Benzodiazepine Tablets Dispensed per Capita in Canadian Retail Pharmacy.* Pointe-Claire, QC: IMS Health Canada.

Depression and Anxiety Barriers for One in Five Working Women

One in five working women report having depression or anxiety, and the majority of these women say that symptoms are their greatest barriers to success in the workplace, according to a new national survey.

Researchers screened 7,260 working women from across Canada for depression and/or anxiety, and then surveyed 1,508 women from that group who met the criteria for major depressive disorder or generalized anxiety disorder, or who were already diagnosed. Most of the women surveyed were between the ages of 35 and 55, lived in a city or suburban community, and had children. Most occupation types, education levels and income segments were represented in the survey.

Adapted from Mental Health Notes, *November 19th, 2004 edition, the e-newsletter of the Canadian Mental Health Association's Ontario Division. Available online at www.ontario.cmha.ca/content/reading_room/mhnotes.asp? cID=5252*

The research was conducted by Léger Marketing for Wyeth Canada, a pharmaceutical company, in association with the Canadian Mental Health Association's National office and Our Sisters' Place, a support network for women with mood disorders associated with hormonal changes.

Women felt that their symptoms of depression and anxiety were greater barriers to their success in the workplace than other traditional barriers such as pregnancy (71% versus 23%), raising children (49% versus 44%) or sexism (54% versus 37%).

Among women with depression or anxiety, 74% said that their symptoms made them feel overwhelmed at work, 59% said that they did not feel motivated to get things done, and 44% stayed home from work. Seven per cent said they had lost their job because of depression or anxiety, while 23% had quit and 21% were on long-term disability leave.

Almost all the women interviewed (91%) wished for better and more accessible help from their employer for treatment of their depression or anxiety. According to the survey, women say employers should educate themselves and be more understanding about mental health issues, should increase the availability of counsellors at work, and should offer more company resources and make them better known to employees.

Almost half of the respondents said that their workplace offers, and they were aware of, an employee assistance program and 20% of respondents had used their workplace program (in BC, 57% had used one), with most saying they were satisfied with the help they received.

For more details, see "Depression and Anxiety among Canadian Women in the Workplace: Executive Summary," November 15, 2004, at www.legermarketing.com

The women interviewed for the survey were optimistic about the potential for remission from depression and anxiety, with 75% believing that it is possible to be completely symptom free. Most women found that their ability to work greatly improved following remission, with 86% saying they were more motivated, 84% worked more efficiently and 79% felt less overwhelmed.

7% said they had lost their job because of their mood or anxiety disorder, 23% had quit and 21% were on long-term disability leave

women bear brunt of role overload

According to a study produced for Health Canada, *Work-Life Conflict in the New Millennium*, job satisfaction and organizational commitment have declined in the last decade, just as high job stress and absenteeism have increased.

So it stands to reason that the physical and mental health of Canadian employees has deteriorated over time, from 44% reporting stress in 1991 to 55% in 2001. Sadly, this is having an impact on the very group that has been struggling for decades to have a stronger and more high-level presence in the workplace, because it's among women that the level of stress, burnout and depressed mood are more in evidence.

"Gender plays a big role," says Linda Duxbury of Carleton University, the study's principal investigator. It's not clear, the researchers say, whether women report these symptoms because they are more observant of their mental state, are less able to cope with multiple stressors or—the one I'd bet on—they have "added stressors associated with paid employment to their lives with little decrease in the stressors associated with their family roles."

Tack on motherhood, which can be associated with much more stress than fatherhood, and it's clear that women are bearing the brunt of this role-overload scenario. Up to 75% of career mothers report role overload at a time when we're moving in a declining labour market, Duxbury points out.

You would think, she says, that "we're going to make sure that we keep everybody. But in order to do that, we've got to allow them to contribute at work and at home."....

But whatever the gender, the impact on employees of work-related stress and conflict between work and family life is tangible. For the employee, we're looking at absenteeism, deteriorating mental and physical health and a low level of commitment to their work. For the employer, we're looking at a disturbing lack of enthusiasm for work. Only about half the 30,000-plus employees who participated in this study are satisfied with their job and view their organization as an "above-average" place to work. "One in three reports high levels of job stress and one in four is thinking of leaving their current organization once a week or more."

The result: a loss to the employer in terms of cold, hard cash. According to the research, "the direct costs of absenteeism due to high work-life conflict are approximately $3 billion to $5 billion per year. "When both direct and indirect costs are included in the calculations," the report states, "work-life conflict costs Canadians approximately $4.5 billion to $10 billion per year."... ❙

Excerpted with permission from Nebenzahl, D. (2003, December 31). The Prince George Citizen, *p. 31*

Painful Pasts

Post-Traumatic Stress in Women Survivors of Canada's Indian Residential Schools

Ingrid Söchting, PhD, RPsych

Ingrid is a clinical psychologist with Richmond Mental Health Services and a clinical instructor in Psychiatry at UBC

The number of Canadian Aboriginal women with a traumatic past is extremely high compared to any other racial group. Sexual abuse rates, for example, appear to be much higher than that of non-Aboriginals, and informal estimates suggest that women living on Indian reserves are especially vulnerable, with a sexual abuse incidence of about 90%. The Canadian residential school system is responsible for a significant portion of this incidence rate. The current high number of physical and sexual assaults perpetrated against Aboriginal women may also be a consequence of the residential school system. Several generations of both men and women have suffered long-term cultural and psychological damage.

This report provides a brief overview of the residential school system followed by discussions of (1) the types of psychological trauma typically seen in former residential school students and (2) the most responsible treatment approaches. The focus is primarily on issues specific to women.

Canada's residential schools

The history of residential schools for Aboriginal Canadians is described in a number of documents.[1–3] Residential schools in British Columbia operated from 1863 to 1984. In BC, there were 16 schools, and attendance was mandatory between the ages of seven and 15. The residential schools were part of a policy of assimilation designed to cut the ties between Aboriginal people and their ancestral culture

and lifestyle. To this end, the residential schools focused on the supremacy of the English language and on Christianity as the only acceptable spiritual belief system.

At present, Aboriginal people are suing the federal government and churches for the various abuses they endured during their residential school stays; however, only physical and sexual abuse are compensated. Some former students state that they had a good residential school experience and felt that it enabled them to become successful in dominant Canadian society. Many others, however, claim that the residential school experience, in addition to physical and sexual abuse, caused severe psychological harm. This has made them less able to function well as adults in most areas of life, including intimate adult relations, parenting and work.[4]

Psychological trauma reactions

Mental health workers offering services to survivors of the residential schools agree that the symptom picture is often broad and includes extremes of impaired interpersonal functioning, poor self-image, inability to control negative emotions, vulnerability to repeated sexual assaults, and serious drug and substance abuse.

Surprisingly, although many survivors report the classic symptoms of post-traumatic stress disorder (PTSD)—intrusions (e.g., flashbacks, nightmares), avoidance (i.e., purposefully avoiding thoughts, emotions, people, places) and hyperarousal (e.g., irritation, agitation, difficulty concentrating)—many do not. This is consistent with studies on other groups of people subjected to long-term physical, sexual or psychological abuse, indicating that many people with an indisputable traumatic past do not develop classic PTSD symptoms. Rather, they develop symptoms such as a sense of being permanently damaged, a tendency to harm oneself or be harmed by others, as well as a general lack of normal psychological development.[5] These latter symptoms are generally referred to as 'complex post-traumatic stress disorder'[6] or, in the case of Canadian Aboriginals, 'residential school syndrome.'[7]

Both pictures of trauma emphasize not only the immediate trauma reaction but also longer-term personality disturbance and impaired capacity for interpersonal relations. Of particular concern is the possibility that untreated complex trauma reactions may negatively affect several generations. Young Aboriginal women whose parents attended residential schools often feel that they did not have adequate role models—particularly regarding sexual education, parenting, education and substance use.

Treatment issues

Any complex trauma presentation needs a careful and comprehensive treatment plan based on a comprehensive understanding of the client. It is rarely enough to target only specific post-traumatic stress symptoms. Careful attention to how the different problems may be connected and to the underlying psychological and psychosocial mechanisms is also helpful. Substance abuse, for example, is often used as a method for coping with high anxiety, which can be triggered in anticipation of, or during, sexual relations for those with a sexual abuse past. At the same time, substance abuse is also one of the most critical risk factors for sexual victimization due to impaired judgement. An effective treatment approach needs to include interventions that target both the past trauma issues, as well as strategies for preventing further sexual assaults. This latter approach ideally includes sexual education and instruction in self-defence, ability to detect danger and assertiveness.

Other important treatment issues include encouraging the client to disclose past sexual abuse within a supportive therapeutic relationship. Most residential school survivors report that they were rejected when they attempted to inform the school staff or their parents about their abuse. Also, many daughters of residential school survivors report receiving little or no support from their parents when disclosing sexual abuse. Our clinical experience suggests this is more likely to happen in cases where the parents haven't addressed their own residential school sexual abuse.

Clinical experience and research has consistently found that being heard and supported following a disclosure is positively related to psychological recovery, and that being disbelieved and invalidated may result in a more chronic trauma reaction. i

footnotes

1 Furniss, E. (1995). *Victims of Benevolence: The Dark Legacy of the Williams Lake Residential School.* Vancouver, BC: Arsenal Pulp Press.

2 Haig-Brown, C. (1998). *Resistance and Renewal: Surviving the Indian Residential School.* Vancouver, BC: Tillacum Library.

3 Law Commission of Canada. (2000). *Restoring Dignity: Responding to Child Abuse in Canadian Institutions*. Ottawa, ON: Minister of Public Works and Government Services.

4 Josefowitz, N. & Barnes, R. (2004, June). *First Nations Residential School Experience: Factors Related to Stress and Resilience.* Paper presented at the convention of the Canadian Psychological Association, St. John's, NF.

5 Wasco, S.M. (2003). Conceptualizing the harm done by rape: Applications of trauma theory to experiences of sexual assault. *Trauma, Violence, & Abuse, 4,* 309-322.

6 Van der Kolk, B.A. (2002). The assessment and treatment of complex PTSD. In R. Yehuda (Ed.), *Treating trauma survivors with PTSD.* (pp. 127-156). Washington, DC: American Psychiatric Press.

7 Brasfield, C. (2001). Residential school syndrome. *BC Medical Journal, 43*(2), 57-112.

Violence Against Women and Substance Use in a Rural Context

> "… he kind of **'sold' me to other people, without protection** . . . And it was made out to be something that was going to be good for us, but he's the one who profited from it . . . Did lots of drugs, but never anything with needles and stuff like that, that you could contract AIDS from . . . he got arrested and put into jail, so that was ***my chance for me to escape*** . . . So I found a foster [home] where both me and my sister had been, . . . and she happened to know where my sister was, which was here in BC. So, I phoned my sister up and said, you know, 'I'm in this bad relationship, in need to get out and can you, you know, *welcome me in?*' So definitely she said 'yes, come on down.' Took the train over here . . . Um, then partied for a long while." – Jocelyn

Sheila Dick and Colleen Varcoe

Sheila is a counsellor/facilitator working to improve living conditions of women in rural BC. She is a member of the Secwepemc Nation and is completing her MEd at the University of Northern British Columbia

Colleen is a nurse and a researcher at the University of Victoria's School of Nursing, focusing on women's health with an emphasis on violence against women

Substance use was a central theme in the experiences of women who took part in a study focusing on the relationship between violence against women and the risk of HIV/AIDS. This study, completed in 2004, was undertaken in 2002 to develop a meaningful strategic plan for the prevention of HIV/AIDS in the Cariboo-Chilcotin region. Concerned community members realized that HIV prevention strategies, such as condom use and negotiation of safe sex, are largely irrelevant to women who are being abused, sexually assaulted, or required to exchange sex for food, shelter, money or protection.

Ethnographic interviews were done with 30 local women who had experienced violence in an intimate-partner relationship that may have placed them at risk for HIV/AIDS. The women were diverse in ethnicity, tended to be younger (16 to 58 years of age), and tended to have lower incomes (average income less than $20,000 per year) reflective of the area population.

As prior studies show, substance use can become a common feature in the lives of women battered by their partners.[1–3] Of the 30 women in this study, 17 described using alcohol and drugs extensively and 13 described themselves as having had problems with alcohol (e.g., "alcoholic," "binge alcoholic," "heavily into alcohol"). Although only two said they had used injection drugs, 10 said they had problems with (i.e., "addicted" or "heavily into") other substances such as cocaine, crack and methadone, and also used alcohol to an extent they considered problematic.

As in other studies,[4–6] multiple experiences of violence and multiple forms of abuse over their lifetimes detrimentally affected the women in this study. All experienced abuse as adults and 14 experienced sexual abuse as children or youth, primarily in the context of intimate or family relationships. Many of the Aboriginal women endured particularly horrific experiences in residential schools and/or abuse by family members who were residential school survivors.

Although some women saw substance use as one way of dealing with abuse, for many, substance use was integral to their lives in other ways. Exposure to substance use in childhood and as young women limited their social and economic options. In some cases, these limited options, together with fear, placed the women in further danger if an abusive partner was using drugs or dealing drugs as part of economic survival. For some women, substance use was part of the abuse: the person perpetrating the abuse used drugs and/or alcohol and required or encouraged the woman to do so as well, and/or the perpetrator abused the woman while she was under the influence of drugs or alcohol.

Physical, emotional, and sexual violations, the women's substance use, and the addictive patterns of their partners create and compound isolation and disconnection from social supports—particularly destructive dynamics in a rural context. Some women in this study relocated geographically a number of times and substance use was implicated in these moves. In addition to the ploy of isolation used by abusive partners, some women moved for affordable housing, employment, safety, or to escape environments or substance-using partners that placed them at risk for HIV/AIDS. For some—especially when they lost their homes or children—escaping the associated stigma and judgement proved extremely difficult in small communities.

Despite horrific experiences of abuse compounded by poverty and emotional and geographical isolation, each woman in the study dealt with the circumstances of her life in constructive ways. Not surprisingly, dealing with substance use figured prominently in their stories of growth, healing and pride.

Given the accounts of these women, there is need

for integrated prevention and treatment that will be effective in a rural context. Policies and services that do not consider the relationship between violence, historical abuse, and substance use and addictions cannot be successful. Yet, we have such policies and services: for example, women's transition houses that are not equipped to accommodate women with addictions, and substance abuse prevention programs that do not attend to the long-term effects of violence.

If women are to change their lives substantially, health and social policies and services aiming to address violence and substance use must be coupled with those that foster women's economic independence and safety.

footnotes

1 Martin, S.L., Kilgallen, B. & Dee, D.L. et al. (1998). Women in a prenatal care/substance abuse treatment program: Links between domestic violence and mental health. *Maternal and Child Health Journal, 2*, 84-94.

2 Fikree, F.F. & Bhatti, L.I. (1999). Domestic violence and health of Pakistani women. *International Journal of Gynaecology and Obstetrics, 65*(2), 195-201.

3 Stark, E. & Flitcraft, A.H. (1996). *Women at risk: Domestic violence and women's health.* Thousand Oaks, CA: Sage.

4 Champion, J.D. & Shain, R.N. (1998). The context of sexually transmitted disease: Life histories of woman abuse. *Issues in Mental Health Nursing, 19*(5), 463-80.

5 Jones, A.S., Gielen, A.C., Campbell, J.C. et al. (1999). Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Women's Health Issues, 9*(6), 295-305.

6 Heffernan, K. et al. (2000). Childhood trauma as a correlate of lifetime opiate use in psychiatric patients. *Addictive Behaviors, 25*(5), 797-803.

> "Before I was, like, nobody . . . I didn't think anything of myself because of all the things I went through and I didn't think that I was beautiful, that I was **strong** or I didn't believe in myself for anything . . . but now, after going to treatment and looking within myself . . . I feel very strong and beautiful. I have a lot of *pride* now. I can stand up and I can walk straight with my head held high." – Strong Native woman

How Widespread are Eating Disorders?

Misconceptions and realities

Erin C. Dunn, PhD and Josie Geller, PhD

Erin is a clinical psychology post-doctoral fellow in Psychiatry at UBC

Josie is a registered psychologist, Associate Professor in Psychiatry at UBC and Director of Research at the St. Paul's Hospital Eating Disorder Program

What are eating disorders?

Millions of young women and girls are affected by eating disorders each year. The two most common eating disorders are anorexia nervosa and bulimia nervosa. Anorexia is characterized by severe weight loss, amenorrhea (abnormal stoppage of menstrual periods), and cognitive features such as extreme fear of weight gain. Bulimia is characterized by binge eating episodes, compensatory behaviours such as vomiting and laxative use, and basing self-worth to a large extent on shape and weight.

How common are anorexia and bulimia?

About 2% of the population will suffer from anorexia at some point in their lives; the rate for bulimia is about 5%. Approximately 10 times as many women as men have eating disorders. Although eating disorders are relatively rare in the general population, they are more common in teenage girls (about 20% of eating disorder cases) and increasingly common in teenage boys (about 7% of cases).[1]

How common is disordered eating?

Relatively few individuals suffer from anorexia or bulimia, but disordered eating behaviour and unhealthy attitudes (i.e., excessive shape and weight concerns) are common. In a recent study, 4% of college women reported using extreme weight control methods (e.g., vomiting) on a daily basis; however, more than half of college women reported daily dieting behaviour (e.g., counting calories).[2] In another study about half of teenage girls reported using weight control methods (e.g., skipping a meal, vomiting) at least once in the past year. Additionally, 18% of teenage girls report frequent dieting (more than five times in the past year).[3] Research indicates that North American females generally want to weigh about 10 kgs. (or 22 lbs.) less than they currently do.[4,5] This may explain the high prevalence of disordered eating in girls and young women.

What are our beliefs about the prevalence of eating disorders?

Despite relatively low rates of eating disorders in the community, popular opinion is that anorexia and bulimia are common problems among women. A recent study surveyed women's beliefs about the prevalence of bulimia in women 18 to 45.[6] Of the women surveyed, 20% estimated the prevalence of bulimia to be greater than 50%, half estimated the prevalence to be from 10% to 30%, and only 10% accurately estimated the prevalence to be less than 10% of community women.

Other research has compared perceptions of eating disorder prevalence in young men, young women, their mothers, and their fathers. Of the four groups, young women were most likely to see bulimia as common.[7] Studies also show that young women view eating disorder symptoms as an acceptable means of weight control.[6,7]

Together, this research suggests that women mistakenly believe eating disorders are common, and they are more likely than young men or older adults to see eating disorder symptoms as acceptable.

Why do we overestimate the prevalence of eating disorders?

Eating behaviours and attitudes exist on a continuum ranging from healthy to disordered. Anorexia and bulimia are at the extreme of disordered. Healthy eating behaviours and attitudes, unfortunately, are not the norm among women. What is common is a general discontent with shape and weight, and a tendency to engage in dieting and weight control practices.

It may be that people accurately perceive the high prevalence of disordered eating, but they mislabel what they observe as 'eating disorders.' This may be especially true in young women. Research suggests that people who engage in disordered eating are more likely to perceive others as having eating disorders, and to view these behaviours and attitudes as acceptable.

The media may also play a role in shaping our perceptions of eating disorders. We live in a diet culture and are bombarded with images and messages that promote the desirability of thinness and the stigma of being overweight. The highly publicized celebrity struggles with eating disorders may also contribute to the perception that eating disorders are pervasive in our society.

What are the consequences of our misperceptions about eating disorders?

People's perceptions about the behaviour and attitudes of others often influence their own behaviour and attitudes. This can be harmful if their perceptions are incorrect. For example, women may eat less or exercise more than is healthy if they think that such behaviour is normal and/or expected. This, in turn, promotes a cycle of unhealthy eating habits and the perception that disordered eating is common.

What helps?

Accurate information

A recent study showed that educating college women about misperceptions regarding dieting, eating and exercising led to a reduction in disordered eating behaviour and adoption of a healthier weight ideal.[8]

Focusing on self-esteem

Prevention programs that primarily target eating disorder symptoms have been associated with increases in problematic behaviours and overestimation of the prevalence of disordered eating.[9] Programs that promote healthy self-esteem independent of shape and weight and that involve participants in critical analysis of the 'thin' ideal had more promising results.[10]

Realizing we are more than our bodies

When we focus so strongly on our bodies and how to keep them slim, we neglect the many more important contributions women make to the world. It is important to recognize, promote and embrace a broader conception of women and their talents and roles.

normalizing bulimia

1982: The gagging smell of vomit assailed my nostrils when I entered the boathouse for the pre-race weigh-in. When I commented on the smell to a teammate, she made the (now ubiquitous) gesture of sticking a finger down her throat. Dozens of lightweight rowers—most of whom had struggled to be strong and fit while keeping their weight below the 130-lb. limit—had forced themselves to purge their breakfasts before stepping on the scales.

I finally understood how several members of my crew had managed to attend all-you-can-eat buffets and pancake breakfasts after every practice that summer (despite the fact that we were on a rigourous diet) while staying under the allowed weight limit.

Years later, several of my fellow rowers were still in therapy for eating disorders.

I now see adolescent girls and young women (perhaps the daughters of my teammates) laugh and exchange knowing looks while making that same finger-down-the-throat gesture—a not-so-secret testament to the acceptance and normalization of bulimia among women in our culture. There is some 'reason' to this madness: bingeing and purging are unhealthy and outrageous responses to unhealthy and outrageous expectations of physical perfection in women and girls in our society.

Cynthia Row

Cynthia is Visions' Editorial Assistant

footnotes

1 Kjelsas, E., Bjornstrom, C. & Gotestam, K.G. (2004). Prevalence of eating disorders in female and male adolescents. *Eating Behaviors, 5*, 13-25.

2 Minz, L. B. & Betz, N. E. (1988). Prevalence and correlates of eating disordered behaviors among undergraduate women. *Journal of Consulting Psychology, 35*(4), 463-471.

3 Neumark-Sztainer, D., Wall, M.M., Story, M. et al. (2003). Correlates of unhealthy weight control behaviors among adolescents: Implications for prevention programs. *Health Psychology, 22*(1), 88-98.

4 Dunn, E.C., Neighbors, C. & Larimer, M.E. (under review). Motivational enhancement therapy and self-help treatment for binge eaters. *Psychology of Addictive Behaviors*.

5 Cogan, J.C. (1999). Lesbians walk the tightrope of beauty: Thin is in but femme is out. *Journal of Lesbian Studies, 3*(4), 77-89.

6 Mond, J.M., Hay, P.J., Rodgers, B. et al. (2004). Beliefs of women concerning the severity and prevalence of bulimia nervosa. *Social Psychiatry & Psychiatric Epidemiology, 39*, 299-304.

7 Vander Wal, J.S. & Thelen, M.H. (1997). Attitudes toward bulimic behaviors in two generations: The role of knowledge, body mass, gender, and bulimic symptomatology. *Addictive Behaviors*, 22(4), 491-507.

8 Mutterperl, J.A. & Sanderson, C.A. (2002). Mind over matter: Internalization of the thinness norm as a moderator of responsiveness to norm misperception education in college women. *Health Psychology, 21*(5), 519-523.

9 O'Dea, J. (2000). School-based interventions to prevent eating problems: First do no harm. *Eating Behaviors, 8*, 123-130.

10 Stice, E. & Shaw, H. (2004). Eating disorder prevention programs: A meta-analytic review. *Psychological Bulletin, 130*(2), 206-227.

Anxiety in Pregnancy and Postpartum

Nichole Fairbrother

Nichole is Postdoctoral Fellow with the Interdisciplinary Women's Reproductive Health Research Training Program, through the BC Research Institute for Children's and Women's Health and the Department of Health Care and Epidemiology at UBC

Despite a vast literature on postpartum depression, very little systematic research has been conducted on anxiety disorders during pregnancy and the postpartum period. The small amount of research that has been done suggests that pregnancy and the early postpartum period may be a time in a woman's life when she is more vulnerable to feeling anxious and even to developing an anxiety disorder.

Several theories have been proposed to account for this increased vulnerability. They include:

- hormonal changes known to occur during pregnancy, birth and lactation
- the stressful nature of pregnancy and the birth of a child
- the feelings of loss of control and of being overwhelmed that often accompany new parenthood
- negative interpretations of normal changes occurring during pregnancy and following birth (e.g., interpreting normal breathlessness of late pregnancy to mean that one's baby is not receiving sufficient oxygen), leading to anxious feelings.

pregnancy and the early postpartum period may be a time in a woman's life when she is more vulnerable to feeling anxious and even to developing an anxiety disorder

Studies have looked at a number of different anxiety disorders during pregnancy and the postpartum period, including panic disorder, generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and fear of childbirth (tokophobia).

Panic disorder

Panic disorder is characterized by the presence of recurrent, unexpected, sudden feelings of panic. Although the evidence is limited, it appears that during pregnancy, some women with this disorder improve, others stay the same and some get worse. There is somewhat stronger evidence that panic disorder tends to worsen during the postpartum period. Further, there are a sufficient number of documented cases of panic disorder beginning in pregnancy and after the birth of a child to suggest that pregnancy and the postpartum period are a time of increased vulnerability for the development of this psychological problem.

Generalized anxiety disorder

GAD involves excessive and persistent anxiety and worry about a number of different areas of one's life. In the only systematic evaluation of postpartum GAD, 4.4% of the women assessed (i.e., three women) met diagnostic criteria in the first eight weeks postpartum. One of these women (1.5%) developed the disorder during the eight-week postpartum period. The other two developed it prior to becoming pregnant.

The kinds of concerns expressed by these women (as well as a number of other participants with subclinical[1] GAD) included worries about money, physical appearance, household chores, cleanliness, parenting ability, employment or schooling, child care, free time, harm occurring to the infant, the baby's appearance, and relationships with others (friends, family and spouse).

Obsessive-compulsive disorder

OCD is characterized by obsessions (i.e., recurrent, unwanted and distressing thoughts, images or impulses) and/or compulsions (i.e., repetitive mental or behavioural acts intended to decrease the distress associated with the obsessions). People with OCD also often avoid situations related to their obsessions.

Approximately 2% to 3% of the general population will suffer from OCD at some point in their lifetime. Several studies of OCD sufferers have identified a subset of patients whose OCD either began or became worse during the pregnancy or shortly following the birth of a child. Taken together, these studies suggest an increased vulnerability to OCD during pregnancy and postpartum periods.

The small body of research in this area suggests that OCD beginning during pregnancy is often characterized by fears that the unborn baby will become contaminated or harmed by toxic substances. In these cases, compulsions involved repetitive cleaning and washing behaviours.

Postpartum-onset OCD typically involves obsessive

footnote

1 the early stages of a condition where symptoms do not yet meet diagnostic criteria

thoughts related to harm coming to the infant. These may be thoughts of accidental harm coming to the infant (e.g., a car accident), or thoughts of actually harming the infant (e.g., pushing the baby under the water in the bath). Obviously, these kinds of thoughts can be highly distressing for the mothers who experience them and can lead to avoiding the infant.

Currently, BC-based investigators are beginning a study on postpartum thoughts of harm towards the infant. They hope to develop evidence-based guidelines for health professionals working with postpartum women who disclose thoughts of harm related to their baby.

Post-traumatic stress disorder

PTSD is characterized by re-experiencing a traumatic event, avoidance of situations and people who remind one of the event, and symptoms of hyperarousal (i.e., agitation and a heightened awareness of the environment). For many, if not most women and their infants today, childbirth is safe and uneventful. However, in rare instances, childbirth may result in injury or a threat to the bodily integrity of the mother, and/or injury to, or even the death of, the infant.

Following a traumatic birth, a woman may develop symptoms of post-traumatic stress disorder. Several studies have found evidence of post-traumatic disorder occurring following miscarriage, stillbirth and other forms of traumatic pregnancy and birth experiences. It appears that anywhere from 2% to 6% of women may meet diagnostic criteria for childbirth-related post-traumatic stress disorder. Even if a woman does not develop PTSD following a traumatic birth, she may be more vulnerable to developing PTSD subsequent to later childbirth experiences.

The empirical literature suggests that postnatal depression and PTSD often co-occur. Some distinctive features of postpartum-onset post-traumatic stress disorder include avoidance of sexual activity due to a fear of becoming pregnant again or from fear of triggering flashbacks of the traumatic birth, as well as fear of childbirth, and parenting difficulties such as mother–infant attachment.

Fear of childbirth (tokophobia)

Tokophobia can occur following a traumatic childbirth, and can be of sufficient intensity to motivate a request for an elective Caesarean delivery or even to terminate the pregnancy. In one study of first-time mothers, all of the women who requested a Caesarean delivery for a subsequent pregnancy reported traumatic memories of their first childbirth experience. The fear of childbirth may be related to a lack of trust of medical staff, fear of dying, fear of one's infant dying, or a fear of pain.

Research in each of these areas suggests that pregnancy/postpartum is a time in a woman's life when she is more vulnerable to developing an anxiety disorder. Unfortunately, for most of these disorders, large-scale studies to properly assess the prevalence of pregnancy/postpartum-onset anxiety in the general population are lacking. At this time, postpartum depression is the only pregnancy/postpartum-related disorder that is routinely screened for.

In light of the evidence presented above, it seems likely that some women who are about to give birth, or who have recently given birth, may be suffering from an undetected and untreated anxiety disorder.

references

Abramowitz, J.S., Schwartz, S.A., Moore, K.M. et al. (2003). Obsessive-compulsive symptoms in pregnancy and the puerperium: A review of the literature. *Journal of Anxiety Disorders, 17,* 461-478.

Bailham, D. & Joseph, S. (2003). Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice. *Psychology, Health and Medicine, 8,* 159-168.

Shear, M. K. & Mammen, O. (1995). Anxiety disorders in pregnant and postpartum women. *Psychopharmacology Bulletin, 31,* 693-703.

Wenzel, A., Haugen, E.N., Jackson, L.C. et al. (2003). Prevalence of generalized anxiety at eight weeks postpartum. *Archives of Women's Health, 6,* 43-49.

Breastfeeding
Cautions and concerns

Anne Price

Anne is Program Director for the Health Canada funded Canada Prenatal Nutrition Program in Burns Lake

Please note: This article is based on observation and by no means suggests that all women with FASD are unable to breastfeed

breastfeeding is without question ideal for infant feeding and nutrition. There may be issues around breastfeeding, however, that are beyond the control of service providers, and persistence in encouraging a new mom to breastfeed can result in an escalation of risk factors for the infant and the mother.

Observations and experiences with high-risk women in the Burns Lake Canada Prenatal Nutrition Program (CNCP) over the last six years reveal that many of the women have fetal alcohol syndrome disorder (FASD) behaviours and characteristics, childhood physical and sexual abuse issues, limited education, and abusive and controlling partners. Many also struggle with poverty, family violence and addiction.

One of the challenges for women with cognitive[1] delays associated with FASD has to do with the fact that breastfeeding doesn't have concrete results like bottle feeding does. Individuals with FASD have difficulty with abstract ideas. In this case, the mother can't see how much milk the baby has taken, so is unable to see the need for more food.

Staff have observed some women with FASD behaviours feed for 20 minutes and assume their baby has had enough food. In spite of support workers' explanations of the size of

an infant's stomach and the fact that nursing newborn babies take a great deal of time, the moms are reluctant to recommence feeding. The baby's ongoing discontent leads to the development of two risk factors: (1) the infant is not getting adequate food and (2) the mother is frustrated by a crying baby she doesn't seem able to console.

Another factor that accompanies FASD is a developmental age far below the woman's chronological age. Although most adults in the program haven't had a formal assessment, workers and facilitators have observed behaviours that are generally more acceptable for eight-year-old girls: playing with dolls or sulking for an ice cream treat, for instance. One mom described the act of breastfeeding as "gross!" So, just as an eight-year-old would not be expected to have the maturity that breastfeeding requires, it may be unrealistic to expect this of some of the women in the program.

In many cases, infants suffer from symptoms associated with prenatal alcohol exposure, which leads to extreme difficulties during feeding. An infant with FASD can take much longer to feed than a typical infant because of an inability to suck properly, hypersensitivity to touch, rigidity, and physical discomfort or tension. Additionally, if the breastfeeding mother is consuming alcohol, the quality of the milk is compromised, as the alcohol level in breast milk is the same as the mother's blood alcohol.

Other factors that may interfere with successful breastfeeding are:

- discomfort associated with the intimacy of breastfeeding if there are unresolved childhood sexual issues
- controlling partners who adamantly refuse to allow women to nurse
- grandparents, aunts and other relatives who persistently encourage bottle feeding
- professionals and paraprofessionals who don't understand the issues high-risk women encounter, so do not provide effective intervention that includes consistency.

Reasons for opposition from partners vary and may include the following:

- a degree of immaturity (if the father has FASD)
- feeling threatened if service providers spend a great deal of time with the mom and focus on her empowerment
- feeling jealous toward the baby, which manifests in an attempt to limit intimacy between the mom and baby.

Many women have limited informal support systems at best, and often have no outside support. And the tenacity and determination that is often necessary to breastfeed successfully is simply not there.

If service providers and professionals lack understanding of the cognitive delays women may have, they can contribute to confusion around breastfeeding, especially if the messages they give are not clear, consistent and presented in a strength-based manner. Mixed messages, lack of support and understanding, combined with the extreme challenges that accompany FASD, can present insurmountable obstacles to a successful breastfeeding experience.

A last caution

It's wonderful to be able to share a successful breastfeeding story. However, it's best to be cautious about our enthusiasm for breastfeeding with mothers who are at risk. Not only can support workers and service providers put a woman's safety at risk should her partner hold strong opposition to breastfeeding, but the infant's nutritional intake and safety can be compromised if the mother is unable to understand breastfeeding.

footnotes

1 in other words: mental process of thought, including perception, reasoning, intuition and memory

2 Healthier Babies – Brighter Futures (HBBF) is a community FAS prevention program that works in partnership with other health and social service agencies to provide support to women at risk of alcohol and drug use during pregnancy. It is funded by the Ministry of Children and Family Development

a success story

One mom with FASD had no informal supports and her partner was vehemently opposed to breastfeeding at the beginning of her pregnancy. This particular father has learning disabilities, and at one point expressed concern for the baby's intellectual development by saying "I hope he's smart." The group facilitator, HBBF[2] support worker and health nurse used opportunities such as this to give the father information about the benefits of breastfeeding for brain development.

Fortunately, before the birth of their child he accepted the idea of breastfeeding and supported his partner to nurse. The mom attends the CPNP groups regularly and is learning about nutrition and infant developmental needs. She has learned to nurture and interact with her baby regularly. These parents are both extremely challenged cognitively and yet their baby is thriving.

You Are Mother

Dawn-Marie Tytherleigh

Dawn-Marie lives in the Fraser Valley. She looks forward to the publication of her first book, Social Abortion

Though the pain is overwhelming, my heart knows that I have been the best mother I could be. After all, I am their mother and God chose me to be their mother. And when I consider my bipolar condition, I feel proud because I know I've faced the odds and they have not consumed me.

When I was a little girl, I would peer into my mother's eyes and there I found joy. We were meant to be together and that is how I thought it would always be. Time proved me wrong. She vanished and I did not hear from her for a long time. I didn't like being without her, but I had to adapt. She was not there to protect me—and I was being abused. This trauma was the beginning of years in a mental health system that I hold little regard for.

Right after the period of abuse, I withdrew. I would not talk, eat, get out of bed or go to school. This was very troubling for the rest of the household. Something had to be done! My stepmother cared about me and tried to get the help I needed. They said it was a "girl thing"—a hormonal imbalance—and they tried everything to balance my moods. It was not that simple, though. I was made a ward of the state and moved to a boarding school run by sisters and social workers. It was great at first, but it didn't take long until I resorted to full-fledged rebellion and hit the road looking for something better in life.

But I got sick again and was branded bipolar. I became a regular face in the revolving door of all the psych hospitals in Vancouver. I spent many visits in seclusion because I was a fighter. No one was going to label me as 'mental.' I just would not have it!

In some ways I was just your average female teenager pushing for freedom, but in other ways I was like a trapped mouse. I felt like a 'specimen' of the system.

As I grew up, I got jobs and stayed close to the guy I loved. He took care of me. In our own world, we forgot about all the months that gobbled up my life when I was manic or depressed. There was always an end to the cycles, but there was never an end to my hope and determination to get on top of this struggle. This seemed such a futile effort; I was constantly knocked down as the girl who would eventually conform.

I decided to celebrate myself as a woman, and when my mother died a tragic death, I celebrated what she would have wanted for me. I am a brilliant and creative person. I am an artist. So I went to art school and did well in post-secondary art classes. I thought: finally, I am like everyone else.

But I had many problems ahead to deal with. My brother died a horrid death—but I still had to get up and conquer, no matter what.

In my early 30s, I became the proud mother of two daughters. Suddenly, I was forced to get out of the 'thicket' and set my course forward for these two little gifts. What I did was remarkable. I bought a home and provided what any child would want. I had a deep sense of joy. It felt like the joy I knew when my mother hugged me and doted on me.

I had no support, though, and when I had setbacks I had to lean on the system. I was offered clinical support, and while at first I thought it was okay, sooner or later it wouldn't be okay.

They took my children away from me. Even though they were in their teens, this event has shattered the place in my journey where I thought I had purpose. My girls are confused. And while the government has twisted the situation to fit its agenda, I still have to believe it will be put right one day.

So now, my fight is to reach out, as a mother in grievous times. I will lobby against the system the way it is now, but I will never lobby against those who are trying to be supportive within it.

If you are a mom who has lost your child because of a label, do not give up. Celebrate the power you have as a woman to overcome all, despite any illness you may be dealing with. We can't always determine what the torrents in life will be, but there is one certainty—we have all been given life, and with it, we can reach to the heights, or we can bottom-feed and watch everyone else have a good time. Conquer, for there is much up ahead, and you belong in the garden of victory just because you are.

Women Need Community Support to Survive

Laraine Michalson, RN, MSN

Laraine is a community health nurse. She has worked for the Sheway program for six years

A story of Hope

Hope is a 28-year-old Aboriginal woman, pregnant, in her first trimester. She spent her youth in and out of foster care and group homes. A boyfriend introduced her to drugs and she became addicted to heroin in her early 20s. She subsequently worked in the sex trade to support both of their drug habits. When the boyfriend became increasingly violent, Hope sought out supports in the community and moved into a women's shelter. She has been started on methadone, a legal heroin substitute prescribed by a physician. This has given her more stability in her life—enabling her to begin making plans for herself and her baby.

Hope very much wants to parent her child and prevent a repeat of her own sad, dysfunctional childhood. She is currently on a waiting list for supported housing and is seeing a counsellor to address her addiction and past trauma issues. She is now receiving health care and nutritional support, as well as financial advocacy to enrol in the provincial income assistance program.

Nowadays, her afternoons are spent at a drop-in centre, where she gets a hot lunch and socializes with other pregnant women. Hope is beginning to develop friendships with other women who share some of her circumstances.

web article
for more background on substance use issues during pregnancy, see the *Visions* article by Dr. Shimi Kang (only available online) at www.heretohelp.bc.ca/publications/visions

Sheway exists for women like Hope

Hope is fictitious, but her profile characterizes the lives of many women at Sheway. These women are fortunate that the Sheway program exists and provides a range of services for pregnant and parenting women who are dealing with drug and/or alcohol issues.

When women first come to Sheway, most have inadequate housing, poor nutrition, and a fear and mistrust of health and social services. Many of the women come to Vancouver from other regions and provinces, so have little or no family support here. Many of them have experienced multiple losses such as the removal of a child and the death of family members.

These women typically lack positive parenting experiences, both during their own childhood and with their own children. A majority of them have been victims of violence and childhood abuse, and as a result, are struggling with illicit and licit substance use. Most have very limited financial resources, poor education and few job skills. Lacking alternatives, they become workers in the sex trade to survive.

Despite the overwhelming odds these women face, the staff at Sheway believe—and the program has proven—that given the appropriate supports, many of these women can successfully parent.

What is faced when seeking help

Motherhood is difficult for even the most well prepared, supported middle-class woman. For women who live in poverty struggling with addiction, the challenges of parenthood can seem insurmountable.

Pregnancy is a time when women become more introspective about their lives and their futures, and they are often motivated to make positive changes. But they find there are insufficient support services and they face many obstacles, including racism and cultural, geographic and attitudinal barriers.

Notably, the women encounter service providers who treat them judgementally and disrespectfully, and so the women avoid seeking health care and other services. Understandably, these women are reluctant to disclose information about themselves to service providers whom they fear may bring legal action or punitive treatment. Pregnant women are even less likely to seek health care if they fear the removal of their children.

Social stigma is another barrier to seeking health care and social services, particularly for women who turn to the sex trade. Society views drug-using pregnant women as evil, unfit and the cause of family breakdown. But with a lack of adequate food, housing, education and skills, these women are unlikely to be able to address their addiction issues.

Interestingly, as one authority, Dr. Mary Hepburn, has noted, "Poor women who use illegal drugs have a higher rate of perinatal death, preterm deliveries, low birth weight babies, and sudden infant death syndrome (SIDS). However, the same incidence is found for women who smoke cigarettes and for those who are poor and non-drug users."[1]

Attaining good maternal–child health is an appropriate goal for society, and poor obstetrical outcomes are costly in many ways. Vilifying pregnant women for drug use in pregnancy and consequent poor infant health, however, distracts society from addressing what the women and their families need most: social housing, adequate welfare funds for food and rent, and culturally appropriate, family-centred treatment programs.

How Sheway helps

The women who come to

Sheway are welcomed by non-judgemental staff and invited to access the services. Some women come for health care during and after their pregnancies. Those who feel they are not able to care for their child may seek support to arrange an adoption. For the women who hope to parent their children, Sheway supports them in their efforts to prepare for parenting.

For these women, even the basic necessities are difficult to obtain. Diapers, formula and baby clothing must be purchased out of the meagre income assistance cheque. Sheway attempts to provide these items when welfare funds run out.

Isolation adds to the stresses of poverty. Food banks are helpful; however, a woman must wait in line alone with a new baby and no convenient way to transport her parcels home. Sheway provides weekly food bags, and limited bus tickets and transportation to appointments when possible.

Many women lack basic life and parenting skills. For women motivated by pregnancy and a love for their children, those skills and knowledge they already have are easily supplemented and supported. For a woman to nurture her baby, she, too, must be 'mothered.' Sheway first makes sure her basic needs—shelter, food, clothing, emotional support—are met, and secondly, helps her realize she can be a capable mother.

There is a great need for services that address the complexity of the circumstances of these women. Sheway is one such program, but is limited to Vancouver residents and by financial constraints.

What can be done now?

For more women like the fictitious Hope to succeed in parenting—and to break the costly cycle of child removal and foster placement—our communities need to increase the number of services that target the unique needs of this population. More of the following services are needed:

- non-judgemental health care that addresses perinatal addictions
- methadone programs that focus on the needs of pregnant women
- hospital–community partnerships (such as Fir Square (see p. 41))
- housing that is safe, affordable, and supportive for isolated women striving to parent (see Crabtree article, p. 40)
- programs that provide nutrition and food services to young families and pregnant women
- treatment centres that accommodate women and their children, and accept women on methadone
- detox beds for women

footnote

1 Hepburn, M. cited in Boyd, S.C. (2004). *From witches to crack moms: Women, drug law, and policy.* (pp. 95-96). Durham, NC: Carolina Academic Press.

web resources

www.bccewh.bc.ca/PDFs/shewayreport.pdf

www.vnhs.net/programs/sheway.htm

Post-Traumatic Stress and Substance Use

Sally Gose

Sally Gose is Direct Services Manager at the Women's Sexual Assault Centre in Victoria. She has worked for 20 years with women who have experienced violence

"If you say to me that I cannot come to a group [about sexual abuse] until I am clean and sober, then you are telling me that I do not deserve to heal." These are the words of a woman who attended a group offered by the Women's Sexual Assault Centre, based on *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* by Lisa Najavits.[1] The Vancouver Island Health Authority funded the pilot group, and the centre is starting a new series this fall.

The goals of these groups are (1) to increase awareness and education by understanding the connection between the effects of trauma and substance use, (2) to learn skills such as grounding, harm reduction and taking care of one's body, and (3) to increase positive beliefs about one's self by decreasing shame and isolation and increasing self-acceptance, hope, personal power and compassion for one's self. The groups do not involve women sharing details of trauma history, or processing the trauma.

Our interest in providing this group came from what trauma survivors told us: women get triggered during alcohol and drug recovery, and come to the centre for counselling. But often the counselling process jeopardizes their sobriety or 'clean time,' so women drop out of counselling. Many of these women do not return for counselling and are frequently in crisis. They blame themselves for not being able to recover or heal and are caught in a cycle of being triggered and using because there is no appropriate service to go to.

The research compiled in the *Seeking Safety* manual underscores what we have learned from women: the rate of post-traumatic stress disorder (PTSD) among women in substance abuse treatment is 30% to 59%;

PTSD may become worse with abstinence; treatment outcomes for women with PTSD and substance abuse are worse than other concurrent disorders, or substance abuse alone; women who have experienced PTSD and substance abuse are vulnerable to repeated trauma; women with PTSD and substance abuse experience a variety of complex life problems such as medical problems, homelessness and poverty.[1]

Our centre worked with the Seeking Safety model and revised it to reflect both the way we work with trauma and the needs of our community. The groups were co-facilitated by counsellors with knowledge in trauma and addictions. The two counsellors blended their expertise and skills to create a safe and informative group experience.

We decided to use a harm reduction model, accepting women who may have been still using substances into the group, but had abstinence as a goal, and referred to substance 'use' rather than 'abuse.' The women were required to have an individual counsellor. The centre accepted community-based referrals and created two connected yet stand-alone groups. The groups ran for two and a half hours once a week for a total of 15 weeks.

Seeking Information (three weeks)—part one of the 15-week group—explores the links between sexual trauma and substance use. Participants look at topics such as defining PTSD, stages and signs of healing, how substance abuse prevents healing, how trauma and substance abuse affect one's body, safe coping, and containment. These three sessions allow women to get some basic information and skills before making the commitment to the 12-week group.

Seeking Understanding (12 weeks)—part two of the 15-week group—examines how substance use and sexual trauma affect the women participants, and explores new ways of healing. Topics include: sleep problems, boundaries, asking for help, healthy relationships, inspiration for healing, and practising coping skills and self-care.

The women in these groups saw the harm reduction approach as positive: "I know if I got drunk or high, I would not get anything out of [the group] ... What happens after a week or two of people telling you it's okay, stop beating yourself up because you're still using... it makes you feel better about yourself... you'll want to heal even more because people are accepting you as you are, not telling you to leave the group."

The response to the groups from the women and from the community has been overwhelmingly positive. Women who have attended say they have gained perspective, self-acceptance, understanding and skills, and have decreased their sense of isolation by connecting and identifying with other women.

The community has made it clear that the approach this group offers fills a gap, and they want it to continue. We are currently meeting with mental health workers, addictions counsellors and women-serving organizations to talk about how this will be achieved. i

footnote

1 Najavits. L. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* New York: Guildford Press.

Continuing the Journey

A way back from trauma and substance use

Katherine B. Oxner, MSW and Veronica Brown

Katherine is Executive Director of Pacifica Treatment Centre in Vancouver. She has more than 25 years experience in the addictions field

Veronica runs the Women's Addiction Foundation resource centre in Vancouver

Tara sounds like any other young mother. While her two-year-old squeals happily in the background, Tara offers her daughter a carrot as she talks about how hard it is to be a single mom. Unlike most young mothers, however, Tara also talks about her life on skid row and the daily challenge of staying clean and sober for herself and her daughter.

Tara started using drugs and alcohol at age nine, trying to escape a painful childhood that she alludes to only vaguely. By 21, she was regularly smoking opium and eventually turned to injecting herself with cocaine and heroin.

For seven years, Tara lived and 'used' on the skid row of Vancouver's Downtown Eastside. That all changed when she found out she was pregnant. When she heard her baby's heartbeat for the first time, Tara decided to stop using, and was admitted to the DEW (day, evening, weekend) program at Aurora Treatment Centre.

After delivering a healthy baby girl, Tara slipped into a deep postpartum depression, and went in search of her baby's father—her former dealer. She relapsed, and lost custody of her baby. It was the realization that she might lose her daughter forever that finally brought Tara to try recovery again.

Unfortunately, Tara's story is all too common. Each year, hundreds of women seek help from addictions services in BC. And each year, these women are cut adrift by a continuum of care that ends abruptly and offers little post-treatment support for those seeking to rebuild their lives.

In 2003, in her first year of recovery, Tara participated in the Continuing the Journey: Aftercare Trauma Healing Group for Women, being piloted at Pacifica Treatment Centre. This is a 12-week facilitated group for women who have completed treatment. During the program, Tara began to understand the connection between her drug use and the traumatic experiences in her life. She also saw the connection between her 'trauma triggers' and her relapse. Tara believes that her experience with Continuing the Journey has been vital to achieving two years free of drugs and alcohol.

Continuing the Journey is a joint project of Pacifica Treatment Centre and the Women's Addiction Foundation. It has been made possible by the generous funding and organizational support of the British Columbia Technology Social Venture Partners.

The program has been developed on the basis of our understanding of the nature of trauma and the relationship between trauma and addiction. Our understanding is that substance use has likely been the women's primary coping strategy in dealing with symptoms related to histories of physical, emotional and/or sexual abuse—and perhaps other traumatic injuries or experiences. These symptoms include unbearable emotional pain, grief, anger, shame, dissociation, eating problems, self-harm, personality disorders and other mental health diagnoses.

In the Continuing the Journey program, the focus is not on the participants' individual stories or the details of the events that got them there, but on their feelings and needs. We look at how the trauma has impacted them: their behaviours, their beliefs, their self-talk and their perceptions and judgements. In a safe and trusting environment, they practise new skills and new ways of relating and connecting with themselves and to the world around them while supporting others in the group to do the same. The group slowly and steadily builds a strong foundation of recovery and healing from trauma and addiction.

The program was started two years ago and we have run six groups so far. We keep the enrolment to 12 women per group and meet once a week for three months. We established the program to provide women with a post-treatment resource to enhance their goals of recovery. Graduates report very positive outcomes, feeling stronger and empowered to make positive changes in their lives. A very successful outcome of the trauma recovery group is the establishment of a mutual self-help group, which meets bi-weekly. The women are supported to continue on the path of connecting with themselves and each other.

We know that Tara's story is one that many women share. By making programs like ours available to women in recovery, we can begin to break the cycle of addiction. We believe that by helping one person, as in the ripple effect of tossing a pebble in a pool, many are helped. Tara's daughter would agree. i

My Fall From Grace

Exercise, well-being and medication side effects

Cynthia Row

Cynthia is Editorial Assistant for Visions Journal

For 25 years, rigourous physical activity—and its cosmetic effect on my body—brought me relief from symptoms of severe depression and anxiety. It also rewarded me with social acceptance, romance and employment. My success in the realm of athletics was a source of pride in my self, bolstering my otherwise battered and negative self-esteem.

I have since lost my ability to engage in sports and outdoor adventure—due to the side effects of medication. This loss and the subsequent weight gain has been a real detriment to me. I fought the decline into inactivity with the same determination I had brought to climbing mountains, but I lost the battle.

My experience illustrates a paradox faced by those struggling with mental illness. We know that one of the best prescriptions for depression and anxiety is moderate or vigourous physical activity, and that experiencing the outdoors can bring spiritual and physical well-being. We know that exercise is an antidote to the most common side effect of psychoactive drugs: weight gain. We know that an additional benefit from activity is improved body image, self-esteem and increased social interaction. Yet the side effects of medications can make exercising nearly impossible, and in some cases, dangerous.

In the 1980s, I was a nationally ranked track athlete and rower. Following my first hospitalization in 1984 for suicidal depression, I was prescribed Imipramine, an 'old-style' tricyclic antidepressant. As a result of taking this medication, I landed back in hospital with tachycardia (heart irregularities), petechiae (rupturing of blood vessels), and high blood pressure. Exercise was definitely out of the question.

Because of my experience with the tricyclic, I refused to try other medications for depression—until the 1990s, when SSRIs (selective serotonin reuptake inhibitors) and other classes of 'modern' antidepressants emerged, promising relief to the mentally ill, with fewer side effects. A lengthy period of psychotherapy sessions without adequate success had indicated I was, indeed, a candidate for drug therapies.

Prozac made me extremely irritable. Paxil, Zoloft, Serzone, Luvox and others left me lethargic and couch-prone. I tried these drugs in systematic trials lasting several months, but the side effects persisted. Effexor gave me some hope; while taking Effexor I was alert enough and had enough energy to exercise. Whenever I trained, however, I felt constant tingling and what felt like electric shocks in my extremities. Nevertheless, I trained through it. Effexor gave me minimal relief, but it ceased to be effective over time.

Loxapine was the nail-in-the-coffin of my athletic life. In 1998, I experienced a psychotic break (insomnia, agitation and hallucinations), and was prescribed Loxapine for 24 months. I tried to keep up my trail running and swimming, but the effects of the tranquillizer, combined with the sedating effect of the Cogentin I took to prevent the tremours Loxapine caused, made it impossible. I spent those two years in bed.

I also had bizarre food cravings, 24 hours a day, when I was on the Loxapine. My substantial reservoir of fitness seeped away. I gained 30 lbs., and in a desperate attempt to control the cravings and to find some relief from anxiety, I took up the all-too-common habit of the mentally ill—smoking.

Trials of more medications followed: Remiron caused hallucinatory waking dreams and weight gain, Epival and Elavil prompted bizarre cravings, and so on. In a cruel twist of fate, one drug that I am now taking comes with a warning to avoid vigourous exercise because it (Seroquel) inhibits the body's ability to regulate its core temperature, increasing the likelihood of seizures.

And so I have 'fallen from grace.' I have lost the helpful endorphine highs, as well as my external attractiveness and sex drive—like it or not, these are highly valued commodities in our society. Gone, too, is one of my main connections to mainstream society: employment that had been based on my wilderness adventures and 'extreme' sports. And, I lost a sustaining personal metaphor of strength.

If, having had a strong athletic background, this has been my experience, I can't imagine what the struggle to exercise is like for someone with a mental illness and little or no athletic background.

Through contemplating the physical changes in my life, I have come to truly understand the shallowness of our society's obsession with the perfect female body (fit, lean, yet voluptuous). But I would like some of my athletic life back, for all the benefits it can bring. Despite improvements in psychoactive medications, being able to exercise while taking them is often impossible, and I challenge pharmaceutical companies to develop drugs that are less debilitating.

web resource

Women's Mental Health: Psychiatric Medication and Weight Gain is a helpful, new fact sheet developed by the Canadian Mental Health Association's Ontario Division. See www.ontario.cmha.ca/content/about_mental_illness/weight_gain.asp

On the Road Again

S. Linda Walker

Linda is a 'mental health consumer.' A mother and stepmother to six adult children, a grandmother, and a wife to her retired husband—Linda also works as a care aide to seniors and is an active community volunteer. She has served on the CMHA North Vancouver and BC Division boards over the past 15 years

I was diagnosed as bipolar almost 18 years ago after waking from a coma, the result of a head injury from a head-on car crash. I may have been genetically predisposed to this mental illness. Or perhaps I had always been bipolar. I don't know—and it doesn't matter. But I would like to share my experience of how fluctuating moods affect my relationships with family and friends—and with God.

When I experience depression, my Christian faith becomes so challenged that it is almost non-existent. I experience this 'low end' of the illness two or three times a year. In those dark times, I stop wanting to go to church with my husband or to be involved in groups with church friends. I have no desire to pray. I no longer believe, and in my heart and mind, I even feel the tendency to mock those who do believe.

I'm not proud to admit these things; I feel quite ashamed. Some might say this is a satanic attack, and perhaps that is one explanation. But I prefer to blame these illogical changes of belief and behaviour on my illness.

The opposite happens when I 'escalate' or 'swing high': I become *more* religious or spiritual. One Sunday last year, I shared this phenomenon with a church group that was taking a course on 'mental illness.' The course was facilitated by a man who has a lot of professional experience working with folks who have mental health challenges. As I tried to explain to the group my experience of overwhelming joy to be back in church singing during worship, I became emotional, overwhelmed and confused. Tears rolled down my cheeks, and my chest felt like it was going to burst.

Was I just experiencing a tremendous mood swing? I don't think mood swings affect one so quickly. The leader comforted me by saying how very glad God must be when I return. I realized that God was simply filling me up with his presence that Sunday. God was telling me in a powerful way that He is with me always. God's love and knowledge of us is so great! How can I not know this all of the time? I am loved unconditionally, and God understands my condition. God knows each one of our unique situations. He loves and cares for us equally. I often sense God's love for me through another person. God has so many ways to let us know that He is with us. I don't always see all the ways.

I have been 'somewhat escalated' the last couple of months. And, yes, I do feel more spiritually minded right now. I am able to contemplate creatively about life without becoming manic or foolish. Thank heaven for prescription medication and a good psychiatrist! I take my medications faithfully because it helps me. The meds don't make this illness go away, but they do diminish the effects. I feel that I am managing my illness; it is not managing me!

My thinking is clearer, and I am able to view my relationships with others in a more positive, rational manner. I don't know why, but I find myself reflecting on so many things: the apparent effects of my illness on my six children, on my ex-husband (I divorced my first husband 25 years ago and re-married four years later), and certainly on my own experiences. I don't pretend to assume that my analysis is completely correct. We can only ever see through our own glasses, can't we? But this time, in my elevated state, something special happened deep inside me. My perspective on my life and my relationships with others is different. I feel less torn and more whole because I have been able to look beyond myself. I have been able to examine the events of my life from the point of view of others, and not just my own.

Could all this be God working a new thing in me? I don't know. Perhaps God has an easier time doing His work in me now. I think God can work His will in a person, in spite of that person having a mental illness. For now, I feel more mentally healthy than I've felt in a long, long time. Healing is so good. I guess I'm "on the road again"!

Bingeing and the Blues

The connection between depression and disordered eating

Victoria Maxwell, BFA, BPP*

Victoria is a mental health educator. Through her company, Crazy for Life Co., she provides corporate keynotes and workshops, with a specialty in depression and the workplace. Her one-person show, Crazy for Life, tells her own story of overcoming bipolar disorder and psychosis. The show has toured throughout Canada and abroad. Victoria welcomes your queries at victoriamaxwell@telus.net

**BFA: Bachelor of Fine Arts / BPP: BiPolar Princess*

I'm not picky. I'll mainline sugar, carbs and fats in any form—ideally alternating between scoops of Snow Star Neapolitan ice cream and thick chunks of cheddar cheese piled on butter-slathered bread along with huge handfuls of Old Dutch potato chips. Sound appetizing? Only to someone desperately needing to extinguish the excruciating feelings of anxiety, low self-esteem and severe depression.

At 17, as I entered university and began dating, I struggled with long, knee-buckling periods of depression. This was also when classic signs of an eating disorder began to emerge. My feelings of despair were just like anybody else's, I thought. I was depressed because my eating was out of control, right? I couldn't have been more wrong

After graduating from grade 12 at the healthy weight of 130 lbs., I decided to lose 'some' weight. I did. Quickly. I exercised and starved myself, consuming only diet cokes, half-muffins and perhaps a 'sandwich' made of a wafer-thin slice of deli meat and lettuce. My weight plummeted to 110 lbs. in just over six weeks. I stand at 5'6" with, normally, a rather athletic build. This was not my ideal weight.

Then, in a moment of 'weakness,' I ate an alarming amount of food. My body was no doubt literally starving. From then on I struggled to stop 'pigging out' as I called it in my journal.

On 'good' food days, I consumed 500–1000 calories and played tennis or ran for at least an hour every day. And, of course, I obsessed about how much I ate, what I ate and what I would like to eat. On 'bad' food days, I 'failed.' I succumbed to my hunger, and binged on 'outlaw' foods. I ate until I felt sick, couldn't move and fell asleep.

After five years of these cycles, starving myself moved into the background as I binged and exercised to maintain my weight. I tried to eat as I thought a 'normal' person would eat, but always returned to bingeing and exercise—and the guilt and shame that came with it.

I knew my eating behaviour was different from other people's. I knew I had an eating disorder. So I enlisted the help of a counsellor at a family services clinic. Through counselling, I recognized that I used food to stuff unwanted feelings into temporary submission. I discovered how unlovable, abandoned, and utterly hopeless I felt. I discovered Overeaters Anonymous. I went to meetings, to therapy, practised assertiveness and set boundaries. I believed, as my therapist did, that if I just 'felt my feelings,' learned to love myself, found better coping tools and came to terms with family of origin issues, I would no longer need to emotionally overeat.

But insights were no match for these deep-cutting feelings of worthlessness. I became an extremely insightful depressed person. Wanting to binge never left me. Either I 'white-knuckled it' (not compulsively eating or exercising, but wanting to with every atom of my being) or I gave in.

Laurynas Navidauskas

For a further four years, I fought the compulsion to overeat. I also fought guilt, depression and anxiety. I called in sick, slept for 14–16 hours a day, didn't shower, didn't call people. The bingeing got worse, and so did my moods. I began to alternate into mania. Eventually one of the manias catapulted into psychosis and I landed in the Lions Gate Hospital psychiatric ward. And still, it took another three or four years, several suicidal depressions and destructive manias and psychoses to fully establish that what I had been enduring was actually bipolar illness.

Guilt, depression, anxiety—aren't these emotions everybody experiences when doing psychotherapy? Perhaps. But the severity and the longevity of these feelings should have been a red flag for my counsellor. My therapist never suggested I was clinically depressed. My GP didn't twig when I went for my yearly physicals and told her how I was feeling, though she should have—there is depression and bipolar disorder on both sides of my family. ▶

My Eating Disorder

Shhhhhhh. Relief settles over my body as I hear the glorious sound of my problems flush down the toilet. I stumble into the bedroom and drop on to my bed. Drained of energy, I have no will to do anything—anything but think about my next binge, that is.

Why is this happening to me? I wonder. Why can't I stop eating?

This hellish, emotional whirl dragged on for four long, devastating years. I quit my regular activities, and isolated myself from friends and acquaintances. When I was in grade 11, the obsession took over, exhaustion from the routine caught up to me, and I dropped out of school. I became extremely depressed, and was bingeing and purging nine to 10 times a day.

My parents knew something was wrong with me, but they couldn't quite figure out what it was. I wasn't dropping weight, due to the bingeing, but I wasn't gaining a huge amount of weight either. It wasn't until I wrote a note to them explaining my problem that they really knew what was going on. The next morning my parents scheduled an appointment with the doctor.

After assessing the problem, the doctor recommended me for an outpatient eating disorder program an hour away from home. I attended the program two days a week for the next seven months, but still grew sicker and sicker each day. I saw numerous psychologists, psychiatrists, nutritionists and doctors, and was placed in several different programs, but nothing helped.

It wasn't until my heart started to fail and I dropped a huge amount of weight in a short period of time that the doctors really started to worry. I was then recommended for the intensive treatment program at Children's Hospital, where I was assessed and accepted. After a few months on the waiting list, I moved in and have since been living there on a regular basis.

I am now in the middle of my third month of treatment, am attending school and am getting ready to go home. When I think about the last four years, I realize how much time and energy my eating disorder took up, and I see what I missed out on in the real world. I feel distressed when I see other people suffering from an eating disorder, and wish that they too could see the advantages of getting better.

After I graduate from high school, I hope to attend college. I want to become a psychologist specializing in eating disorders, so that I can help patients overcome this painful disease.

Caitlin M.

Caitlin is recovering from bulimia

Bingeing and the Blues | *cont'd*

If only I had known depression could be an illness and not just a set of feelings. If I had known the behaviours I exhibited were classic signs of depression, perhaps something could have been done sooner.

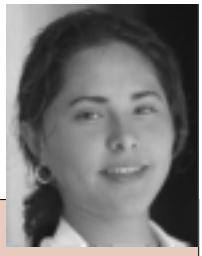
I continued with psychotherapy and began trials of medication. The bingeing continued throughout the search for the right kind, combination and dosage of meds. Many prescriptions later, I finally began to feel like myself. I also noticed that as my doctor and I refined my medical cocktail, my bingeing and compulsive exercising began to diminish.

A year ago, my overeating stopped being a problem. Now, as long as I continue to do therapy, take medication and manage my emotions well, my eating patterns remain healthy. And so does my mood. Though I still experience minor manias and mini depressions, they are much less severe and shorter in duration.

I feel sad that the true culprit—the mood disorder—was not targeted sooner. Once my illness was properly treated, the feelings of hopelessness and self-loathing (classic signs of depression) began to fade—and so did the compulsive overeating.

I'm not saying my time in therapy was wasted, but I was dealing with more than psychological issues. I have a psychiatric (read 'physiological') illness and I need more than therapy to stay healthy. Medication is an essential part (though only one part) of my holistic recovery plan. Taking medication is not necessarily right for everyone, but it is for me.

My psychiatrist says that for some of us with a mood disorder, not taking medication is like boxing with our hands tied behind our back. With the right meds, our hands become untied, though we still have to fight the good fight. And I'll be damned if I go down without a good fight.



amanda's story

"...The fat comments poured out and I wasn't fighting back anymore. Instead, I began to listen. What if I really am fat? As the days and weeks went on I cut back more and more, not realizing that I was slowly starving myself.

My parents took me to our family doctor and explained to him my recent weight loss and the absence of my period. He responded with: "All young adolescent girls lose weight as they grow, and as for the periods, they are always inconsistent at first." So I kept on dieting, and playing hockey and basketball. I read diet and health food books, and exercised to the extreme, spending hours on the stationary bike. By the end of December, I had lost 40 lbs..."

Amanda Johnson

Amanda is recovering from anorexia. She lives in Vernon

to read the whole of Amanda's story, go to www.heretohelp.bc.ca/experiences

Moving Forward with Women's Addiction Treatment in BC

Carol Savage

Carol is a former provincial women's services consultant working in program development and management in BC's Alcohol and Drug Services (now Addiction Services). She currently works with mental health and addiction services in the Central Vancouver Island region

alarmed. That's the only way to describe how I've felt recently when challenged—not by the expected sources—but by allies within the mental health and addictions system in our region. In these times of 'making do,' or at best, making the 'business case' in community services, I have become accustomed to justifying to others how our limited resources are applied in the BC addiction services system of care. But when those I normally look to for wisdom and support start asking for justification, I become alarmed.

The challenges come in the form of various questions: Why should we have treatment resources specifically for women in the addictions system when we don't have them in the mental health system? Why do we need this program specifically?

In an environment where it is essential to make the most of the resources we do have, these questions are reasonable, and we answer them as well as we can. We're content that, for the time being at least, we are able to maintain the substantial gains BC has made over the past 15 years. Women and men throughout the province—on provincial and local committees, working with community partners or on their own—have continuously improved women's addiction treatment services.

What are those gains? To illustrate, I will list a few examples of those in which I have participated.

When I began working with Alcohol and Drug Services (ADS) in the mid-'80s, Victoria (like many BC communities) had an active Women's Committee that provided leadership, learning and support for colleagues throughout Vancouver Island.

During the late 1980s, ADS regional management partnered with Aurora House in Vancouver to develop a parallel residential treatment centre for Island women. Maiya House operated for several years, until decisions were made to create Aurora Centre as a Centre for Excellence within BC Women's Hospital, and to fund women's intensive day treatment programs as an option in local communities.

In local areas, start-up of 16-Step groups was supported, and partnerships were forged with women-serving agencies such as transition houses and sexual assault centres. ADS was involved in developing the LINK training program that explored the relationships between substance misuse and violence.

During the years ADS was part of the former Ministry for Children and Families, new harm reduction methods and programs were implemented for women with addictions who were also parenting (e.g., Step Stones in Nanaimo).

The creation of Aurora Centre has solidified our gains because it provides a provincial focus and connection point for the ongoing development of women's addiction services. Aurora Centre and staff of BC's Women's Hospital (including guest editor for this edition of *Visions*, Nancy Poole) have been key in the development of Health Canada's *Best Practices in Treatment and Rehabilitation for Women with Substance Use Problems*,[1] and in the recent BC framework document: *Every Door is the Right Door*.[2]

To remind ourselves why these gains matter, let's recall what our clients have taught us over time: the life experiences women bring to their problem substance use and to their recovery, the impacts of their use, the supports and services they value, the barriers they face, and the factors that determine their treatment outcomes are often substantially different than for men. What the women who participate in our Nanaimo Clinic talk about—apart from the obvious importance of emotional safety—is that experiencing recovery with other women, and seeing their own recovery reflected in other women, is one of the greatest therapeutic tools we provide.

In my current work assignment, I have been forced to think deeply about how to protect what we have created so far. And I finally realized I need to think about the challenge differently. This shift of thinking was helped by re-reading the guiding principles from the 1991 recommendations of the Alcohol and Drug Programs' Women's Committee.[3] The following reflect my changed outlook:

1. **A commitment to avoid 'addictive thinking.'** Specifically, more (of the same) is not necessarily better. Thus, we are not looking automatically to expansion but rather at what we have and how we can improve it.
2. Comprehensive **changes to the system must occur as a process** rather than an event.

It is important to not only maintain the gains, but to continue moving forward on the base we have established. If we can continue to be open to an evolving system, stay clear on our purpose and principles, demonstrate knowledge and confidence in our own experience as well as the evidence base, and continue to challenge as well as support one another, what comes next may not be a loss; it may be another gain. i

footnotes

1 Health Canada. (2001). *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems.* Ottawa, ON: Health Canada.

2 BC Ministry of Health Services. (2004). *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction.* Victoria, BC: MOHS.

3 BC Ministry of Health and Ministry Responsible for Seniors. (1991). *Recommendations of the Women's Sub-Committee, Alcohol and Drug Programs.* Victoria, BC: MOH.

Good Drugs, Bad Drugs

Pregnancy, substances and social attitudes

Susan Boyd

Dr. Boyd is Associate Professor with the Faculty of Human and Social Development at the University of Victoria

Reprinted with permission from a section entitled "Medicalization" in (2004). From Witches to Crack Moms: Women, Drug Law, and Policy. *Durham, NC: Carolina Academic Press. pp. 82-84.*

Women's bodies have long been under the gaze of medical and public scrutiny, and women's individual responsibility for the outcome of their pregnancies places a burden on them that is unrivalled in any other area outside of parental responsibility. Women's concern for their pregnancies is fed on by medical professionals who construct new reproductive technologies (RTs) as positive and necessary and as providing a 'choice' for women. However, the new reproductive technologies have not necessarily created more choice; choice and access to some RTs is severely restricted for those not rich and white enough. At the same time that health care, education, housing, and social services have been cut, funding for reproductive technologies has increased, even though there is little scientific evidence to suggest RTs improve maternal outcomes.

As social factors that shape pregnancy, such as nutrition and poverty, are ignored, some women are offered expensive, intrusive, and selective technology to improve their chances of becoming pregnant. However, our love affair with technology is misguided. At the same time that the medical profession and much of the public praise reproductive technologies—such as in vitro fertilization, which often results in multiple births due to fertility drugs—they are also making efforts to limit the reproduction of women of colour, the poor, and those suspected of using illegal drugs. Racial and eugenic ideologies and practices shape reproductive technologies, risk assessment, 'care' and maternal drug policy.

Lynn Paltrow, of the National Advocates for Pregnant Women, notes that we place women who use fertility drugs and have multiple births (up to six children) on a pedestal and those suspected of using illegal drugs like cocaine during pregnancy in prison.[1] As medical professionals seek to help 'some' women conceive with fertility drugs and new reproductive technologies, women who use illegal drugs are offered sterilization. White women, and their multi-birthed in vitro infants, have graced the cover of popular magazines such as *People*. They are proclaimed as heroes, and individual, religious and corporate sponsors have rewarded them, giving them free homes, diaper service, groceries, and money. Most of these women also took fertility drugs to stimulate multiple ovulation, which contributes to multiple births. Unlike the national attention given to mothers using illegal drugs, little attention has been given to the severe health problems many of these multi-birth in vitro infants are born with and the health problems many of them will experience as they mature. Because a woman's uterus cannot physically hold five full-term infants, multi-birth infants are born prematurely, leaving them vulnerable to health problems such as visual disabilities and respiratory distress syndrome.[2] There are also risks to the mother, including negative side effects from the fertility drugs and rupturing of the uterus. For those mothers who take fertility drugs in conjunction with in vitro fertilizer, further risks associated with the surgical procedure are involved.

Moral reformers are not rallying to criminalize women who take fertility drugs to induce ovulation, even though the negative impact on their fetuses and the negative birth outcomes are undisputed. For these mothers are constructed as upholding conventional gender-role norms, and are seen as self-sacrificing and maternal. Outside the obvious ramifications of trying to care for three to five infants at the same time, disabilities are five times more common and immediate and long-term health problems more prevalent in multi-birth children than single-born children.[3] While moral reformers claim that infants born to mothers who use illegal drugs will be a drain on medical, social and legal resources, they fail to note that premature infants whose mothers used fertility drugs are also a drain on these resources. Nor do they comment on the cost of care in intensive care units, which can run up to $210,000 US for an infant under 2.2 lbs.[4] In addition, the fact that fertility drugs and in vitro fertilization are experimental is rarely explored. Critics note that in vitro fertilization failure rates are as high as 85–90%, very expensive, and are neither accessible nor a 'choice' for all women.[5]

Our collective love affair with medical technology, which is constructed as an aid to those who can afford it, especially in the United States, deflects our attention from questions about the quality of life and who gets selected to reproduce and to parent. It also diverts us from asking why illegal drug use during pregnancy is seen as harmful (given the evidence of such harm is sketchy at best), when some legal drugs and reproductive technologies can contribute to poor birth outcomes and permanent disability.

footnotes

1 Paltrow, L. (2001). The war on drugs and the war on abortion: Some initial thoughts on the connections, intersections and the effects. *Southern University Law Review, 28*(3), 201-253.

2 Koren, G. (1997). *The children of neverland: The silent human disaster.* Toronto: The Kid In US; and Strong, T.H. (2000). *Expecting trouble: What expectant parents should know about prenatal care in America.* NY: New York University Press.

3 Launslager, D. (1994). From one to five: Mulitple births and the family. In G. Basen, M. Eichler & A. Lippman (Eds.), *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies.* (Vol. 2, pp. 117-126). Maple Pond, ON: Voyageur.

4 Strong, 2000

5 See Basen, Eichler, Lippman, 1993/4 (Vols. 1 & 2)

Substance Use and Indo-Canadian Women

Kalyani Vittala and
Nancy Poole

Prepared in 2002 for the Women's Addiction Foundation, a public foundation committed to the physical, mental, emotional and spiritual wellness of women whose lives have been affected by their misuse of, or dependency on alcohol or other drugs. Part of BC Women's Health Centre. See www.womenfdn.org or call (604) 875-3756. Reprinted with permission.

'Indo-Canadian' refers to people who trace their roots back to the South Asian subcontinent. They are a highly diverse population embracing many religious, cultural, and linguistic traditions.

Substance use among Indo-Canadian women is relatively low, as they usually shun illicit drugs, alcohol, and tobacco based on their cultural attitudes and religious taboos. In a Toronto-area study, the rate of substance use varied: 88% of Sikh women said they had never consumed alcohol, compared to 76% of Hindu women.

Despite these low rates, some Indo-Canadian women do face substance use problems. And those who have been born in Canada are at higher risk, as research has shown that among immigrants in general, each successive generation is slightly more at risk for alcohol, drug and tobacco use.

Substance use issues for Indo-Canadian girls and women

Conflict with parents and culture

Substance use is on the rise among the current generation of Indo-Canadian women. When they do use alcohol and tobacco, their reasons often include conflict with parents and emotional resistance to the double standard between genders. (Teenage girls and young women in many Indo-Canadian families are given far less personal freedom than their male counterparts.) Outside the family, experiences of racism and peer pressure may also contribute to their substance use.

The violence/alcohol link

Some Indo-Canadian women face violence and abuse at home related to alcohol use by a spouse or another relative. The problem is serious as the rate of alcohol abuse among Indo-Canadian men is approaching that of males in mainstream society.

Prescription drug abuse

Many Indo-Canadian women are vulnerable to depression because of their social isolation, loss of extended family support, racism, alienation, and domestic violence. This means they are at risk of being overprescribed antidepressants.

Barriers to getting help

The greatest barriers to Indo-Canadian women seeking help are cultural attitudes and the strong stigma attached to substance use and mental health problems. Indo-Canadian women often find it very hard to look for outside help, because they do not want their husbands, fathers, or sons to 'lose face' within the community, and do not want to be shunned by their families for getting help. They may blame themselves for substance misuse or abuse problems. This self-blame can also be encouraged by the community.

Another barrier is lack of information and outreach into Indo-Canadian communities by social and health care services. Existing services can also be insensitive or even racist. Many studies show that people from minority groups are frequently treated differently and/or inappropriately by the medical system, compared with people from the mainstream.

Language can also be a barrier, especially when a woman does not have the words to express her feelings in English.

Finally, Indo-Canadian women have strong traditions of seeking community-based help and guidance from people such as extended family members, elders, and spiritual leaders. Unfortunately, these people may be unable to give a woman appropriate support and useful advice about treatment services.

What works?

Culturally relevant service options

Many Indo-Canadian women prefer more familiar forms of healing such as yoga, Aryuvedic medicine, and homeopathy. Services that include these traditional approaches are more helpful.

Service in one's first language

Inroads are being made by alcohol and drug services towards hiring counsellors who can speak languages other than English—including Hindi, Punjabi, and Tamil.

Integrated services

Another good approach is to include alcohol and drug counselling programs into general ethnic community services. Some BC examples are Deltassist Family and Community Services (Delta and Surrey), and Mosaic (Vancouver), which work with immigrant and visible minority communities on a range of issues.

Safe and confidential services

It is a risk for many Indo-Canadian women to defy cultural strictures and seek help for substance use and violence problems. Therefore, it is extremely important that services create safety and ensure confidentiality.

Practical supports

For all women, providing practical supports (such as financial support for child care and transportation) can make the difference in their ability to access the help they need and deserve.

Promising directions

The Centre for Addiction and Mental Health in Toronto has done research into best practices for reaching an ethnically diverse population. Their publication *Cultural Diversity: A Handbook for Addiction Service Providers* (1994) outlines a series of goals and guidelines for setting up treatment programs. This is but one resource designed to help the alcohol and drug field provide culturally competent care.

It is important that service providers address barriers to care related to language, gender, culture and ethnicity, and work toward the following:

- Increasing the number of treatment providers who speak Hindi, Punjabi and Tamil languages.
- Do outreach to ensure that Indo-Canadian women can find alcohol and drug services when they need them.
- Promote trust in women needing help, ensuring that they will find safety, respect and sensitivity in alcohol and drug services.
- Involve representatives from the Indo-Canadian community in helping us define and deliver culturally competent care. i

resources

community

- Alcohol and Drug Referral Service Toll-free: 1-800-663-1441 or (604) 660-9382
- Deltassist Family and Community Services, North Delta Alcohol and Drug Program: (604) 591-1185

print

Adrian, M., Dini, C.M., MacGregor , L.J. et. al. (1995). Substance use as a measure of social integration for women of different ethnocultural groups into mainstream culture in a pluralist society: The example of Canada. *International Journal of the Addictions, 30*(6), 699-734.

Alcohol-Drug Education Services. (1989). *Alcohol/Drug Education Needs Assessment: Four BC Ethnic Communities.* Vancouver, BC: Alcohol-Drug Education Services.

Clarke, K.I.M. (1999). Assessing the impact of South Asian male alcohol use on their female relatives. *Alcohol and Alcoholism: International Journal of the Medical Council on Alcoholism, 34*(1), 96-97.

Dubey, A. (1999). The language of care. *Journal of Addiction and Mental Health, 2*(4), 11.

Health Canada. (1996). *Immigrant Women and Substance Use: Current Issues Programs and Recommendations.* Ottawa, ON: Office of Alcohol, Drugs and Dependency Issues, Population Health Directorate.

Masi, R., Mensah, L. & McLeod, K. A. (1993) *Health and Cultures: Exploring the Relationships (Vol. 2).* Oakville, ON: Mosaic Press.

McGlynn, C. (1999). Substance abuse and cultural communities. *Journal of Addiction and Mental Health, 2*(4), 12.

SHARE Family and Community Services. (1993). *Identifying and Responding to the Needs of Ethnic Women and Seniors in the Tri-City Area.* Coquitlam, BC: SHARE.

Tsang, B. (1994). *Cultural Diversity: A Handbook for Addiction Service Providers.* Toronto, ON: Addiction Research Foundation.

Weber, T.R., Biring, P. & Mutta, B. (1993). *Punjabi Community Health Project.* Toronto, ON: Addiction Research Foundation.

The 16 Steps for Discovery and Empowerment

An alternative to 12 Step programs

Candace Plattor, MA, RCC

Candace is a counsellor at Watari and a therapist in private practice, specializing in addiction. She offers Self-Care for the Caregiver workshops and facilitates staff training and client groups for the 16 Steps of Discovery and Empowerment. Candace welcomes inquiries at (604) 254-9417 or at ceplattor@telus.net

Most of us know someone who is involved in a program that utilizes the 12 Steps as developed by Alcoholics Anonymous. There are 12 Step programs for almost every addictive behaviour: substance misuse, shopping, eating, sex, gambling, and co-dependency in relationships. Millions of people all over the world attend 12 Step meetings on a regular basis. In fact, it seems that anyone not involved in such a program is now in the minority.

I attended several different 12 Step programs during the early years of my recovery from addiction. These programs helped me tremendously. Eventually, however, several aspects of the 12 Step program became problematic for me. As I began to discuss my concerns with others who were in recovery, I found that I was not alone in what I was experiencing.

One of the most common complaints about the 12 Step model that I heard, from both men and women, concerned the use of the words "God" and "Him" and "His will for us." Many of us found ourselves becoming increasingly resistant to the patriarchal and religious undertones in many of the Steps.

And, many of us also realized that we didn't appreciate being encouraged to explore our shortcomings and defects of character.

We were told that we were not, under any conditions, to change the way any of the Steps were written. Therefore, in order to feel that we fit in—a deep yearning that so many of us have in our early recovery—we needed to find a way to be in agreement with principles that had been written in 1935 by two financially well-off, white Christian males.

The implicit message we received from many others in the program was that, if we could not feel positively about the Steps, then there was something wrong with us. As a result, many of us hid our true feelings; we became less authentic as we diligently attempted to work our program of recovery.

This was not a healthy situation for addicts who wanted to change their behaviour patterns and get well. But, for a very long time, 12 Step programs were virtually the only 'recovery' game in town.

I don't deny that 12 Step programs such as Alcoholics Anonymous, Narcotics Anonymous, Codependents Anonymous and Al-Anon have helped a significant number of people around the world achieve and maintain sobriety from their addictive behaviours. However, after many years of working in the addiction counselling field, as well as having maintained my own recovery for over 15 years, I have become aware that these programs are not appropriate for all people.

I became even more convinced of this when, in 1992, I read Dr. Charlotte Kasl's book *Many Roads, One Journey: Moving Beyond the 12 Steps*. In this groundbreaking book, Dr. Kasl—herself a recovering addict who had attended 12 Step programs for many years—shared how she had come to the same point so many of us had: the 12 Step philosophy of powerlessness, shortcomings, and a masculine "God" simply didn't work for her anymore. She yearned for a program of recovery that would accommodate everyone regardless of financial status, gender, nature of addictive behaviour, or spiritual orientation.

Dr. Kasl made the courageous decision to change the wording of the Steps so they would align with the person she was becoming. The resulting 16 Steps is a holistic program of "discovery and empowerment" that is very different from the 12 Steps. Rather than emphasizing our defects and focusing on what is wrong with us, this model encourages us to learn how to become our authentic selves by enjoying our strengths, celebrating our creativity, letting go of our shame and guilt, and trusting our own inner wisdom.

In Step One of the 12 Steps we are required to admit that we are "powerless" over our addiction, and that our lives have become "unmanageable." Unless we agree to admit this, we are told that we are "unwilling to go to any lengths" to deal with our addiction, and that we cannot go on to any of the next steps. This feels quite shameful for people who decide to "admit" rather than to rock the boat.

In the 16 Step model, however, the first step is very different. It assures us that we can take control of our lives and that we do not have to rely on anything or anyone external in order to feel better about ourselves. For many of us, especially women and other marginalized groups of people, this is a new and refreshing concept. Step Two in the 12 Steps tells us that we must rely on an external higher force in order to "restore us to sanity," which implies that we are "insane" before we agree to do this. This is not an easy message for many people to accept.

In the 16 Steps, the second step talks about the choice we have to open ourselves to the "healing wisdom" we all have inside us. This is a very different way of looking at life, the world, and recovery from addiction for those of us who are used to the 12 Step model.

I am extremely grateful to Dr. Kasl for having the courage and foresight to develop the 16-Step model. If you are dealing with substance abuse issues or other addictive behaviours and would like an alternative to 12 Step programs, you may find what you need in the 16 Steps for Discovery and Empowerment. i

references

Alcoholics Anonymous. (1976). *The Big Book: The Basic Text for Alcoholics Anonymous* (3rd ed.). New York: Alcoholics Anonymous World Services.

Kasl, C.D. (1992). *Many Roads, One Journey: Moving Beyond the 12 Steps.* New York: HarperCollins.

Plattor, C. (2003). The 16 Steps: An alternative to 12 Step programs. *Insights, 15*(1), 10-11. Newsletter of the BC Association of Clinical Counsellors.

dr. kasl's 16 Steps

1. We affirm we have the power to take charge of our lives and to stop being dependent on substances or other people for our self-esteem and security.
2. We come to believe that God/the Goddess/Great Spirit/Higher Power awakens the healing wisdom within us when we open ourselves to that power.
3. We make a decision to become our authentic Selves and trust in the healing power of the truth.
4. We examine our beliefs, addictions and dependent behaviour in the context of living in a hierarchical, patriarchal culture.
5. We share with another person and the Universe all those things inside of us for which we feel shame and guilt.
6. We affirm and enjoy our strengths, talents and creativity, striving not to hide these qualities to protect others' egos.
7. We become willing to let go of shame, guilt and any behaviour that keeps us from loving ourselves and others.
8. We make a list of people we have harmed and people who have harmed us, and take steps to clear out negative energy by making amends and sharing our grievances in a respectful way.
9. We express love and gratitude to others, and increasingly appreciate the wonder of life and the blessings we do have.
10. We continue to trust our reality and daily affirm that we see what we see, we know what we know, and we feel what we feel.
11. We promptly acknowledge our mistakes and make amends when appropriate, but we do not cover up, analyze or take responsibility for the shortcomings of others.
12. We seek out situations, jobs and people that affirm our intelligence, perceptions and self-worth and avoid situations or people who are hurtful, harmful or demeaning to us.
13. We take steps to heal our physical bodies, organize our lives, reduce stress and have fun.
14. We seek to find our inward calling and develop the will and wisdom to follow it.
15. We accept the ups and downs of life as natural events that can be used as lessons for our growth.
16. We grow in awareness that we are interrelated with all living things and we contribute to restoring peace and balance on the planet.

Finding—and Sticking with—Medication that Works

Linda Pook, BA (Psych.), BSW

Linda moved to Vancouver from Montreal in 1993. She has been a social worker for five and a half years

I was 23 years old when I received an article from my father about the benefits of taking Prozac for depression. I found it quite odd that my father would send me such an article, as we had never had any heart-to-heart discussions about anything before, let alone depression. I guess he saw something in me that caused him to think I would benefit from antidepressants.

It was a year before I actually tried Prozac. I was scared to take medication that would alter my brain chemistry. I didn't know what to expect. Would taking medication change me into a completely different person?

I finally came to realize that my personality had actually always been suppressed due to my depression. Depression robs you of your energy, your passions and your will to live. So, I thought, what did I have to lose?

Prozac caused me to become hypomanic—I had an abundance of energy and felt highly elated. I began to do things that were completely out of character for me. I transformed from a shy, introverted and low-energy person to an extremely outgoing, extroverted and gregarious person. It was great to finally break out of my shell and to break free from the dark cloud that had followed me everywhere. What I didn't realize was that my high would eventually peak. I crashed, and depression hit me hard.

Prozac was not the right medication for me, but it was the first step in finding the right one. When I finally stabilized on the right medication, my true personality came out. My social anxiety and shyness decreased, my anger diminished and I became more motivated and outgoing. For the first time in my life, I didn't want to die.

Despite my new-found 'normalcy,' however, depression wasn't finished with me. Depression took much more from me than my mental health: it also took my good friend and soulmate. Jonathan was my guardian angel. He had always helped me through my darkest times. He encouraged and supported me, and would hold me when I couldn't face the world. His unconditional love got me through my years of depression. But after discovering the miracle of medication, I didn't rely on him as much as I had. I was so caught up in my own newly found happiness that I didn't notice Jonathan's depression. Jonathan lost his battle with depression: on June 26, 1997, he took his life.

Jonathan's death didn't force me back into the depression I had fought so hard to overcome, but it did lead me into mourning. Even though I was dealing with this huge loss, I was determined never to go back to living a life filled with depression. I grieved but remained on my medication. This prevented me from going into a deep depression. After about a year, I came out of mourning. I was still on medication, which continued to control my depression.

Despite my loss, I was so grateful for having my depression under control that I decided I wanted to give something back to the community. And so, I became a child protection social worker.

Through my work, I have discovered that many mothers known to child protection services also confront some form of mental illness. Unfortunately, many of these women's illnesses are undiagnosed and untreated, and often interfere with their parenting ability.

Mental illness can be crippling and if not properly diagnosed and treated can render people dysfunctional. Many people self-medicate when they suffer from mental illness, which can result in substance abuse. This, in turn, often prevents people from being able to fully function in life, which sometimes causes them to lose the things most important to them. As a child protection social worker, I help these people get the help they need to put their families back together again.

It has been 10 years since I started taking medication, and I have been on several different antidepressants. Every couple of years the medication stops working, but I manage to find another one that does work, and eventually I go back to ones previously taken.

I am forever grateful for the medication that has taken away the dark clouds that I lived with for so many years of my life. I have developed nothing but strength, motivation, happiness and serenity, and have a very rewarding career. I feel like I have my life back!

Body Image and Physical Activity
New perspectives for self-care

Kate Maliha

Kate was a fitness director and personal trainer for over 12 years. She is currently in private practice as a movement coach, combining body image techniques with somatic education. She also teaches body image workshops to high school students across the province. Kate can be reached at (604) 224-5449 or homebodies@shaw.ca

For many women, the body doesn't always seem like a very safe place. This can be especially true for those coping with mental health and addictions issues. In some of these cases, it seems safer to numb bodily sensations than to fully experience a range of feelings. If this happens, we lose the natural cues from our bodies that tell us how we are feeling, how to regulate ourselves and when we are in emotional danger.

The punishment perspective

Many of my clients had early experiences that instilled a 'punishment' perspective of physical activity, making it difficult for them to do physical activities as an adult. Coaches, gym teachers, parents and other adults unknowingly reinforce this idea that physical activity must be painful and that a high activity level or a slim physical size is virtuous. I have seen the damage these ideas can cause, bringing a sense of shame and humiliation to a child who may later develop an unhealthy relationship with eating and exercise.

The media and advertising also reinforce the punishment perspective of exercise by creating a climate of fear and shame around the female body. The underlying message is usually that successful girls and women under-eat and over-exercise, and to do so is morally virtuous. Many girls and women internalize the idea that they are not good enough. They punish themselves with unnatural eating and exercise habits instead of making healthy lifestyle choices based on being in touch with their appetites and on a sense of enjoyment.

The self-care perspective

Health and body image are enhanced by physical activity. We can focus on the good feelings associated with moving our bodies rather than on our appearance. Far too often, however, we think of our bodies as vessels to be viewed by others, and our attention is on how others experience our bodies. When we move our bodies solely for the purpose of changing our appearance, we lose a valuable opportunity to connect with and to nurture ourselves.

My clients deal with a variety of issues, including eating disorders, addiction, poor body image, and exercise disorders. Many clients experience considerable fear around the body and they have preconceived ideas about exercise.

One client over-exercised constantly, to the point of fatigue, colds, joint injury and general erosion of her health. Against the advice of her physician, she continued to do increasingly strenuous exercise, risking permanent joint damage. As we worked on body image, relaxation techniques and creative movement in a safe environment, she came to see that her behaviour was self-destructive.

Although many of us have internalized the idea that our bodies need to be controlled, we can learn to discontinue self-harming behaviours and replace them with nurturing ones.

Creating strategies for self-care

Much research has been done on the development of guidelines or exercise protocols for conditioning and disease prevention, but up until recently very little has been done on exercise and mental health. New studies in exercise psychology are attempting to learn more about women's mental relationship to physical activity. For instance, two recent studies by McMaster University researcher Kathleen Martin Ginis found that women felt worse about themselves when (1) exercising in front of a mirror and (2) when they weren't exposed to a variety of fitness leaders of different shapes and sizes.[1,2] These findings reinforce what I have already learned when working with my clients and I look forward to more research in this field.

For many of us, it is very difficult to let go of the idea that the body must be controlled and punished with diet and exercise. We are constantly bombarded with conflicting health information and the continual message that the purpose of physical activity is weight loss.

Nevertheless, a healthy relationship with physical activity is possible when one's goal is self-care. Below are some strategies for creating a healthy relationship with your body and with physical activity.

Making physical activity a more nurturing experience:

- **Avoid exercising in front of mirrors** when you can
- **Create an atmosphere of emotional safety**
- **Realize that you have your own specific shape** and learn to appreciate your uniqueness
- **Dismiss media and advertising images** that make you feel bad about yourself or that urge you to criticize the bodies of others
- **Challenge criticism** of your body and the bodies of others
- **Realize that your body is precious** and you are worth taking care of
- **Focus on the pleasure** that movement brings rather than on appearance

- **Pay attention to how your body feels** and respond appropriately to signals of pain or fatigue by resting/discontinuing the activity
- **Experiment** with ways to make physical activity pleasurable and peaceful. You may want to incorporate the use of candles, music, scents, colour and imagination/creativity.

footnotes

1 Martin Ginis, K.A., Jung, M.E. & Gauvin, L. (2003). To see or not to see: Effects of exercising in mirrored environments on sedentary women's feeling states and self-efficacy. *Health Psychology, 22,* 354-361.

2 Fleming, J.C. & Martin Ginis, K.A. (2004). The effects of exercise video models on women's self-presentational efficacy and exercise task efficacy. *Journal of Applied Sport Psychology, 16,* 1-10.

Focusing on Healing

Disordered eating, trauma, addictions

Judy Lyon, RPC, FOTT

Judy is certified as a Focusing Oriented Therapist and Trainer specializing in trauma. She is a counsellor at the Aurora Centre and also works in private practice. Judy can be reached at (604) 809-1717 or jplyon@shaw.ca

In my role as a counsellor in both residential treatment and private practice, I've encountered numerous women struggling with issues relating to trauma, disordered eating, self-harm and substance misuse. According to researcher Nancy Poole, over the past five years an average of 35% of women attending the Aurora Centre residential and day treatment programs for drug and alcohol misuse also report experiencing symptoms of disordered eating.

In my own experience, as a woman in recovery from all these same issues, it's difficult to find a professional trained to look at how these issues may be interrelated. And unfortunately, it is also difficult for many women to find treatment for disordered eating if they are still using mood-altering substances, and equally difficult for those active in disordered eating behaviours to find treatment for substance misuse issues.

Most therapies I tried acknowledged part of my struggle (either thoughts or behaviour) but discounted other aspects of my experience. As a client, I often felt misunderstood or unheard, which amplified my sense of loneliness, shame and isolation. I was highly dissociative,[1] which made it difficult to feel or to be empowered—I wasn't even connected to me! I needed something that would honour and give voice to 'all those parts' of me, no matter how misunderstood or dysfunctional they were, so I would be able to honestly integrate and express my needs, feelings and experience. Then I could have been taught and encouraged to express myself in ways less destructive than disordered eating, self-harm or addiction-focused behaviours.

Almost three decades ago, Dr. Eugene Gendlin of the University of Chicago, published his book *Focusing*, in which he talks about his experience and research as a psychotherapist. He noted that the clients who were making progress and experiencing shifts in self-understanding were all doing something similar in their sessions, regardless of the type of therapy they were receiving. These observations led Dr. Gendlin to define a very personal, body-focused process, which he named Focusing.

Focusing is a way of bringing attention to one's own body and listening in a compassionate way to what is there. It is a remarkably respectful technique that helps an individual develop an 'Observer Self' and attune to the body's knowing or wisdom. For example, I had been taught through Focusing to notice or observe what I was doing. If I began to overeat or to starve myself, I was to notice myself doing it and then to become gently curious about what else might be going on for me at that time. Often I found I was feeling fearful or anxious about an upcoming event—which really had nothing to do with food, my shape or size. In the past, I would have been very critical of myself for bingeing or starving, and the cycle of self-abuse would have increased. Instead, with these new skills, I was able to make healthier choices for dealing with my feelings.

Focusing can be applied in a number of therapeutic situations: recovery from post-traumatic stress due to illness, accident, abuse or neglect; chronic pain due to illness or accident; stress management; depression, grief and/or complex life issues; and self-awareness and personal development.

The technique works wonderfully for someone who may be ambivalent—committed to change, and at the same time, fearful of making change—about their healing or recovery process. Focusing is a way to gently heal those parts that seem the most stuck and unresolved. It teaches and encourages the practice of mindfulness, which greatly reduces dissociation.[1] By listening with care and compassion to those 'places' within ourselves that are hardest to resolve, those places can then naturally shift towards wellness.

In short, I find Focusing to be all encompassing. It allowed me to embrace all of my feelings, thoughts and experiences, and helped me achieve an overall sense of acceptance.

footnote

1 Dissociation is a mental process, which produces a lack of connection in a person's thoughts, memories, feelings, actions, or sense of identity. During the period of time when a person is dissociating, certain information is not associated with other information as it normally would be.

reference

Gendlin, E. (1981). *Focusing*. New York: Bantam Books.

Changes in Substance Use, Violence and Stress Among Women in Transition Houses in Rural Areas

Lucy McCullough, Natasha Jategaonkar, Lorraine Greaves, Cathy Chabot, and Nancy Poole

We are a team of researchers associated with the British Columbia Centre of Excellence for Women's Health (BCCEWH) in Vancouver, one of four women's health research centres in Canada, funded under the National Centres of Excellence in Women's Health program. BCCEWH fosters collaboration on innovative, multidisciplinary research endeavours and action-oriented approaches to women's health initiatives, women-centred programs and health policy

The British Columbia Centre of Excellence for Women's Health (BCCEWH) recently carried out a study of the interconnections between substance use, violence and stress among women staying at transition houses in rural and urban areas across British Columbia. The study was carried out in collaboration with 13 transition houses that are members of the BC/Yukon Society of Transition Houses.

In this article, the reports of women who were staying at transition houses in rural areas (i.e., population 30,000 or less) will be compared with those of women in urban areas (i.e., population greater than 30,000) with respect to their levels of substance use while moving through the transition house experience.

Women with significant levels of substance use were interviewed twice—at the time of entry into the transition house and again three months later. At the first interview, both rural and urban women reported drinking at levels that indicate alcoholism (84% and 86%, respectively). At the time of the second interview, women reported decreased use of alcohol and other substances, as well as less stress in many areas of their lives. We found that structural issues, such as housing, transportation and access to health care, were integrally related to women's stress and substance use. Hence it is useful to examine how the experiences of rural women might differ from those living in urban centres.

Nineteen women from rural transition houses and 51 from urban transition houses were comparable on many demographic characteristics. The average age for each group was 35 years, the majority had children, and most were living on very low annual incomes of $10,000 or less. The majority (53%) of urban women were collecting social assistance, while only 32% of rural women reported receiving social assistance. At the same time, 21% of rural women were neither working nor collecting benefits, perhaps indicating greater financial dependence on their partners.

Physical abuse was common for both rural and urban women, with approximately half saying that their partners frequently scream and yell at them, and more than a third reporting that their partners frequently act like they want to kill them. Rural women were more likely than urban women to report frequent non-physical abuse, with a distressing 100% saying their partners frequently belittled them or became upset if dinner or housework was not completed punctually.

Rural and urban women differed in their patterns of binge drinking; that is, having three or more drinks on one occasion. The majority (85%) of rural women reported binge drinking during the few months prior to accessing help at the shelter. A smaller proportion (59%) of urban women engaged in binge drinking, but on a greater number of occasions.

A rural woman who worked in the sex trade talked about her reasons for drinking as being connected to the problems she faced in trying to access services: "My reasons [for drinking] are because it helps me when …I feel like my rights have been taken away with legal issues….I feel that I've been stripped of my feelings, opinions…like no one really cares about me in this world, a hopeless feeling. I feel like I've been raped by the system."

Urban women were much more likely to report using stimulants (i.e., crack, cocaine and methamphetamine) than rural women (62% and 16%, respectively). Interestingly, urban women's use decreased significantly to 30% by the time of the three-month follow-up interview, while there was no change among rural women. The large decrease among urban women may be a reflection of proactive discussions regarding drug and

Transition houses play a vital role in providing women and their children with safe housing and related supports when they have experienced violence. According to the Transition Homes Survey conducted in 2002, a total of 3,287 women were residing in shelters in Canada and 2,401 (73%) of those women were admitted for reasons of abuse.[1]

alcohol use among staff and residents and success in connecting women to needed services, which urban houses were more likely to report.

Fragmented social services were a common barrier to both groups of women trying to improve their lives. Many participants said they had difficulties navigating the social services system because individual programs are not coordinated to deal with multiple issues. A rural woman said: "I feel that I am forced to tell my story over and over again without anybody listening to me. This makes me give up on the system."

Housing, legal and money issues emerged as factors causing women great stress, particularly at the first interview. However, three months later at the second interview, rural women were more likely than urban women to note that housing and legal issues were still causes of great stress. A number of women said that money stressors prevented them from leaving their violent relationships earlier. One rural woman stated: "…when I was on my own, I had to get my own place, child care, pay all my own bills, etc. So it was easier to just go back to the abusive partner who has the job, the house, the drugs, etc."

The positive work of transition houses was validated by the results of this study, as significant improvements in stress and substance use were seen among the women following the shelter experience. However, rural women may face increased difficulty due to limited access to related health and social services.

Increased integration and awareness of the interconnections between substance use, mental health, experience of violence, and needs for income/social service supports are needed, among substance use treatment providers and mental health and social workers, particularly among those who work in rural settings.

We thank the Alcoholic Beverage Medical Research Foundation for funding this project, the participants for sharing their experiences, and the transition houses for the important work they do.

More information on the findings of this study will soon be available on the following websites:

- British Columbia Centre of Excellence for Women's Health at www.bccewh.bc.ca
- BC/Yukon Society of Transition Houses at www.bcysth.ca

footnote

1 Statistics Canada. (2003, June 23). Family violence. *The Daily*. Retrieved November 15, 2004, from www.statcan.ca/Daily/English/030623/d030623c.htm

Structured for Success

Working with adults affected by FASD

Jeanette Turpin

Jeanette is Executive Director of the Northern Family Health Society in Prince George

The Northern Family Health Society is a non-profit society that has been operating in Prince George for more than 16 years. Our core program is Healthiest Babies Possible (HBP), a Pregnancy Outreach Program (POP) funded by our local health authority. In the past few years, we've added Health Canada's Community Action Plan for Children (CAPC) and the Canadian Prenatal Nutrition Program (CPNP) to our programming options.

Our agency has had the benefit of several research opportunities that focus on the lives of women and their families. We use a participatory action approach, and issues we have examined include family resiliency, mentoring at-risk young women, and better understanding how women recover from substance misuse. A theme that continually weaves through each of our research initiatives is fetal alcohol spectrum disorder (FASD) prevention.

In the spring of 2003, Northern Family Health received funding for a project that grew out of a conversation with a child protection worker. In this child protection worker's opinion, there are a growing number of families entering the child protection system for whom referral options have little or no effect on the parenting capacity of the individuals being referred. She felt that the referral agencies were providing quality services, but they didn't appear to be meeting the needs of these parents.

Through further discussion with the child protection worker, it became apparent that the parents she was talking about had characteristics similar to individuals with FASD. Research around intervention strategies with adults affected by FASD generally, and parenting strategies for persons affected by FASD specifically, is limited. What we do know, at least anecdotally, is that traditional approaches to enhancing parental capacity don't work. The short-term/time-limited nature of these approaches to intervention also fails to meet the needs of the families who are affected by this disability.

The discussion with the child protection worker led to the expressed wish: "Wouldn't it be great if we could get funding to try out a different approach to working with these families!"

Currently, we are in the midst of just such an initiative, which we've named Structured for Success. It has two components—a research piece and a pilot program focusing on intervention. The research will

parallel, as well as document, the process of the interventions.

The intervention component is a collaborative effort between MCFD Child Protection Services, Addictions Services, Mental Health and the Northern Health Authority. Each agency is contributing either a full-time or half-time person to make up a 'wrap-around' team (i.e., one that develops uniquely individualized supports and services). This team will work with families in which the identified parents have poor adaptive functioning and whose parenting capacity or family resiliency has been compromised by suspected or diagnosed FASD and/or other types of brain damage, including adult mental health issues and/or alcohol and drug misuse.

The framework for intervention will be based on a neurocognitive model that Diane Malbin (FASNET, Portland, Oregon) has helped develop. This model considers FASD behaviours less as pathological (i.e., caused by mental or physical disorder) and more as direct or indirect statements about the characteristics of the disability.

The intervention approach we intend to use will take this neurocognitive approach a step further. Environments will be targeted for intervention in order to provide appropriate supports and accommodations for the individual. This will minimize the impact of the disability for that individual and the people around them.

Pulling together the intervention team has taken longer then we had anticipated. Bringing these partner agencies together has been a coordination and scheduling nightmare. However, the support we have received from our partner agencies has been amazing. It truly is a collaborative effort.

We are now in the initial stages of developing the team. The people who will be moving over to become part of our Structured for Success team have been identified, and the FASD training is underway. We hope to begin taking our first clients in December 2004.

Project updates will be posted at www.nfhs-pg.org

web resource

learn more about FASD at www.heretohelp.bc.ca/publications/factsheets/fetalalcohol.shtml

Harm Reduction and Housing

YWCA Crabtree Corner

Wendy Lund

Wendy has been employed as a housing support worker with YWCA Crabtree Corner Housing

I was hired in 2003 by the YWCA of Vancouver as the evening housing support worker for the new YWCA Crabtree/Sheway Housing program. This program offers temporary harm-reduction housing for women who are pregnant or who have children younger than 18 months for whom they may or may not have custody. In most cases, the women have been referred by staff at Sheway, a program offering support services to women who have issues with substance abuse (see p. 22).

YWCA Crabtree Corner Housing, located in the Downtown Eastside of Vancouver, is also home to the relocated YWCA Crabtree Corner and Sheway programs. The women are able to take advantage of a continuum of services, all within the building in which they live. They can start with a nutritious breakfast downstairs at YWCA Crabtree Corner. After breakfast they can settle their children into Crabtree Corner Child Care Centre on the second floor. In addition to the warm and caring staff, the child care centre has a beautiful, safe, clean outdoor play area.

Residents then have access to a number of services that provide the support they need to make changes in their lives: the FAS/NAS (Fetal Alcohol Syndrome/Neonatal Abstinence Syndrome) Prevention Project, Nobody's Perfect parenting groups, the Community Kitchen, food and nutrition programs, primary health care services, counselling services, healthy child development programs and advocacy services.

The evenings are busy on the fourth and fifth floors of the building where the 12 housing units are located. That is where the housing support workers can be found. The residents seek us out for a variety of reasons. They may need help accessing information about community programs, pregnancy, parenting, education or employment. They may ask for help in writing a letter, filling out a form, or may want to talk about what their goals are, and what support they need to achieve them. They may have had a bad day and need to talk about it. They may feel ready to go to detox and will ask us if there are beds available. They may want to tell us what they are planning to cook for the next resident meal, or what items they are putting on the agenda for the next meeting. They

Fir Square at BC Women's Hospital

Maternity care and substance misuse

Yalile Seaman

Yalile is the Fir Square social worker. She has a master's degree from UBC, where she focused on health care and community development

Fir (Families in Recovery) Square

In January 2003, BC Women's Hospital opened the Fir Square program, which provides maternity care for women struggling with substance misuse. Women are admitted to the unit for withdrawal management and stabilization. Length of stay ranges from one day to several months, depending on the woman's degree of instability. Women can be admitted several times during their pregnancy based on their needs and commitment to participating in the program.

For referrals to the Fir inpatient unit, call (604) 875-2229; for the Thursday outpatient clinic, call (604) 875-2160

Following a harm-reduction approach, the program's goals are to reduce the substance use and risky behaviour of the women and to have more women go home with their babies postpartum. Women are at different stages of readiness to change their lifestyle; therefore, they guide their own care planning.

A multidisciplinary team is available to support these women. The team consists of nurses, physicians, a senior practice leader, a dietitian, a social worker, an alcohol and drug counsellor, an infant development worker, a spiritual care worker, music and recreational therapists, and a reproductive mental health psychiatrist.

Rooming-in

Fir Square has a 'rooming-in' philosophy based on family-centred care—i.e., keeping mother and baby together on the ward. Rooming-in strengthens a mother's caregiving skills and her confidence to parent, offering the mother the possibility of going home with her baby.

The program has found that the number of babies experiencing withdrawal and the number of babies requiring treatment with morphine is lower when mothers are the primary caregivers. Babies are supported through the withdrawal symptoms that usually begin within the first three days after birth. A baby's readiness for discharge is based on the objective measure of weight gain over two or three consecutive days.

Care Planning and Delivery

The Fir team plays a valuable role in empowering the mother to have a stronger voice and to increase her participation in the process of determining what is best for the baby. There are weekly care planning meetings with the Fir team, the woman, her community supports, and Ministry of Children and Family Development (MCFD) workers to facilitate a consensus decision-making process that addresses ▶

Harm Reduction and Housing | cont'd

may ask to borrow a video, and we may just sit down and watch it together. Or, maybe we will go for a walk and show them the nearby community garden they never knew existed. Maybe one of us will take one of these women, who may not have been treated with dignity and respect for a large part of her life, to a gala dinner, giving her an experience unlike any she'd had before.

As staff we have deliberated about how we should measure the success of our program. Not all of the women without custody who move in will be reunited with their children, and those who are not will be traumatized by it. This trauma will be compounded by all the other traumas they have experienced in their lives and will likely push them further into substance abuse and risk-taking activities. These women are anaesthetizing themselves to avoid feeling the pain of all the grief and loss they have suffered. The anticipation of confronting this pain and sadness makes stopping their drug use a major challenge. We are there to support them and to assure them they are making the best choices they can. We do not judge them for the choices they make.

YWCA Crabtree Corner is located in Vancouver at 533 East Hastings Street

Other women in our program will give birth and return home to Crabtree Corner from the hospital with their babies, and those children will remain in their care. Some mothers will come home from the hospital alone; they require more time and support before being reunited with their children.

When the women leave Crabtree Corner Housing services, our relationship with them does not necessarily end. We may not hear from them for some time, but some return, either to say hello to the staff or to access the services downstairs at Crabtree Corner or Sheway. This continued relationship is an indication that we have gained a woman's trust. This is the most important thing we can achieve and is a large measure of the success of our program.

Watching each of these women with their children is a privilege. The joy and beauty in these mothers' faces when they see their children touches my heart beyond belief. Hearing from women that living in this housing has made a difference in their lives and seeing them create homes that speak of dignity and self-respect for them and their children—this is the best measure of the success of our program.

family needs as early as possible. An educational component about substance use and the effects on babies has proven beneficial for all parties involved in planning for a baby. The protection concerns and expectations of MCFD are clarified to ensure families are in safe home environments. In terms of evaluating a mother's parenting capability, Fir staff acknowledge the research that says that women with babies in their care relapse less often.

On evaluation forms, women have reported a sense of self worth and a greater bond with their babies as a result of opportunities to parent while at Fir and after leaving the hospital. If a baby is going into foster care, the foster parent is required to have teaching sessions with the infant development worker, and with the mother and baby at least once before they are discharged from Fir. The rapport building between mother and foster parent is extremely important when mothers are working towards parenting in the future. It can influence the frequency and quality of visits the mother makes to the foster home after discharge from Fir.

The program tries to address identified gaps in the continuum of care for pregnant and early postpartum women with addiction issues, and advocates for safe housing, treatment and parenting programs, financial and legal aid, and dual support. Fir Square has a close partnership with community resources that provide a wide range of services for pregnant women and women with children up to 18 months. A long-term goal of the Fir program is to create a second-stage house and treatment program for women on methadone and their babies; the lack of this type of support prevents families from staying together.

The care providers at Fir strive to improve service delivery. Staff have seen improved perinatal outcomes, including increased birth weights, a decrease in infants requiring treatment for withdrawal, and an increase in mothers who are able to safely retain custody of their newborns. Educational workshops are organized to facilitate connection with health care providers throughout BC. Data is also being collected for research purposes—to highlight the need to change how maternity care is provided across Canada.

It is essential that as a society we recognize addiction issues and the challenge of caring for these families in the context of poverty, community disconnection, and limited funding for social programs.

relevant resources

Covington, S. (1999). Theoretical perspectives: How addiction works and how women recover. In *Helping Women Recover: A Program for Treating Addiction.* San Francisco: Jossey-Bass.

BC Reproductive Care Program. (1999). Principles of perinatal care of substance using women and their infants; and Discharge planning guide for substance using women and their newborns. *Substance Use Guidelines 1 & 2.* Retrieved November 15, 2004, from the BC Reproductive Care Program website: www.rcp.gov.bc.ca

Hepburn, M. (1993). Drug misuse in pregnancy. *Current Obstetrics and Gynaecology, 3,* 54-58.

Johnson, K., Gerada, C. & Greenough, A. (2003). Treatment of neonatal abstinence syndrome. *Archives of Disease in Childhood Fetal and Neonatal Edition, 88*(1), F2-F5.

Kennell, J.H. & Klaus, M.H. (1998). Bonding: Recent observations that alter perinatal care. *Pediatrics in Review, 19*(1), 4-12.

Lvoff, N.M., Lvoff, V. & Klaus, M.H. (2000). Effect of the baby-friendly initiative on infant abandonment in a Russian hospital. *Archives of Pediatric & Adolescent Medicine, 154*(5), 474-477.

Nishimoto, R.H. & Roberts, A.C. (2001). Coercion and drug treatment for postpartum women. *American Journal of Drug & Alcohol Abuse, 27*(1), 161-181.

Richter, K.P. & Bammer, G. (2000). A hierarchy of strategies heroin-using mothers employ to reduce harm to their children. *Journal of Substance Abuse Treatment, 19*(4), 403-413.

Poole, N. & Isaac, B. (1999). *Apprehensions: Barriers to Treatment for Substance-Using Mothers.* Retrieved November 15, 2004, from the BC Centre of Excellence for Women's Health website: www.bccewh.bc.ca

Prodromidis, M., Field, T., Arendt, R. et al. (1995). Mothers touching newborns: A comparison of rooming-in versus minimal contact. *Birth, 22*(4), 196-200.

Effective Treatment for Women with Substance Use Problems

Aurora Centre's approach

Gail Malmo, MA, MSW

Gail is Program Director at Aurora Centre in Vancouver

Background

The Aurora Centre has been providing treatment to women with substance use problems for over 30 years. Throughout these years we have worked with over 6,000 women from all regions of the province, from all walks of life, and they have all shared the same problem: serious addiction to alcohol and/or other drugs.

The growth and development of the Aurora program to some extent mirrors that of the substance use field generally. In our early days, in the '70s, we were a grassroots organization, with volunteers and good intentions as the dominant treatment modality. As knowledge of effective substance use treatment practices developed, Aurora refined and changed its practices and approaches. Today, we offer a highly professional treatment program based on 'best practices' and ongoing evaluation

of client outcomes and client satisfaction.

In addition to research and best practice literature, we rely on the women we serve and what they tell us about what has helped them most. Underlying our approach is an abiding belief in the ability of our clients to reclaim what they have lost during their addiction and to uncover and discover their real, beautiful selves as the mothers, daughters, sisters and partners that they are.

What does treatment at Aurora Centre look like?

We know that the process of addiction, treatment and recovery is different for men and women. It is therefore crucial that women have the option of a women-specific treatment facility. At Aurora, women find a physically and emotionally safe and supportive environment in which to address their substance dependency. The centre offers both residential and day program treatment options.

many-issues approach

Our approach is based on the belief that effective treatment includes helping women understand and address the many issues underlying their use of substances. Issues common to women experiencing substance use problems include:

- Previous history of trauma
- Mental health problems, with depression being one of the most common
- Issues of guilt and poor self-esteem
- Relational issues—with spouses, partners, families and children
- Poverty, discrimination and lack of power and control over their lives

Using a biopsychosociospiritual model, the Aurora program assists women in treatment to understand the connection between the above issues and their use of substances. The women come to realize how they may have used substances to cope with, and numb, the pain they are experiencing in their lives. We help them make the connection between their substance use histories and issues such as grief and loss, unhealthy relationships, family patterns, and sense of self. As they begin to understand these connections, the women are able to better identify their potential relapse triggers and to develop a solid plan for long-term recovery.

One of the most important gains our clients make is the connection with other women. Isolation is common in the process of addiction, and being able to establish deep bonds with other women is a significant factor in women's recovery.

Residential treatment

Our residential program is six weeks long. Using a combination of group therapy, education sessions, videos and individual counselling, we help our clients set goals and work toward improving their emotional, physical, mental and spiritual lives. Women are supported in taking healthy risks to change their behaviour, improve communication skills and develop greater self-awareness and understanding of their patterns of use. In keeping with our holistic approach, clients also participate in regular fitness programs, yoga and meditation, and music and art therapy. In the last week of treatment, clients focus on preparing to return to their lives outside Aurora Centre. This includes developing a relapse prevention plan.

Day treatment

Aurora offers day treatment to women who live within commuting distance of Vancouver. Women may choose our five-week intensive program or a two-week program designed for women in early recovery. Day treatment is ideally suited to women who have stable home lives and who do not require the structure and support of a residential environment. Our day programs are similar in approach to our residential program.

Barriers to getting help

Treatment works. We see evidence of this every day at Aurora. But the process is not always smooth, and women often encounter numerous barriers to receiving the help they need.

The field of substance abuse treatment is beginning to recognize that important differences exist between men and women's risk factors for use, patterns of use, and their treatment needs. While the rate of women's substance use is lower than men's, women are more vulnerable than men to some serious health consequences. For example, because of the way women absorb and metabolize alcohol, they are more vulnerable to organ-related damage than are men.[1] That women may experience more serious consequences from substance use despite overall lower levels of use than men, suggests that seeking and receiving treatment early is of vital importance.

Unfortunately, women tend to face more barriers to accessing treatment than men do. Some of these barriers are external (e.g., lack of family support, lack of accessible treatment resources) and some are internal

> "The centre was wonderful. I learned how to relax and have fun again. It's been a long time. The groups, the women and the tears were more healing than I thought possible."
>
> ~ client of residential program

> "I regained confidence in myself, my feelings and my opinions, and I regained connection with other women and the world. Thank you."
>
> ~ client of day program

resource

Ritch, A. (2001). *Aftercare Programming at the Aurora Centre: An Evaluation.* Vancouver, BC: Women's Addiction Foundation. The report evaluates four aftercare programs (smoking reduction, vocational planning, trauma counselling and parenting programming), discusses the barriers to participation and proposes solutions. Executive Summary and ordering information at www.womenfdn.org/Resources/aftercare.html

(e.g., the woman's own perception of her problem, her self-worth).

A study done by our research consultant Nancy Poole found that the two biggest barriers to treatment identified by women interviewed were shame (internal barrier) and fear of losing their children (external barrier).[2] The issue of stigma continues to be an important factor for women who misuse substances, and it is compounded by their role as primary caregivers of children. Women tend to internalize this stigma, which results in feelings of severe worthlessness and shame. This often prevents them from reaching out for help. And it is not difficult to see how the fear of losing their children —a very real, and very terrifying concern for many women—prevents them from stepping forward and admitting to serious addiction problems.

It is exceedingly important that human service and health care professionals working with women understand these barrier dynamics, and that they provide both non-judgemental support to help women acknowledge harmful substance use and to guide them in identifying appropriate treatment resources.

Measuring success

Measuring success in addiction treatment isn't easy. It is not enough to simply measure abstinence rates, for there are many other elements in a woman's life that need to change if she is to sustain the gains made in treatment. In addition to abstinence rates, Aurora measures how well women who have completed treatment are doing in the following:

- Overall improvement in physical health, emotional health, spiritual life, vocational status and legal status
- Improvements in relationships with partners, families and children
- Continued participation in alcohol/drug counselling, self-help groups or other support groups/counselling

Success in managing substance use appears to correlate with improvements in the above areas. In 2003, an average of 88% of both day and residential treatment clients reached reported either abstinence, or a brief relapse followed by a return to abstinence, at three months post-treatment. At the time of discharge from Aurora, the vast majority of these women had shown marked improvement in their self-esteem and depression levels, as well as their sense of hope for the future.

While a successful treatment outcome for women with substance dependency problems is not always straightforward or guaranteed, we do know that treatment readiness and client motivation are two factors which have a great impact upon treatment outcomes. The Aurora Centre relies on professionals working with women prior to admission to assess these factors, and as much as possible, to ensure that a referral to Aurora is the right treatment at the right time.

We know too, that, as has often been said, treatment is a journey, not a place. Our clients leave Aurora with an array of new skills, and renewed self-confidence in their ability to live a full and satisfying life free from the harms of addiction. Above all, they take with them the sense that they are worthy of a better life.

But treatment is only one step on the journey to full recovery. We know that the women who complete our treatment programs need ongoing practical and emotional support as they rebuild their lives in their respective communities. It is our hope that they find this support where and when they need it. With the right combination of effective treatment, together with an array of aftercare services, women can and do recover from the harms caused by addiction.

For further information about Aurora Centre programs, or to refer a woman to Aurora, email aurora@cw.bc.ca, or call (604) 875-2032

footnotes

1 National Institute on Alcohol Abuse and Alcoholism. (1999). Are women more vulnerable to alcohol's effects? *Alcohol Alert, 46.* Retrieved November 15, 2004, from www.niaaa.nih.gov/publications/aa46.htm

2 Poole, N. & Isaac, B. (2001). *Apprehensions: Barriers to Treatment for Substance-Using Mothers.* Vancouver, BC: British Columbia Centre of Excellence for Women's Health.

Seeking Solace and Safety

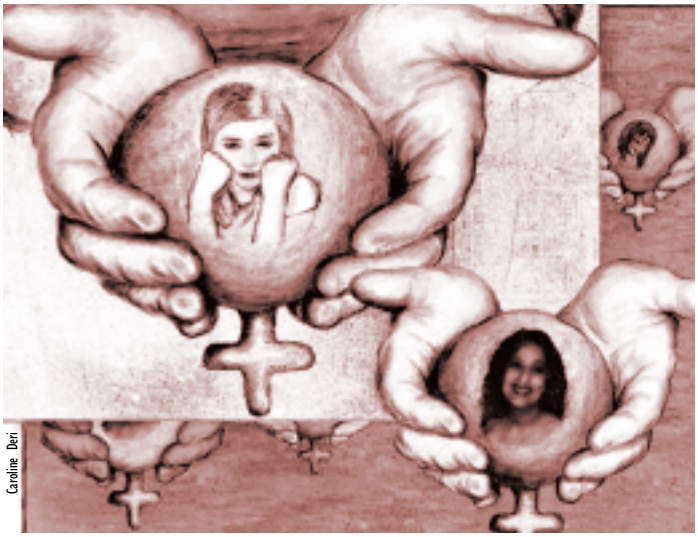
Trauma-informed training at Riverview

Kathleen Whipp, MSW, RSW

Kathleen is a therapist, consultant and trainer in private practice, specializing in trauma, mental health and substance issues since 1987. She is involved in mental health research initiatives at the BC Centre of Excellence for Women's Health

Twenty years ago it was taboo to talk about violence and trauma while people were in contact with the mental health and addictions services where I worked. At that time, I was a graduate student in psychiatric social work and counsellor in an addictions recovery home for women. I also volunteered at two women's centres that encouraged empowerment, creativity and peer support in recovery from trauma. They helped survivors make sense of their pain. These centres saw addictions as efforts to self-medicate and encouraged a harm-reduction strategy.

My graduate research led me to discover a few clinicians—such as Dr. John



Briere, with UCLA and Klinic Community Health Centre in Winnipeg—who were documenting the numbers of abuse survivors they were seeing. Dr. Judith Herman at Harvard Medical School was organizing sexual abuse support groups in her outpatient department. Drs. Elaine Carmen, Patricia Rieker and Trudy Mills identified a "victim to patient process."[1] A groundswell of knowledge has been slowly building since that time.

We are now living in an exciting era, where research on trauma and the brain complements the wisdom originally shared in women's programs throughout North America—including the centres I worked in 20 years ago. More effective therapies are being developed and backed by research. Vancouver General Hospital now sponsors an annual trauma conference, has a post-traumatic stress disorder (PTSD) clinic, and an Integrative Personality Program. Trauma specialists are documenting the impacts of violence, neglect and discrimination on our mental health that go beyond the diagnosis of PTSD.

For more information, visit www.kathleenwhipp.com

One of the last frontiers to understand is the role of trauma and recovery for survivors who are diagnosed with serious, persistent mental illness (SMI). Riverview Hospital found high rates of disclosures of physical and sexual abuse in a sampling of 72 women and men in hospital.[2]

A review of studies of women diagnosed with SMI compared a lifetime history of physical or sexual abuse among this group (51 to 97%) with histories in general population studies of 14 to 34%.[3] Dr. Marina Morrow of the BC Centre of Excellence for Women's Health recently documented that while "an awareness of violence and abuse is critical for understanding mental illness" and supporting recovery, it has been "routinely overlooked" in our province.[4]

Many staff have not been trained in this area. Only a few mental health teams have an abuse resource worker, who cannot meet all the demand for services.

At Riverview Hospital in 2000, the Vulnerable Patients Task Group was organized to address some of this need. I was invited to design and pilot training for staff under the guidance of this group, which included a cross-section of professional staff plus family representatives and consumer advocates from the Mental Patients' Association.

Our goals were to increase patient safety and to minimize retraumatization while in hospital. In my earlier research, survivors reported that mental health staff too often inadvertently repeat the dynamics of trauma in their efforts to help patients. Since the 'safety stage' of recovery from trauma is the foundation for later work, the group planned to equip staff with knowledge of 'coping and containment skills' for survivors.

In order to promote hospital-wide ownership of the project, an organizational development approach was essential. The trauma training was connected to other treatment practices, and related presentations were hosted at hospital grand rounds. We gave a workshop, Safety, Voice and Choice, at Riverview's annual patient conference. Two wards were chosen for training because committee members recognized that the staff were already doing good work with some patients with trauma histories, even though most staff didn't have previous trauma training. These staff members were also asked to give feedback on the training's effectiveness.

Since severe early trauma survivors have understandable difficulties with trust and boundaries, staff often find themselves 'splitting' in their reactions; some tend toward empathy, for example, while others believe limits are most important. This dynamic can only be avoided when all staff working together are trained together. All 70 staff of these two wards, including the physicians, took the training in interdisciplinary groups. In-house co-facilitators were prepared to take the workshops to other parts of the hospital.

An evaluation of this training by the BC Centre of Excellence for Women's Health found 85% of staff rated the sessions as "very helpful" in raising issues that are relevant in their work. A "definite increase in confidence" was reported "in their ability to work with patients with severe trauma histories."[5]

The training package, now called Seeking Solace and Safety, can be customized to any mental health setting.

footnotes

1 Rieker, P. & Carmen, E. (1986). The victim to patient process: The disconfirmation and transformation of abuse. *American Journal of Orthopsychiatry, 56*(3), 360-370.

2 Fisher, P. (1997). *In-house Study at Riverview Hospital.* Unpublished study prepared for the Trauma Services Group, Coquitlam, BC.

3 Goodman, L.A., Rosenberg, S.D., Mueser, K.T. et al. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future directions. *Schizophrenia Bulletin, 23*(4), 685-696.

4 Morrow, M. (2004). Violence and trauma in the lives of women with serious mental illness often overlooked. *Canadian Women's Health Network Magazine, 7*(2-3). Retrieved November 15, 2004 from cwhn.ca/network-reseau/7-23/7-23pg7.html

5 Poole, N. (2002). *Evaluation report on the Vulnerable Patients Project.* Coquitlam, BC: Riverview Hospital.

Pregnancy Outreach Programs

Maria Burglehaus

Maria is the nutritionist at Sheway in Vancouver's Downtown Eastside and Secretary of the BC Association of Pregnancy Outreach Programs

For 20 years, Pregnancy Outreach Programs (POPs) have provided a place where women can go for support to have a healthy baby. POPs were created to reach out to women who do not access typical prenatal information and services. There are now over 46 programs in BC. They are located in community centres, health centres and friendship centres. They are well supported by agency partnerships and volunteers and by donations from the community.

POPs are free programs where a woman can access:

- nutrition and health counselling
- food hampers, prenatal vitamins and food vouchers
- peer group support
- referrals to counselling services, life skills programs, parenting programs and breastfeeding support
- support to cut down or stop smoking and to reduce exposure to second-hand smoke
- help to deal with an alcohol or drug issue
- arts and crafts activities and music therapy
- instruction on caring for and feeding her baby

The programs have been very important in reducing the chance of having a low birth-weight baby. They stress the benefits of support and prenatal services to a healthy pregnancy. POPs recognize that cultural barriers and limited finances affect a woman's ability to access resources, particularly healthy foods and transportation. They also recognize that mental health issues and/or alcohol and drug issues may be affecting a woman's life and her ability to get support in her pregnancy. The effects on her infant and on her health are minimized when a woman participates in a POP. Program workers are trained to help a woman build on her strengths. Program staff work in partnership with each woman, supporting her and the decisions she makes, as well as offering information, education and assistance.

While it is often the woman who refers herself to Pregnancy Outreach Programs, a community service or health service provider can make the referral with the woman's permission.

Spending time together

Trusting relationships are built between POP program workers and the women they serve. Program workers have the opportunity to meet with the women weekly during the prenatal and postnatal periods. Staff are trained and skilled in supporting and connecting with women. Throughout the pregnancy, it is not uncommon for a woman to have concerns or worries. She may have anxiety about the delivery of her baby. She may wonder how well she will be able to bond with her baby. At a POP, the woman is shown great understanding and compassion, and her privacy is respected.

Outreach at home and one-to-one

The worker can do outreach, arranging a one-to-one visit at the woman's home or a safe place of her choice. A woman will be offered this service for any of the following reasons:

- She is feeling isolated
- She has specific health issues
- She is uncomfortable in a group setting like a drop-in
- She has specific language or cultural needs
- She requests one-to-one counselling

Offering to introduce women to services

POPs build partnerships with other community services. Service providers will be invited to POP luncheons so the POP participants have an opportunity to become comfortable with workers from other agencies. Often a POP worker will introduce a woman to a new service by going to a first appointment with her. Service providers say it is often that first connection with a POP worker that helps a woman trust and connect with other services in her community. POPs open doors and help each woman build her own circle of support.

For program information and location of a POP near you, please visit www.bcapop.ca

Spreading the word

In 1996, the BC Association of Pregnancy Outreach Programs (BCAPOP) was formed. The 46 programs and several partners make up the association's membership. The BCAPOP board and committee members are POP coordinators and program workers. BCAPOP helps:

- Program workers share ideas with each other
- Communicate best practices
- Communicate and organize training workshops and provide funding assistance for training
- Connect with partners such as the BC Ministry of Health Services, Health Canada, First Call BC and the BC Reproductive Care Program
- Coordinate efforts to address FASD, substance use issues, mental health issues and other challenges that program participants face

The association's monthly teleconferences are well 'attended' by POP coordinators and program workers. These provide an opportunity for the workers to support each other in work that demands much energy and compassion. They share their experiences and get a chance to recharge themselves. Another key opportunity for learning and sharing is our BCAPOP annual conference.

Women's Mental Health: General

- BC Reproductive Mental Health Program. Website contains recent best practices guidelines around depression, anxiety and psychosis before, during and after pregnancy; also features personal stories; and fact sheets on other reproductive mental health issues beyond pregnancy and postpartum like PMS, menopause, infertility and pregnancy loss. See www.bcrmh.com
- Morrow, M. & Chappell, M. (1999). Hearing Women's Voices: Mental Health Care for Women. British Columbia Centre of Excellence for Women's Health. See www.bccewh.bc.ca/PDFs/hearingvoices.pdf
- Kornstein, S.G. & Clayton, A.H. (Eds.). (2004). Women's Mental Health: A Comprehensive Textbook. New York: Guilford Press.
- *Visions: BC's Mental Health Journal.* (1998). Vol. 1, No. 3. Women's Mental Health. See www.cmha-bc.org/visions or call 1-800-555-8222 to order hard copies.

Stress and Depression

this list is not comprehensive and does not imply endorsement of resources

don't forget all the resources listed at the end of Visions articles as well

- Nelson, D.L., & Burke, R.J. (Eds). (2002). Gender, Work Stress, and Health. American Psychological Association.
- Stoppard, J.M. & McMullen, L.M. (Eds). (2003). Situating Sadness: Women and Depression in Social Context. New York: New York University Press.
- Whitney, D.K., Kusnir, A. & Dixie, A. (2002). Women with depression: The importance of social, psychological and occupational factors in illness and recovery. *Journal of Occupational Science, 9,* 20-27.

Addiction

- Health Canada. (2001). Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems. See www.hc-sc.gc.ca/hecs-sesc/cds/pdf/women-e.pdf
- Centre for Addiction and Mental Health resources. Call 1-800-661-1111 or email marketing@camh.net to order.
  - Is It Safe for My Baby? Risks and Recommendations for the Use of Medication, Alcohol, Tobacco and Other Drugs during Pregnancy and Breastfeeding (2003)
  - The Hidden Majority: A Guidebook on Alcohol/Other Drug Issues for Counsellors Who Work with Women (1996)
  - Women and Alcohol (1996)
- Integrated Mentor Program in Addictions Research Training (IMPART) is a multidisciplinary training institute and fellowship program aiming at training and developing a provincial and national network of Canadian health researchers specializing in research related to women and addictions: www.addictionsresearchtraining.ca

Body Image and Disordered Eating

- Canadian Research institute for the Advancement of Women. (1999). That Body Image Thing: Young Women Speak Out. Young women's essays on a wide range of body image topics. Can be ordered online: www.criaw-icref.ca/pubs/publicationDetails_e.asp?id=96
- The Strength to Resist: Media's Impact on Women and Girls [video]. (2001). 33 minutes. Award-winning documentary presents the ideas of girls, young women and leading authorities in the fields of psychology of women and girls, self-esteem, eating disorders, gender studies, violence against women and media literacy. Study and curriculum guides also available. See www.cambridgedocumentaryfilms.org/beyond.html

Violence and Traumatic Stress

- Stopping The Violence. The Ministry of Community, Aboriginal and Women's Services. Includes information on community-based counselling, transition homes, and second-stage housing. www.mcaws.gov.bc.ca/womens_services/stopping-violence/index.htm
- BC Centre of Excellence for Women's Health. (2002). Violence and Trauma in the Lives of Women with Serious Mental Illness: Current Practices in Service Provision in British Columbia. See www.bccewh.bc.ca/PDFs/violencetrauma.pdf
- Centre for Addiction and Mental Health resources. Call 1-800-661-1111 or email marketing@camh.net to order.
  - First Stage Trauma Treatment: A Guide for Therapists Working with Women. (2003).
  - Bridging Responses: A Front-Line Worker's Guide to Supporting Women who Have Post-Traumatic Stress (2001)
  - Women: What Do These Signs Have in Common? Recognizing the Effects of Abuse-Related Trauma (2004)

BC Partners for Mental Health and Addictions Information | c/o 1200-1111 Melville Street Vancouver, BC Canada V6E 3V6