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Mental health and substance use  
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BC's Mental Health and Addictions Journal

# visions

Vol. 6 No. 4 2011

social support

origami: therapeutic magic

mental health camp: breaking  
the silence, setting us free

## visions

Published quarterly, *Visions* is a national award-winning journal that 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. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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## letter to the editor

Perhaps if homophobic people (i.e., those afraid or very uncomfortable around gay and/or lesbian people) could knowingly get acquainted with openly homosexual people, the former may not be so predisposed to dislike the latter's presence. I used to be homophobic, until, while attending a clubhouse, I met a new member who was/is a gay teen. At first, he told me he was bi-sexual, for he felt that declaring such would be less intense than being out-right gay; though, not long after, he trusted me enough to come out as fully gay. However, on two occasions, he told me that he actually was not gay—that his homosexuality had been all naught but some sort of mental phase he'd been mixed up in, usually after hospitalization and/or religious-influence episodes.

This was at a point, however, when we had (at least as far as I'm concerned) become friends, especially him being one who, like myself, knew and loved almost every episode of *The Simpsons*; indeed, he and I would joke and clown around into belly-shaking laughter. But more so, he was also compassionate and simply a nice guy, all around. Although I had occasionally let him know of both of my Earthly and spiritual objection to the homosexual lifestyle, I also let him know that he was more than welcome around me and that I'd gladly lend him an ear with any of his daily problems—particularly when some other clubhouse members would give him a hard time (which fortunately was rare) over his homosexuality, including thumping his head with a Bible or two. All said and done, nobody has the right to give a homosexual person a hard time simply because of his/her sexual orientation, let alone physically assaulting him/her for it.

— Frank G. Sterle, Jr., White Rock, BC

## editor's message

A 9-1-1 paramedic I know told me about a visit he made to the home of an elderly woman. It turns out she had called because she had no one in her life and wanted someone to talk to and share a cup of tea with. Now, I'm not suggesting anyone use 9-1-1 like that, but is it any wonder that story of social isolation sticks in my mind? Or the story I heard recently of a gentleman in Vancouver's Downtown Eastside who, though he had a single room of his own, still chose to sleep in a local homeless shelter because of the sense of community he had there. Do we really get it? Social support is absolutely fundamental to our well-being. And we need to talk about it much more than we do now.

The Public Health Agency of Canada lists social support second in its list of 12 'determinants of health' (those bigger picture things beyond the health care system that impact our health). Now, I don't know if that means it's second in importance, but I wouldn't be surprised. Having people—family, friends, neighbours, peers, whoever they are and whatever we call them—who care about us, support us and include us, well, there's nothing more basic than that to mental health.

It was a privilege to work with and learn from our Guest Editor this issue: an economist, an Officer of the Order of Canada, and a renowned researcher on the economic, personal and community benefits of social well-being. I first heard of John Helliwell when he spoke at a CMHA conference some years back. He made 300 people in suits sing the kindergarten song "The more we get together, the happier we'll be." He was right back then. And he's still right.

Sarah Hamid-Balma



*Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness.*

### footnotes reminder

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



# Social Cures Have Good Side Effects

Guest Editor John F. Helliwell

Each of the articles this issue of *Visions* illustrates, in its own way, the magic of the social cure. Humans are social beings, hard-wired to gain pleasure and meaning through social relations—and especially through opportunities to do things together.



*John is based at the University of British Columbia and is co-director of the Social Interactions, Identity and Well-Being program of the Canadian Institute for Advanced Research.*

For example, in recent experiments at Oxford, rowers showed remarkable increases in endorphin release (as monitored by higher pain thresholds) by doing the same workout together rather than alone.<sup>1</sup>

Best of all are social relations in circumstances aimed at improving life for others. In this issue, Rosemary Browne states: “The benefits of doing origami are somehow multiplied for me through sharing the art form.” That “somehow” is always there, as witnessed by the following quotes from Sophia Kelly’s article on the buddy system:

- “It is families helping families in a non-medical forum. I believe it helps both the buddy and the match.”
- “It gives me great satisfaction and

pleasure to be a volunteer for the Buddy Program. Being able to help in some small way is even better.”

- “I have provided an ear to listen and my experience with the mental health system. I have given encouragement and gained a friend.”

It’s been known for decades that people, whether patients or not, live happier and healthier lives when they have, and can maintain, meaningful social connections. Modern experiments in clinical and care settings are showing that even quite modest changes in the social environment can produce significant improvements.<sup>2</sup> Indeed, experiments and survey evidence alike show that the psychological benefits from reaching out to others are apparent all over the world.<sup>3</sup>



Individuals tend to underestimate the satisfaction and sense of well-being they'll obtain from reaching out to help others.

One of the best therapies for those with physical or mental illness is provided by the chance to reach out and help others. The quotes above, and the cited research, provide examples. However, while the benefits of providing and maintaining social supports directly to patients are increasingly well documented, less attention is being paid to the benefits received by those who reach out to others.

There are two difficulties in achieving these gains. One is that individuals tend to underestimate the satisfaction and sense of well-being they'll obtain from reaching out to help others. The second difficulty, which is particularly applicable in the case of those with depression, is that the illness itself limits both the ability and the will to reach out to others. As Nichole Fairbrother notes in her article:

"Many of us will pull back from other people when we are experiencing mental health or substance use problems. In this way, mental health or substance use problems can lead to problems with social support and aggravate our feelings of loneliness. For these reasons, reconnecting with others in healthy, supportive ways is often an important component of managing most mental health or substance use problems."

This poses a puzzle—that the most valuable part of the social cure may be the most difficult to deliver. It is often simpler to give direct aid—whether in the form of drugs, therapy or social supports—to those with depression. That is a natural place to start. But it's often not enough, and in any event may not be the best way to respond. And the systems that develop to support these

direct services, once they are in place, might not easily be changed.

For a solution that will be of the most help to all, it's necessary to think beyond direct aid. We need to find ways to enable people who are depressed and excluded to become engaged with others in that most rewarding of ways—by working together for the benefit of others.

Perhaps the best way of making this happen more often would be to emphasize group-based approaches over individual approaches. Groups can naturally transform themselves into self-organizing mutual aid teams. From there it's only one more short and natural step for the group itself to reach out to connect with and assist others. And, group managers should see what can be done to have fun in the process; people will remember and will want to repeat golden moments.

The social cure's positive side effects are doubly valuable: they increase the well-being of the original patients, and at the same time, they enlarge the circle of people who benefit. An 'epidemic' to be cherished. ▼

# Social Support

Nichole Fairbrother, PhD

## What is Social Support?

Social support is the physical and emotional comfort given to us by our family, friends, co-workers and others. It's knowing that we are part of a community of people who love and care for us, and value and think well of us.

We all need people we can depend on during both the good times and the bad. Maintaining a healthy social support network is hard work and something that requires ongoing effort over time.

### Forms of social support

Support can come in many different forms:

#### Emotional support

This is what people most often think of when they talk about social support. People are emotionally supportive when they tell us that they care about us and think well of us. For example, if you separated from your partner or lost your job, a close friend might call every day for the first few weeks afterwards just to see how you are doing and to let you know that he or she cares.

#### Practical help

People who care about us give us practical help such as gifts of money or food, assistance with cooking, child care, or help moving house. This kind of support helps us complete the basic tasks of day-to-day life.

#### Sharing points of view

Another way for people to help is to offer their opinion about how they view a particular situation, or how they would choose to handle it. In sharing points of view, we can develop a better understanding of our situation and the best way to handle it. For example, if

you tell a friend about difficulties you are having with your teenage son, she may offer a point of view you hadn't considered, and this may help you to better address the situation with your child.

#### Sharing information

It can be very helpful when family, friends or even experts give us factual information about a particular stressful event. For example, a friend who recently married might provide information about the cost of various components of their wedding, or a cancer survivor might provide information about what to expect from different types of cancer treatment.

*This background article is a fact sheet called Wellness Module #3: Social Support, prepared by Nichole for the Anxiety Disorders Association of BC on behalf of the BC Partners for Mental Health and Addictions Information, 2004. Excerpted with permission of BC Partners. For the complete factsheet, see [www.heretohelp.bc.ca/skills](http://www.heretohelp.bc.ca/skills).*

Social support does the best job of protecting us from the effects of stress when we believe that emotional support is easy to come by, and we have at least one person we can confide in.



### Getting your support needs met

Many of the people who are a part of our lives can provide social support. These can include our parents, spouse or partner, children, siblings, other family members, friends, co-workers, neighbours, health professionals and sometimes even strangers. We are unlikely to have all of our support needs met by just one person. Also, different people may be able to provide different types of support (e.g., our mother may be great at helping with child care, and our best friend might give great advice).

In general, the best support comes from the people we are closest to. Research has shown that receiving support from people we have close emotional ties to does more for our emotional and physical health than support provided by people we are not particularly close to. For example, having close friends listen and care for you during a stressful time will likely do more for you than receiving the same support from someone whom you don't know very well.

### Social support and mental illness

There is good evidence that social support plays an important role

in mental health or substance use problems. For example, people who are clinically depressed report lower levels of social support than people who are not currently depressed. Specifically, people coping with depression tend to report fewer supportive friends, less contact with their friends, less satisfaction with their friends and relatives, lower marital satisfaction, and confide less in their partners. It is likely that lack of social support and feelings of loneliness can make us more vulnerable to the onset of mental health or substance use problems like depression. However many of us will pull back from other people when we are experiencing mental health or substance use problems. In this way, mental health or substance use problems can lead to problems with social support and aggravate our feelings of loneliness. For these reasons, reconnecting with others in healthy, supportive ways is often an important component of managing most mental health or substance use problems.

Intimate relationships with a spouse or partner are particularly important when it comes to well-being. For example, not having a close intimate

relationship (i.e., a spousal type relationship) puts us at risk for depression. However, it isn't being unmarried (single, widowed, divorced, etc.) that makes us vulnerable to depression, it's having a bad marriage! This is particularly true for women. Unsupportive relationships with our family (e.g., negative or overbearing attitudes and behaviours) have also been related to the relapse of symptoms in both schizophrenia and depression.

### The pros and cons of support

#### The pros

Research tells us that it is important to have at least one close friend. Having many close friends may not do us any more good than having only two or three close friends. Research also tells us that social support does the best job of protecting us from the effects of stress when we believe that emotional support is easy to come by, and we have at least one person we can confide in.

#### The cons

On the other hand, unhappy or poor quality relationships with other people have been shown to have a negative impact on mental health and well-being. Conflictual, distressing relationships may do us more psychological harm than positive social relationships can do us good. For example, compared with people who are single, separated or divorced, people who are married and can talk with their partners are less likely to have problems with depression. However, people who are married but cannot talk with their spouse are at much greater risk of clinical depression compared with others. It may be that poor quality relationships impair our ability to cope with stress much more than good quality relationships protect us. The greatest benefit of social support



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Take a cooking class or join a hiking club. To meet new people, you will have to step outside your usual activities and lifestyle.





## How Much Support Do I Have In My Life?

This is a brief self-test to help give you an overview of the supports in your life. It can help you see where you have good supports in your life and where you might need to improve your supports.

To take the self-test, rate each statement as it applies to you out of five:

### Friends

Not at all like me    Not very much like me    Somewhat like me    Much like me    Very much like me

When I am with my friends, I feel completely able to relax and be myself	1	2	3	4	5
I share the same approach to life that many of my friends do	1	2	3	4	5
People who know me trust me and respect me	1	2	3	4	5
When I want to go out to do things I know that many of my friends would enjoy doing these things with me	1	2	3	4	5
I have at least one friend I could tell anything to	1	2	3	4	5
People who know me think I am good at what I do	1	2	3	4	5
I feel very close to some of my friends	1	2	3	4	5
My friends would take the time to talk over my problems, should I ever want to	1	2	3	4	5
When I'm with my friends, I don't feel alone	1	2	3	4	5

add your ratings:  +  +  +  +  =

then divide by 9 for your **Friends Score:**

**A**

### Family

I feel like I can always rely on my family	1	2	3	4	5
No matter what happens, I know that my family will always be there for me should I need them	1	2	3	4	5
People in my family have confidence in me	1	2	3	4	5
My family lets me know they think I am a worthwhile person	1	2	3	4	5
People in my family provide me with help in finding solutions to my problems	1	2	3	4	5
I know my family will always stand by me	1	2	3	4	5

add your ratings:  +  +  +  +  =

then divide by 6 for your **Family Score:**

**B**

Your total score: **A** + **B** =  then divide by 2:  / 5

### What does my score mean?

The closer your score is to 5, the more supported you feel. If your scores are lower than 3, you may wish to think about how you could improve your supports or find more supports.

You can also take this test online at [www.heretohelp.bc.ca/skills/module3](http://www.heretohelp.bc.ca/skills/module3).

may come from the protection from unhealthy relationships that it provides.

## How do I improve my social support network?

### 1. **Don't be afraid to take social risks:**

Making new friends and acquaintances means that you will have to take some risks. You will need to seek out and introduce yourself to new people. Ask a friend to help you if this is hard for you (e.g., come to a party or event with you). If you have always been shy, and this has got in the way of you finding the support you need, consider gaining the help of a professional. Of course, parties and events aren't the only social venues at which to meet people; informal gatherings, community centres, recreational courses or clubs, volunteer positions, schools and workplaces are also common places to meet people.

### 2. **Get more from the support you have:**

While being careful not to overwhelm support providers, ask for what you need from others and be as specific as possible in your requests. It's a mistake to think that people will automatically know what you need—you will have to tell them.

### 3. **Ask for help:** Ask the people you know to help you broaden the network you have. If you have recently become single, ask your friends to introduce you to other single people your age. If you have recently come out, ask people you know who have gay friends to introduce you to them.

### 4. **Make a plan:** Figure out what kind of new support you need and brainstorm different ways you might be able to find it. Link to problem solving module once completed.

### 5. **Create new opportunities:** Take a cooking class or join a hiking club.

## related resources

### When might I want to change my social support network?

See Nichole's great tips by reading the full version of this article online at [www.heretohelp.bc.ca/skills](http://www.heretohelp.bc.ca/skills)

To meet new people, you will have to step outside your usual activities and lifestyle. If you just keep on doing what you always do, hoping to meet new people, you probably will fail.

### 6. **Let go of unhealthy ties:** This can be very difficult. Walking away from any relationship is painful. This is no less true because the relationship is doing you harm. But sometimes this is what we need to do. If all of your friends are involved in activities you want to avoid (e.g., using recreational drugs or shoplifting), you will need to let go of these friendships or risk getting back into your old habits. Use your judgement—sometimes we can simply spend less time with certain people (e.g., friends who don't like to exercise or meet new people) without abandoning the friendship altogether.

### 7. **Protect your marriage:** We know that a good marriage offers protection from depression and a bad marriage makes us vulnerable. If your marriage is faltering, do what you can to improve it. Don't be afraid to seek professional help when you need it.

### 8. **Be a joiner:** Sometimes the best way to find the support you need is through a support group. If you need support for a highly specific problem (e.g., raising a child with Downs) you may only be able to find this support through a formal group setting.

### 9. **Be patient:** While very much worth the effort, making new friends is time-consuming. Recognize that you may need to meet many new people in order to make just one new friend. Building intimacy also takes time. It may be several months from the time that you meet someone before you feel really close to them and that you can count on their support.

### 10. **Avoid negative relationships:** We know that negative, conflictual relationships are hard on our emotional health. The negative aspects may be obvious (e.g., abuse) but other times they can be more subtle (e.g., excessive dependence or over-controlling). Sometimes it may be the other person's behaviour that is the primary problem but more often we are also involved in some way—even if it is just the unhealthy ways we are responding to the negative person in our life. As much as possible, avoid long-term relationships that are more negative than positive. Sometimes this can be hard—especially when these relationships are with family members. In this case, try to limit the amount of contact with these people (or buffer that contact with other helpful supporters), and avoid relying on them for support. ▼

# View From the Ruin

Julianne Kim

I came to Canada in 1975 from Seoul, South Korea. I was 19 and too full of bravado to admit anything of the pain, fear and anxiety I felt. I was anxious all the time and reacted to this discomfort with aggression: throwing things, yelling, accusing, picking arguments until violence occurred.

I didn't know what mental illness was. And, if there was popular education about mental illness available in Canada at the time, I wasn't aware of it. How could I be? It took me many years to become fluent enough in English to be aware of the nuances in Canadian life. But I did know that 'crazy' people in Korea were tied up, ridiculed, physically abused and hidden from others.

There are similarities between having a mental illness and being an immigrant. With both there is the fear and loneliness of alienation, discrimination and isolation.

## My youth in Korea

I started drinking at 13 and loved its effect. When I was 14, I was expelled

from school after a suicide attempt, having swallowed tranquillizers in a suicide pact with my best friend. My mother had been on retreat at a Christian seminary for about a year, and this brought her home. I transferred to another school, skipped classes and drank nearly every day with friends.

My delinquency was rooted in my home environment. I was the only child of a single mother who struggled with social disruption and poverty caused by the Korean War (1950–1953). My mother's dream of becoming a teacher or journalist, involved in modern social movements with her activist peers, was broken by deep depression. This was never diagnosed. My mom was so bogged down by

*Julianne is a 55-year-old Korean-Canadian artist and mother of three children. She lives on disability pension and volunteers at the Mood Disorders Association of BC office in Vancouver.*

*Julianne would like to dedicate this story to her mother, Yong Sok Kim.*



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Shame, fear and anger dominated my life. As a teenager, I fantasized all the time: I wanted to be with some other people, some place else, living a happier life.

physical ailments that these overshadowed the depression. As for my father, I only saw him three times in my life, on short visits.

Home was a gloomy and volatile place where no one felt safe. My mother and I lived with my aunt, her child and a nephew, who were all dealing with pain at least as great as my mother's. The nephew had lost his mother to suicide before the war, and his father was shot during the war. The other cousin had schizophrenia and drank heavily, which frequently ended in physical violence against his mother and mine. My aunt and my mother engaged in bitter accusations—though these episodes alternated with periods of acceptance and deep caring. I constantly clung to my mom. I had stomach aches and suffered anxiety whenever she was away.

Shame, fear and anger dominated my life. As a teenager, I fantasized all the time: I wanted to be with some other people, some place else, living a happier life. When I found alcohol, I was relieved.

At 16, however, I met my future husband, and he helped change my outlook positively. Eight years older than me, Sam was a shining young man who was going to overcome all life's troubles with faith and hard work. He admired my artistic endeavour for school projects and was full of suggestions and help. He was also able to help my mother financially. I stopped drinking, excelled in art courses and graduated as a top student.

#### Canada...

Coming to Canada meant leaving all the pain behind and starting a new life. Sam was reunited with his mother 19

years after she had left her two sons following an ugly divorce. I joined Sam as his fiancé, and we were married in Toronto a week later.



David encouraged me to paint and to devote my energy to nurturing myself, rather than striving for outer success. I am very grateful for this.

But the open wounds of my youth were not at all healed. And my husband, who had also been traumatized as a result of the war's effect on his family, had been even more traumatized by losing his mother at age nine. A grim life followed: he was beaten and put to work in factories while attending high school at night. Valiantly Sam tried to cultivate the patience, hard work and kindness I so admired.

Working hard at menial jobs, under great pressure to assimilate and succeed, sadly, we began to fall apart.

Both of us showed signs of strain: my husband, through drinking that ended in physical abuse and impulsive overspending, and I through a string of extramarital affairs and defiance against social norms. I'm sure I was the only Korean woman in Toronto at the time who smoked cigarettes publicly, and even worse, in front of my in-laws (a big no-no). I started and quit many college courses, neglecting my need to learn and grow.

After 11 years of marriage, I fled back to Korea, leaving behind my daughter Irene, who was 10 at the time. I filed for divorce and began serious daily drinking. I was resigned to the pain, remorse and depression.

When I came back to Canada a year later, in 1987, I was desperate for a different life. One of my fantasies while a teenager in Korea was to become a hippy in America. All the music, drugs, beautiful arts! All fun, no work!

By the time I came to Canada, the hippie era was over. But my new common-law partner David had lived through the '60s. We moved to BC in 1990 with my then two-year-old son William, and I decided to drop out of Korean-Canadian society. I became a pot smoker and welfare recipient who was living with a 'foreign' man, with a child born out of wedlock.

I had a really hard time being a mother, though I loved my children very much—Noah was born in 1992. But I couldn't manage making breakfast for the kids day after day, or dinner, for that matter. In fact, anything I had to do, I resented and avoided if I could.

As an adult, my anxiety erupted regularly with my menstruation,



I had turned 50, was broke and had a bad drug habit. Ultimately, I felt rootless, in or out of society. I decided to go to Narcotics Anonymous (NA).

when mood swings devastated me. The only way I found relief was by throwing raging tantrums, which shattered what little peace and joy I'd built up since the last fit. Doing this over and over was a hell I didn't know how to get out of.

David realized early on that I had problems and steered the children from harm whenever I became hard to deal with. He also encouraged me to paint and to devote my energy to nurturing myself, rather than striving for outer success. I am very grateful for this.

In 1997, after a bad fit, I ended up in hospital emergency in the Fraser Valley, where we were living. I was seen by a psychiatrist who kept me there about a week and sent me home with antidepressants. But in 1999, David and I separated. My moods and fits had taken their toll on him.

Having joint custody, I moved near David in Vancouver to minimize the damage the split would cause the children. But I was very isolated and experimented with street drugs (ecstasy, LSD, mushrooms, alcohol), looking for peace and calm. In 2002 I saw a Vancouver psychiatrist, who diagnosed me with borderline personality disorder.

My addiction to marijuana lasted 19 years. I came to an end and a bottom in 2006. I had turned 50, was broke and had a bad drug habit. Ultimately, I felt

rootless, in or out of society. I decided to go to Narcotics Anonymous (NA).

### **My recovery**

Narcotics Anonymous (NA) provided me with a place to go when I had nowhere else. Sharing with people who suffered addictions resulting from their trauma was a revelation. And it gave me a structure, so I didn't feel like I was floating around or falling. I attended NA for three and a half years.

I've recently stopped attending NA. I completed the full 12-Step program, but hadn't bonded socially with group members—except for my current partner John. His support of my recovery—his love, kindness and understanding—cannot be overlooked.

My illness is still present in my occasional depression, mood swings and a tendency to argue with loved ones. What I fear most is an imagined or real alienation from my small family. I still experience severe paranoia, lashing out at the people I love, believing they hate me.

Today, I am fortunate to enjoy the support and presence of all my children: Irene, William and Noah, and grandchildren Cedar and Naoli. They help me immensely with my sense of belonging. My daughter and I had prolonged difficult times, but she is very kind to me these days, especially since I stopped using pot. My two sons are very nice

young men who give me love and humour me about my weird ways—but they understand that I love them.

In spite of the fact that my family of origin caused me pain, I love them and miss them. I now understand how hard it was for them to lose their children, husbands, wives, mothers, brothers and sisters, grandparents, homes and money to war, and then face life broken. I don't blame anyone for my mental illness and addiction. I'm glad to finally understand it. ▼

# My Portfolio of Support

Ian Chovil

## In the beginning

My onset of schizophrenia was what is called “insidious,” meaning a gradual onset of symptoms. For me, this occurred from ages 17 to 25 (between 1971 and 1979). Over that time I lost my girlfriend, all my friends and my family.

*Ian has been living with schizophrenia for 35 years. As a Consumer Consultant with the Homewood Health Centre in Guelph, Ontario, he made presentations on mental illness for 10 years. Awards received include a 1998 Flag of Hope Award from the Schizophrenia Society of Canada. Visit Ian's website at [www.chovil.com](http://www.chovil.com).*

I failed school and couldn't work, ending up in psychosis,<sup>1</sup> homeless for six months and, in 1980, without anyone in my life who could have helped me get the medical attention I needed.

Over the next 10 years I survived an untreated psychosis, including one attempted suicide. I lived five of those years in Victoria and five in downtown Toronto. Somehow I managed to stay employed, but it was a challenge to keep a roof over my head and food on the table. I lived in abject poverty.

I had only imaginary friends—who often became enemies. When I got in trouble with the law in Toronto in 1988—breaking windows where I lived,

angry at the ‘aliens’ for not transferring my mind to another body—I spent a night in jail. I was subsequently sentenced to three years probation with the condition that I see a psychiatrist for those years. It was only then that I started to get medical care for schizophrenia, although I didn't start on medication or get better for several years.

During my probation and the last few years of my psychosis, I became alcoholic. I thought the hop flowers used to flavour beer were a treatment for involuntary ‘celibacy,’ and so began drinking 12 beers a day after work. Before long I was unemployed and drinking my homemade beer all day, every day. My psychosis became much more intense. Behind in the rent, I was in danger of becoming homeless again.

## A new beginning

In 1990, the psychiatrist convinced me to go into a residential addiction program at the Homewood Health Centre in Guelph, Ontario. As part of the program we attended Alcoholics Anonymous (AA) meetings, where I realized that I wasn't alone, and that many people around the world become alcoholics, even doctors and lawyers. I also learned that I had a genetic vulnerability to alcohol—my father had really loved his booze.

My psychosis faded in the sheer luxury of the hospital, and I started taking



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medication for schizophrenia upon discharge. I felt quite abandoned, however, once I was released.

I went to AA for several years after I left the treatment program and stayed sober, but never really fit in well there. It was far too religious for me, and I couldn't get past the first step. I could acknowledge that my life "had become unmanageable" (Step 1), but from Step 2 on I was expected to believe in "God."<sup>2</sup> I was raised anti-religious and had no conception of God. I also didn't feel I had amends to make to other people; I had only hurt myself with my drinking. Many AA members were married with full-time jobs. I have never been so fortunate.

I did go to a day program after leaving Homewood, where I developed "human" (as opposed to alien) friendships with other people with mental illness. The day program was three afternoons a week of mostly playing euchre and Scrabble. But I also started to spend time with these new friends at other times. We went hiking and biking together, spent time in coffee shops, and had each other over for dinner. We laughed together at our wild delusions and shared our experience of poverty on disability support. Alcohol was far too expensive to waste money on and simply wasn't part of our lives.

With each year on medication I improved a little and became more and more capable of accomplishments I could take pride in. After about five years on meds, I tried volunteer work, then got a newspaper route, and then a paid work experience at the Homewood. Within 15 years of starting on meds, I had a half-time staff position doing community education. I had colleagues, bosses, programs I

initiated and was responsible for, and volunteers I trained who were paid honourariums. I did outcome studies, made presentations at conferences, and wrote articles that were published in research journals.

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My parents lived far away and I didn't see much of them. Their support for me grew as I gained accomplishments—which is a little sad, because I needed their support most when I had nothing. "Nobody knows you when you're down and out."<sup>3</sup> There is a lot of truth in that.

#### **A setback turned around**

When my job in community education ended unexpectedly after 10 years, I didn't know what to do with myself—my work was my life. I no longer had all the human contact that work had provided. And I no longer had the feeling of accomplishment from doing my job. I had put all my eggs in one basket, and that basket was taken away from me. I had inherited money and was living comfortably, but all I

could think about were my losses and my empty life.

After a year or so I started to become delusional again. And I started drinking again because it seemed to help my restless legs syndrome (RLS)<sup>4</sup> that became unbearable in the winter of 2007. My doctors were polite and expressed concern about my drinking, but were unable to do much about the RLS. In my mind the RLS was a weapon of powerful outside forces trying to harm me. My only friend became the beer I was drinking. But alcohol is just a chemical that doesn't care if you live or die. This 'friend' destroyed my health and took all my money.

I became scared of alcohol and what it did to me, so started seeing an addiction counsellor. I tried attending AA meetings, but again never got past the first step. Gradually I stopped drinking and began to rebuild my health and take pleasure in other activities.

I started to appreciate how exquisite nature is, how beautiful humans can be. The movie *Avatar* had something to do with this transformation. [*Avatar* is the 2009 American film, directed by Canadian James Cameron, about the impacts of a mining company from Earth on an indigenous tribe on a fictional moon.] My awe and love of nature increased dramatically after seeing that movie. I started to appreciate the people I knew. I got a part-time job, working eight hours a week. And the RLS subsided some, becoming more of a nuisance than a threat.

#### **Support and activity: investments in me**

It's been a slow process making the investments of my time and energy in activities and relationships

that are good for me, and it hasn't been easy. Schizophrenia, when it's disabling, tends to isolate you from the community. I never married, have no career skills, no kids, no grandkids, no membership in community organizations, no religion (all my friends are super religious), no big plans for the future, no specialized skills with which I could contribute to the broader community. It's been a humbling experience, which is why I like people with schizophrenia so much: they're usually very nice people.

I've been going to a weekly peer group for over 10 years. Most of us have schizophrenia. There is no structure to the meeting. We introduce ourselves with a question of the day (my idea), which anyone can suggest. It could be something simple like your favourite television show or something more personal like how you express yourself.

That way we learn more about each other. We often go on to discuss related topics. A psychiatrist attends and participates; we can ask him questions about symptoms or whatever. We have some money from a drug company to subsidize recreational activities on other days, and plan those ourselves. We go strawberry picking every spring, for example.

For me, the essence of peer groups is the shared common experience. In this case: poverty, celibacy, lack of full-time employment, interrupted education and romantic life, dependence on government disability cheques and subsidized housing, daily medication, disability, and a relatively small circle of friends that doesn't include many people who don't fit the above criteria. At the same time, we are all unique and our differences make the group interesting.

My life is much more diversified now: some volunteer work, my part-time job, hiking with friends, bicycling in the country, my daily run, growing tomatoes on my balcony, listening to music, inviting people to dinner, helping friends, going to my peer group, taking vacations when I can afford them, reading the Guardian newspaper, and learning to cook new things.

I've learned that it's my relationships with other people that keep me stable, sober and sane, and I'm grateful to the people in my life. ▽



# within sight

a new resource for multicultural communities



News



Events



Resources



Programs

The BC Partners for Mental Health and Addictions Information have launched Within Sight, a new e-newsletter. Within Sight highlights new or useful mental health and substance use resources for multicultural communities, such as events, services, publications and agencies that help you access information in many languages.

Within Sight will also keep you up to date on new multilingual resources available on Heretohelp. It's published in English and is aimed at mental health and substance use professionals as well as people working in immigrant, refugee and multicultural services. Within Sight is free and delivered to your inbox every two months.

**To sign up, visit [www.heretohelp.bc.ca/other-languages](http://www.heretohelp.bc.ca/other-languages) or email [withinsight@heretohelp.bc.ca](mailto:withinsight@heretohelp.bc.ca).**

The multilingual webpages and Within Sight are funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.



# It's Okay to Ask for Help

Robin Rebeiro

I've always considered myself a strong person emotionally. The idea of asking for help made me feel that I was somehow weak, and this was a side of myself I never wanted anyone to see. But a couple of years ago, I decided that I did need help—after trying for a long time to convince myself that I didn't.

## One Christmas ...

I knew I wasn't myself during Christmas of 2008. One thing I live for every year is to embrace the Christmas spirit. Since I was a child, I've always felt great comfort at this time of year: feeling cozy indoors when it's chilly outdoors; the warm feeling of having my family around.

That Christmas, however, I felt nothing but fear and anxiety. This made me feel scared and very alone.

I've dealt with anxiety most of my life, primarily in the form of panic attacks. Out of nowhere I would suddenly feel like I couldn't breathe, I'd get heart palpitations and an overall nervous feeling. But the overwhelming demands of life in 2008, between holding down a management job and trying to balance time with my family, made the anxiety more severe. I was having panic attacks more frequently—and thoughts I had trouble getting out of my head that were so disturbing I felt like I was going crazy.

I was experiencing what my psychiatrist diagnosed as obsessive-compulsive thoughts. My obsessive thoughts were mainly centred on my then three-year-old son. I was having violent images of something happening to him. I began to fear going near him, thinking that these thoughts somehow meant that I wanted to hurt him—which I would never want

to do, nor have I ever done. I don't know what was scarier: having those disturbing thoughts, or being afraid that I was pushing my son away.

My psychiatrist explained that depression in some people comes out in obsessive thoughts that generally focus on something or someone that is near and dear to you. This explained why my thoughts focused on my son, because his well-being is always my main concern.

The night before New Year's Eve a comment my best friend Vanessa had made several months before suddenly popped into my head. It was something along the lines of: "You don't have to be sad or neurotic to be depressed."

*Robin is a 35-year-old woman, married with a five-year-old son and working as an Executive Assistant. She has a history of anxiety and has also dealt with depression in the past two years. Robin is still working through her anxiety with the assistance of her doctor and psychiatrist.*



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## Vanessa's experience showed me that it's not only okay to ask for help, but it's necessary.

For so long I had tried to convince myself that I wasn't suffering from depression because I didn't feel sad or emotional and because I did want to live my life to the fullest. Sometimes people's perception of depression, including my own, are far from the reality of the illness. But on this night Vanessa's comment reminded me that clearly, I needed to open my eyes to what depression meant for me personally. It helped me understand that depression is different for everyone.

### The spirit of Vanessa

Vanessa and I have a very deep bond; I feel that she was my first soulmate in life. She went through a period of serious depression a few of years ago, and I remember feeling completely helpless. At the time, it was hard for me to fully understand what she was going through, but I tried to comfort her as

much as I could by listening as she told me what she was experiencing and what she was feeling. It made me want to cry, but I tried hard to be strong for her. I told her she would get better and that I loved her and would always be there if she ever needed me.

Then on that December 30<sup>th</sup> night two years ago, I became very afraid. I couldn't cope any more as the obsessive thoughts took over my mind. My anxiety heightened to the point where my hands went numb. The level of adrenalin in my body seemed out of control and I couldn't calm myself down.

After months of denying it to myself, I finally admitted that I needed help. I went to St. Paul's Hospital in Vancouver, where the nurses and psychiatrist helped me in a way that I will never forget. They assured me

there was help out there for me and that I wasn't alone in what I was experiencing. Just hearing that my symptoms were common effects of depression and that others have been through the same issues relieved me immensely.

It was Vanessa's voice that helped me go to St. Paul's that night. If it hadn't been for her own experiences with depression, I wouldn't have accepted or recognized my own.

I am so thankful to Vanessa for helping me realize that I was ill, but also that I could be fixed. I had taken her lead and valued myself enough to ask for help, just as she had done. Vanessa's experience showed me that it's not only okay to ask for help, but it's necessary. We now can appreciate how much it helps just to talk to each other about our experiences with depression and assure each other that we're not alone in our battles.

### Help heals

It wasn't so hard after all to ask for help—in fact, it's what has kept me going on my road to recovery. Asking for help—from both medical and personal perspectives—doesn't make you weak. It takes courage and strength to overcome your fears, and it takes acceptance and love from yourself and from those around you to help heal your soul. ▼



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# Origami: Therapeutic Magic

Rosemary Browne

I have been teaching origami—the Japanese art of folding paper to form objects—for the past nine years. I have studied the art form for 16 years. I fold every day, and when time and circumstances permit, I fold for most of the day.

I became enthralled with origami after a calligraphy workshop where we folded five pieces of paper that, when opened, became a three-dimensional star.

Eight years ago I became ill with depression and anxiety. Right at the onset of my illness I realized origami was having a positive effect. If I was feeling really anxious, doing origami calmed me down. I also noticed that as I began to fold the paper, my ruminating thoughts—those negative, emotion-based thoughts that go round and round in your head—were replaced with focused attention. A sense of pride and accomplishment followed once the model (the created object) was completed. Additionally, giving a model to someone else was a joyful experience. And I felt even more joy when I taught someone how to fold.

I began my weekly volunteer teaching position a year ago at the Daly Pavilion, the psychiatric unit of Kootenay Boundary Regional Hospital in Trail, BC. I wanted to share the joyful experience of origami as well as its benefits with the patients there. Origami doesn't require artistic or creative ability. It's a gentle art form that exercises the mind and delights the soul.

People don't readily volunteer on psychiatric units. Through my own journey with mental illness, I knew how the struggle to cope is often

compounded by judgment, misunderstanding and stigma. So, committed to ending the stigma of mental illness, I arrived at the Daly armed with paper, passion and personal knowledge of the therapeutic value of origami.

## Folding at the Daly

The activity coordinator at the Daly Pavilion first assesses patients to see who is well enough to engage in origami (e.g., whether their behaviour would be appropriate; how medicated they are). She then gives me an overview of the various illnesses and behaviours of the patients who may be attending.

We both understand that the hardest part of our work is “the gathering” of patients to join in, as they are often in a state of mind where initiative and decision-making are paralyzed. However, once they arrive and the sheet of paper is in front of them ... the magic begins.

The weekly origami session at the Daly is an hour and a half long. Attendance ranges from one to as many as six patients. The activity coordinator is always present during the sessions and acts as my other pair of hands, assisting patients when they have difficulty with a step.

Sharing my experience of how origami helped me to cope with mental illness helps the patients/students feel more

*Rosemary teaches origami in the psychiatric unit of Kootenay Boundary Hospital in Trail. A retired preschool teacher from Victoria, she has taught origami and pine needle basketry at Selkirk College. As a volunteer, Rosemary shares the joy of origami with local brain injury, stroke, seniors, women's and church groups.*

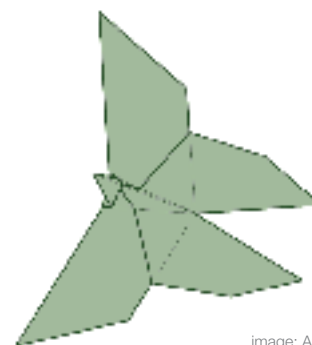


image: Atsushi Tajiri

Step-by-step instructions for this origami butterfly available in the online version of this article at [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca). A mobile of this butterfly model hangs at Daly Pavilion in Kootenay-Boundary Regional Hospital.

at ease and helps to establish trust. I know immobilizing depression; I know chaotic thinking. When I'm asked, "Why do you come?" I reply, "I know origami will help."

I always begin the class with a simple model to assess each patient's capabilities. By observing their level of concentration and response to instruction, I increase or decrease the level of difficulty for the subsequent models.

I teach using mainly a visual method: I describe verbally what I'm doing as I demonstrate the folding step-by-step. We finish each and every step together. This creates an awareness of others and a common goal. The models in each session are always completed, so the goal is achieved by all. Sometimes patients are so keen that it's not unusual to teach up to five models in the hour and a half.

I greatly admire the patients' courage to engage in the folding, as most who attend are often on sedative medication. Origami works both the left and right brain hemispheres intensely. At times I

can visibly see the conflict between the effects of medication and the stimulation to the brain as a result of folding. Origami usually wins the battle because the act of being mindful—the moment-to-moment awareness—overrides the medication and brings clarity to the mind. Origami instantly provides both distraction and focus.

Most of the models we fold would be categorized as low intermediate (LI). This is a wonderful success for first-time folders: completing as many as five LI models. The patients' sense of joy, mastery and relief from chaotic thinking or despair is clearly visible. Their body language is much different when they leave the session than when they arrived: their heads are held higher as they gather up the beautiful paper objects they themselves have made. For a brief period of time, origami has rescued them from the aimless, bored wandering on the ward—what I call "the Daly shuffle"—and given them purpose.

The origami class is also a non-threatening social setting for the patients.



Photo: Rosemary Browne

## related resources

**Origami Resource Center:**  
[www.origami-resource-center.com](http://www.origami-resource-center.com)

**Oriland:** [www.oriland.com](http://www.oriland.com)

There's no pressure to talk or socialize. Yet I've observed that those who are not confident socially will often begin to engage with others between folding models or in helping others with certain steps of the model. Patients encourage each other. Sometimes they interact through animating action models. Often, conversations continue after the session is over.

### What's good for the student is good for the teacher

Teaching origami at the Daly helps me therapeutically, as well as the patients. It gives me purpose and keeps me focused. The benefits of doing origami are somehow multiplied for me through sharing the art form.

The sincere appreciation expressed by the patients for giving them the opportunity "to fold" has been the most rewarding of all my origami teaching experiences. And it's very gratifying to witness participants' emotions—sadness, confusion, disillusionment—vanish while we fold. I feel pride and accomplishment in helping ease people's emotional pain, if only for a little while.

I have seen a patient suffering from schizophrenia with recent paranoid delusions join our group, successfully complete the models, join in conversation and leave with a smile. Oh, the magic of origami! ▼



# Family Members Need Social Support

## THE FAMILY SUPPORT BUDDY PROGRAM

Sophia Kelly

Family members are sometimes worried their entire family will be judged or discriminated against if people know one of their members has a mental illness. Keeping this concern to themselves can mean that these family members may be cut off from the social support they would otherwise expect when a relative is seriously ill.



*Sophia is Manager of several projects for the BC Schizophrenia Society and a consultant in private practice in areas including project management, health education and online outreach. She designed the Family Support Buddy Program. Sophia can be reached at [onlinesupport@bcss.org](mailto:onlinesupport@bcss.org).*

Providing support for family members in caring for loved ones with a mental illness has been shown to improve health outcomes for both the family and the ill loved ones. Family support hastens client recovery from mental illness and addiction, lowers the risk of death, reduces reliance on health care services, reduces the rate of rehospitalization and relapse, enhances medication compliance, and improves client interpersonal functioning and family relationships.<sup>1</sup>

Mental health services may not have a mandate to provide services or referrals to family members. Fortunately, family support groups are offered in many locations around BC. However, the support groups aren't always a good fit in terms of location, times scheduled or in some other way, such as style of delivery. For instance, men are generally less likely to

attend support groups.<sup>2</sup> Also, many people prefer to talk one-on-one with someone they know will understand.<sup>2</sup> And, family members who have become familiar with mental health services and have been supporting their loved ones effectively for some time may find that support groups that were helpful when they were in crisis no longer meet their needs.

### About the Buddy Program

The Family Support Buddy Program was developed in 2005 by the BC Schizophrenia Society (BCSS) with funding through the BC Partners for Mental Health and Addiction Information's Heretohelp. The Buddy Program was designed to complement existing family support services offered through BCSS. These include the family support groups and individual support and programming provided by regional coordinators.

## related resources

**BRIDGES:** This peer-led education and support program helps people rebuild dreams that have been shattered by illness and treatment. For information, visit [www.bcscs.org/bridges](http://www.bcscs.org/bridges).

**Family Respite Program:** For more information on how primary caregivers can arrange for self-care breaks from caregiving, visit [www.bcscs.org/respite](http://www.bcscs.org/respite).

**Reach Out:** Online support for people who care about someone with a mental illness, along with links to family resources, is available at [www.support.bcscs.org](http://www.support.bcscs.org).

In 2006, the Buddy Program was piloted for six months in Vancouver, Surrey and Williams Lake. Evaluation showed that both volunteers and clients clearly felt their involvement had provided useful information and had reduced their stress.

The Family Support Buddy program matches peer support volunteers with family members (i.e., relatives, spouses, partners and family of choice) of people with a serious and persistent mental illness. The volunteers, who are also family members of someone with a mental illness, provide one-on-one listening during a scheduled weekly phone call or visit. Each pairing is meant to last for up to eight phone calls or visits.

The program is not meant to replace support groups—it's meant to provide support to people who are unable to attend a support group or who prefer to speak one-on-one with someone about their situation. Talking to someone who has been through what you are going through can be a big help. Peer support can help people feel hopeful. It can also help them figure out how to look after themselves as well as care for their ill family member or friend.

Buddy Program volunteers are not counsellors, but because they share the experience of supporting a person with a mental illness, they understand the feelings and concerns involved. Buddies may offer also useful information about other programs and services. They are also trained to refer any crisis needs or situations to the program coordinator.

The program also focuses on making the experience a rewarding and useful one for the volunteers. Many of the volunteers have already been providing informal support to other family members within their communities, which can be overwhelming at times. So, we organize monthly social, recognition and check-in events for these “veteran” family members. Volunteers say they appreciate the support, particularly for setting clear boundaries around their time and involvement. Our program puts energy into preventing burnout and preserving these important community assets—our volunteers.

One important difference between a buddy-style program and ‘paraprofessional’ peer support programs, such as those most commonly seen aimed directly at people with a mental

illness, is in the level of training and involvement of the volunteers. For the family support buddy program, the training and volunteer time commitment is low. This makes it feasible for family members with full-time jobs or caregiving responsibilities to volunteer. The type of peer support programs that provide more extensive training sometimes do so as part of a path to paid employment in a helping field. The buddy program volunteers are not seen as paraprofessional helpers or counsellors. They provide the same level of support they would provide as peers within a support group.

After the pilot, BCSS Vernon offered the Family Support Buddy Program until early 2009, when funding for this popular program was cut.

### You can start a Buddy Program!

The materials to start a family support buddy program at your organization or agency are available for non-profit use, free of charge. The Family Support Buddy Toolkit is designed to provide all the coordination, administration and training tools needed to start and run a family support buddy program. It includes a coordinator's guide, buddy guide, forms and procedures, and a full set of training handouts and transparencies for overhead projection. The coordinator's guide provides an overview that gives organizations interested in hosting this program an idea of the funding, staffing and resources they will need to have in place.

*All the Buddy Program materials are available for download on the BC Schizophrenia Society website at [www.buddy.bcscs.org](http://www.buddy.bcscs.org).* ▼

# Mental Health Camp

## BREAKING THE SILENCE, SETTING US FREE

Isabella Mori

Like many movements, Mental Health Camp started organically. Airdrie Miller, a high school science teacher and blogger who has lived with depression for many years, had an idea. She envisioned a panel discussing the effects of people talking about their experiences with mental illness online—on blogs and on social media sites like Twitter and Facebook (see sidebar).

Her idea became reality in 2009 at Vancouver's annual blogging conference, Northern Voice. Miller invited Internet strategist Tod Maffin and me to take part. Tod, too, has lived experienced of mental illness. I have been in the counselling field since the early 1990s and have been active in Vancouver's thriving social media scene since 2005.

The reaction to the panel, held in February 2009, was unexpectedly positive. There was quite a buzz in the hall afterwards. People commented on how important the topic was and mentioned how disappointed they were that the panel had only lasted 45 minutes.

I was hanging out with my friend Raul Pacheco-Vega at this point. Suddenly, we looked at each other and said, "Maybe we should have a mental health camp!" And thus it was born: Mental Health Camp, the conference about social media and mental health.

We didn't waste any time: our first Mental Health Camp—the first ever conference of its kind—happened in Vancouver exactly two months later. Inspired by our success, a group of activists organized a second camp in Toronto in May 2010. And Raul and I organized a third camp, which took

place in Vancouver on July 10, 2010, at the University of British Columbia. There were 30 to 60 participants at each of these conferences.

### What is Mental Health Camp?

Mental Health Camp is a gathering of people who are interested in mental health. There are no 'experts.' Raul, for example, is an environmental scientist who is interested in mental health on behalf of his many friends who are struggling with mental health issues. Regardless of their backgrounds, therapists, consumers, journalists,

*Isabella has been working in the field of mental health, counselling, psychotherapy and movement therapy for 18 years. She is also a blogger and a cofounder of Mental Health Camp, a conference about mental health and social media.*

### social media terms



**Blog:** An online space where a writer or organization regularly posts commentary, ideas or opinions. Posting an article on blog is often called "blogging," and a person who maintains a blog is often called a "blogger." Blogs may be an independent website or a part of a larger website.

**Facebook:** A popular social media service that helps people connect with other people, groups and organizations. Users can share information with friends, form common-interest groups and have public or private conversations.

**Twitter:** A popular micro-blog and social media service. Users post short messages or "tweets" publically or to certain friends. Posting a tweet is often called "tweeting." The maximum length of a tweet is 140 characters.

**Chat group:** Any forum that lets users communicate in real time.



There is no expectation that people ‘should’ out themselves or should be loudly vocal in furthering mental health issues. Everyone does their part, whatever that happens to be.

mental health advocates and others all participate on the same level. And we recognize that people often occupy more than one of these roles.

Mental Health Camp is about erasing stigma and discrimination, and everyone is committed to this. We realize there are many different ways to do this using social media, such as blogging about mental health, participating in online chats and so on. Yet there is no expectation that people ‘should’ out themselves or should be loudly vocal in furthering mental health issues. Everyone does their part, whatever that happens to be.

Mental Health Camp organizers are passionate about creating a value-centred atmosphere. Inclusivity, kindness and equality drive what we do. There is also a desire to keep this on a grassroots level that values storytelling and real, lived experience. We

always ensure there are people at the conferences who can provide emotional support if needed.

The conference takes place face to face, but many participants have their laptops or other mobile devices open. They may update their statuses on Twitter or Facebook with short reports, thoughts or opinions on the presentations while participating in the session.

#### What happens at Mental Health Camp—a sampler

At Vancouver 2009, Canadian blogger Terra Atrill spoke about mental health among so-called “mommy bloggers”—the thousands of bloggers who write about their experience as mothers. For a long time their blogging topics revolved around perfect moms driving perfect children to perfect afternoon activities in perfect cars. This was shattered when one influential mommy blogger experienced severe

post-partum depression and blogged about it throughout her ordeal. This empowered other ‘perfect’ mothers to come out of hiding and talk about their mental health issues.

In Toronto, attendees and presenters formed action groups to take the ideas that arose during their event further. One idea that emerged was starting a Twitter chat group. According to Anne Ptasznik, one of the organizers of Mental Health Camp Toronto, the people interested in this chat group connected with a US-based Twitter chat group (#mhsm) and decided to band with them. The chat time was adjusted to 6 p.m. PST on Tuesdays. Anyone who wants to participate in the chat group needs to sign up for a Twitter account; a pseudonym can be used. (See glossary sidebar for more information on chat groups.)

At Vancouver 2010, sessions included a live, online radio show by Jay Peachy of CJSF (90.1 FM), which is based at Simon Fraser University. Peachy is an award-winning broadcaster and arts-based mental health advocate whose weekly radio show focuses on issues of mental wellness, creative expression and personal sustainability.

Another session looked at how blogging has helped homeless teenagers deal with mental illness. This blog—run by Covenant House, a Vancouver agency that provides housing, counselling and other services to teenagers in trouble—gives voice to the creative works of some of the young people Covenant House serves.

Typical for this type of informal conference, the Covenant House presentation was as much about engaging conversation and raising questions as it was



## related resources

For more information on **Mental Health Camp**, visit [www.mentalhealthcamp.org](http://www.mentalhealthcamp.org) or Twitter @mentalhealthc. You can also find links to other mental health-related blogs on the Mental Health Camp website.

about providing information. Questions included, for example: Is posting [the sometimes very graphic] youth art potentially harmful to the young person's reputation, or is it an authentic and meaningful form of expression? Or, what might be the impact of "outing" oneself as a Covenant House client or as someone with mental illness?

The presenter, who had just recently started blogging, felt encouraged by the conference participants to get even more youth involved. There was a recognition that "the more 'truth' there is on the Web about mental health, the more

people will understand the complexity and prevalence of an infliction many people will face at some point in their lives."

### Social media dos and don'ts covered

As the presentation by Covenant House shows, Mental Health Camp contains a lot of discussion of how social media can best be used, including what not to do and what to be careful about. Almost every presentation includes at least a short discussion about the boundaries of social media. Some of the boundary issues are, for example: using levels of anonymity or privacy to protect oneself from potential

discrimination because of having a mental illness; handling the hostility that other social media participants occasionally display; dealing with triggers that can arise when reading or writing social media content; and so on.

### Giving mental health awareness a lift

The enthusiastic tweeting of the 64 attendees at the Toronto camp brought mental health into the social media spotlight. One participant tweeted to another, "I think hanging with you today dissolved some of my internal stigma." At one point, the Toronto Mental Health Camp became the second-most talked about topic on Twitter in Canada.

This is pioneering work; exciting work. The topic of mental health/illness often feels heavy, even musty. Injecting novelty gives the topic a lift, breathes air into it. ▽



## mental health + substance use information now available in many languages



### languages

Arabic	العربية
Traditional Chinese	繁體中文
Simplified Chinese	簡體中文
Farsi (Persian)/Dari	فارسی
English	English
French	Français
Korean	한국어
Punjabi	ਪੰਜਾਬੀ
Russian	Русский
Spanish	Español
Japanese	日本語
Vietnamese	Tiếng Việt

Finding quality information on mental health or substance use can be hard—and it can be even harder to find information in other languages. We've launched 11 new web sections to help you find information you can trust.

Visit [www.heretohelp.bc.ca/other-languages](http://www.heretohelp.bc.ca/other-languages) for information, fact sheets, self-tests and more. These multilingual webpages are funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

# Community Navigator

## BRIDGING HOMELESS OUTREACH

Suzanne Gessner, PhD

*I was introduced to Donna\* by a worker in our CMHA office. She asked if I could help Donna get on to Income Assistance. Donna was a victim in a violent gas station robbery in 2007, resulting in severe post-traumatic stress disorder. Donna has full-blown anxiety attacks when she is around anyone except her daughter.*

*Suzanne was the most recent Director of Public Policy and Community-Based Research at CMHA BC Division; she recently returned to her background in education and linguistics.*

*This article is adapted from Community Navigator project files.*

\*pseudonym

*She breaks out in a sweat, her breathing and speaking become very difficult and she has to fight the desperate urge to flee. After exasperating dealings with WorkSafe and with her Employment Insurance medical benefits running out, Donna could no longer afford food or rent. The exercise of applying for Income Assistance (IA) was overwhelming and seemed impossible for her to do.*

### From Homeless Outreach to Community Navigator

BC Housing's Homeless Outreach Project was first piloted by Canadian Mental Health Association (CMHA) BC Division in 2006-2007. It has been very successful in connecting homeless people with housing throughout the province. Evaluation of the initial pilot revealed that most homeless outreach clients, many of whom are living with a mental health and/or substance use problem, benefit from follow-up support.

In October 2008, the Ministry of Housing and Social Development, in partnership with CMHA BC Division, announced Community Navigator, a two-year pilot program in response to the need. The program ran in six locations through CMHA branches: Prince George (Prince George Branch), Williams Lake (Cariboo/Chilcotin Branch), 100 Mile House (South Cariboo Branch), Cranbrook (Kootenays

Branch), Kelowna (Kelowna Branch), and North and West Vancouver (North & West Vancouver Branch). Each of these communities participated in the Homeless Outreach Program, and Kelowna and Prince George also offer Aboriginal Homeless Outreach.

### What is a Community Navigator?

A Community Navigator supports clients to address quality-of-life issues that affect their health, wellness and connection with the community they live in.

This is how one Navigator helped Donna, a Community Navigator client: *I immediately established a trusting relationship with Donna and assisted her through the IA intake process. I also assisted Donna in applying for Persons with Disability, and thankfully her application was accepted.*

*Donna and I worked on setting up a network of friends and services that she could access without experiencing anxiety. Initially, I would have to go to the bank with her as a support person. I would sit with her as she made a phone call to a friend to arrange a coffee. At first, the coffee would be drive-thru as she was not able to go into public places. Eventually we could go into a coffee shop. When Donna's landlord suggested her dog was becoming a problem, I took Donna to make arrangements for dog*

*obedience classes. I also assisted Donna through a WorkSafe appeal, accompanied her to see her new mental health worker, helped her with budgeting and attempted to get a consolidation loan for her.*

Navigators may assist in many areas of a client's daily life. They connect with clients contacted through the Homeless Outreach Program to provide one-on-one support for client-defined goals beyond housing. They also help clients access income support that they are entitled to, such as Income Assistance, Persons with Disability (PWD), CPP disability benefits, GST rebates, income tax rebates, Climate Action Dividend, Shelter Aid for Elderly Renters (SAFER) and advocacy with income assistance personnel. Navigators play an important role in connecting clients with services for physical and mental health (including substance use problems) and advocate for their client at doctor appointments. But Navigators also work to foster social supports for their clients. For example, a Navigator may:

- Facilitate supervised access visits with children in Ministry care
- Recognize the clients' skills by connecting them with community volunteer opportunities
- Facilitate client involvement in leisure and recreation activities and engage community volunteers to develop support networks
- Money management, banking, grocery shopping, and other life skills support
- Investigate and assist with work opportunities
- Liaise with landlords where necessary to help clients retain their housing
- Attend court with clients and help clients resettle in community after release from the justice system

At the launch of Community Navigator, we defined our top three goals: helping individuals access income, helping individuals access health care services, and helping individuals build stronger support networks.

### Goal 1: Client income

One of the main goals of Community Navigator is to assist clients with accessing higher levels of income. The Persons with Disabilities (PWD) process was identified as being particularly difficult for clients to access on their own, and Navigators help clients with any and all possible means of support. This includes:

- Basic income assistance
- Canada Pension Plan, Guaranteed Income Supplement, Spousal Allowance
- Employment Insurance
- Rental Supplements
- Rental Assistance Program
- Income tax returns and other credits

### Goal 2: Client health

Many Navigator clients are dealing with a variety of ongoing health issues. Of the individuals we served, 43% had a permanent physical health issue, 43% had a substance use problem, 69% had a reported or diagnosed mental health issue and 39% experienced both a mental health and substance use problem. Some clients experience health problems in more than one of these categories.

Navigators spend a great deal of time connecting clients with health, mental health or substance use services. Completion of the PWD form required that the client be assessed by a doctor, and this has proven to be one of the biggest challenges of the program: finding doctors who are willing to take

on the client and spend the time needed for the PWD process. In addition, Navigators estimate that they have secured regular GPs to provide ongoing care for about 46 clients, or less than 20% of the people served. While some clients may not want a regular GP, it is often the case that GPs will not take on Navigator clients as regular patients.

According to client descriptions, Navigators report that in many cases, their role as an advocate at doctor's appointments greatly improves the attitude of the doctor towards the client. This, in turn, results in better health outcomes



Navigators play an important role in connecting clients with services for physical and mental health (including substance use problems) and advocate for their client at doctor appointments.

for that client. Many clients experience stigma and discrimination from health care workers. This is supported by research on attitudes of health care providers.

Without Navigator connections, most navigator clients would usually only access emergency services, and then only when the problem has advanced to a stage that may be more difficult to treat. Although connecting client with health care services may be costly in terms of staff hours, the emergency option is far more expensive. Community Navigator provides a path that benefits both the client and the health care system.

Here are some examples of ways a Navigator helps clients access adequate medical services and some of the challenges they may encounter:

- Dental health—Process of navigating assessment, extraction and dentures can take up to six months.
- Physical health—Process of moving clients from walk-in clinics to a family physician often takes several months.
- Mental health—For some clients, the process is quick. For others, it may take several approaches. The Navigator role is critical to ensure the even when the client has access, the clinical staff are aware of any behavioural changes or challenges a client is experiencing in the home or community. Some clients will attend the initial appointment, but feel too overwhelmed or intimidated to continue.
- Ongoing chronic health issues—As a navigator address one issue, another issue often comes up
- Access to daily living aid and medical supplies not covered by medical, such as bath bars, walkers,

tub chairs, wheel chair ramps, eye glasses, and other necessities.

- Transportation to and from medical appointments

### Goal 3: Personal support networks

Upon taking an individual as a client, Navigators work with the client to define short- and long-term goals. This includes talking with clients about their supports and ascertaining whether the client wants to address issues relating to personal support. In many cases, the client's mental disorder or substance use has severed many of their personal relationships. However, relationships and personal support networks are often not a priority until underlying issues like income and health are addressed. For clients who do wish to develop greater support, Navigators work with them to build their networks. Navigators have been trained through PLAN's (Planned Lifetime Advocacy Network) network facilitation program. They have also taken Wraparound training. This method works at building a team of both professional and personal support around an individual. To date, there have been some great successes with network development.

### Housing issues: Where are they living?

At the time of contact with the Navigator, 31 clients were absolutely homeless, 17 were homeless due to crisis (e.g. living in a women's shelter), 51 were "hidden homeless" (e.g. couch-surfing, temporary or unsafe housing), one had just left a reserve and 122 were at risk of homelessness.

While Homeless Outreach workers are generally the ones securing housing for clients, many clients may need to change their housing after becoming a Navigator client. So Navigators spend about

10% of their time on housing-related issues. Approximately 23% of clients have been assisted with housing issues.

### Client activity

Navigators are available to work on a large range of client-defined needs. We have made 1,829 connections with primary care physicians, housing providers, employment programs, recreation services and individuals who help to increase a client's personal support networks. On average, seven different community connections were made to each client.

### What does all this mean?

Community Navigators are filling a gap on the housing continuum. Their role is crucial to supporting and enhancing the existing services for people who are homeless or at risk of homelessness. Whether helping clients apply for higher levels of income assistance, connecting them with a doctor who can manage their mental and physical health issues or working to build a network of people they can rely on, Community Navigators are a crucial part of an effective provincial housing strategy.

Donna, who overcame severe post-traumatic stress disorder and accessed income supports, connected with friends and service providers, appealed a WorkSafe decision and worked with her landlord, is just one example of Community Navigator's successes. Donna's Navigator says:

*It has been one year since I met with Donna and she is now in a two-month Empowered to Work Mentoring Program. I hear from Donna less and less. She is busy and managing her anxiety and own life quite effectively. ▼*



# Eating Disorders and Social Support

Shelley Hine, MA, RCC and Mimi Hudson, MA, RCC

“In the process of recovery from physical or emotional illness, addiction, and specifically eating disorders, social support is the very ‘cradle’ in which recovery takes place.”<sup>1</sup> With eating disorders, the cradle metaphor is very apt. The love and support of a network of caregivers is crucial to a child’s healing and successful transition to adulthood.

The stress of living with an eating disorder takes its toll on the whole family network. The immediate family, in particular, needs support to handle emotions and develop coping strategies to see the child through illness, recovery and relapses.

Support can be found both online and in traditional face-to-face groups. Either way, social support groups tend to work co-operatively and can offer a

comprehensive approach to meeting cultural and social needs. This helps to create a sense of empowerment.<sup>2</sup>

At Family Services of the North Shore (FSNS), we have been running a support group open to parents, partners and friends of individuals with an eating disorder since 2007. The group runs twice monthly, and attendance numbers run anywhere from two to 15 people. In over three years, the group has

*Shelley is a child and family therapist at Family Services of the North Shore. She also facilitates the Eating Disorder Support Group for Parents, Partners and Friends, and provides online and telephone support in the Jessie’s Legacy Eating Disorders Prevention and Support Program.*

*Mimi is Director of Community Programs at Family Services of the North Shore and has been a parent educator and group facilitator for nearly 20 years. She is chair of the North Shore Education Committee for the Prevention of Disordered Eating, and supervises the Jessie’s Legacy Eating Disorders Prevention and Support Program.*



These parents feel a lot of judgment. They judge themselves, and they get judged out in the world. They need a soft place to land, and this group provides that.

consistently been made up of parents, with only a few exceptions.

This group came to us fully formed. Two activist mothers of children suffering with eating disorders decided they were tired of not finding the support they needed for themselves. As the emotionally supportive figures in their families, they were exhausted

from constantly feeling bewildered and helpless in the face of their children's eating disorder. And they were tired of feeling the kind of blame for causing the eating disorder that used to typically be targeted at mothers.

These women reasoned that there had to be others feeling the same way, so began their own group. After

managing to create the group they wanted, they found it difficult to get the benefit they needed while having to be both participants and facilitators. They felt that the reputation and work of FSNS would be a good fit for the group, and we felt the group fit our mandate to provide self-help and mutual aid.

### **The FSNS support group: a soft place to land**

In this support group, participants talk about exceptionally difficult topics. Where else can you say that you've put a lock on your fridge and kitchen cupboards, and get total understanding and acceptance from people who've "been there" too? Or that not only is your daughter suffering from an eating disorder, but now she's struggling with alcohol problems? Or that the eating disorder has caused her to blow her semester at university and she wants to come home, and you don't know if you want her home?

Parents can even find ways to laugh together at the kind of dark humour that can come from living with the 'whacked-out' reasoning of this disease. This is a disease that defies logic; in some ways, you have to live it to know. This disease can create isolation for families, because it can be difficult for others to comprehend that the reason someone is starving themselves has nothing to do with food. For example, the friend you generally trade good advice with may not be able to grasp the fact that what your family is up against is far more complex than just your too-thin child not making the "obvious" choice to eat more.

These parents feel a lot of judgment. They judge themselves, and they get judged out in the world—they've been blamed in various ways for their child's



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## family services of the north shore

**Family Services of the North Shore (FSNS)** is an accredited not-for-profit community-based agency that offers education, support and counselling services. With the Jessie's Legacy program, the agency leads the provincial work in eating disorders prevention. Jessie's Legacy provides eating disorders prevention education, resources and support for BC youth, families, educators and professionals. FSNS is one of the seven BC Partners for Mental Health and Addictions Information.

Family Services of the North Shore is expanding the work of Jessie's Hope Society to ensure that the provincial prevention work becomes Jessie's Legacy. Jessie Alexander was a young North Shore woman who died in 2002 of complications from a long-standing eating disorder.

### **Jessie's Legacy Eating Disorder Prevention Program**

Offers phone and online support and referral  
In the Lower Mainland call: 604-988-5281 ext 204  
Toll-free for the rest of BC: 1-888-988-5281  
E-mail: [jessieslegacy@familyservices.bc.ca](mailto:jessieslegacy@familyservices.bc.ca)  
Visit the website at: [www.familyservices.bc.ca](http://www.familyservices.bc.ca)

illness. They need a soft place to land, and this group provides that.

This is not to say that it can't be difficult for a first-timer at the group. It can be very hard to arrive believing that your child will be fine because you've caught the eating disorder in its early stages, only to find parents who began the same way and have been struggling for years. It can be very hard, when you expect to hear about a cure, to instead hear members say, "If there was one thing that worked, we'd all be doing it. There isn't."

As one group member said, "I was so freaked out after my first time that I didn't come back for two years... but I'm glad I finally did." Over time, this woman has become one of the group's most valuable assets—its "elders."

These are parents who keep coming back—even though their child may be mostly recovered—to pass the wisdom they've gained on to parents who are just beginning the struggle.

Most of the information people in the group receive is from the "tried and true" experiences of other parents, which makes it invaluable. One of the strongest messages a parent will hear at the group is how crucial it is to take care of yourself. One can get lost in the sheer volume of demands: specialized understanding, medical visits, family dynamics and navigating changed relationships. With this constant focus on getting your child well, it's very easy to burn out. And one of the most helpful things you can do for your child is to model strength with your own self-care. If you make your own physical, emotional and psychological health a priority, when your child is ready to finally heal, he or she can look to you as an example.

Another more difficult message is that you don't have a lot of power to "make" someone else well, other than monitoring their need for emergency medical intervention. Becoming well and staying well has to ultimately come from them, and they often don't really want a lot of input from you. As is true with most things, advice needs to be sought in order to be of value. It can be a helpless feeling to know that your very sick loved one doesn't want the good advice you can provide.

What you can actively do, however, is to always let them know they are loved. With an eating disorder, the journey to health can be an intricate process. It is entirely likely that, as your loved one heals, your relationship will also be a part of this healing process. ♥

*The Eating Disorders Support Group for Parents, Partners and Friends meets every second and fourth Monday of the month (except holidays) from 7:00 to 8:30 p.m. We meet at Family Services of the North Shore, Suite 101, 255 West 1st Street, in North Vancouver. The group is free, and everyone is welcome. To register, call Vicki at 604-988-5281 ext 202.*

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