No. 14, Spring 2002

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

BC's Mental Health Journal
Visions

Anxiety Disorders in Children and Youth

BC's Mental Health Journal

Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA: the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family, service providers and community members. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal. Please send your letter with your contact information to:

Mail: Visions Editor, CMHA BC Division
1200-1111 Melville Street
Vancouver, BC V6E 3V6
Tel: 1-800-555-8222 or (604) 688-3234
Fax: (604) 688-3236
Email: office@cmha-bc.org

The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division or its branch offices.

Editorial Board
Nan Dickie, Dr. Rajpal Singh,
Dr. Raymond Lam, Victoria Schuckel

Executive Director
Bev Gutray

Editor
Eric Macnaughton

Production Editor / Design / Advertising
Sarah Hamid

Staff Contributors (for this issue)
Eric Macnaughton, Sarah Hamid, Harkirat Kaur

Printing
Advantage Graphix

CMHA is grateful to the Ministry of Health Services for providing financial support for the production of Visions.

editor's message

Anxiety disorders have been overlooked for too long. We've failed to notice the adults who live with these disabling conditions, and we haven't realized that many of these same people struggled with them as children.

In fact, anxiety disorders as a group are *the* most common mental disorders in our young people. The US Surgeon General in his recent report noted that 13% of young people aged 9-17 have some form of anxiety, and noted that for a small but significant minority of these young people, the condition is "severely disabling," meaning that the symptoms have significant ongoing impacts on school and on relationships.

Why has it taken so long to come to our senses and realize the magnitude of the problem? Part of the reason is that anxiety disorders are by definition "internalizing disorders" meaning that young people withdraw and suffer in silence, out of view from the people who could potentially notice or help. We've also thought of anxiety as having to do with the many stages and phases that young people pass through as they grow and develop, and this is undoubtedly true. But we've also believed that anxiety serious enough to be classified as a "disorder" was most often temporary. We now know that this isn't true in the majority of cases.

In this issue of *Visions* we'll take a look at the basics of anxiety disorder, looking at the signs and symptoms of its various manifestations, such as panic, social phobia, obsessive-compulsive disorder and post-traumatic stress disorder. As usual, we'll look at the disorders from an experiential perspective, from both the consumer and family vantage point.

Our look at treatment alternatives will take a strong focus not just on early intervention but prevention, as research into potentially effective preventive alternatives is proceeding on a number of fronts, and interventions are being adapted for young people from diverse ethnocultural backgrounds. In our own province, the opportunities for support are limited, although a number of helpful alternatives exist. So we'll take a look at what *does* exist and help readers understand how to access those resources.

Anxiety disorders are imminently manageable, so it makes sense to provide the resources that can help young people and their families get to the point where they *can* manage them, before the damage is done.

Eric Macnaughton

subscriptions and back orders

Visions subscriptions are $25 for four issues. Back issues are available to read on our web site at **www.cmha-bc.org.** Or call us to order hard copies at $7 apiece. Back issue themes include:

- Anxiety Disorders in Children and Youth (No. 14)
- Employment (No. 13)
- Spirituality and Recovery (No. 12)
- Mood Disorders (No. 11)
- Housing (No. 10)
- Cross Cultural Mental Health (No. 9)
- Sexuality, Intimacy and Relationships (No. 8)
- Poverty, Income and Unemployment (No. 7)
- Approaches to Building Mental Health Accountability (No. 6)
- Community Inclusion (No. 5)
- What is Mental Health? (No. 4)
- Women's Mental Health (No. 3)
- Rehabilitation and Recovery (No. 2)
- Early Intervention (No. 1)

advertising

Complete advertising rates are available online at www.cmha-bc.org or contact Sarah Hamid, Visions Production Editor, for more information at shamid@cmha-bc.org or (604) 688-3234.

what's inside

BACKGROUND

2 Editor's Message Eric Macnaughton
4 Disabling Disorders Too Often Overlooked (guest editorial) Lynn Miller
6 Panic Disorder in Young People
7 Obsessive-Compulsive Disorder in Young People
8 Post-Traumatic Stress Disorder in Children and Youth

EXPERIENCES AND PERSPECTIVES

9 The Struggle to Juggle: Understanding Teenage Stress and Anxiety Harkirat Kaur
10 A Different Kind of Teenage 'Angst' Sarah Hamid
11 A Living Journey Through OCD Sarah Hamid
12 US Help Closer for Ailing Teen Wendy McLellan
13 Doug: A Case Study of a University Student with OCD Enid Weiner
14 Heading off the Dragon Karen Gram

ALTERNATIVES AND APPROACHES

17 Helping Anxious Children
18 Tourette's and Other Tic Disorders
18 How is Obsessive-Compulsive Disorder Treated?
19 How is Panic Disorder Treated?
20 Virtually Facing Real Fears Zoë Macdonald
21 Eye Movement Desensitization and Reprocessing Steven Taylor
23 Achieving Balance Through Ayurveda Zoë Macdonald
24 Using Dogs to Help Children Heal Nicholas Read

PREVENTION OF ANXIETY

26 Anxiety Disorders Prevention: A Summary of Issues Eric Macnaughton
28 Ethnocultural Intervention: Australian Strategy for the Prevention of Anxiety Paula Barrett / R. Sonderegger

BC SERVICES AND RESOURCES

29 Taming Worry Dragons Jane Garland
30 Conference Raises Issues of Refugee Child and Youth Trauma Eric Macnaughton
31 Anxiety Disorders Association of British Columbia
32 BC Anxiety Resources Harkirat Kaur
34 Your Anxious Child (book review) Chris Balma
34 Ode: To a Tortured Mind (poetry) Frank G. Sterle, Jr.
35 Resources

Disabling Disorders Too Often Overlooked

Lynn Miller, PhD, RPsych

Lynn Miller is the President of the Anxiety Disorders Association of BC and an instructor in the Faculty of Education at the University of British Columbia

Anxiety disorders are the most common class of psychological disorder in children, adolescents and adults. This may seem surprising, as other emotional disorders that are more readily "seen" or which are distracting in classrooms or play groups often get more attention from family, from teachers, and from the media. By definition, however, anxiety happens internally, or privately. Parents and teachers frequently do not see a child's anxiety because children may not talk about their concerns or they may see themselves as oddly different from their friends. Children and adolescents with anxiety are described very often as being sensitive. Sometimes, however, children with increased levels of worry and fear may react with anger or aggression, usually out of frustration or fatigue. Anxiety disorders are therefore easily overlooked in children and adolescents.

Anxiety is normal

Anxiety means feeling worried and nervous. It is a normal human reaction to stressful situations or even new situations. We are all born with anxiety and fear. For instance, humans rightly fear cougars and heed warnings to stay out of the forest. In this way, anxiety is adaptive, as it acts as a motivator and protects our life. This is often referred to as the fight-or-flight reaction, as anxiety can be an automatic response mechanism for dangerous situations. But anxiety may not be so obvious, as when anxiety about a job interview helps motivate someone to update a resume, polish shoes, and present him or herself in a more formal light. Fear and anxiety exist conceptually on a continuum, and different people have varying innate amounts of each.

Anxiety can be confused with developmentally appropriate displays of fear, worry or shyness. In fact, most children display fears during childhood as they grow. Younger children often display fear of the dark, fear of being separated from their parents, and fear of spiders or snakes. Older children worry about fitting in with friends, transitioning to different schools, doing well on tests, or performing in an athletic event. It's normal in childhood to worry about school performance, fitting in or adults arguing.

These concerns are usually transitory, and in most cases alert us to a threat of some kind. Adaptive anxiety helps a child prepare for an in-class speech; maladaptive amounts of anxiety create significant fear and eventual immobility in another child who cannot speak in front of the class. The degree of distress, impairment or interference with daily life decides what is "normal" and what is problematic. Anxiety disorders in children refer to developmentally *inappropriate* fears or appropriate fear that leads to excessive distress or dysfunction.

Types of childhood anxiety disorders

The main categories of anxiety disorder are described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Roughly 10% of all children are on the mild end of the anxiety continuum, and approximately 2% are at the more extreme end with significant impairment in daily functioning. While the descriptions below appear to be different disorders, in children especially, many of the symptoms can "overlap."

- *Separation anxiety disorder* occurs in 2% to 4% of children, and is the most common anxiety disorder found in children. The child's reaction to separation is beyond that expected for the developmental level and may involve feelings of panic. Symptoms may include worries about harm to a loved one, reluctance to go to school (see next), or somatic complaints (e.g., headaches, stomach aches).
- *School refusal* is often related to separation anxiety but can also result from unpleasant events or other students at school.
- *Generalized anxiety* disorder (2-3%) is characterized by excessive worry about many things in the child's life. This can also manifest itself in perfectionistic tendencies towards schoolwork.
- A *specific phobia* (2-4%) is a marked fear of a specific object (e.g., sewers, needles, snakes, etc.), which usually involves avoidance of that feared object and anything having to do with it (e.g., stories, pictures).
- A *panic attack* (2%) is a specific period of time where there is a sudden onset of apprehension, fear, or terror. Panic attacks are usually accompanied by some physical symptoms (e.g., difficulty breathing, chest pain, choking feeling, etc.).
- *Agoraphobia* is worry about places (e.g., malls, crowds, bridges).
- O*bsessive-compulsive disorder* (1-2%) is characterized by obsessions (i.e., persistent thoughts which are distressing) and compulsions (i.e., repetitive behaviours such as hand washing or checking the order of things). These symptoms cause much distress and occur for more than one hour a day.
- *Social phobia* (1%) concerns worries about being in social or performance situations (e.g., going to parties, sleepovers, speaking in front of the class).
- *Post-traumatic stress disorder* (1%) is persistent re-experiencing of traumatic events (e.g., violent auto accident, witness to violent death), accompanied by feelings of arousal or fear.

Nature of anxiety

Anxiety is made up of three separate components: **physiological** symptoms (e.g., sweaty palms, racing heart, stomach aches or butterflies), **behavioural** symptoms (e.g., avoidance or refusal to participate in things) and

cognitions or thoughts (e.g., "If I stay overnight, I'm afraid I'll wet the bed and everyone will laugh at me").

Cognitive-behavioural interventions (CBT), which target the three components of anxiety, have the most extensive research support in treatment, early intervention, and prevention of anxiety disorders in children and adolescents. These psychological treatments have advantages in terms of the cost of treatment and acceptability to children and families. Professionals teach children (and their families) CBT techniques to help manage their anxiety at appropriate levels. Understanding the nature of anxiety and gaining the ability to recognize and tolerate increased levels of anxiety are typical tasks.

Anxiety can also be treated with medication. Medicines work gradually over a period of weeks, and often things continue to get better over a few months. Two types of medications are commonly used to treat anxiety: benzodiazepines and antidepressants. Depending on the medication, the drug is continued for at least 6 months, and then can be cut down slowly to make sure that symptoms don't flare up. Some people can come off the medicine, but many people need to take it for much longer. The medicine may also need to be continued for a long time if the symptoms come back. Other medication can be taken on an "as needed" basis. Family physicians and psychiatrists closely monitor medicine choice and levels.

Anxiety can get better or be better controlled, but the tendency stays with people. If it is not managed, it can persist and may develop into adult psychological problems. It is important to intervene early with children who show initial signs of anxiety, to teach them tools to understand and control it. Anxious children can become very skilled and confident at managing their anxiety, and this is an achievement that helps them cope with future life challenges with extra skill.

Why parents and teachers need to pay attention

Often, anxious children are impaired in their learning due to higher rates of absenteeism and lower rates of participation in classroom and extracurricular activities. Children also suffer from impaired interpersonal development both with peers and with non-family adults because anxious behaviours discourage interaction. These effects are too often parlayed in later adolescence and adulthood to more severe anxiety disordered behaviours, depression, substance abuse, higher rates of medical utilization, lower rates of post-secondary completion, lower income levels, and loss of employment.

School-based research of children who suffer from all serious emotional disorders reveal that less than a third receive help. That makes more than two-thirds of children who would qualify for help for mental disorders unlikely to receive treatment. Children with anxiety and depressive disorders are shy, inhibited, and avoidant: rarely do these behaviours encourage teachers to take action, as teachers are consumed with classroom management issues of children with attention-getting behaviours. Anxiety disorders in children warrant more notice from educators, clinicians and researchers.

Precisely because educators have the opportunity to observe and interact with students consistently and on a sustained basis, they are in a unique position to help in the identification, treatment and referral of anxiety disorders. As anxiety disorders seem to "run" in families, family education and involvement are clearly indicated. Early intervention with children and families, appropriate cognitive skill development and prevention strategies aimed at reducing the effects of future unpredictable stressors are key to a child's healthy development. There is consensus in the research community that programs involving parents, families, peers, and schools are important in the *prevention* of anxiety disorders. In terms of *treatment*, there is support for partnerships between these groups and clinicians.

Environment or heredity?

The debate on whether anxiety is learned, that is, environmental, or inherited has resulted in many scholars finding that the development and maintenance of anxiety is an interaction of the two, and nearly impossible to separate into clear categories. Many agree that most anxious children are born with temperamental predispositions to shyness, often have parents who are anxious or have depressive problems, or may have been exposed to traumatic environmental events.

Economic burden

In economic terms, because anxiety is so prevalent, the cost to the health care system is substantial. For anxiety disorders alone, the financial estimate of direct and indirect costs for Canada is $4.23 billion annually (1990 US dollars).

What can parents and educators do to help?

First, if you suspect that your child may be suffering from an anxiety disorder, *contact your local physician* and express your concerns. Be specific about your suspicions, and suggest the professional consider evaluating your child for an anxiety disorder. Bring this publication to your physician to guide your questions.

Become informed. Anxiety is widely misunderstood, especially in children. You need to be an informed consumer of mental health services. There are several helpful books (see page 36) on the market that can be useful resources for the parent. There are also several web sites (see page 35) that offer sound suggestions, forums for parents to "chat" together over common concerns, and often print resources. Your local mental health centre may also be a source of information on professionals who treat anxiety.

The family and the school are very important keys to helping a child learn to control anxiety. Each has the potential to help or hinder a child's response to treatment, and therefore needs to be part of the plan for helping the anxious child. An anxious child, the family and the school can form a very complex relationship, which may need the sustained intervention of someone quite familiar with anxiety disorders in children, family dynamics and school systems. ■

Panic Disorder in Young People

Our bodies have an alarm system, just like houses and cars. This alarm goes off to tell us that there is danger and we had better get ready for action. It probably worked very well in situations where we were confronting wild animals on a daily basis. In our modern world, we shouldn't need to use this system very often, except in real physical danger. But sometimes this alarm system goes off anyway, just like a "false alarm" in your house or car.

Adapted from "Panic Disorder in Young People" prepared by BC Children's Hospital's Mood and Anxiety Clinic and the Anxiety Disorders Association of BC. The full pamphlet series can be found at www.anxietybc.com

Panic disorder is like having an overactive alarm system. Panic attacks seem to occur for no good reason. The problem is, just like a loud alarm system, the attack itself is very frightening. Treatment for panic disorder focuses on resetting the alarm system to be less sensitive, and teaching people how to overcome the fears that the attacks create.

Panic disorder is puzzling to families

When panic occurs in young people, they often can't explain to anyone what is happening, and may become very upset, angry, withdrawn or refuse to go to school without being able to say why. Adults may become frustrated because they can't understand why the child is behaving so differently.

Panic attacks are not just in your head

In many cases, panic symptoms are so dramatic and physical that children or teens are investigated for all kinds of medical problems with their heart or stomach, or are even thought to be having seizures, until someone figures out that the real cause of these symptoms is a panic attack.

Panic disorder is like having an overactive alarm system. The problem is, just like a loud alarm system, the attack itself is very frightening.

What are panic attacks?

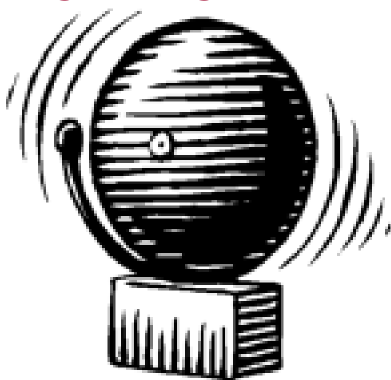
A panic attack is a sudden, terrifying feeling of fear and physical anxiety symptoms.

Physical symptoms that might occur:

- racing heart
- fast breathing
- choking feeling
- dizziness
- sweating
- chills or flushing
- upset stomach
- changed vision or hearing
- tingling in hands and feet

Thoughts and feelings that might occur:

- terrified feeling
- fear of losing control
- fear of fainting or dying



This whole experience can last from 5 to 20 minutes, but may leave an anxious feeling behind even after it is gone. The most common result of having panic attacks is that people avoid the situation in which an attack occurred. This can lead to *phobia.*

What is the difference between panic attacks and panic disorder?

Panic attacks are quite common, with a third of people having an attack at least once in a lifetime, usually in a stressful situation or when they are overtired or have had too much caffeine.

Panic disorder is much less common, occurring in about 2% of people. In panic disorder, recurrent panic attacks occur frequently for no apparent reason, or they cause such anxiety that people can't go on with their usual activities. They may feel afraid to leave the house, be fearful of being alone, withdraw from school or other activities, or lie awake at night worrying.

What causes panic attacks?

The tendency to have panic attacks runs in families.

Factors that can trigger panic attacks:

- lack of sleep and not eating regularly
- caffeine in soft drinks, coffee or tea
- alcohol and marijuana
- overwhelming stress
- certain situations or phobias
- certain times such as the onset of adolescence
- medical problems such as overactive thyroid
- some medications, especially for asthma

Although stress may play a role by upsetting sleep or increasing the sensitivity of a "panic alarm," panic attacks occur even when people are not particularly nervous or stressed.

How serious is panic disorder?

Panic disorder is not physically serious although it can feel very dangerous for your body to have these reactions. But it is serious in the sense that it greatly interferes with daily life.

Here are some of the complications of panic disorder:

- agoraphobia (fear of going out alone)
- reluctance to go to school
- separation anxiety (fear of being away from parent)
- sleep problems
- depression
- drug and alcohol use in teens
- unnecessary investigations for physical abuse

How does panic disorder relate to other anxiety problems?

- **Social phobia** is the fear of speaking in front of a group of people and sometimes of meeting new people. These situations may be associated with panic attacks.
- **Specific phobias** are fears of things like elevators, heights, dogs or flying. Sometimes the phobias were triggered by having a panic attack.
- **Separation anxiety disorder** occurs in younger children and is a fear of being separated from parents. We now think that this is often triggered by having a panic attack that leads the child to fear being alone.
- People suffering from **post-traumatic stress disorder** or **obsessive compulsive disorder** may have some panic attacks. Young people with clinical depression may also develop panic symptoms.

Obsessive-Compulsive Disorder in Young People

Obsessive-compulsive disorder (OCD) can occur in people of all ages, and often starts in childhood. It is a problem that tends to come and go over time. Often it starts gradually but sometimes it starts suddenly or quickly becomes severe.

The symptoms of OCD are **obsessions** (upsetting thoughts that keep coming back) or **compulsions** (habitual patterns such as checking or washing over and over) which happen so often that they interfere with daily life.

Obsessive-compulsive disorder is treatable, but first it has to be recognized. In children, it may look like unreasonable anxiety, temper tantrums, stubborn habits, lack of cooperation or other behavioural problems. In teenagers, it may lead to avoiding school or friends, and fighting with parents. People with OCD are very stressed and can be irritable, angry and withdrawn. Parents may be frustrated and confused by the behaviours.

People are often very embarrassed about the kinds of obsessive thoughts they have because they don't make sense or seem "crazy" to them. They try to cover up their compulsive habits, because they know they don't make sense either. They end up feeling very alone and afraid.

Obsessive-compulsive disorder is a serious mental health condition that can and does get better, usually with a combination of medicine and practicing ways of changing the obsessive thoughts and compulsive behaviours.

Who can help?

Start with your family doctor. Check the local mental health centre or Ministry of Children and Family Development office for other resources. You may be referred to a psychologist or psychiatrist for further assessment or treatment. With help, young people and their families can free themselves from the trap of OCD.

How common is OCD?

About 2 or 3 out of every 100 people have OCD in their lifetime. Most of them keep it a secret, and most do not get treatment because either they don't think help is available, or they are too embarrassed to seek it out.

What are the symptoms?

The criteria for symptoms of OCD are obsessions and/or compulsions that are severe enough to interfere with school or work, family relationships or that take up a lot of time (more than an hour a day).

Common obsessions

These thoughts occur repeatedly in spite of the child's efforts not to think them:

- Fear of germs
- Violent thoughts
- Frightening or rude mental pictures
- Fear of doing something wrong in future
- Fear of having already done something wrong
- Constant self-doubting
- Need for things to be even or symmetrical

Common compulsions

- Checking (e.g., locks)
- Counting
- Washing hands
- Doing work over to get it "perfect"
- Making things "even"
- Asking questions (i.e., to receive reassurance)
- Needing to confess things
- Collecting or hoarding things
- Touching things

Effects of these symptoms

Children or teens may be constantly upset or easily irritated because they are so busy worrying about their obsessive thoughts that they can't handle thinking about or doing anything else. They may not want to go anywhere, may not be hungry and may stay in their room a lot of the time, trying to sort out their thoughts. Children may ask for constant reassurance from parents because they are worried about illness or germs.

Washing hands, counting or checking things may take several hours a day. Sometimes children will insist that other members of the family do these things, too. For example, no one may be allowed to touch the child's plates, door or clothes because of the risk of spreading germs.

What about families?

Usually the whole family gets mixed up in the disorder. Parents may start to do the checking for the child to try to save time. Everyone has to go out the right door, or wait until the child has flicked a light switch ten times when leaving the room. People tiptoe around the ▶

Adapted from "Obsessive-Compulsive Disorder in Young People" prepared by BC Children's Hospital's Mood and Anxiety Clinic and the Anxiety Disorders Association of BC. The full pamphlet series can be found at www.anxietybc.com

Post-Traumatic Stress Disorder in Children and Youth

All children and adolescents experience stressful events that can affect them both emotionally and physically. Their reactions to stress are usually brief, and they recover without further problems. A child or adolescent who experiences a catastrophic event may develop ongoing difficulties known as post-traumatic stress disorder (PTSD). The stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred (e.g., they may be the victim or a witness of physical abuse, sexual abuse, violence in the home or in the community, automobile accidents, natural disasters (such as flood, fire, earthquakes), or may have been diagnosed with a life-threatening illness). A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his or her relationship to the victim(s).

Adapted from a factsheet produced by the American Academy of Child and Adolescent Psychiatry.For the full series see www.aacap.org

Following the trauma, children may initially show agitated or confused behaviour. They also may show intense fear, helplessness, anger, sadness, horror or denial. Children who experience repeated trauma may develop a kind of emotional numbing to deaden or block the pain and trauma; this is called dissociation. Children with PTSD avoid situations or places that remind them of the trauma. They may also become less responsive emotionally, depressed, withdrawn, and more detached from their feelings.

A child with PTSD may also re-experience the traumatic event by:

- having frequent memories of the event, or, in young children, engaging in play in which some or all of the trauma is repeated over and over
- having upsetting and frightening dreams
- acting or feeling like the experience is happening again
- developing repeated physical or emotional symptoms when the child is reminded of the event

Children with PTSD may also show the following symptoms:

- worry about dying at an early age
- loss of interest in activities
- physical symptoms such as headaches and stomach aches
- more sudden and extreme emotional reactions
- problems falling or staying asleep
- irritability or angry outbursts
- problems concentrating
- acting younger than their age (for example, clingy or whiney behaviour, thumbsucking)
- increased alertness to the environment
- repeating behaviour that reminds them of the trauma

The symptoms of PTSD may last from several months to many years. The best approach to intervention is prevention of the trauma. Once the trauma has occurred, however, early intervention is essential. Support from parents, school and peers is important. Emphasis needs to be placed upon establishing a feeling of safety. Psychotherapy (individual, group or family) which allows the child to speak about their experience is sometimes possible, and if not, therapy that allows the young person to draw, play or write about the event can be helpful. Behaviour modification techniques and cognitive therapy may help reduce fears and worries. Medication may also be useful to deal with agitation, anxiety or depression.

Child and adolescent psychiatrists, psychologists and other mental health professionals can be very helpful in diagnosing and treating children with PTSD. With the sensitivity and support of families and professionals, youngsters with PTSD can learn to cope with the memories of the trauma and go on to lead healthy and productive lives. ■

OCD in Young People (cont'd)

child to prevent his or her outbursts of rage and frustration when compulsions are not done "enough" or "just right."

What causes OCD?

OCD is one of the best-researched childhood disorders, but it is still not fully explained. We know this much: although OCD does run in families, what causes OCD is not known. There is likely a genetic component that makes one vulnerable to OCD but it often must be combined with events that occur in the child's life for the OCD to be fully expressed. Like many other problems, it is a combination of genetics and the environment. ■

The Struggle to Juggle:
Understanding Teenage Stress and Anxiety

Harkirat Kaur

Harkirat is a Simon Fraser University co-op student presently working for CMHA BC Division

We've all been there: that awkward, pimple-bursting, giggly, rabble-rousing phase of life we so fondly call adolescence. The years between twelve and eighteen are a time of all-round growth and development, when we are leaving behind the innocence of childhood and busy becoming the people we want to be. The teenage years are full of conflicts and contradictions. While it's a time ripe with the promise of youth and exuberance, it can also be a scary place to be. Today's youth are faced with countless stressors that make anxiety an everyday part of a teenager's life.

School takes up a high proportion of a teenager's life, and it can be a major stressor. There can be tremendous pressure to do well on examinations, get good grades, and get into a good college. Moreover, the transition from junior to senior high school can be a very stressful experience, as teenagers must adjust to new ways of learning, and take more responsibility for their academic performance.

Parents are another influential — and potentially anxiety-provoking — force in a young person's life. Teenagers are trying to find their way in the world, while often still being dependent on their parents financially and emotionally. Conflicts can often arise from high parental expectations or when a youth wants to assert his or her independence.

Jonathan is a 14-year-old youth who was born in Montreal, spent his childhood in Hong Kong, and returned to Canada last year to continue his education in Vancouver. He says that there can be a lot of expectations and pressure from parents for their kids to act a certain way and do well in school. It can be frustrating when kids don't get what they want. Jonathan's situation parallels those faced by many youth dealing with parental restrictions on their life. He adds that relationship issues are another common source of anxiety for teenagers.

The teenage years are a time when youth are beginning to explore relationships and take them beyond the platonic level. In addition, this is also the time when youth are exploring their own sexuality, and this can bring up a lot of issues. Many youth grapple with the question of sexual orientation. In a society where different types of sexuality are still not fully embraced, this can be a difficult time for youth who are finding out that they don't "fit in" in terms of their sexual identity.

Puberty also brings physical changes that a young person has to adapt to, and can cause significant anxiety over body image. Youth are often worried about being "normal" and "fitting in." Media images of beauty stereotypes only add to the desire to conform to society's accepted definitions of beauty. Moreover, physical maturity requires emotional maturity as well, as youth now may have to grapple with such issues as pregnancy, sexually transmitted diseases, abortion and young parenthood.

Peer pressure is a significant anxiety-invoking presence in a teenager's life. It is often what leads a teenager to smoke, drink, and do drugs. Peers can also cause a lot of tension and fear. Bullying is a serious issue for young people today. It is bad enough that there is so much pressure for teenagers to conform; bullying only serves to cause more anxiety, shame and fear. Youth are often bullied for being different in some way, whether it is their sexual orientation, colour of skin, language difficulties, or simply because the bullies believe they can get away with it. This can often lead to violence. Gang violence, rape, homicide, and school shootings are increasingly becoming everyday occurrences.

In addition to all these stressors that most youth have to worry about, some youth have even more on their plate. For young immigrants like Jonathan, the additional pressures of getting used to a new society, a new language, having to make new friends, and having to adjust to a new way of doing things often produces a lot of anxiety. Even for a lot of young people of colour living in Canada, conflicts can often arise between the culture they come from and the mainstream culture they are a part of. In addition, there are many youth who live in poverty and have additional worries about money, jobs, and sometimes having to live on the street.

Perhaps some anxiety is necessary in everyone's lives. However, when anxiety becomes crippling and all-consuming, teenagers need to find ways to reduce the day-to-day stresses in their lives, so that they can partake in the more positive aspects of their youth. Although it is easy to sentimentalize youth and see it as a time of excitement and opportunity, we must not forget that today's teenagers go through a lot in their daily lives. In acknowledging the reality of young people's lives, we acknowledge their presence, their hopes and dreams, and their fears. We need to let them know that they are not alone in this world, and that there are places they can go and things they can do to help. ◾

A Different Kind of Teenage 'Angst':

Recollecting a Panic-Ridden Adolescence

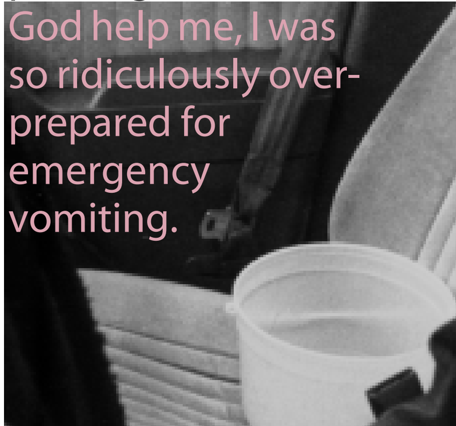
Sarah Hamid

Sarah is Communications Coordinator at CMHA BC Division. She is also Visions Production Editor/ Designer

I have always felt that I've inherited a hypersensitive nervous system from my mother, and she, from her mother. When there's a surprising noise or explosion in a movie, we're the ones in the theatre who will physically jump out of our seats and gasp audibly — and then shrink back in embarrassment. These days, it seems that everyone else, desensitized by the 'action' in daily life, is seeking bigger and bigger thrills and adrenaline rushes. Not me. I think life is pretty exciting the way it is.

I first started to realize that my mind and body were prone to 'excitability' around the time that I was getting used to a double-digit age. I remember that I was really excited about the first day of Grade 6, so much so that I found it hard to get to sleep. When I finally did, I ended up having a nightmare and woke up with a start in the middle of the night. Wide awake now, my mind became active and I got so worked up thinking about going back to school, I had to run to the bathroom and throw up. I still remember how the next day I had asked my friends if they had thrown up too, as if my reaction was the norm. They just looked at me funnily. It was then I realized I probably shouldn't mention my vomiting incidents to anyone. Looking back now, after that day I never felt "excited" about anything because to me, excitement felt the same as nervousness.

Or if I was driving alone, I'd put an empty ice-cream pail on the passenger's seat.


God help me, I was so ridiculously over-prepared for emergency vomiting.

From around age ten to age eighteen, I routinely (and secretly) experienced panic attacks whenever there was a special outing or event about which I was uncertain, or whenever I felt someone had expectations of me. I make this distinction because, for example, I never had anxiety writing exams or driving because I felt I had control over my test performance or what the car did. But all the fun things that everyone else loved to do, it seemed, I would 'freak out' over. These could be vacations, sleepovers, birthday parties, or even just a family meal at a restaurant. Someone would make the mistake of inviting me to these activities days or weeks in advance — way too much time for me to think about it. My fears started out as 'what if they don't have a good time at my house?' or 'what if I sleep funny and they make fun of me' or 'what if I can't finish what's on my plate? — someone I care about will have wasted their money.' Soon enough though, the *only* fear I had was having another attack: the horrible tingles down the spine, the knot in the tummy, the heart rate and breathing accelerating, the nausea, the sweating, and that horrible feeling that the world was going to end. So why didn't I just *avoid* the 'fun' activities that were common triggers for my panic? Because then people might suspect something was wrong and I wasn't about to give them the satisfaction of judging me. Also, I hated "missing out"; I knew I'd regret it later if I did. Besides, after a couple of hours, I'd relax enough to have fun.

So I developed a proactive campaign to prepare for an attack. For example, what frightened me most about having a panic attack was that there was the possibility — though it rarely happened — of vomiting. I could disguise a panic attack in a crowd, but throwing up is harder to hide and would have concerned my friends and family. So to tackle this foe, I had come up with two strategies:

1. Since anxiety and a full tummy don't mix well, I made sure I didn't overeat. Often after having a meal, I'd run and lie down on my bed for a few seconds to make sure my stomach didn't feel too full. I never stayed hungry or anything, I'd just focus more on medium-sized meals.
2. Whenever I went on an excursion that might have triggered an attack, I made sure a bathroom was accessible in case I had to ever-so-inconspicuously run in and throw up. In cases where that wasn't possible — like during a long drive — I'd put a plastic bag inside a paper lunch bag, fold it up, and put it in my pocket. Or if I was driving alone, I'd put an empty ice-cream pail on the passenger's seat. God help me, I was so ridiculously over-prepared for emergency vomiting.

In senior high where I was a sociable, popular, straight-A student involved in many extracurricular activities, the panic attacks were less frequent but a kind of social anxiety combined with obsessive-compulsive-like behaviour took over. I became hyperconscious about being made a fool of by my peers even though my peers really respected and liked me. It was so bad that if someone just happened to be laughing when I walked by, I'd always assume they were laughing at me. Or I'd worry about embarrassing underarm sweat patches that people might see if I raised my hand (I'd go to the washroom during recess and lunch to make sure I didn't have any patches — realizing, of course, that the more I thought about it, the more likely I was to sweat over it). My hand would quickly and casually check my pant zippers to

make sure they were pulled up, my bra straps to make sure they weren't showing, and the backs of my skirts to make sure they weren't tucked into my underwear by accident. During the worst of it, I must have checked these kinds of things at least a dozen times during school hours. I hated that I kept doing it but I couldn't help it. After school and at home, I was relaxed and fine.

In 1996 — actually, for reasons totally unrelated to my anxiety — I began a battle with major depression. My depression ended up completely dissolving my anxiety. Why? Because I went from a state of hyperawareness of other people's judgments and petty details to the exact opposite: in my depressive state, I was barely aware other people even existed; they all felt like robots or movie extras. I had no time to care about zippers and bra straps when I wasn't eating and would spend half the day sleeping and half of it crying. All I cared about was getting through the day and surviving. Ironically, depression has given me a perspective I longed for all those years in my childhood and adolescence. I'm happier now than I've ever been and for almost six years now and counting, I haven't had any anxious symptoms. Okay okay, I still jump out of my seat a little at the movie theatre, but that doesn't count — I like to think I get more bang for my movie buck that way.

A Living Journey Through OCD

Sarah Hamid

Like other young people living with a mental illness, 19-year-old Jason Marr of Delta has probably faced more anguish and frustration in two decades of life than most people will in a lifetime. You see, Marr has a severe case of obsessive-compulsive disorder.

Marr's behaviour first started to look different between the ages of six and eight. "I'd like things really clean and stuff. And I'd wash a lot," recollects Marr of his earliest symptoms. "Nobody knew what they were [his behaviours] and nobody really paid any attention to them. I didn't. I just thought, oh you know, I don't know why I'm doing this."

The symptoms disappeared for some years only to reappear with a different face in junior high school. "In school — it started in grade 8 — I'd be at my locker and I'd have to check things over and over again: put my stuff in my bag and if it didn't *feel* right, I'd take it out and put it back in the locker." He still didn't suspect that he had a condition that needed intervention, instead chalking the odd behaviour up to teenage quirkiness: "I thought, maybe I'm just different, you know?"

Beyond the compulsive need to re-check his school bag, another more disturbing feature would plant itself in Marr's mind and further dictate his schedule and routine, often as soon as he returned home from school. When most kids his age would have been dumping their clothes on the bed and lounging in front of the TV, Marr was racing against an enemy in his mind.

"When I had homework," explains Marr, "I'd run and put my bag down and run upstairs because I didn't want images that I get which are like a movie reel in the head. I didn't want those to start because I'd basically be physically stuck until I could get rid of the images."

Not even stopping for a snack or bathroom break, Marr must have appeared to be a super-keen student in his passion to finish his homework. But grades were hardly his driving motivation. "The images, back then, were violent ones. And they were thoughts, too, like 'this feels wrong,' or 'what if my family gets hurt or something, gets into a car accident' and maybe I'm wishing for it? It was hard to do homework. I'd really have to struggle."

At the end of Grade 9, a baffled Marr family, especially Jason, was finally able to put a name to this behaviour: obsessive-compulsive disorder (OCD). Just by chance one day, Marr's parents had seen a segment about the condition on BCTV News and after phoning in to get the details, soon paid a long-needed visit to UBC's Anxiety Disorders Unit. The diagnosis of OCD was made relatively quickly using a standard questionnaire screening tool. "I wasn't surprised by my diagnosis," says Marr. "I was just, like, 'these all match,' 'they all match!' And they said the images were totally part of OCD."

Into Grade 10 now, Marr's OCD was getting worse. "It got to the point where I'd stay at school til about 5 o'clock checking my bag. School ends at 2:50 but I'm still there and the hallways are empty. Even the janitors had gone home already. It just got really bad and I had more of a difficult time doing my homework."

Of course, Marr was not experiencing these symptoms in a social vacuum. He had to navigate his OCD with inquisitive and impatient school *friends* as well as school *work*. "My friends used to be, like, 'c'mon, let's go home' or 'yeah, c'mon, just put 'em in the bag and let's go.' They didn't know or understand. And I'd be just like 'oh, I'll just meet you there' or 'I'll catch up with you along the way' but, of course, I never did." ▶

It got to the point where I'd stay at school til about 5 o'clock checking my bag. School ends at 2:50.

In Grade 11, the OCD got progressively worse. Marr was now staying at school until six o'clock, caught in the vicious cycle of obsessive thoughts and compulsive bag-checking. He didn't fare much better during class time either. "I was having a really difficult time reading because I'd re-read paragraphs even though I knew I'd read them. When I was reading them — even if I was at the last word of the paragraph — and I'd get an image that would make the paragraph feel bad, I'd have to read the paragraph backwards to get rid of all the bad feelings, then read it again with, hopefully, no images."

Watching her son deteriorate, Jason's mother enrolled him in the Surrey-based Adolescent Day Treatment Program halfway through Grade 11. There, mornings were dedicated to school work and afternoons to group work. "It's like a school with 16 kids. There was actually one kid with OCD there who I still keep in touch with." During his stint with the Day Program, Marr's doctor tried medication to help his OCD. "Yeah, the doctor gave me this medication and it made me gain, like, 40 pounds in a month and I looked funny because I was short back then. It was like 15 pounds a week! It's not a medication for girls <laughs>. It didn't help at all either; it just made me fat and stuff."

The next development in his illness, which took place two-and-a-half years ago, led to what Marr describes as the most difficult time in his life: "My images were getting more vivid, more frequent and they were just horrible. Basically, I'd go to bed the night before, say, at 9 and I'd be in bed until 6 pm the next day. And I'd lay there without food, without going to the washroom. Not sleeping though — with horrid, horrid images and I'd be stuck there. I'd be rewinding to try and get rid of the images. It's a compulsion. Say there were forty images — still images like from a camera — and they'd run together. Then, like a VCR, I'd run backwards from the 40th to the 39th and 38th — you have to have a good memory to do it. And that's the thing: if you couldn't remember, you'd kind of get stopped and say 'okay, okay, I gotta remember before I get more images' and then more images start and then you have 40 more to do, plus this 40 you haven't done yet. Rewinding made me feel like I was negating them, going back to feel that I'm fine, I'm okay, I'm okay now, getting a fresh start." With these in-bed rewinding marathons running on and off over six months, Marr lost sixty pounds and he and his family grew increasingly anxious about how to help stop the behaviour.

For the Marr family, the next step, which until this point had remained untried, was admission to an inpatient psychiatric ward for two weeks: a place he hated. "Some of the staff there made fun of the kids, not only me but these other kids that were having problems. To me it was odd, making fun of kids and stuff. My time there completely made my OCD worse. I'd be in bed for two or three days after that. It'd be absolutely horrible. And I would *hurt* from laying in bed in that one weird position for so long."

A year later, Marr decided he'd try going back to school. "It didn't work though," he says. "I left after two weeks because I couldn't handle it. Just walking there, I'd get stuck with images. I'd get stuck anywhere I went because of these horrid images."

The family was beginning to run out of options. When it comes to describing Marr's experience with various kinds of counselling-based treatment interventions, one of his phrases sums it up best: "I've seen *a lot* of people." So having tapped out BC's facilities, the Marrs took Jason to a special anxiety treatment centre in Sacramento, California.

Marr explains that there are only five centres of its kind in the world, centres that he says "can treat OCD properly." Unfortunately, they're all in the US (Wisconsin, New York, Missouri, and two in California. There's also a live-in program in Boston).

Was the trip worth it? "Yeah, it totally helped. I got over a lot of things in the month that I was down there. It was totally different from what I've been having. It was really intensive exposure therapy for hours every day. I'd basically do stuff that I didn't want to do or felt I couldn't do, and just sat with the feeling and we worked on different ways to deal with it. Examples were shoes I didn't even want to touch or wear: I'd wear them and I'd touch them for like two hours. And I'd have a spoon in my mouth for two hours. And I had to make tapes about my images and listen to them. It was hard but it made it a lot better."

It's been almost a year since the treatment in Sacramento. Marr is still involved with the Delta-based OCD support group where he's been able to meet a lot of other kids with the disorder. He finds it helpful for support but not for easing his symptoms. Asked how he is doing today, Marr replies that he's been starting to slip back a bit since Christmas: "I think I'm slipping a bit because there's no help here. In BC, they don't know how to treat severe OCD, I guess. I don't think there are enough experts here who know what they're doing." He supposes it would

US Help Closer for Ailing Teen

Wendy McLellan, *The Province*, October 26, 1999, p. A15
Reprinted with permission.

A nine-month mixup over government procedure seems to be all that's been keeping a Delta teen from getting the help she needs in the US. Natasha Heidebrecht, 19, suffers from severe obsessive-compulsive disorder and, despite drugs and therapy by trained specialists, her illness has only got worse, *The Province* reported on Sunday.

Natasha's psychiatrist, Dr. Cyril Melck, asked the BC Health Ministry last January to approve her stay at a Massachusetts hospital with an intensive residential program for such disorders. His efforts were blocked when some Ministry official requested a second, then a third opinion on Natasha's illness. The third doctor said Natasha could be treated at the Anxiety Disorders Clinic at the University of BC Hospital, where she is now. [note: 'now' is 1999]

But Health Ministry spokesman Jeff Gaulin said yesterday all the Ministry needs is a letter from Natasha's psychiatrist and some information on the Boston program to support sending her for treatment. "For whatever reason, the process got derailed and the doctor [Melck] was given inappropriate advice," Gaulin said.

"This is terrible — we certainly extend our apologies to the family." Once the Health Ministry gets some information on the clinic, "it just takes a couple of days to make a decision," Gaulin said. Asking for additional medical opinions is not part of the procedure for considering out-of-country treatment, he said.

Natasha's mom, Gayle Heidebrecht, said she has all the details on the Boston program. "We've never been requested to give more information," Heidebrecht said. "Finally, I feel a faint ray of optimism."

The program at McLean Hospital, just outside Boston, is the only one of its kind in North America and costs about $300 a day less than Natasha's bed at UBC Hospital. The government paid for another BC resident to attend the program last year.

facts

obsessions = unwanted ideas or impulses that repeatedly well up in the mind of the person with obsessive-compulsive disorder

compulsions = in response to obsessions, most people with OCD resort to repetitive behaviours and rituals called compulsions

Famous people who have or are thought to have OCD:

- Donny Osmond
- Howard Hughes
- Howie Mandell
- Roseanne Barr
- Charles Darwin
- Florence Nightingale
- Marc Summers
- Howard Stern
- Billy Bob Thornton
- Hans Christian Anderson
- Woody Allen

According to the National Institute of Mental Health in the States, at least one third of adult OCD is reported to have begun in childhood.

In child OCD, male sufferers outnumber females by a ratio of 3 to 2 (but adult OCD affects men and women equally).

be helpful to return to Sacramento, but expense is a barrier. To have it done here wouldn't be any less expensive either since psychologists are the professionals who administer the treatment and services by psychologists are not currently covered by BC's Medical Services Plan; even through private insurance, there is only very limited coverage — not adequate to sub-sidize the number of hours Marr would need for this aggressive approach to exposure therapy. In the meantime, Jason's mother tries to continue some of the exercises with him and regularly liaises by phone with the Sacramento clinic staff.

Still too sick to re-attend school, Marr finds time for reflection. If he were to meet a young person who was just beginning his or her journey with OCD, Marr would offer this advice: "Try and stop it pretty early and learn about it because it can seem really strange if you don't learn about it."

At the same time though, he would be honest about the recovery process: "It's a debilitating illness and kind of like schizophrenia; it's a complicated disease that's complicated to treat. You need lots of time, effort and money."

Faced with a mentally-exhausting illness, the inability to complete his final year though he knows he's smart and could do anything, and school friends who have long since faded into the woodwork, Marr is cert-ainly at risk for depression. However, he says he tries not to get depressed — frustrated, yes, but not depressed. Instead he thinks about the future a lot.

"I think I'm going to beat my OCD because I've started to look down the road and I'm thinking 'I don't want to have this forever. I don't want to have this right now and I definitely don't want to be, like, 70 and thinking 'I still have this. I've wasted my whole life.' That would be a tragedy. But I don't know what's ahead." ■

Doug:

A Case Study of a University Student with Obsessive-Compulsive Disorder

Enid Weiner, EdD

Doug is a university graduate with depression and obsessive-compulsive disorder (OCD). The following is excerpted from a case study of Doug's university experience, written by Enid Weiner of York University, which can be found in its full form in The School Book, *edited by Bonnie Pape and Ed Pomeroy, and published by the Canadian Mental Health Association's National Office. Ordering information can be found at www.cmha.ca*

Doug was diagnosed with a learning disability in grade school. When Doug began university in the fall of 1990, he was reassessed at the university's Learning Disabilities Program and was informed "that he did not meet the criteria for participation in their service." He was referred to the support service for students with psychiatric disabilities and soon after was diagnosed with depression and an obsessive-compulsive disorder. In retrospect, Doug found it helpful to be told the diagnosis. "I didn't see it as an illness, until Dr. C. told me what it was. I used to think it had to do with my personality."

As a result of his OCD, Doug spent about six hours a day in compulsive behaviours. "You get the feeling that you have to do these things or something bad will happen. There is nothing rational about it. This makes the physical aspect of coming to school or anything in my life difficult."

When due to his OCD Doug had to write things over and over in class, he would cover his notes because he felt "very embarrassed, ostracized and ashamed." "I felt I should be in kindergarten." These feelings had a negative impact on Doug's self-esteem and his willingness to work with other people. "When you aren't functioning, you start feeling that your are just not smart and then you get more depressed and it spirals."

Doug found it necessary to take breaks every 20 minutes when doing his homework, so that it took him four hours to do one hour's worth of work. "Sometimes, with OCD, just trying to write an introductory paragraph would be an impossible task. I would get to the second sentence and I would have to do some bizarre ritual. By that time, my concentration would be shot and whatever I had in my head was gone. I would then have to start over again to try and formulate the thought I was thinking." ▶

Doug did not find the academic material difficult. His organizational problems, however, resulted in his feeling overwhelmed by the amount of information he had to digest. These feelings further exacerbated his depression. "The problems I had in class made it harder for me to digest all this work and then I got very frustrated and I found myself getting very depressed, and then I started having a lot of problems with OCD." Doug feels that most of the time he was playing "catch-up."

Doug slowly learned to come to terms with his illness. "If you accept that you have a problem, that it's not you, that you are a smart person, that you are worthwhile, then that goes a long way in dealing with it." It was not until a late stage in his studies that he accepted a reduced course load and began not to enroll in early morning classes, for which he was unable to wake up on time. In retrospect, Doug remarked that he would have paid attention better in class, if he had sat in the front row. However, often he arrived late and felt conspicuous and seated himself where he felt he would not be noticed. Although it was suggested that he tape-record his lectures, Doug was reluctant to do so. He felt that his OCD would result in his stopping and starting the tape, though he never tried this strategy.

Doug did not engage in treatment with a therapist until the very end of his studies. He attributes this delay to long waiting lists and his inability to find someone whom he felt could actually help him. He pursued this route more vigorously only as he was getting read to graduate.

Since seeing a cognitive therapist, Doug has recently been able to say that his OCD is "a minor inconvenience," instead of his main obstacle to getting on with his life, and that he is learning to manage his illness better. He now realizes that "with a good strategy you can go a long way in helping yourself as opposed to just letting the illness take over." He has come to value the importance of "taking care of external problems by getting counselling outside of school."

He is hopeful that he will find a way around his illness so that he can extend his periods of productivity and be able to pursue an interesting career. He says that if he is ever to return to university for graduate work, he will have to have his illness under control.

Doug had a great deal of advice to give to other students with mental illness: "You have to persevere. You have to see your illness as an illness and see your problems as symptoms of an illness, not as personal deficiencies. You have to have a goal that you are working towards. Don't bite off more than you can chew. Keep a good mental attitude. Get treatment. Don't give up."

Doug earned his BA in five years, while living at home with his family. Doug believes he learned a great deal at university, mainly about himself. "Much as I complain about it, I can't estimate the benefits I have also attained by being there and they are kind of hard to quantify." The development of Doug's critical thinking skills helped to play a role in his taking charge of his life and in his seeking an appropriate and beneficial treatment approach for himself. He thinks he would have functioned much better at university had he received proper therapy at an earlier stage of his studies. He understands that he has finally moved from a position of learned helplessness to one of efficacy. ■

Heading off the Dragon

Parents of mentally ill children have a difficult time getting an accurate diagnosis, and now another hurdle is looming — government services, already scant, are being threatened by budget cuts

Karen Gram

Reprinted with permission from the Vancouver Sun, October 8, 2001, p. C1

Imagine. You give birth to a baby boy. You hold your breath until you hear his first cry. Impatiently, you wait as the doctors check him. When you first hold him, you count his fingers and toes.

You check his reflexes and watch to see his eyes move. As the days pass, you still hold your breath always checking that your baby is responding properly to stimuli.

Gradually, you let the air out, relaxing as your baby develops normally. For nine years you nurture your son, marking the milestones along the way and feeling so proud of him.

Then, for no apparent reason, he starts to act strangely. He hasn't fallen, hurt his head or developed symptoms of any disease. But he isn't the same. He refuses to go to school, withdraws from his friends, prefers to stay home than go to favourite haunts.

This is the scenario Keli Anderson of Pitt Meadows experienced when her son James, a bright attentive nine-year-old, began his descent into a mental illness neither he nor his family understood or recognized.

And according to the Surgeon-General of the United States in a new report on mental health in children and youth, this situation is all too common. About 21% of children aged nine to seventeen have a diagnosed mental or addictive disorder with at least minimal functional impairment. That's more than one in five children; 11% of the same group suffer significant impairment and 5% live with an extreme functional impair-

ment due to a mental disorder. The numbers are similar around the world. James fits into the most serious category.

At first, he stopped paying attention at school, then he got into fights and then, over the summer, he withdrew from all the activities he had previously enjoyed, including playing with his friends. When school started up in the fall, James refused to go. He said he knew something bad would happen to him.

Anderson took him to the doctor who thought James might be depressed and prescribed antidepressants. But then James started tearing the house apart, says his mom. "He was running laundry and vacuuming all day and he never stopped talking. He talked so fast we couldn't understand him."

A counsellor at James' school decided James had school phobia, based on his refusal to attend. Treatment for phobias involves helping the phobic person confront their fears, Anderson explains.

So she dragged her son to school and left him sobbing, begging her not to leave, while someone held him down. "It wasn't good for any of us," she says. After that, doctors believed James had obsessive-compulsive disorder because he was obsessing about something bad happening at school.

Anderson quit her job to stay with her son, homeschooling him for grades five and six. He returned to school in Grade 7, but Anderson had to come too, staying in the classroom all day.

Finally, a year and a half after she began seeking explanations for his behaviour and following seven weeks in the psychiatric ward of Children's Hospital, James was diagnosed with separation anxiety and bipolar disorder. He was properly medicated for the bipolar condition.

This delay in diagnosis appears commonplace. Gayle Grass, an author based in Perth, Ontario, whose sister and son developed a mental illness, explains, "There are so many barriers along the way and the biggest one is the stigma."

That is why she decided to write a book for children going through it. Called *Iris the Dragon, Catch a Falling Star*, the book describes a young boy who begins to experience confusion and anxiety. He doesn't understand what is happening until he meets and confides in a dragon. The dragon handles the issue without blame or emotion and teaches him techniques to calm himself.

image courtesy of **Catch a Falling Star: A Tale from the Iris the Dragon Series** by Gayle Grass

Although the diagnosis helped to get James' mood swings under control, the boy, now 12 and entering Grade 8, still suffers from extreme anxiety when separated from his mother. Anderson says the diagnosis experience left her feeling like James was a guinea pig with the experts tapping their chins and saying: "Hmmm, let's try this. If that doesn't work, we'll try something else."

"You wouldn't do that with a diabetic, give them something other than insulin."

Diagnosing children with mental illnesses can be difficult because it's not always clear if it's a developmental delay or a chemical imbalance, says Dr. Jane Garland, psychiatrist and director of the mood and anxiety disorder clinic at Children's Hospital.

"You have to put it in context," she says, citing bed-wetting as an example. It's normal for 15% of five-year-old boys to wet their beds. But two years later, the percentage falls to 5%, and it is no longer 'normal.' Likewise, anxiety is normal at certain stages of life. But not if it persists over time. "With almost any symptom, we have to put it in a developmental context." It's that developmental context that is the worst part of a mental illness for children because the illness can interfere with normal development. It can take a long time to get back on track.

That's why Anderson and others formed an association called FORCE, (Families Organized for Recognition and Care Equality) aimed at getting early intervention and programs for children.

Part of the problem is that children's mental health is the responsibility of the Ministry of Children and Family Development (MCFD) instead of the Health Ministry, notes Anderson. MCFD is primarily concerned with the protection of children, not their health.

Anderson remembers her first visit with a worker in MCFD. The worker was less concerned with the health of her son than with the safety of her daughter if James had another episode.

"Imagine going to them with a health crisis and now you have to worry that they will take your other kid." Child mental health never belonged in that ministry, says Anderson, her comments echoed by Garland and many others in the field. ▶

Parents of children with mental illnesses must become detectives in order to ferret out the help they need. Here are a few web sites that can be helpful:

www.nami.com This is the web site of the National Alliance for the Mentally Ill, an American organization that is at the forefront in providing relevant information to parents. It also has links to other sites.

www.surgeongeneral.gov This excellent site offers a detailed assessment of current theories, risk factors and treatments of all forms of mental illness.

www.iristhedragon.com The web site of author Gayle Grass where you can order the book or check out good Canadian and American links.

But now, with Health and Education the only ministries protected from massive cuts, the issue is critical.

"If something is going to be cut from McFamilies [MCFD], it sure isn't going to be protection," says Anderson. "It will be child mental health. It is so low on the totem pole."

[Editor's Note: Due to lobbying by groups such as FORCE, leading child psychiatrists and CMHA, and due to increased attention within government, cuts to children's mental health were minimized in the latest budget.]

The system fails these kids, Anderson argues. They are traumatized by the disorder and then by the system.

"These are kids who have some part of their body that is in trouble and [experts] are saying they just need a better parenting plan. But this is not about kids seeking more attention. How crazy are we to even think that. It shows huge disrespect. When a child breaks her arm, we fix it, we don't blame the parents."

It's a natural reaction from a parent of a child with a clinical mental disorder, especially since the Anderson home is full of love and stability. It's a middle-class, two-parent, two-child family.

Garland says parents aren't to blame. Mental illnesses are brought on by a complicated interplay of genetics, temperament, family relations and the broader social context in which the person lives, she explains. It can be triggered by a specific traumatic event or just develop organically.

But Garland says parents of children with a mental illness must learn new parenting techniques because these techniques are an essential component in the child's therapy.

"It's true that most parents will encounter experts who seem to imply that if only the child had better parenting, there wouldn't be a problem," she says. "But it's not that parents are part of the problem."

Garland says doctors have observed that many children — and adults — having a psychotic episode reorganize their minds quickly when put in hospital with very strict routines, including bedtimes, meal times and organized activities.

"We're trying to give the child's world some order. So we ask everyone — parents, schools, everyone — to be extremely consistent."

Garland agrees with Anderson that childhood mental illness does not get the resources it needs. "If a child has cerebral palsy, they get all kinds of resources. If a child is abused, there are all kinds of resources, but what about a child with a serious mental illness who is looked after by the family? That is a group of kids that falls between the cracks. It doesn't fall into any category of support."

In the Lower Mainland, there's one preschool program offered through the Alan Cashmore Society with a day program for the kids, therapy and training for parents and families. There is one school-based program for adolescents. Both have long waiting lists and can only handle a handful of clients at a time. There is no such program for elementary-school-aged kids.

"One of the things we do need, clearly, is more things like (the Alan Cashmore society)," Garland says.

Gayle Grass agrees with Anderson and Garland that early intervention is essential.

"It's like diabetes," she says. "You do more damage by not attending to it. By the time the disease is full-blown it is so much work and money to deal with it. Why not just prevent it?"

Prevention or recovery are possible most of the time. Some people will always have a propensity to develop a mental illness. But citing diabetes again, where those predisposed can delay the onset, Garland says that if schizophrenia or bipolar disorder were properly treated and caught early enough, they could be managed and not interfere as much with development.

Others, like anxiety disorders or depression, do go away in 75 to 80% of patients, though they may experience another episode later if they encounter another trigger. Triggers can be anything stressful, but Garland says puberty and bullying are common ones.

Grass would like those with the potential for a mental illness to be given the opportunity to learn early how to reduce the stresses in their lives. She'd like special education programs in which such children could have an individualized program and, especially essential she says, are annual assessments.

"There are a lot of possibilities and solutions, but we need a lot of awareness and funding." ■

The FORCE (Families Organized for Recognition, Care and Equality) is a newly formed society aimed at helping parents and loved ones locate and obtain services for children experiencing a mental illness. In addition to disseminating resources and ideas through newsletters, public forums and their web site, the society is also active in advocating with decision-makers for more early intervention and mental health programs for children.

To contact the FORCE:

Phone: (604) 878-3400

Mail: 19779 Wildwood Crescent South
Pitt Meadows, BC
V3Y 1N2

Web: bckidsmentalhealth.org

Helping Anxious Children

In most cases, the tendency to be anxious stays with a person throughout their life. So we need to help anxious children develop coping skills to manage their own anxiety eventually. This starts with parents helping them by going through the following steps. Older children and teens can do some of this for themselves:

1. **Assessment:** Have a child's general health checked by the doctor. Untreated allergies, anemia, ear infections or other problems make it harder for anxious children to cope. The doctor can also check out whether panic attacks or obsessive-compulsive disorder, which need very specific treatment, are present. For some kinds of anxiety, medicine may be suggested, but in most cases, treatment includes learning new coping skills.

2. **Look after the basics:** No one copes well when they are tired or hungry. Anxious children often forget to eat, don't feel hungry and don't get enough sleep. Establish bedtime routine (see below) and offer frequent, nutritious snacks. Anxious children rarely eat a large full meal. They are better to "graze" as long as the snacks cover the basic food groups in a day.

3. **Establish routines:** Routines reduce anxiety. But anxiety tends to disrupt routines. So you need to work hard to build regular patterns so life is more predictable. Have the child help plan the routine. Making an attractive schedule for the fridge gives a sense of control and order. This is not the kind of child who copes well with a disorganized, "spontaneous" family style. Help the child adjust to changes by gradually introducing them and preparing them in advance.

4. **Bedtime routines are especially important:** Start at least an hour before the planned bedtime, build in a story, a chat time, some warm milk or snack. A warm bath ahead of time may help. The ritual helps the child gradually relax. It is important that parents not get into the habit of sleeping with the child or having them fall asleep in the parents' bed as this becomes a habit which is hard to break. Settle them with some quiet music or a story tape, and check in briefly at planned intervals (5 min. for young child, 10-15 min. with older) so they don't need to worry about where people are. A good routine can take several weeks to establish, but everyone will feel better once it is in place.

5. **Plan time for homework and projects:** This needs to be a regular part of the schedule, as anxious children tend to procrastinate. Because anxious children become overwhelmed, breaking the job up into small chunks, setting a specific time to work, and rewarding themselves for each bit done are tools they need to learn. Often the hardest part is getting started, so knowing that the TV program is on afterwards, or having computer time to look forward to can help to start.

6. **Firm, consistent parenting:** Anxious children feel calmer when life is predictable, when they know what is expected of them, and what the consequences will be. Setting limits is a challenge for parents, however, when the child becomes so upset. With practice, everyone can feel more secure, and children are relieved to have adults in charge.

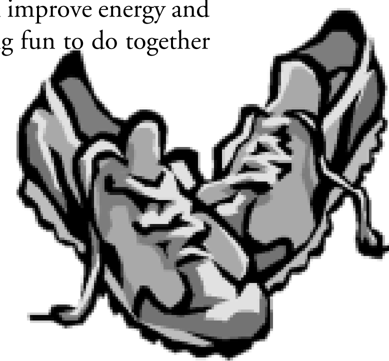
7. **Tools to relax:** Teach the child a way of relaxing by mental imagery and progressive muscular relaxation, described in the booklet *Taming the Worry Dragons*.

8. **Tools to cope with worrying:** "Locking up" worries in an imaginary box or setting a scheduled "worry" time are some tools to control the amount of energy worry takes up. Other ideas are to mentally "pull the plug" on the worry, "take out the worry disk so it's not using up all the RAM," "caging the worry dragon," or whatever image suits a child's interests. Fortunately, most anxious children have a talent for "creative worrying" which can be harnessed for creative problem-solving instead.

9. **Taking risks:** Anxious children need to try some experiments like making phone calls, talking to a new friend, and encouraging themselves through positive "self-talk" instead of imagining the worst. Parents can model these tools by using them too.

10. **Physical exercise:** This is helpful not only in relieving stress, but also in triggering a physical "relaxation response." Anxious children often feel "tired all the time" because they are always exhausting themselves with worry, so they don't feel like exercising. But exercise will improve energy and reduce worry. Try to find something fun to do together rather than making this a chore. ■

Adapted from "Anxiety Disorder in Young People" prepared by BC Children's Hospital's Mood and Anxiety Clinic and the Anxiety Disorders Association of BC. The full pamphlet series can be found at www.anxietybc.com



For more information

See the booklet *Taming the Worry Dragons* for more ideas. To order, phone (604) 875-2345 ext. 5102. Contact your local mental health centre for counselling and parent support.

How is Obsessive-Compulsive Disorder Treated?

Adapted from "Obsessive-Compulsive Disorder in Young People" prepared by BC Children's Hospital Mood and Anxiety Clinic and the Anxiety Disorders Association of BC. The full pamphlet series can be found at www.anxietybc.com

Behavioural treatment

One of the most effective psychological treatments for obsessive-compulsive behaviour (OCD) is exposure plus response prevention (ERP). Very basically, ERP involves exposure to the feared situation and then prevention of the compulsions.

For children, this can be challenging. They often have trouble understanding why they need to co-operate with stopping the compulsive behaviour. They become angry, upset and desperate and may even threaten to run away or hurt themselves or other people. Professionals trained in cognitive-behavioural approaches (CBT) try to work with children to help them understand that the OCD is like a monster that is running their lives and they have to fight back. If we can help them to team up with their parents to fight the OCD, everybody feels successful, and the OCD is brought under control. Sometimes children need to be brought into the hospital to do this, because it is so hard for parents to do at home.

Medications

There are half a dozen medicines that work for OCD. The oldest and most effective is clomipramine (Anafranil). However, newer medicines such as fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), citapratolam (Celexa) and sertraline (Zoloft) have the advantage of fewer nuisance side-effects. Sometimes adding another medicine such as lithium, clonazepam (Klonapin) or pimozide (Orap) will boost the effect of the main drug.

Medicines work gradually over a period of weeks, and often things continue to get better over a few months. The drug is continued for at least six months, and then can be cut down slowly to make sure that symptoms don't flare up. Some people can come off the medicine, but many people need to take it for much longer.

The medicines work well, but may not completely take away the compulsive habits. The medicine may also need to be continued for a long time, as the symptoms tend to come back. Never discontinue these medications abruptly and always consult a physician prior to decreasing them.

Rebuilding confidence

Having OCD leads to problems with school, friends and family. Kids can feel pretty badly about themselves and their lives when OCD is running the show. As they get better, they need extra help at school, and some "coaching" to get back into their usual interests and activities.

OCD complications

- Not going to school
- Not sleeping or eating well due to worries
- Becoming discouraged or depressed
- Becoming socially isolated
- Substance abuse in teens
- Family problems

Related problems

These things are found more commonly in people with OCD or in other members of their families:

- Other anxiety disorders such as panic disorder
- Clinical depression
- Eating disorders
- Tic disorder and Tourette's

Does OCD get better?

It does, but it takes some teamwork. The child, family, doctors and counsellors need to work together to beat this. ■

Tourette's and Other Tic Disorders

Adapted from the web site of the UCLA Child and Youth Anxiety and OCD Program (www.npi.ucla.edu/caap)

Tourette's and other tic disorders are characterized by repetitive, involuntary muscle movements (motor tics) and/or repetitive, involuntary vocalizations (vocal tics). They are often associated with obsessive-compulsive disorder. Common tics include eye blinking, grimacing, shoulder shrugs, throat clearing, sniffing and grunting. Tics are quite common in childhood with up to 13% of boys and 11% of girls manifesting frequent tic-like behaviours. Although chronic tic disorders, such as Tourette's disorder, are much less common (< 1%), they can be associated with a variety of other problems in childhood including aggressiveness, impulsivity, mood disturbance and poor social skills. Unchecked, chronic tic disorders can have a significant negative impact on family relationships and functioning.

Treatment

The most common treatment approach for tic disorders is a combination of behaviour therapy and medication. The primary behavioural treatment approaches for tics are self-monitoring and habit reversal training. In self-monitoring, youngsters learn to recognize and record their tic behaviours and the situations in which they are most likely to occur. Habit reversal training involves teaching youngsters to systematically engage in a new and opposite muscle behaviour whenever they feel the urge to tic.

Since tics often worsen in stressful situations, relaxation training and other stress management techniques are used to help these young people deal with stress. In addition, reward charts help children track their progress and earn small rewards for treatment gains.

The most common medications for chronic tics and Tourette's syndrome include haloperidol, pimozide, guanfacine, and clonidine. Newer medications, including SSRI medications such as fluoxetine, fluvoxamine, sertraline and paroxetine, as well as risperidone and olanzapine are also used in some cases. Although many of the anti-tic medications have significant side-effects, they can be very effective in decreasing tic frequency and intensity.

Related Resource

BC Children & Women's Hospital, Neuropsychiatric Clinic. See www.cw.bc.ca/mentalhealth/srvnp2.asp for more information about provincial resources for treatment of Tourette's.

How is Panic Disorder Treated?

Treatment usually involves a combination of medicines, behavioural changes, and psychological counselling of some kind. Here are the goals of this treatment approach:

Reduce anxiety intensity and frequency

This can require medication, but in mild attacks people can learn to stop them by relaxing or doing something like taking a drink of water or splashing water on their face. This seems to cut off the alarm.

Psychological treatment

Cognitive-behavioural therapy (CBT) has been proven to reduce symptoms of anxiety in children in 75-80% of cases. When the family is involved in treatment, more impressive gains can be seen. CBT is offered by specially trained professionals using a standardized model of therapy. Active components of treatment include challenging the frightening thoughts of physical harm or embarrassment and getting used to the physical sensations of anxiety by either bringing them on purposely (e.g., spinning to induce dizziness) or naturally (e.g., exercising to increase heart rate) and finally entering previously-avoided situations.

Medication

- *Minor tranquillizers [alprazolan (Xanax) and klonazapam (Klonopin)]*

These sedative medicines seem to tone down the alarm system. They act quickly, within a few days, and may even be used while a longer-acting medicine is being started. The main side-effects are sleepiness and trouble concentrating. There is some risk of addiction with these medications, so they should be used carefully with a doctor's monitoring.

- *Antidepressants [paroxetine (Paxil) and citapratolam (Celexa)]*

These medicines seem to reset the alarm system so that it doesn't go off as easily, but they are not generally sedatives and are definitely not addictive. Some have side-effects such as dry mouth and weight gain, and the dose needs to be monitored at higher levels because they may affect heart electrical activity if the dose is too high. The newer antidepressants have fewer side-effects but may be more expensive, and may still cause stomach upset. Any of these antidepressant medicines can temporarily worsen the attacks in the first week so the dose is raised slowly and often sedatives are used to prevent this at the same time.

Overcome the anxiety

Stopping the panic attacks is in fact often easier than clearing up the other problems that result. These include temper tantrums and separation anxiety in younger children, refusal to go to school, phobias, worrying and general loss of confidence. These difficulties often take months to sort out, while the attacks may be shut down in a few weeks. Here are some techniques that can help:

Basics:

- Get enough sleep
- Eat regularly
- Establish a regular routine
- Avoid caffeine, alcohol and drugs
- Have parents set consistent, confident limit-setting with fair consequences and rewards for successes

Face the fears: "Practice" going into feared situations, starting with a short period of time (15-20 min.) and working up. Having a trusted person along at first can help. It is important to stay there if a panic attack does occur, as running away will worsen the avoidance problem in future.

Rebuild confidence: Develop assertiveness and social skills by joining activities, practicing calling friends, becoming more physically active, and taking some risks.

Change self-talk: When people have panic attacks, they tend to develop "worst case scenario" thinking about everyday stresses. Practice more encouraging ways of talking to yourself.

Control the worries: Learn tools to control worries such as locking them in a "worry box," writing them down or talking them over with someone.

Choose a healthy environment: This includes hanging around with people who make you feel more confident, not people who put you down. Making these changes can be a lot of work, but it pays off.

Does panic disorder go away?

Usually it does. Sometimes it goes away on its own, but generally it takes some professional help. It may come back again at another time, even ten or twenty years later. But what you learn in dealing with it this time can help you tackle it if it ever does come back.

Other resources?

Start with your family doctor or local mental health centre for more information or to have the problem assessed.

Adapted from "Panic Disorder in Young People" prepared by BC Children's Hospital's Mood and Anxiety Clinic and the Anxiety Disorders Association of BC. The full pamphlet series can be found at www.anxietybc.com

Virtually Facing Real Fears

Zoë Macdonald

Zoë is an undergraduate studying communications and psychology at Simon Fraser University. She has recently been volunteering for CMHA BC's Education Department

Virtual reality is not just for entertainment anymore. Today, children and youth with specific phobias such as fear of heights and fear of the dark can use virtual reality to overcome their fears. Virtual reality, or VR, creates an illusion of real-life situations through the use of computer and optical technology. Originally created for entertainment, VR is a relatively new option for people seeking treatment for phobias.

A phobia is an extreme fear of an object or situation, which may result in panic attacks or extreme avoidance of certain situations. Phobias are distinct from general fear in that they disrupt everyday life due to the level of anxiety that they produce. They often emerge in childhood, possibly as a result of a trauma such as a dog bite. It is also believed that phobias may arise from negative associations, such as the association of darkness with feeling completely alone.

Treatment of phobias traditionally has been done in the real world through *in vivo* exposure therapy. This type of treatment exposes the individual to a feared situation and helps the person to think differently about the situation. For example, a person with a fear of elevators may begin by stepping into an elevator for a short amount of time while a therapist encourages him or her. On the next visit, the same person may ride the elevator up one flight. By the end of the therapy, the person may be able to ride the elevator up to the top floor. The idea is to allow people with phobias to gradually face fears head on. A therapist will help them unlearn fears by talking them through the exposure experience one step at a time.

Although VR technology does not have convincingly realistic graphics, the sensation experience in VR therapy has been called a "sense of presence." According to VR advocates, users feel as though they are in the virtual world rather than the real world. A study conducted by Clark Atlanta University reviewed several phobia experiments and concluded that measurable reactions in VR therapy, such as heart rate, are comparable to those in real world therapy.[1] Furthermore, successes in VR exposure therapy have been positively applied in the real world.

Moreover, in some situations, *in vivo* exposure therapy is impractical. A person with fear of flying would not be able to enter and leave a plane at will, nor afford to take several flights of varying lengths. Also, it may be difficult for someone with a phobia to even request exposure therapy with the knowledge that it will lead to a direct encounter.

VR allows people to affordably experience 3D representations that are believable while knowing that they are safe and may stop at any time. This may account for VR's growing popularity in the mental health field. Since an initial study in 1995 by Rothbaum and Hodges in the United States, virtual reality therapy clinics have begun operating across North America.[2] In Vancouver, two therapists have opened the Virtually Fearless Phobia Treatment Centre with programs to help combat fear of flying, driving, public speaking and claustrophobia.[3]

Fear of public speaking is one of several phobias that clinicians can treat with virtual reality therapy. Virtual environments created by Georgia Tech and Emory University researchers are being used in psychologists' offices throughout the US and Canada.

The appeal for children and youth is that they can undergo exposure therapy in a safe and private environment, without fear of having an anxiety attack in public. Also, the appeal of an entertainment technology is high, and may help parents to encourage young people to undergo VR exposure therapy and overcome their fears. The method may be virtual, but children and youth with specific phobias may have real world success as a result. ■

footnotes

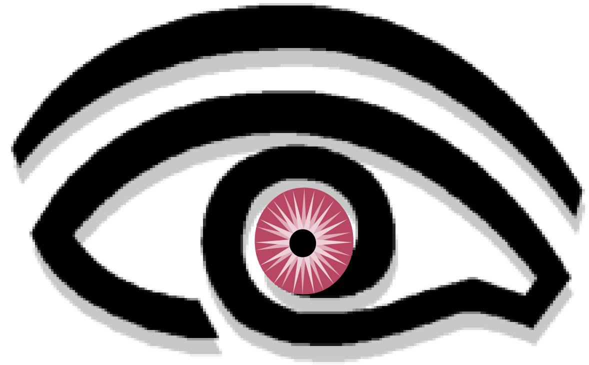
1. Virtual Reality Therapy: An Effective Treatment for Phobias – http://utenti.lycos.it/dualband/pdf2/north.pdf
2. for more information about this study, see www.emory.edu/EMORY_MAGAZINE/winter96/virtreality.html
3. For more information about the Virtually Fearless Phobia Treatment Centre, please contact Richard Green and Doug Cohen at (604) 254-8646.

other references

- VR Therapy for Spider Phobia – www.hitl.washington.edu/research/exposure
- Virtual Reality Exposure Treatment of Phobia – is.twi.tudelft.nl/~schuemie/survey.pdf
- The Virtual Reality Shrink – salon.com/tech/feature/2001/01/09/schizophrenia/print.html

Eye Movement Desensitization And Reprocessing

When Should it Be Used to Treat Children and Adolescents?



Steven Taylor, PhD

Treatments for anxiety disorders in children and adolescents are often developed by taking therapies used for treating adults, and then adapting them for childhood problems. Behavioural and cognitive-behavioural therapies, for example, are among the best established psychological treatments for adult anxiety disorders. These therapies have been successfully adapted for treating various anxiety problems in children and adolescents, including panic disorder, social anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (PTSD).

The same approach has been taken with eye movement desensitization and reprocessing (EMDR). EMDR methods used for adults have been extended to the treatment of anxiety disorders in children and adolescents. Several books have been published by clinicians advocating the use of EMDR in treating youths, although there is very little scientific information on the effectiveness of this treatment. In this article, I will consider three issues to help readers decide if and when to use EMDR. First, what is EMDR and does it have a convincing scientific rationale? Second, is it useful for treating adult anxiety disorders? Third, is it useful for treating children and adolescents?

What is EMDR and does it have a sound scientific basis?

EMDR is a controversial but widely-used method, mostly for treating post-traumatic stress disorder (PTSD). The controversy about EMDR stems from two main sources. First, it lacks a convincing scientific rationale. The main intervention in EMDR requires the patient to recall trauma-related memories — along with associated bodily sensations, thoughts and feelings — while also attending to some form of external oscillatory (swinging motion) stimulation. Such stimulation is typically induced by the therapist moving a finger from side to side across the patient's field of vision; this induces eye movements. After each set of eye movements, the patient is asked to notice what memories, images, thoughts or feelings arise, and then more sets of eye movements are induced until distress is reduced.

Advocates of EMDR have been unable to come up with a convincing explanation of why this method would be effective. Some scientists have likened EMDR to mesmerism, which was an early form of hypnosis. Research shows that eye movements themselves do not contribute to the efficacy of EMDR. This raises doubts about the efficacy of other forms of oscillatory stimulation used in EMDR. Other researchers have suggested that there is nothing new to EMDR; that it simply consists of conventional cognitive-behavioural methods, such as imaginal exposure and coping techniques. EMDR might be useful in treating PTSD, but not for the reasons advanced by EMDR adherents.

Is EMDR useful in treating adult anxiety disorders?

The second main source of controversy concerns the efficacy of EMDR. Some proponents claim that it is more effective and works more quickly that conventional PTSD therapies. Clinical scientists have expressed doubts about these claims. Many of the early EMDR treatment studies had serious flaws in their designs, and it has not been until recently that more rigourous studies have been conducted. We recently conducted a randomized, controlled study that compared three treatments for chronic PTSD: behaviour therapy (consisting of imaginal and live exposure to distressing but harmless trauma-related stimuli), EMDR, and relaxation training. Figure 1 (next page) shows some of the results, which is for the 45 patients completing treatment (15 in each treatment condition). We found that all three treatments were effective in reducing PTSD symptoms, although EMDR was not statistically more effective than relaxation training. Behaviour therapy tended to be the most effective, and tended to exert its beneficial effects more rapidly than EMDR. With the accumulation of studies such as these, clinicians and consumers of mental health services will eventually be in a good position to decide which treatment is likely to be most effective for them.

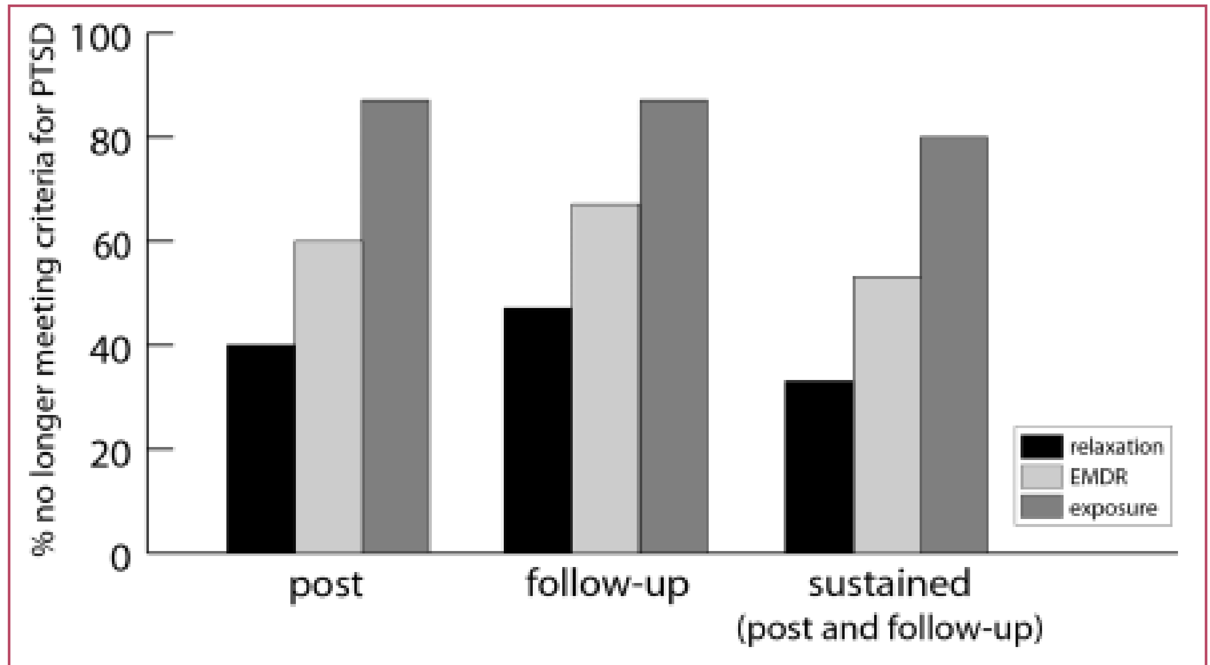
Although EMDR appears to have some value in treating adults with PTSD, the research is not so encouraging for the treatment of other anxiety disorders. Recent studies of panic disorder suggest that conventional treatments such as cognitive-behavioural therapy are more likely to be useful than EMDR.

Is EMDR useful in treating children and adolescents?

Despite enthusiastic claims by proponents of EMDR, there is a lack of sound scientific research ▶

Steven is a professor and clinical psychologist in the Department of Psychiatry at the University of British Columbia. Address correspondence to Steven Taylor, PhD, Department of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver, BC, V6T 2A1. E-mail: taylor@unixg.ubc.ca

figure 1 - percentage of patients no longer meeting criteria for PTSD after treatment



on the value of this treatment for children and youth. The available information is not very encouraging. The best research comes from two controlled studies by Dr. Peter Muris and colleagues at Maastricht University in the Netherlands. Their work suggests that EMDR is of limited value in helping children overcome phobias. Conventional treatments, such as behaviour therapy, have been shown to be more effective. Little is known about the value of EMDR in treating other anxiety disorders.

Conclusion

EMDR has been found to be useful in treating PTSD in adults. Little is known about its value in treating PTSD or other anxiety disorders in children and adolescents. The available scientific evidence suggests that EMDR is not as effective as behaviour therapy in treating children with phobias. In comparison, there is a good deal of evidence that behavioural and cognitive-behavioural treatments are effective in reducing anxiety disorders in children and adolescents. These treatments, and not EMDR, should be considered the psychotherapies of first choice for treating children and adolescents. If, for a given patient, these therapies are unsuccessful, then alternatives might be considered, such as EMDR.

Further reading

Chambless, DL, & Ollendick, TH. (2001). Empirically supported psychological interventions. *Annual Review of Psychology*, 52, 685-716.

Muris, P, & Merckelbach, H. (1999). Eye movement desensitization and reprocessing. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 7-8.

Muris, P, Merckelbach, H, Holdrinet, I, & Sijsenaar, M. (1998). Treating phobic children: Effects of EMDR versus exposure. *Journal of Consulting and Clinical Psychology*, 66, 193-198.

Taylor, S. (2000). *Understanding and treating panic disorder*. New York: Wiley.

Tell your story in our pages

Our next issue of Visions (due out this summer) is on SENIORS' MENTAL HEALTH. If you have a story idea you want to share, contact our editor Eric Macnaughton at (604) 688-3234, toll-free at 1-800-555-8222 or via e-mail at emacnaug@cmha-bc.org

Achieving Balance Through Ayurveda

Zoë Macdonald

If you are looking for something more than what Western medicine prescribes, you are not alone. A recent survey found that the majority of Americans who identify themselves as depressed or anxious also use complementary or alternative medicine; in a Canadian survey, more than one in every ten British Columbians has turned to such medicine. One form of alternative medicine that is growing in popularity as a helpful complement to Western medicine is Ayurveda, an approach to health that originated in India approximately 6000 years ago.

Ayurveda is based on Indian scriptures that include instructions for physical and mental well-being. Despite its ancient origins, it remains well trusted and respected in India as a medical approach. The general underlying principle of Ayurvedic medicine is that everybody has three energies or *doshas*: *vata* (air and ether), *pitta* (fire and water) and *kapha* (water and earth). Each person has a unique composition of the three doshas, and when these are in a balanced state, all systems and organs function properly. However, external forces such as improper diet, emotions or bacteria can put a person's composition out of balance. If the imbalance is maintained over time, disturbances and damage to the body may occur, especially in areas identified as susceptible.

According to Ayurveda, each individual has a unique constitution of three doshas with one or two predominant doshas. A practitioner can determine from behaviour patterns what type of conditions a person is prone to. For example, a constitution of vata dosha is susceptible to anxiety disorders, due to the ease of vata becoming imbalanced. It is important to note that anyone is capable of vata dosha imbalance. However, those with a vata constitution are more likely to develop vata dosha imbalance.

It is difficult to match Western categories such as phobias, post-traumatic stress disorder, and obsessive-compulsive disorder with an Ayurvedic equivalent. Ayurveda approaches disorder as an imbalance. Specific disorders are symptoms of imbalance or the external signs of an inner disturbance. Each disorder can be traced back to one of the three doshas. Anxiety disorders are commonly associated with vata dosha imbalance.

Designed for all ages and all people, Ayurvedic treatment is intended to bring energies into balance through lifestyle, diet, herbs, meditation and exercise. Thus, the approach is holistic and health-oriented in nature. For example, if someone has insomnia, a common recommendation would be to eat foods that are nourishing and calming, create an environment that is relaxing while awake, use some recommended herbs, yoga and meditation. According to Ayurveda, these environmental changes will bring the energy into balance, allowing the body to correct itself.

Due to the individual nature of treatment, each person who wishes to use the Ayurvedic approach should consult someone who has formal training. India, as a country that grants Ayurveda equal status as Western medicine, has a program that requires six years of full-time university study plus hospital experience prior to licensing. Because each person has different percentages of doshas, consultation with a university-qualified Ayurvedic doctor is recommended.

An Ayurvedic consultation consists of speaking to an Ayurvedic practitioner to determine a predominant dosha. Then, the practitioner investigates whether there is anything out of balance. If so, the practitioner talks to the person to determine what his or her environment is, and therefore why there is an imbalance. Next, the practitioner investigates which system the imbalance affects and to what extent. Ayurvedic medicine is carried out through discussion, feeling and pulse rating. The pulse rating is not a count of someone's pulse, but an energy reading. An Ayurvedic practitioner may look at the skin, eyes, tongue and nails for clues. Ayurveda believes that each part of the body is a microcosm of the body and can offer clues. For example, looking at the tongue may give clues about the digestive system. ▶

eating foods that are easy to digest — like cooked vegetables and whole grains — can help ease anxiety

practical tips

Vata imbalance may lead to mental and physical restlessness, poor sleep patterns and anxiety. Therefore, it is most associated with anxiety disorders. Dr. Sukumaran, an Ayurvedic doctor in Vancouver, gives us some tips:

- Always consult an Ayurvedic doctor before self-diagnosing or self-medicating
- Eat more nourishing foods, which includes increasing liquids and oils in your diet
- Eat foods that are easy to digest, such as cooked vegetables and whole grains
- Eat smaller quantities of food at a time and more often
- Introduce more regularity into your life by creating routines. Vata people tend to be scattered in their organization
- Try to go to bed as early as possible every evening
- In the evening, engage in relaxing activities
- Have daily oil massages. This can be self-applied or done by someone else
- Spend more time with close people. If you are vata imbalanced, you need more cuddling, affection and emotional support
- Use less light in the evening and increase the amount of natural light in the daytime. Fluorescent and artificial lights should be avoided whenever possible
- Read more relaxing novels
- Go for walks or go swimming instead of running
- Avoid crowded places that are loud and noisy
- Flying in an airplane is not recommended because it is a fast-moving vehicle
- Avoid stimulants
- Vata-imbalanced people do not cope well with deadlines and time limits. Avoid this type of pressure wherever possible
- Try herbal supplements as recommended by an Ayurvedic doctor. Because the herbs are mostly grown in India and are described in Sanskrit, it is not recommended for self-medication due to the possibility of misuse
- If you or your family member is taking another medication, check with your doctor for known interactions between herbal and pharmaceutically-based treatments

In North America, Ayurveda is recommended as a complement to Western medicine and has been growing in popularity with advocates such as Dr. Deepak Chopra. Several books have been published about the topic and can be found in local libraries. There are Ayurvedic schools and clinics in the United States, but there is still no licensing program in North America. Several Ayurvedic doctors, licensed in India, practice in British Columbia. Efforts to create a professional association are still underway. Meanwhile, if you are looking for a supplement to your traditional treatment, Ayurveda may help you regain and maintain balance.

Making an Ayurvedic connection...

An Ayurvedic association is being formed in BC. The best way to contact the association is to call the secretary, Dr. Mandeep Singh at (604) 761-9442. The President of the association is Dr. Varma who can be reached at (604) 228-1537. Dr. Sukumaran, who gave us the majority of information in this article, can be reached at (604) 431-0950 for more information. Today in Canada, Ayurvedic medicine is not covered by most medical plans.

Thank you to Dr. Sukumaran for providing the bulk of information used in this article.

Using Dogs to Help Children Heal

Child psychologist Dr. Susan Lomax says her dog Bear brings out the 'sweet and gentle side' of angry kids

Nicholas Read

Reprinted with permission from the Vancouver Sun, March 10, 2001, p. B7

Dr. Susan Lomax, a child psychiatrist at BC's Children's Hospital, wants to make something clear: Bear, her dog, has never cured anyone.

"I can't say that I really heal anyone, so he certainly can't," Lomax says. "To say so would trivialize what I do. But he is a tool. He helps me do my job better."

It is tempting upon meeting Bear, a five-year-old black lab cross and SPCA refugee, to want to ascribe some sort of basic, of-the-earth medicinal power to him. To believe that once upon a time he transformed a disturbed and unhappy child into a bright and joyful one with one shake of his paw. It would be make such a storybook ending. But that would be wrong. Despite the magic he works in the hospital's child and adolescent psychiatric emergency ward, he doesn't perform miracles. Neither does Lomax, the ward's clinical director.

But as she says, he does help her help the violent, disturbed, anxious, aggressive and even psychotic children she sees regularly in her practice.

- **He helps her by breaking the ice with them.** "As soon as they see a dog, they say, 'Aww, you've got a dog.' It immediately softens up the room and humanizes the place," she says.
- **He helps her reach children who don't want to be reached.** "He opens up an avenue for me. He allows me to ask, 'Have you got a dog?' and that's a way of finding out about the child's family."
- **He helps her set limits.** If a child is behaving badly or aggressively and using threatening language, Bear will step in and calm things down. Once, when he sensed that Lomax might be in danger from a teenage girl, he sat

beside the girl and immediately defused the situation. After that, Lomax was able to talk to the girl about her problems.

Because Lomax's patients are children, she guards their privacy fiercely. Consequently, she won't cite any particular cases in which Bear made a difference. But she is adamant about his worth and the worth of other animals in work like hers. "Dogs are non-judgmental," she says. "They don't react in the way people do. They don't care what you say. Research shows that pets in general help bring anxiety levels down."

If Bear isn't wanted, however, Lomax won't force his company on anyone. Some religious groups regard dogs as dirty, for example. "I try my best not to surprise people with him. I ask if they're okay with dogs, and if they're not, I make sure they don't see him." But most of her patients have no objections, she says. A couple of resident psychiatrists developed allergies, but that was their tough luck. "They couldn't say anything because I was their supervisor," Lomax jokes.

Otherwise, Bear is pretty much a hit with everyone. Violent kids are always gentle with him. Aggressive kids always speak sweetly to him. They love it when he shakes a paw, accepts their treats, and rolls over and plays dead when they shoot him with an invisible gun. "The boys especially like that," says Lomax. "It's people who bring out the bad side of kids. Animals bring out their sweet and gentle side." At Christmas, Lomax even makes him wear a Santa's cap in the ward. He doesn't like it, she admits, but "it's fun for the kids. And he has a silly owner." Jennifer Melsness, a nurse in the same ward, is such a fan that she says Bear makes it unnecessary for her to use restraints or medication to calm down very difficult children. Bear does it for her.

Bear isn't the first dog to carry medical credentials in the hospital, however. Lomax's previous dog, Lucy, also came to work with her and fulfilled many of the same duties. Lucy was a bit more highly strung, however, so she had to be watched more carefully. Lomax would trust Bear with anyone.

No specific studies have been done on the benefits of animals in practices such as Lomax's, but clinical research does prove the efficacy of animals in reducing stress levels and blood pressure. Just stroking a pet has been shown to have a profoundly calming effect on people in a variety of situations, from the workplace to palliative care units. But Lomax is certain that if formal research was done, it would prove what she already knows: that having a dog around is good for everyone.

Certainly she's not alone. Two other psychiatrists at the hospital use dogs in their practices, and one of the pediatricians sneaks a little dog in under her coat against hospital rules. Needless to say, Lomax won't divulge her name. The hospital's media department says there are areas within the hospital where animals are permitted to visit when it's thought appropriate. Other areas are off-limits for medical reasons.

Lomax also believes dogs could help deal with bullying situations at schools. They could defuse aggressive situations, she says, be used as distractions, as teaching tools for how to discipline with affection, and even to "talk" to the kids about bullying. Recently, Lomax spoke about her work with Bear at Langara College as part of an eight-week course on the health links between people and pets sponsored by the BC SPCA. Conceived by Nadine Gourkow, a graduate of the animal welfare program at the University of BC, the course is titled "The Human-Animal Bond: Links to Health, Violence Prevention and Therapy." "I believe that we are on the threshold of a significant increase in animal involvement in a wide range of therapeutic disciplines," said Gourkow. Other animal protection groups agree. "How heartening that Dr. Lomax and others like her have realized the natural ability of animals, particularly dogs, to help people," says Karen Colterjohn of the Vancouver Humane Society. ■

other options

In addition to pet therapy, there are a number of other creative treatment options for the relief of anxiety including the following:

- avoiding caffeine
- adopting a vegetarian diet
- incorporating chamomile or magnesium into your diet
- acupuncture
- aromatherapy
- biofeedback
- homeopathy
- laughter and/or humour therapy
- hypnosis
- massage
- meditation
- music therapy
- Tai Chi
- yoga

To consult some clinical references backing up each of these methods above, visit www.healthyroads.com/mylibrary/data/altcaredex/htm/amm0041.asp

Remember to consult a qualified health care practitioner prior to making any changes to your current treatment regimen.

Anxiety Disorders Prevention:
A Summary of Issues and Program Interventions

Eric Macnaughton

Eric is Director of Policy and Research at CMHA BC Division and Visions' Editor

Lately, there has been a lot of excitement about intervening early in the course of anxiety disorders, or preventing the emergence of these conditions in children and youth who may be at risk. The US-based Center for Mental Health Services, and the Australian Early Intervention Network have both published recent reviews of prevention and early intervention programs, a number of which have achieved positive results. This article, and the accompanying table, outlines the relevant findings related to anxiety prevention in an effort to give the reader a sense of how these programs work, who they benefit, and what their strengths and drawbacks may be.

Sound Basis for Intervention: Considerations

An effective prevention strategy should be based on sound knowledge of the risk and protective factors associated with the issue in question (i.e., anxiety disorders), and based on reliable methods of identifying individuals who may be at risk. It also requires consideration of those factors that are most amenable to intervention, (a) in a way that minimizes the potential stigma of intervening with individuals who may be at elevated risk, but who still don't actually *have* that problem; or (b) minimizes the risk of intervening unnecessarily for individuals whose problems may be temporary.

In the past, this last consideration had dampened interest in anxiety prevention or early intervention. However, there is more recent evidence that anxiety in children is not a passing phase and that, if not addressed, will tend to persist into adulthood in the majority of young people who develop a disorder.

Risk Factors

We also possess stronger information about which factors put a young person at risk for anxiety disorders. These discoveries have enabled conceptually-sound interventions to be developed. Some of the risk factors relate to the social environment, and there is evidence that poverty is associated with increased likelihood of developing an anxiety disorder. Similarly, there is evidence that living in environments with greater exposure to trauma and other negative life events predisposes a young person to developing an anxiety disorder.

Other identified factors have to do with parental anxiety which may create a genetic risk *and* an environmental one: anxious parents may 'model' anxious behaviour or thought patterns for their children, and at the same time, they may restrict the young person's opportunity to develop confidence and skill in the face of potentially fearful or threatening situations — often social ones. Other identified risk factors relate specifically to the children themselves. In particular, these are inhibited temperament, poor social problem-solving skills and unpopularity with peers.

Protective factors include "positive future expectations" and the development of problem-solving skills. "Positive future expectations" relate to beliefs about the young person's own ability to cope or succeed in the face of potentially fearful or threatening situations. The development of problem-solving skills, as suggested above, has been identified as a process that strongly relates to parent/child interactions, and the ability of the parent to create the conditions where the young person can gain the opportunity and skills to deal with potentially fearful situations in proactive and constructive ways.

references

The Australian Early Intervention Network for Mental Health in Young People (2000). *Early Intervention for Anxiety Disorders in Children and Adolescents: Clinical Approaches to Early Intervention in Child and Adolescent Mental Health,* Vol. 2. Downloadable at auseinet.flinders.edu.au

Greenberg, M. et als. "Prevention in School-Aged Children: Current state of the field", *Prevention,* 2001, Volume 4, March 30. See journals.apa.org/prevention/volume4/pre0040001a.html

Seligman, M. et als., "The Prevention of Depression and Anxiety", *Prevention and Treatment,* 1999, Volume 2, December 21. See journals.apa.org/prevention/volume2/pre0020008a.html

summary of anxiety prevention program chart ▶

The chart to the right summarizes a number of promising programs, whose participants range from young children through middle childhood and early adolescence, on to later adolescence and young adult-aged university students. It describes the target group, the goals and methods used, as well as evidence for the effectiveness of each. In terms of target groups, most focus on "at risk" groups, who possess some of the known risk factors for anxiety, or who experience some signs of anxiety which do not meet the formal criteria for an anxiety disorder (this is known as "indicated prevention"). In terms of methods and goals, many programs seek to build problem-solving skills, using the techniques of cognitive-behavioural therapy. Most are supervised by trained therapists, and are guided by an established program manual.

It should be noted that most, if not all, of these research-based interventions were carried out on individuals of primarily Caucasian origin. Give the focus on social problem-solving, a comprehensive approach to anxiety prevention needs to be flexible to the social behaviour associated with various ethnocultural groups. While the evidence for effectiveness is promising, the limited cultural relevance of research results needs to be kept in mind. (For an example of a culturally-sensitive anxiety prevention program, see the following article.)

Another factor to be considered as these programs are disseminated is their efficacy in situations with less trained staff, as most of the programs cited used highly trained therapists, a resource which would not be widely available.

A review of anxiety prevention program interventions

	Target	Methods of Intervention	Goals of Intervention	Effectiveness Evidence
Home-visit intervention (LaFreniere & Capuano)	pre-schoolers with anxious/withdrawn behaviour	■ parental education and training ■ social support development	■ increase positive parenting skills ■ sensitize parents to developmental needs ■ increase social competence of child ■ parental stress management	■ significant improvements in social competence of children ■ decreased parental stress ■ no evidence as yet whether gains are maintained on follow-up
Interpersonal Cognitive Problem Solving (ICPS) (Barrett et. al)	children 4-10 yrs, in school settings	■ teaching "everyday problem-solving techniques" ■ 20 minutes per day over four months ■ carried out by trained teachers, and at home by trained parents	■ increase creative and proactive problem-solving, especially within social context	■ reduced impulsive and inhibited behaviours with inner-city mothers and 4-year-olds, with gains maintained at 1-year follow up
Dadds'/ Barrett's adaptions of Kendall's "Coping Cat" Workbook and "FEAR" Program	children 7-14 identified as "at risk" for anxiety disorders through screening instrument	■ 10 weekly group problem-solving sessions (group-based cognitive-behavioural therapy) ■ parent training on child management, effective modeling and reinforcing children's training ■ carried out by trained therapists and graduate students	■ graduated exposure to fearful stimuli ■ relaxation training ■ creation of positive future expectations ■ encouraging proactive (vs. avoidant) problem-solving ■ increase social problem-solving ■ parental anxiety management	■ 16% in treatment group showed onset of anxiety disorder vs. 54% in "monitoring group" ■ program gains maintained at 2-year follow-up ■ middle childhood/early adolescence shown to be "window of opportunity" for prevention
Stress Inoculation Training (Kiselica)	grade 9 students with self-reported anxiety symptoms	■ 8-session group-based training ■ emotion-regulation coping skills training: progressive relaxation, cue-controlled relaxation, cognitive restructuring ■ assertiveness training ■ carried out by trained counselling psychologists and graduate students	■ reduction of anxiety levels ■ reduction in associated problems: school performance, peer relations, depression, oppositional behaviour	■ reduced trait anxiety levels ■ reduced stress levels ■ results only reported at 4 week follow-up
Latent Inhibition	youth at risk of developing phobias to aversive and potentially traumatic situations such as dental or medical procedures	■ aversive experience is preceded by non-traumatic one; e.g., young person is given a routine dental appointment before a painful procedure	■ prevent phobias for specific potentially traumatic events	■ dental fears less likely compared to control group ■ "modeling" (seeing others cope with similar experience) and coping skills training using CBT significantly lowers distress for children undergoing bone-marrow surgery
Trauma exposure and relaxation approaches	youth who are at risk of developing an anxiety disorder are exposed to traumatic experiences	■ encouraging children to describe their reactions to an event ■ reassurance that reactions are understood and normal ■ exposure to stimuli related to event together with relaxation skills	■ both methods seek to enable "emotional processing" of event	■ limited evidence for trauma debriefing and exposure therapy ■ some evidence that exposure may be harmful to some individuals
Penn Prevention Program for the prevention of anxiety and depression (adapted for college students)	college students at risk for depression and anxiety as rated by "Attributional Style Questionnaire" scores	■ 8-week group-based prevention workshop ■ used cognitive-behavioural techniques and training such as behavioural activation strategies (e.g., time management), assertiveness training, interpersonal skill training, and stress management training ■ carried out by trained cognitive therapists and graduate students	■ change explanatory style, reduce hopelessness, and dysfunctional attitudes, increase self-esteem ■ decrease depression and anxiety by influencing these "mediating variables"	■ workshop group had significantly fewer episodes of generalized anxiety disorder, and fewer self-reported anxiety symptoms ■ dysfunctional attitude reduction mediated anxiety prevention ■ effect size "moderate" but potentially very significant

Ethnocultural Intervention:

Australian Strategy for the Prevention of Anxiety in Non-English Speaking Young People

F – Feeling worried?
R – Relax and feel good
I – Inner thoughts
E – Explore plans
N – Nice work so reward yourself
D – Don't forget to practice
S – Stay cool and calm because you now know how to cope

Excerpted from an article by Paula Barrett and Robi Sonderegger. The original article appeared in the Winter 2001 issue of *Synergy*, the journal of the Australian Transcultural Mental Health Network (www.atmhn.unimelb.edu.au/about/synergy.html)

Although considerable evidence purports that psychosocial treatments and prevention programs are effective in reducing anxiety and depression, the suitability of employing Anglo-Australian standardized therapeutic programs for use with non-English speaking background (NESB) populations has been questioned.

One of Australia's leading family and peer group-based cognitive-behavioural early intervention and treatment programs, the clinically validated FRIENDS program has recently been the centre of much attention with its application to participants of diverse cultures, both nationally and internationally.

The program name is an acronym for the strategies taught. FRIENDS is specifically designed for school-aged children, featuring two parallel programs for primary school and high school, each consisting of 10-weekly sessions.

A group leader's manual clearly describes the activities that therapists need to implement in each session, and children work through their own personalized workbook detailing the strategies discussed in each session. Lessons include learning how to practice relaxation exercises, thinking helpful thoughts, changing negative thoughts to positive thoughts, graded exposure to difficult situations, problem-solving strategies, recognizing feelings in yourself, recognizing feelings in others, and helping oneself and others to feel good. The manuals permit flexible implementation to allow for cultural individuality and the needs of any specific group.

The recent trial of the program in Australia with clinically anxious female refugees from the former Yugoslavia, revealed that while the program was effective in reducing clinical anxiety from pre- to post-intervention, the efficacy of the intervention may have been enhanced by tailoring the program to specific migration issues presented by the participants. The authors concluded that there was not only a need to modify some of the existing activities to make them more culturally sensitive, practical to administer, and easier for NESB participants to understand, but also to allow for specific examples that addressed relevant migrant needs (e.g., cultural adjustment difficulties).

In order to evaluate the efficacy of FRIENDS in reducing anxiety and building emotional resiliency among NESB students, and gather practical suggestions on how FRIENDS activities could be culturally modified to better meet the needs of culturally diverse youth, more than 200 NESB primary and high school students from Brisbane and the Gold Coast participated in a year long research program.

At different stages throughout the project, students of former-Yugoslavian, Chinese, and mixed ethnic backgrounds participated in either the FRIENDS program or a parallel 10 week wait-list condition. A total of 10 groups were run in six different schools.

The outcome of the project was overwhelmingly positive, with school principals, deputy principals, ESL coordinators, and bilingual teacher aides acknowledging positive in-class and playground behaviour change among NESB students who participated in the program. FRIENDS participants also showed significantly greater improvement in self-esteem (primary school students only), level of anxiety, and future outlook, than the young people who did not participate in the test program.

The general consensus from the feedback given by facilitators and participants was that the program would benefit from flexible open forums for group discussion on topics of cultural concern and interest, as well as the incorporation of music, art and creative stories that are personally relevant to young NESB migrants.

Over a series of months, changes were made to existing activities featured in the FRIENDS program, culminating in a brand new group leader's Universal NESB Supplement to FRIENDS manual (UNSF). Although now ready for administration, the UNSF manual will continue to evolve and be modified over the coming months following eventual validation trials with NESB students around Australia. ■

For more information

To learn more about this research project or the FRIENDS program, please contact Dr. Paula Barrett, Griffith University, at p.barrett@mailbox.gu.edu.au or Stephen May, Australian Academic Press at Stephen@australianacademicpress.com.au

Taming Worry Dragons:

Empowering Children and their Parents to Master Anxiety Symptoms

E. Jane Garland, MD, FRCPC

Jane is Clinical Head of the Mood and Anxiety Disorders Clinic at BC's Children's Hospital, Clinical Associate Professor at the University of British Columbia and Consulting Child Psychiatrist for the Vancouver Coastal Health Authority

Anxiety symptoms can hold children and families hostage. Like relentless tyrants, they strip away freedoms, joy, relationships and achievements. By the time an anxious child comes for help, they are often not attending school, not able to go out to play with friends, tormented by worries day and night, and worse — everyone is mad at them! Parents are exhausted staying up at night trying to comfort them, and then furious that their child won't go to school in the morning. And parents find that they are not getting a lot of support. The school is frustrated —"how can we teach a child who isn't here?" Parents are suspected of poor parenting skills, or of having "something wrong at home" to cause the child's difficulties. Relatives usually have plenty of conflicting advice, and also seem to insinuate that if you were better parents, somehow this mess would not be happening. But what can you do when a child is panicked beyond recognition at the mere thought of being separated from the parent or facing school and the outside world?

Anxiety is one of the most common mental health issues affecting children, with a rate of about 10% at any given age; about 2% of children are significantly functionally impaired due to anxiety problems. The most common are separation anxiety disorder in younger children, generalized anxiety disorder in older children, and social phobia at any age. Obsessive-compulsive disorder and panic disorder are less common but among the most disabling. Recent research has told us a great deal about childhood anxiety and its treatment. Medications such as serotonin-targeted antidepressants do help, but symptoms commonly return after they are discontinued. Most families would like to have strategies to use over the long term because they know that anxiety symptoms are often chronic or recurrent. Cognitive (thinking) and behavioural (action) treatments are effective, but are more difficult to administer with younger children. At any age, the need to challenge anxious thoughts and expose yourself to anxiety-provoking situations is much easier said than done.

Taming Worry Dragons is a treatment model that was developed by Dr. Jane Garland (psychiatrist) and Dr. Sandra Clark (psychologist) at the Mood and Anxiety Disorders Clinic at BC's Children's Hospital. This model has been helpful to many children and families, and is used by therapists in the community, by mental health teams and by other hospitals in BC and Ontario. It takes all the ideas of cognitive-behavioural treatments and adapts them with imaginative features that are appealing to children. Through some positive reframing, children learn that they have a "talent for creative worrying" and an "overactive alarm system" which work together to feed uncontrollable worries. When they worry, their body alarm goes off. This causes a racing heart, upset stomach and many other symptoms, which tell them that something terrible is going on. The creative imagination then conjures up bigger and more horrifying possibilities. The result is huge, scary, noisy and bossy "worry dragons" in their mind that then terrorize not only the child, but also the family. The challenge, therefore, is to tame these dragons using a variety of tools.

Children buy into this model which is consistent with their natural interest in fantasy and heroism. They are able to draw, describe, investigate and — eventually — tame their dragons. They use "trapping" tools of thought stopping (worry box, turning off the worry machine), compartmentalization with a schedule, and distraction tools such as exercise and activities. They then learn more sophisticated "taming" tools, including listening to and changing self-talk. Like all dragon-slayers they need to practice. They set a hierarchy of tasks for themselves in the training process, and determine how many units of "courage" would be needed to tackle each task.

However, the focus is more on taming than "slaying" because, realistically, rarely does anxiety disappear altogether. The focus is on developing confidence in their ability to cope with anxiety. Furthermore, part of the problem in anxiety disorders is "anxiety sensitivity," or an over-reaction to normal physiological sensations or upsetting thoughts. Hence, desensitizing anxious feelings and mobilizing coping strategies are the keys to mastering anxiety. For some children, it becomes clear that medication "tools" are also needed to help reset the panic alarm or reduce obsessive worry. Parents have a major role as on-the-spot "coaches." Creating a family team for taming worry dragons helps to reduce frustration and family conflict over anxiety. School personnel and relatives can also become coaches and helpers. Children especially enjoy learning the worry-taming tools in groups, which are now provided in many schools and mental health settings across the country.

With worry-taming tools, children can tackle the real-life problems of separating from parents, going to school and venturing into challenging social situations. They are also equipped to cope with new challenges which will inevitably arise in the future: entering high school, exam stress, going away to camp, and other developmental tasks. We hope that with these skills, future exacerbations of anxiety symptoms may be reduced or more quickly resolved.

Taming Worry Dragons books are available through Children's Hospital, by calling (604) 875-2345 ext. 5102 at the BC Research Institute for Child and Family Health

Conference Raises Issues of Refugee Child and Youth Trauma

Eric Macnaughton

This past November, a conference entitled *Refugee Mental Health: Moving Ahead* was held at Simon Fraser University. While the event raised issues pertaining to a broad spectrum of the immigrant and refugee population, it highlighted a number of concerns specifically relating to youth.

From a demographic point of view, conference attendees learned that immigrant mental health issues are almost by definition youth-focused — using the United Nations definition of youth as under age 30 — since over 50% of recent immigrants and refugees are younger than 25.

On the first day of the conference, a panel of recent refugees discussed how recovery from torture and trauma was a particularly difficult issue *after* landing in Canada, as ironically the post-traumatic effects often come to the fore only after the refugee family has gained the security of refugee status. One panelist, a refugee from Guatemala, worked as a psychiatrist in his country of origin, treating victims of post-traumatic stress syndrome, only to experience the symptoms himself after arrival in Canada. His children now experience nightmares of their experiences. The events of September 11th have re-traumatized them and intensified the feelings to the point where they can't be left alone at night. Another refugee from Guatemala related how his own trauma led to alienation and drug abuse, negatively impacting his children.

Participants also pointed out that given the widespread nature of trauma in their history, their reactions needed to be seen by the mental health service system as "normal," without pathologizing those experiences within the disease model. By contrast, others expressed concern about accessing help for themselves or their children, given the tendency of trauma victims to appear "well" at the time of their visit to mental health services, even though they might in fact be suffering serious problems at home.

Settlement services are picking up slack for the lack of mental health services which may be more effectively delivered through the formal mental health system. Service providers from both agency streams felt they "stretched their mandates" when attempting to provide such care, and felt that there was a need for agencies from various sources such as schools, religious groups, and social services to identify gaps and make collaborative efforts to fill them. The need for more child and youth services was identified as a pressing need by a survey taken in preparation for the conference.

Outside the conference venue, *Médicins Sans Frontières* put on a display entitled "Childhoods Interrupted by War" (see below), likened by the organizers to a "war diary" written by children between ages six and twelve who had experienced the Bosnian conflict. As the organizers write: "the suffering caused by war is in fact barely expressed in words, because children confronted with the barbarous behaviour of adults fall silent." Hence these children expressed their experience through drawing, creating pictures which related to before, during and after the war, which raised issues such as the death or disappearance of parents and the destruction of their homes or villages. The exhibit also displayed the incredible strength and resilience of the child artists, some of whom still held strongly to their hope for a different, better future. Despite the trauma endured by the children, the drawings can rightly be described as "bursting with life." ■

Related Resources

"Healing the Minds of War-Exposed Children." *The Journal of Addiction and Mental Health*, Vol. 4(6): www.camh.net/journal

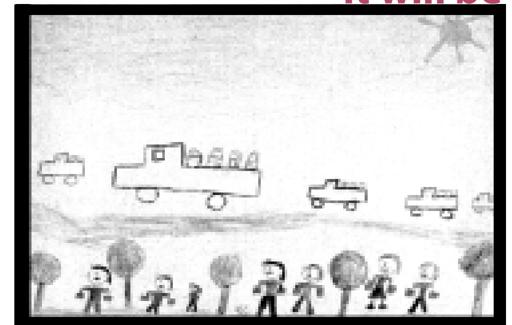
Preventing Double Trouble: Targeting Early Intervention for Refugee Children and Youth. [Teacher Resource Manual]. Ausienet: auseinet.flinders.edu.au/resources/auseinet/stream3/s3projects-Preventi.php

These drawings are the product of a 10-year-old child named Mersiha from western Bosnia. Reproduced courtesy of Médecins sans Frontières Canada (www.msf.ca)

it was

it is

it will be



Anxiety Disorders Association of British Columbia

We are a small, but growing group of concerned individuals who suffer from an anxiety disorder, have a family or loved one who suffers, or are health professionals who work with people who suffer from this disorder. We are a new organization, collaborating since early Spring 1999.

What do we do?

We are dedicated to:

① Promoting awareness of anxiety disorders
② Improving access to information about anxiety disorders
③ Improving access to treatment for anxiety disorders

How can we do this?

First, we need your help. We want to reach out both to those who are suffering from an anxiety disorder and to the people who love them and let them know that it is treatable. No matter how awful it feels, it is not fatal, you are not weak or going crazy, and thousands of other British Columbians are suffering right along with you. You are not alone.

Second, we want the government to get serious about helping the thousands of people that these disorders affect. We want the government to know that treating people correctly is the most cost-effective alternative. Not doing so costs far more in medical expenses for ineffective treatments in addition to the indirect costs of lost productivity and job absenteeism.

Third, we are developing self-help groups throughout the province. These groups will be led by a trained leader in methods and activities that have been proven (i.e., empirically validated) to be helpful in reducing symptoms of anxiety. These groups will have access to other trained health professionals when needed.

We want to see day treatment programs, a residential treatment program, and increased outpatient resources. Ultimately, a clinic dedicated to the range of anxiety disorders would best serve the citizens of BC. In the short term, an infusion of funds for the existing overtaxed services would go a long way.

What have we done so far?

We have been very active. We hold an annual public information night in the spring of each year in Vancouver. Due to the overwhelming positive response, we are committed to holding these public forums annually. We have established contacts with other mental health organizations to unite forces. We have met with government officials and intend to continue these collaborative relationships. We have a PR campaign. We have information brochures and newsletters. We are adding new members to our association in order to be a viable presence in the legislature during financial negotiations for treatments. We are training leaders to return to their communities to start self-help groups. We participate in tele-mental health conferences to reach rural community members and helping professionals. We have a web site which is filled with information and links related to anxiety disorders. This includes a forum where anyone can post a question or get connected to others. Log on!

Interested in joining?

Please contact us at:
Anxiety Disorders Association of BC
119-4438 West 10th Avenue
Vancouver, BC V6R 4R8
(604) 681-3400
www.anxietybc.com

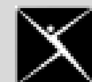
ANXIETY PUBLIC INFORMATION SESSION
Thursday, April 11, 2002

7 to 9 pm, John Oliver School Auditorium, 530 East 11th Ave. (at Fraser), Vancouver

To download a flyer or agenda, visit www.anxietybc.com

Not able to attend this year? Don't worry. These public events are held annually in April. Monthly member meetings are also held in the Lower Mainland. Check the What's New page of the ADABC web site for meeting details.

Co-sponsored by CMHA BC Division
www.cmha-bc.org



CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

BC Anxiety Resources

compiled by
Harkirat Kaur

The following is a list of resources across the province for places to go for information, referral and services related to anxiety disorders. Where possible, this list focuses on resources specific to children and youth. The list attempts to be a guide and is by no means exhaustive. For a more complete listing of anxiety disorders resources in your community, consult the "Red Book" (in the Lower Mainland) or its web site at www2.vpl.vancouver.bc.ca; outside the Lower Mainland, consult your local community services directory (for contact numbers see the "Community Directories" link at www.vcn.bc.ca/isv).

Ministry of Child and Family Development (MCFD)

Province-wide **1-800-663-7867 (Enquiry BC)**

Free mental health programs and services that promote the healthy development of children, youth, adults, and families. Contact information for your regional office available through Enquiry BC. In Prince George, Richmond and Vancouver, MCFD regional services are provided through contracted organizations (Intersect, Vancouver Community Mental Health Services, and Richmond Health Services, respectively.)

Your local mental health centre

Province-wide **1-800-661-2121**

Provides free one-on-one counselling, and may offer support groups. Wait lists possible. Contact information can be found in the Blue Pages under 'Health Authorities' or by calling the BC Mental Health Information Line at the toll-free number above or (604) 669-7600 in the Lower Mainland.

BC Children's Hospital

Mainland BC and the Yukon **(604) 875-2654**

Provides services to children and youth with mental disorders on an inpatient basis, urgent care, outpatient (mood and anxiety clinic) and outreach basis. See www.cw.bc.ca/mentalhealth/index.asp.

Queen Alexandra Centre For Children's Health

Vancouver Island and the Gulf Islands **(250) 477-1826**

Mental health services include a 25-bed child and adolescent psychiatric facility serving Vancouver Island and the Gulf Islands.

Anxiety Disorders Association of BC

Vancouver **(604) 681-3400**

Seeks to increase awareness of anxiety disorders, their symptoms, treatment options and to influence government to increase funding for services. Maintains a web site at www.anxietybc.com that contains very useful information about the different types of anxiety disorders (with a section on children and anxiety), personal stories, provincial support group information, past newsletters, and a forum for discussion.

Canadian Mental Health Association

Province-wide **1-800-555-8222**

CMHA has 22 branches across BC. All branches offer a supportive environment and can provide information about anxiety disorders. Ask for our publications, available in print or online (at www.cmha.ca). Many branches offer support services for dealing with anxiety. For example, CMHA North Shore runs a Consumer Support Network, which includes two support groups for anxiety disorders and our Delta and Prince George branches run OCD support groups. Contact your local CMHA for other resources in the community. Contact information is available from the online CMHA directory at www.cmha-bc.org.

Families Organized for Recognition and Care Equality (FORCE)

Lower Mainland **(604) 878-3400**

Assists parents in finding services for their children who are going through a mental health crisis. Maintains a web site at www.bckidsmentalhealth.org. Also advocates for services for children with a mental illness.

Crisis and Urgent Response Resources

Your local crisis line

Check the front inside cover of your phone book or visit **www.mheccu.ubc.ca/community/crisislines.cfm**

Child and Adolescent Response Team (CART)

Vancouver **(604) 874-2300**

Crisis intervention for children and adolescents with urgent mental health issues. Provides short-term counselling, assessment, and referral services. Weekday service only.

BC Children's Hospital, Urgent Assessment

Vancouver **(604) 875-2654**

Adolescent Crisis Response Program (ACRP)

Delta, Langley, Surrey, White Rock **(604) 585-5561**

Crisis intervention for adolescents 12 to 18 with urgent mental health issues. Provides short-term counselling, assessment, and referral services. To access the service, you will need a professional referral (mental health worker, psychiatrist, GP, etc.).

Kids Help Phone

Canada-wide **1-800-668-6868**

24-hour bilingual telephone counselling and referral service for children and teens experiencing a wide range of problems.

National Youth Crisis Hotline

Canada-wide **1-800-448-4663**

24-hour telephone counselling and referral line for teens.

Parent Help Line

Canada-wide **1-888-603-9100**

24-hour telephone counselling and referral line for parents.

Support Groups

Childhood and Adolescent OCD Group
Lower Mainland (604) 522-8513

Support for parents of children with obsessive-compulsive disorder. No fee involved. Admission by self-referral.

OCD Groups (not child and youth specific)
Delta/Surrey (604) 943-4576
Vancouver (604) 275-3466
Victoria (604) 250-4414
Prince George (250) 561-8033

Support for people with obsessive-compulsive disorder and their families. No fee involved. Admission by self-referral.

General Anxiety Information and Support
North Shore (604) 987-2111

Offered by CMHA North and West Vancouver every few months. Free short-term support groups on living with anxiety disorders.

Panic Disorder Support Group
White Rock and Surrey (604) 538-2522

Peace Arch Community Services program. No fee involved. Admission by self-referral. Group led by a professional.

SE-CURE
Lower Mainland and Victoria (604) 453-1914

Addresses panic, anxiety, and agoraphobia. Various locations. No fee involved. Admission by self-referral.

Recovery Inc.
Delta (604) 581-4881
White Rock (604) 531-4522
Coquitlam (604) 464-6375
Vancouver (604) 538-3399

Weekly peer-led groups held in these communities, using cognitive-behavioural tools. The focus is on behavioural symptoms rather than diagnosis.

Trauma

Vancouver Association for Survivors of Torture
Vancouver (604) 299-3539 or 1-866-393-3133

Support for survivors of torture through individual and family counselling, specialized referrals, and a drop-in centre.

Vietnam Veterans in Canada
Maple Ridge (604) 462-0450

Provides information and support for post-traumatic stress.

Women Against Violence Against Women
Vancouver Crisis Line (24-hour): (604) 255-6344
Business Line: (604) 255-6228

Support for women (14 and older) who are survivors of rape or sexual assault. Operates a rape crisis line and offers support groups, one-on-one counselling and advocacy.

Services at UBC

Anxiety Disorders Clinic
Lower Mainland (604) 822-1788

Provides free clinical treatment for people with panic disorder, obsessive-compulsive disorder, blood-injury phobia, MVA (motor vehicle accident)-induced post-traumatic stress disorder, and hypochondriasis. Admission through referral from doctor or mental health professional only. Must be 18 or older.

OCD Treatment Study / Traumatic Stress Clinic
Lower Mainland (604) 822-8040

Other Related Services

Ridge-Meadows Mental Health Self-Support
Maple Ridge (604) 467-8418

Offers a *Coping with Anxiety and Panic* workshop, and other general services for mental health. Registration may be required.

Mood Disorders Association
Province-wide (604) 873-0103

Offers support groups throughout the province for people with mood disorders (with and without anxiety) and their families.

Northwood House Counselling Centre
Houston (250) 845-7379

Provides counselling and other outpatient mental health services to children and adults with acute or chronic mental illnesses including severe anxiety disorders. There is usually a one-month waiting list. No cost involved.

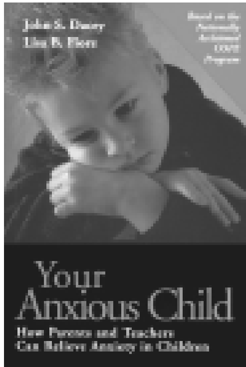
profile

The OCD support group in Prince George has been supporting people with OCD and their family members for several years. In the beginning, finding a suitable location was a major challenge. The initial meeting place at the Prince George Health Unit was problematic as group members with OCD had concerns about germs, a health issue that is often exacerbated in people with OCD. Eventually, the group found a safe space in the office of the local Canadian Mental Health Association branch, where they have stayed for the last two years.

Rose Doroty has been with the group for the last four years. She started attending sessions when her son became ill and took charge of the group when the previous co-ordinator left. She says that there is a lot of sharing of information in the support group. This is especially important in rural areas where resources are a lot harder to find. "Talking definitely helps. For me, it opened up the concept of the disorder even more, and I was able to be more empathetic, understanding and accepting of my son," she notes.

Managing a support group for anxiety disorders in a rural area certainly has its challenges. According to Doroty, because rural communities are smaller and more close-knit, people are often afraid of being identified with having a mental illness, and being stigmatized as a result of it. The fear of stigma commonly comes from family members as well.

The Prince George OCD support group welcomes people from all kinds of backgrounds, ethnicities, and age groups. It currently has about 15 members, with seven or eight 'regulars'. Rose has found that it is more difficult for the group to attract young people, who often find that they are unable to relate to the older people in the group. The sessions can also leave them feeling depressed, as they sometimes give them the sense that they will be grappling with the illness for the rest of their lives. For this reason, there has been some interest in starting an OCD support group in Prince George specifically for children and youth.



Jossey-Bass, 2000; 242 pp.

Your Anxious Child:

How Parents and Teachers Can Relieve Anxiety in Children

BY John S. Dacey and Lisa B. Fiore

Review by Chris Balma

Chris is a writer and graduate student based in Vancouver. He also designed CMHA BC Division's new web site

Dacey and Fiore are proponents of the COPE program, a system of anxiety management, imagination building, and self-appraisal strategies for children with anxiety disorders. *Your Anxious Child* lays out the four-step program in detail, offers some general definitions and background information, and even discusses parenting styles. At every stage, the book offers stories, examples, activities and practical tips to help readers set theory into action. COPE is a drug-free approach, and borrows from a breadth of already-established psychological approaches to anxiety treatment: psychoanalytical, behaviourist, family systems and especially cognitive.

The C stands for ***calming the nervous system***, the first step in Dacey's program. A host of relaxation techniques are covered: breath control, sensory awareness, massage, biofeedback, paradoxical thinking, self-hypnosis, autogenic training, visualization, prayer and meditation. Most importantly, the authors go to great pains to adapt some of the more difficult techniques for younger children.

Dacey and Fiore contend that anxiety problems—particularly in children — are in large part caused by faulty perceptions and factual misunderstandings. As a result, the second step in the COPE program, ***originating an imaginative plan***, involves a series of mental problem-solving and imagination-building scenarios that strengthen a child's ability to confront their fears. In effect, COPE sees a child's imagination as a major weapon in the battle against anxiety: story writing, puzzle solving, remote association and lateral thinking are all covered. After parent and child have gone through the activities, they develop an anti-anxiety plan. Interestingly enough, imaginative flexibility not only helps children develop the tools they need to deal with anxiety disorders, it's also a great help to parents trying to pinpoint the source of anxiety.

The last two stages of the COPE program involve maintaining momentum and measuring results. The P stands for ***persistence***, a commodity that often runs in short supply when setbacks occur. Most of the advice here is commonsensical (rewards, risk taking, building courage through inspiring stories), but worth wading through. Finally, the E: ***evaluating and adjusting the plan***. Particularly useful here are Dacey and Fiore's strategies for evaluating anti-anxiety efforts: goal thermometers, charts, pulse measurement, drawings, interviews and checklists.

Despite the subtitle, *Your Anxious Child* is geared more toward parents — teachers and guidance counsellors would likely incorporate only portions of the system into educational environments. And whether parents institute every aspect of the COPE program or not, the background information and definitions offered by the authors will give them the vocabulary they need when consulting professional therapists.

poetry

Ode: To a Tortured Mind

Frank G. Sterle, Jr.

Frank lives in White Rock

Oh what can I do when you're prevalent,
when you're overwhelming my consciousness
with distortions of thought causing distress
which indeed understates what has been sent
to me, since youth, from some Black place Hell bent
though you would say that the bitter duress —
with which you torture me, procure much stress
— is but my whining with long precedent.
But you, my tortured mind, make me resent
those who are "at fault" as I do regress
in my mental state; so I'll not repent
nor deny you, tormenter, nor suppress
the cruel anguish you know I represent
till death — the sufferer's day of success.

General Links

- Canadian Network for Mood and Anxiety Treatments: www.canmat.org
- Anxiety Disorders Information Centre: www-fhs.mcmaster.ca/direct/anxiety/anxiety.html
- Lifeline – Anxiety Disorder Newsletter: www.designandcopy.ca/lifeline
- Child Anxiety Network: www.childanxiety.net
- www.healingwell.com/anxiety
- anxiety-panic.com
- www.anxieties.com
- anxiety.mentalhelp.net
- www.anxiety-panic-stress.com

Online Chats / Discussion Forums

- Anxiety Disorders Association of BC: www.anxietybc.com
- CMHA BC Division anxiety message boards: www.cmha-bc.org/content/involved/message/message.htm
- Canadian Online Anxiety Forum: go to forums.sympatico.ca, then click on HealthTalk
- www.paniccenter.net/support/index.cfm
- anxietyselfhelp.com's Chat Room or Message Board

Screening Tools

- Anxiety Disorders Association of America: www.adaa.org/Public/ScreeningTool.cfm
  - Anxiety disorder in adolescents: a self-test
  - Anxiety disorder in children: a test for parents
  - Anxiety disorders: self-test for family members
  - Generalized anxiety disorder self-test
  - Obsessive-compulsive disorder self-test
  - Panic disorder self-test
  - Phobia self-test
  - Post-traumatic stress disorder self-test
  - Social phobia self-test

- A general anxiety disorders screening questionnaire www.freedomfromfear.org

Educational Videos

- From the Anxiety Disorders Association of Manitoba. Researchers and consumers share their insights. Emphasis is placed on the role of cognitive-behavioural therapy.
  - *"Whirlwind of Terror" An Overview of the Six Major Anxiety Disorders*
  - *"Panic Disorder" Frightening, Disabling, Treatable*
  - *"Social Anxiety Disorder" Much More Than Shyness*

Videos are $29.95 each or $80 for all three. To order, go to www.adam.mb.ca or phone (204) 925-0600

Online Articles on Child and Youth Anxiety

- Anxiety Disorders Association of Manitoba: www.adam.mb.ca/articles.html
  - *Parenting Your Anxious and Fearful Child*
  - *Father and Son*
  - *Stress Busters for Kids*

- Health Canada:
  - *Anxiety Disorders: Future Directions for Research and Treatment* (discussion paper) www.hc-sc.gc.ca/hppb/mentalhealth/pubs/anxiety
  - *Anxiety Disorders and their Treatment: A Critical Review of the Evidence-Based Literature* www.hc-sc.gc.ca/hppb/mentalhealth/pdfs/anxiety_review.pdf

- A host of anxiety-related and other mental health articles for kids and parents: www.aboutourkids.org

- Child Development Institute:
  - *Anxiety Disorders in Children and Adolescents* www.childdevelopmentinfo.com/disorders/anxiety_disorders_in_children.htm
  - *Helping Your Child Deal with Fears and Phobias* www.childdevelopmentinfo.com/disorders/fears.shtml
  - Other books for parents and children: www.childdevelopmentinfo.com

- Kid's Health for Parents (the Nemours Foundation)
  - *Coping with Anxiety, Fears and Phobias* www.kidshealth.org/parent/emotions/feelings/anxiety.html
  - *Coping with Night Terrors* www.kidshealth.org/parent/general/sleep/nghtter.html
  - *Does Your Child have Obsessive-Compulsive Disorder?* www.kidshealth.org/parent/emotions/behavior/OCD.html

- Center for Mental Health Services / Knowledge Exchange: *Anxiety Disorders in Children and Adolescents* www.mentalhealth.org/publications/allpubs/CA-0007/default.asp

- "New Developments in Treating Anxiety Disorders in Children." P*sychiatric Times.* Sept. 2001 www.mhsource.com/pt/p010946.html

- "Summary of the Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorder." *American Academy of Child & Adolescent Psychiatry*, 1997. www.aacap.org/clinical/Anxtysum.htm

- Anxiety Disorders Association of Victoria (Australia): *Origins and Treatment of Anxiety in Children* www.adavic.org/should.htm ▶

resources

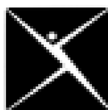
This list is meant as a guide only and not meant to be exhaustive. While we have attempted to include helpful references, inclusion in this resource list does not necessarily reflect content endorsement by CMHA BC Division

Books and Guides

- *Anxiety Disorders in Children and Adolescents: Research, Assessment and Intervention.* Wendy Silverman & Philip Treffers (Cambridge, 2000)
- *Anxiety Disorders in Children and Adolescents* [Clinical Practice, No. 22]. Syed Arshad Husain & Javad Kashani (American Psychiatric Press, 1992)
- *Anxiety Disorders in Children and Adolescents.* John March (Guilford, 1995)
- *Treating Anxious Children and Adolescents: An Evidence-Based Approach.* Ann Wignall et al. (New Harbinger, 2000)
- *Goosebumps and Butterflies.* Written and illustrated by Yolanda Nave (Orchard, 1990)
- *Keys to Parenting Your Anxious Child.* Katharine Manassis (Barrons, 1996)
- *The Developmental Psychopathology of Anxiety.* Michael Vasey & Mark Dadds (eds.) (Oxford, 2001)
- *Helping Students Overcome Depression and Anxiety.* Kenneth Merrell (Guilford, 2001)
- *A Handbook of Childhood Anxiety Management.* Kedar Nath Dwivedi & Ved Prakash Varma (eds.) (Arena, 1997)
- *Catch a Falling Star: A Tale from the Iris the Dragon Series.* Gayle Grass (Stoddart Kids, 2002)
- *Helping Your Anxious Child: A Step-by-Step Guide for Parents.* Ronald Rapee (ed.) (New Harbinger, 2000)
- *Your Anxious Child.* John Dacey and Lisa Fiore (Jossey-Bass, 2000)
- *Taming Worry Dragons: A Manual for Children, Parents and Other Coaches.* Jane Garland and Sandra Clark (BC Children's Hospital, 1995 (revised 2000)). Also available in 2001 editions: *Taming Worry Dragons Workbook* and *Therapist's Manual for Taming Worry Dragons*.

If you've liked what you've just read …

… please help us continue producing this quality publication and give generously to CMHA BC Division at the address below or online at cmha-bc.org



CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

CMHA BC Division
1200 - 1111 Melville Street
Vancouver, BC V6E 3V6