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

BC's Mental Health Journal

Visions

What *is* Mental Health?

How do we define mental health?
How is mental health different from mental illness?
Can we have mental health if we have a mental illness?
What are our barriers to mental health?

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 Canadian Mental Health Association, 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 members, service providers and community.

In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association is grateful to the Ministry of Health, who has assisted in underwriting the production of this journal.

The Canadian Mental Health Association invites readers' comments and concerns regarding the articles and opinions in this journal. Please send your letter, including your name, address and phone number to: "Visions" Editor, Canadian Mental Health Association, BC Division. Suite 1200 - 1111 Melville Street, Vancouver, BC V6E 3V6 or e-mail to: office@cmha-bc.org

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

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GUEST EDITORIAL

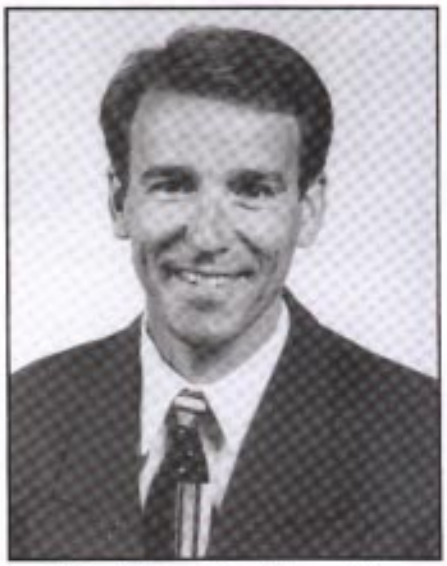
Mental Health Pivotal Dimension of Optimal Health

Dr. Ian Pike

Health promotion is a term that has gained widespread popularity in recent years and people in general are becoming more aware of and interested in their own health. Typically, health promotion programs are focused on physical health. Almost no programs consider the promotion of mental health. In many ways, however, health promotion is in fact much more to do with mental health than with physical health. Programs that fail to address mental health not only miss a major component of health, but miss the very dimension that makes us a person.

Mental health may be the pivotal dimension of optimal health. Self-concept, self-responsibility, competence, and realism are among the major factors of optimal health. Whether we smoke and exercise are important determinants of health, but whether we live longer, healthier and happier lives because we jog and eat right is questionable. We do know, however, that strong social supports, such as family and friends that we can count on, regardless of the situation, are the best predictors of longevity.

In everyday use, however, the term mental health often means mental illness. A community mental health center is a place where those with mental illness can receive treatment. In our health services system, departments of mental health provide services and operate facilities for the treatment of mental illness. Virtually all agencies that provide service, advocacy, research and training in mental health, spend the majority of their resources on mental illness.



Dr. Ian Pike *is a firm believer in the value of health promotion in the workplace as a business strategy. He has over 15 years experience in providing consultation, facilitation and applied research services to organizations in the private, public and not-for-profit sectors in the area of absence management, workplace health and wellness promotion. He was the director of Employee Health and Safety Services at the Healthcare Benefit Trust and the past director of the Dr. Paul Schwann Centre, and applied health and research centre at the University of Regina.*

What do we mean by mental health? Before addressing this question it is helpful to understand what mental health is not. Mental health is not merely a lack of symptoms. Unhealthy people may often not show any symptoms of illness. Mental health does not mean simply the absence of mental illness. Similarly, it is not merely the continual presence of positive signs either. We should not expect that the mentally healthy individual is, for example, happy at all times. All healthy people have emotional highs and lows.

Mental health cannot be defined by the ability to make adjustments. Joining the KKK and persecuting blacks, for instance, may have been a successful adjustment to society in the southern states in previous decades, but we would not point to it as an example of mental health. In fact, those that refused to adjust to a KKK-driven society were more likely to have been the mentally healthy members of that society.

Continued on opposite page

GUEST EDITORIAL

The ability to function is no better a criterion. Mentally healthy people are able to function in all areas of their lives. However, the ability to function is not exclusive to mentally healthy individuals. Many individuals with mental illness function well and excel in many circumstances. And persons who have a mental illness can strive for, and achieve mental health.

Finally, we cannot define mental health as never having needed help with an emotional problem. We would never say that because someone has never seen a physician, they are necessarily physically healthy. There are many people who have never received any kind of treatment or help who may be in need of assistance with emotional issues.

What then do we mean by mental health? A review of the more prominent literature reveals ten characteristics of mental health that seem to be constant. While the concept of mental health continues to evolve, these important characteristics stand out as defining mental health.

The mentally healthy are AUTHENTIC. They respond to events in a genuine, spontaneous way. They are not phony or pretentious, and feel no need to edit or censor themselves to make an impression or get approval. They are real, and operate in the here and now.

The mentally healthy are REALISTIC. They know the difference between what is and what ought to be, and between what they can change and what they cannot change. The mentally healthy person is able to accept those things that cannot be changed, has the strength to change those things that can, and the wisdom to know the difference.

The mentally healthy are SATISFIED. They recognize their own needs and what they must do in order to satisfy them. They do not, however, waste energy on satisfying needs that do not promote personal growth. They are competent in that they know how to satisfy their needs and they do.

The mentally healthy are IN CONTROL. They feel they are in control of their own lives and take personal responsibility for their actions and feelings. Mentally healthy people take deliberate steps to attend to and promote their own mental health.

The mentally healthy are OPEN TO EXPERIENCE. They experience both their internal and external realities accurately and fully. They welcome new experiences as opportunities for growth. Even experiences such as grief are seen as having potential for growth.

The mentally healthy are CAPABLE OF INTIMATE RELATIONSHIPS. They are open to the risks and the satisfaction of physical and emotional intimacy. Giving and receiving love, the ability to trust in another and be open in sharing feelings are hallmarks of mental health. Physical intimacy is a natural extension of emotional intimacy for the mentally healthy individual.

The mentally healthy are TOLERANT AND ACCEPTING OF OTHERS. Racism, sexism and ageism are not compatible with mental health. Mentally healthy people judge others on their individual merits and do not expect them to fit within a narrow limit of belief or behavior.

The mentally healthy can REACT IN A VARIETY OF WAYS. They do not react in a stereotyped fashion. They are able to balance, for example, their ability to lead by their ability to follow; their ability to judge by their ability to empathize; their ability to act by their ability to yield.

The mentally healthy ENJOY LIFE. The ability to enjoy the major elements of life – family, community and work is a major characteristic of mental health. These elements do not have to be perfect, however. The mentally healthy are able to enjoy and take pleasure in the ordinary things in life.

The mentally healthy are SELF-ACCEPTING. Probably the most crucial characteristic of mental health is a positive self-concept. A sense of comfort, liking self, and feeling worthwhile is one of the most universally recognized characteristics of mental health. Nearly all of the characteristics of mental health are predicated on accepting and liking oneself, and all are facilitated by positive self-concept.

The answer to the question, what is mental health is now somewhat clearer. Mental health does not mean simply the absence of mental illness. It can be described by characteristics that are predicated on self-acceptance and a positive self-concept. In order to optimize mental health, individuals should understand these characteristics as they relate to their own lives, and attempt to integrate them as a way of living. The purposeful pursuit of mental health is by its nature a contributor to positive mental health.

Editor's Message

We have many ways of describing mental illness, provided to us by a scientific method which classifies all the signs and symptoms of pathology. But how do we conceptualize mental *health*? Is mental health one thing in and of itself or is it found within or created by constellation of factors? And if the latter is the case, then how many of these factors are found internally and how many others depend on our external world?

If we have a mental illness, can we also have mental health? If I have a label of manic depression, but I work hard to keep well by balancing my responsibilities, my rest and my play, wouldn't I have mental health? But if I don't have a label of mental illness, yet my life outside work is spent primarily alone, watching television, how am I exercising my mental health?

And how do we recognize the difference between mental health and mental illness?. It can be subtle. One of the ways to recognize when we are moving from health to illness is at our vulnerable points and the barriers that exist which keep us from attaining mental health. This issue hopes to explore some of the ways we see and envision mental health. Let us know if you find it helpful.

Our next issue ask the question, "How welcoming is your community?" If you know a group or individual who has created a more welcoming and inclusive place for people with a mental illness to work, live, and/or play, let us know.

Dena Ellery is general editor of *Visions: BC's Mental Health Journal.*

Mental Health Outcomes in Mental Health Promotion

Catherine Willinsky and Bonnie Pape

At CMHA, we believe that mental health is promoted through processes or activities which remove those barriers that may prevent people from having control over their mental health. We also believe that the responsibility to develop human potential is shared among society and individuals.

Mental health promotion often refers to strengthening people's ability to bounce back from adversity and manage the inevitable obstacles that life tends to throw in our path. But any measures which foster, protect, and improve mental health can be seen as mental health promotion.

These include approaches as diverse as mutual aid, sound urban planning and equitable social policy development (Health and Welfare Canada, 1990). Mental health promotion can also refer to more individual-level interventions(such as stress management) to cultivate skills, attitudes and behaviours conducive to mental health.

In 1996, Health Canada sponsored an international workshop on mental health promotion. That workshop resulted in the following definition: ***Mental health promotion*** *is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for equity, social justice, interconnections and personal dignity* (Centre for Health Promotion, 1997)

Within a model of mental health promotion, positive mental health outcomes are a result of a process which includes Issues and Settings (a focus for mental health promotion, or setting where mental health promotion is needed), Actions and Strategies (ways to promote mental health), then Evaluation (measuring effectiveness of mental health promotion activities).

Positive Mental Health Outcomes:

The purpose of mental health promotion

What are the outcomes that mental health promotion aims to achieve? Identifying some of the positive mental health outcomes helps us clarify the elusive concept of mental health. It includes the capacity to rebound from difficulties, a sense of control over our circumstances, and the ability to manage the obstacles life tends to throw our way.

Resiliency . . . is commonly understood to mean the quality that allows an individual or group to function well despite negative odds: "Life is a constant up and down, and we can never get rid of problems, crises, sorrow and pain. Being able to bounce back in the face of these inevitabilities is an important aspect of mental health" (Joubert & Raeburn, 1997).

Two fundamental concepts are associated with resiliency: risk factors and protective factors. *Risk* involves experiencing a number of stressful life events (e.g. moving, transitions) or a single traumatic life event (e.g., divorce, bereavement). *Protective* factors are defined as the skills, personality factors and environmental supports which contribute to resiliency. They provide a buffer as well as a reservoir of resources to deal effectively with stress (Health Canada, 1995).

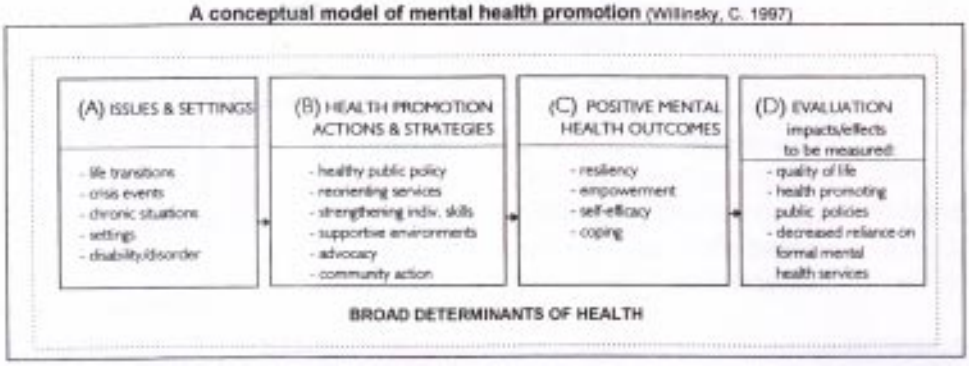
Empowerment and Self-Efficacy . . . The concept of empowerment is the bedrock upon which mental health promotion efforts are built. Increasing people's sense of control and mastery is crucial for everyone, whether they live in an institution of in the community. Having a sense of control over one's life is strongly related to feelings of personal well-being. The related concept of self-efficacy refers to the sense that one can influence events or make desired changes happen - again a feeling of control over the environment.

Whether in the workplace, at home, or in the community, whether young or old, all people have to have power and control over their own lives in order to have good mental health. This fundamental principle can be applied whenever and wherever mental health promotion activities take place.

Coping . . . refers to the cognitive and physical skills and resources available to and used by individuals to help them deal with the problems, stress and strains of daily living, or life events causing stress. Everyone experiences stressful life events in their lifetime, but there are strategies which can make the events more manageable. For example, reframing a situation to view it in a more positive way, or practicing relaxation techniques to deal with stress can help people to cope with difficult circumstances and thus enhance mental health.

Mental health promotion can help to normalize daily experiences (instead of creating fear) by focusing on coping rather than diagnosing, by validating people's feelings, and acknowledging stress."

A conceptual model of mental health promotion (Willinsky, C. 1997)



Excerpted from the Social Action Series paper, Mental Health Promotion, *CMHA National Office, Toronto, ON (1997)*

Seniors' Mental Fitness: New Westminster Program Leads in Research & Development

Sandra Cusack, Ph.D.

During the past decade, Century House, a 2100-member seniors centre in New Westminster, has played a leadership role in supporting innovative lifelong learning projects. During the past five years, the research and development of mental fitness programs has proceeded in three distinct phases: I, the Lifelong Learning Project (Needs Assessment), II, the Mental Fitness Research Project and III, the Mental Fitness Pilot Project.

Phase I, the Lifelong Learning Needs Assessment, concluded:

Lifelong learning means different things to different people and encompasses all learning, formal and informal. Mental Fitness is just as important as physical fitness, though less visible and more difficult to measure. In fact, mental fitness is the key to healthy and productive aging. But what is it and have do we exercise it?

Phase II, the Mental Fitness Research Project, was designed to address these questions, and the research team concluded that:

Mental Fitness is vital to healthy aging, encompassing many skills that can be developed. Like physical fitness, it is a condition of optimal functioning that is achieved through regular exercise and a healthy lifestyle. Mental fitness includes creative thinking, clear thinking, problem solving, memory skills, learning new things, and expressing ideas clearly, setting personal goals and developing positive mental attitudes such as: (1) optimism, (2) mental flexibility, (3) self-esteem and confidence, and (4) a willingness to risk.

Phase III, the Mental Fitness Pilot Project, involved the development and implementation of an 8-week pilot project program and a 5-week mini-series for people aged 50+ to exercise their mental abilities. Eighteen people (ranging in age from 63 - 83) participated in the series of 8 all-day intensive workshops covering the following topics: Goal Setting, Critical Thinking, Creative Thinking, Positive Mental Attitudes (PMA), Speaking Your Mind, Learning and Memory, and Mentally Fit for Life. Twenty-five people (the maximum enrollment) attended the five week series of 3-hour workshops. The focus of the mini-series was on three key components of mental fitness: goal setting, critical thinking, and creative thinking.

Century House now has a long waiting list of people who want a mental fitness program; people from other seniors groups and centres want a mental fitness program; and people in other parts of the province and across North America want resource materials and programs.

The Mental Fitness Challenge

Mental fitness is a way of life that promotes a healthy body, mind, and spirit, and it is the key to a healthy, productive aging society. The benefits of mental fitness go well beyond the group of people taking the course. All members of the community, regardless of age, gain a better understanding of how important education, learning, and mental fitness are throughout life, and they gain greater respect for the mental abilities of older people from their associations with senior leaders who are powerful role models of healthy aging. Based on mental fitness research, Century House received the US National Institute of Seniors Centers 1997 Research Award for research that contributes to innovations in seniors centres. All those involved are deeply honored by the award, and committed to further sharing and exchanging of resources with other groups in British Columbia, across Canada, the United States, and around the world.

RESEARCH PUBLICATIONS to watch for:

Cusack, S.A. & Ginsberg, B. (1997). Mission possible: promoting a vital age-integrated society. *Critical Issues in Aging*, 1, 54-56.

Cusack, S.A. & Thompson, W.J.A. (1998, in process). *Research as Emancipatory Learning: A method with attitude for creating a new old age. London;: Ashgate.*

Cusack, S.A., & Thompson, W.J.A. (1998, accepted). Mental Fitness: developing a vital aging society. *International Journal of Lifelong Learning.*

RESOURCES AVAILABLE

- . Lifelong Learning Needs Assessment
- Mental Fitness Research Project Report
- Mental Fitness Pilot Program Report

(Cost is $10, including shipping, for individual reports or $25 for all 3 from the Gerontology Research Centre, Simon Fraser Research Centre, Simon Fraser University at Harbour Centre, 515 W. Hastings, Vancouver, BC V6B 5K3 Tel: 604/291-5062)

Sandra Cusack, Ph.D., is the Guttman-Gee Research Fellow in Educational Gerontology at Simon Fraser University at Harbour Centre in Vancouver. Her article is excerpted from Gerontology Research Centre News, *Vol. 16, Number 4.*

Working Together for Mentally Healthy Children

Dr Rosalind Baltzer Turje

"Communities provide children and families with social support in the form of belonging, stability and continuity" ~from *Building a National Strategy for Healthy Child Development, Discussion Paper*, May 1997.

The Motivation

When the North Shore Health Region planned for health goals, the topic of children's health came immediately to mind. Service providers and public are overwhelmingly aware of the increase and level of youth violence and the use of anger (towards self and others) to deal with problems and life stage transition. It is clear that too many children and youth are not coping effectively. Where are those positive coping skills? Where is the resiliency? We know that everyone, young and old, is challenged in coping with every day stresses. And dealing with traumatic events is beyond the skills of many. We can look to parents to strengthen the child's skills but it us apparent that not all parents have the skills.

There is an understanding that education, support and early intervention in childhood enhance a child's mental and emotional development. And an essential criteria for being healthy is having the skills to cope with day to day living, normal development and with significant life issues and traumas. With this in mind, the Region adopted an interim health goal: **increasing the positive coping skills and resiliency in children 10 years of age and under.**

The Plan

A lead person was appointed to guide a process with an initial task of identifying the resources internal to the health region and the creating a broader coalition that would ensure that all available resources in the community were focused in the most efficacious manner on meeting the goal.

The Challenges

The Working Group... the dilemma was achieving a broad representation, looking towards collaborative relationships and bringing in the people 'in the know.' When choosing the membership for the group it became clear how much the ability to cope is a determinant of health status. For this group, participation was needed from: providers in early childhood development, maternal health, child health, alcohol and drug, mental health, family health; community service partners including protection service, justice system, special needs groups, family services and education; and children, youth, parents, family and general public.

A Partnership... Healthy Beginnings Initiative and the Ministry for Children and Families made a natural partner. To ensure that the community was working together, the task group became a joint venture. Together we addressed the two issues: **Healthy Beginnings and Coping Skills**. The final membership included providers from maternal and child health, mental health, family services, support services and community development. Other participation, particularly of parents and family, was sought (and will continued to be pursued) through individual feedback and focus groups.

Choosing the priorities... involved an exercise in identifying health issues and specific goals. The goals led to specific objectives and strategies. The process was inclusive, promotion oriented, measurable through outcomes and achievable (at least in part) for this year. A brainstorming session showed the diversity in issues ranging from nutrition and safety, to social connectedness and family support. We identified the need to recognize and address both visible and non-visible at-risk groups. We identified the need to enhance parenting skills, support parents, recognize the roll of educators and community action, and, the need for effective disbursement of information.

Choosing the strategies... included decisions on which issues were important. We knew that we had six subgoals: (1) increase parent knowledge and awareness; (2) increase children's ability to build and maintain healthy relationships; (3) enable parents to provide a safe and nurturing environment for children; (4) strengthen family support; (5) increase accessibility of services; and, (6) increase the community's capacity to address coping and resiliency issues. A decision was made that all these would have to be met to effect change as they interrelated and mutually inclusive. To meet the goals, the strategies were aimed at particular audience, i.e. children, parents, family, service providers and community.

Target task groups were formed and are currently working on their focused tasks and specific projects that meet the subgoals. Examples of the projects are: development of drop-in-like family places, including more parenting information and training in prenatal classes, widely distributed information and support of current programs that meet the primary goal of increasing children's positive coping skills.

The Rewards

As with any project, there is a yearning to see action and have completion. This project may never meet completion. In fact, it will be a continual process. **We share the common goal of supporting children's positive coping skills which will enable them to think constructively and effectively solve problems and make decisions. We want children to have the resiliency to cope successfully in the face of significant adversity or risk. We want children to grow and develop into adults that can continue to promote health and well-being in themselves and their children.**

The process of bringing people together to talk about solutions and plan collaboratively is the first step in building the community's capacity to address the issues surrounding coping and resiliency. For many of the group members this was the first time they worked together. We shifted our thinking and doing... immediately. We formed partnerships with a common goal of creating some-

Continued opposite

Wellness 101: Mental Health tips from a 'professional'

Barbara Bawlf

Many people in the mental health field think it is necessary to bring in consultants to teach employees about wellness. It is my opinion that maintenance of wellness is a topic consumers are experts on. As one who has direct experience with a mental illness, I would like to share my thoughts on sustaining one's well-being.

- It is important to recognize the warning signs of stress- exhaustion, irritability, change in appetite, etc. I used to ignore these warning signs and go beyond them until I became burned-out and often depressed. Now I catch myself when I am on overload, and cut down on some of the activities I'm doing. At times this involves saying "No" to people, but I think it is essential for my mental health.
- Taking time for oneself is also a crucial part of maintaining wellness. Going for a solitary walk, listening to music, or pursuing a hobby (in my case, bird-watching) can be very therapeutic and create a break from outside worries.
- Physical activity, as I'm sure you've heard before, is always a good stress-reliever. It doesn't always have to be terribly vigorous, but doing something you like is helpful. I actually find doing housework to be a way of releasing tension.
- Reading a good book or even watching mindless TV or movies can provide a good escape and method of relaxation, even though you might not want to admit to your best friend what you watched.
- Balance in life is the best way I can think of to express what I try to do to maintain wellness. We all need both work and play to keep healthy.

Continued from previous page

thing better. We share enthusiasm for what could be...and we still do and will continue to do so as we meet the challenges of testing our strategies and putting them into practice.

Rosalind Baltzer Turje is Director of the North Shore Community Mental Health Services, and coordinator of the planning process which will guide children's mental health services.

Mental Health

Ian LeBrasseur

I never liked anyone telling me what to do or be. In that sense I was always trying to be independent, assertive and looking out for myself.

It was hard growing up with a sunny disposition, being the oldest child, staying out of everyone's way, with strict parents and still have some time to myself. I used to go hiking - day hikes and overnight hikes in the surrounding area. That seemed to have instilled in me a sense of myself if not a sense of belonging.

I had original ideas on how things should be. Some features of this thinking to note are: not to think, not to experience time, the ideals of the child as variously explained in popular songs, like from Pink Floyd, Simon and Garfunkel, etc. These ideals form the basis of the experience of enlightenment.

The book *1984* should be pretty self-explanatory. It 'triggered' a mental illness, at age 10. This started or initiated a shift in my thinking. I started to behave 'intelligently,' i.e. using mail drops, compartmentalizing everything. My family, school, and friends were all distant. It was very frustrating to try and get along like this and still deal with everyday routines and tasks. There was a sort of private world, separate from my public life. I suffered a lot from paranoia.

Like trying to make sense of the way text lines up on a page, I always sort of supposed it should be like a table, lining up in a meaningful pattern. Like, what is the difference between data and meaning. What is meaning? Why shouldn't I try and make sense of car license plates. Poked & prodded into listening to 'voices' on the radio, by guys trying to get writing in the element surrounding me. Part of this was my disposition but I never felt comfortable expressing myself. On the other hand, I was a loner, anti-social, and an introvert.

Recovery: Working toward mental health

I took more of an interest in the 'world' as part of my recovery, which included lots of activity and involvement in the community. Included in this effort was the following: starting a daily routine, attending college which led to remembering of 'thinking' skills and formation of some study habits. Picking up some education (Grade 12) and the start of higher education. I did perhaps a half-dozen public seminars, meetings and interviews, did a cable TV interview, talked on the radio. There was quite a bit of involvement at the clubhouse and the mental health unit. I see a worker regularly.

The experience of living and dealing with conditioning and conformity was a great help in my understanding of the way of centering, of living in the present. Some of these methods of approach stand out as milestones, like navigational aids that once used can be recognized again the further I progress. This makes it possible to use a slower route and become a bit steadier, which makes dealing with the public easier. There is one problem though, I encounter feedback (from the public) which just complicates and confuses issues. Naturally, writing this little essay helps communication and aids understanding. Generally, those who are the public are logical, and those who are seekers or dreamers of one sort or another, act intuitively.

Ian LeBrasseur lives in Port Alberni. This is one of several chapters of Ian's work, describing his insights and his multi-faceted journey toward mental health.

"What are you, pagal?": Cultural barriers to mental health

Sujata Dey

Editor's note: While this article is primarily about cultural definitions of mental illness, it does cause us, by reflection, to also envision new understandings of what mental health is.

"Pagal!" When I heard that word as a child, I knew it was time to run. Growing up as the descendants of immigrants from India, *pagal* is one of the few bad words that I could remember. The word means "crazy" or "mentally ill." I remember pagal was a condemnation — something my mother used when she was really angry at one of us kids.

Mental health disability is something which takes on a very different meaning in non-Western cultures. In some cultures, such as in Southeast Asia, there can be no concept for it — just an idea that some people go through "ups and downs." In some cultures, people with mental health disabilities are seen as the result of a curse or being in possession of unbelievable powers. The result is that new immigrants often don't get services which make sense to their way of life.

Lisa Hanna is a researcher in sociology at Ottawa's Carleton University. She interviewed caregivers of people with manic depression and schizo-affective disorder as part of a study she directed. To get a diverse sample, Hanna purposely shied away from support groups, which she says tend to be white and middle-class. "If an Asian woman wants to attend one of these groups, her culture isn't considered, say, if she is a Muslim woman. And that's problematic."

Hanna worries that as less money goes into mental health, society will rely more on support groups and other services which may not be culturally sensitive. She says these services will not include the diverse values about mental health which non-Western cultures hold.

"Many cultures view it as a punishment from God. Egyptians perceive mental illness as one being in possession of demons."

Other times, the phrase "mental illness" simply draws a blank. Kalpana Das is the Executive Director of the Intercultural Institute of Montreal. She has been doing cross-cultural workshops for health providers about mental health. "First, mental health as a concept: What does that mean? What is stress? They don't know what you are talking about. Mental health, or mental illness, is more biomedical. Other cultures — Asian cultures, or African cultures — view health issues more holistically, as some kind of balance with the soul.

"In India they have the notion that something is 'not well,' that their inside is not well. The mother is worried about something. The children are worried about studies or something that happened. It is a disharmony within the family.

"If you had a psychological problem, in many cultures you would go to the family," says Hanna. "You wouldn't go to a special psychiatrist or a doctor on the other end of the system."

Das says instead of focusing on biomedical treatment, South Asian cultures will look for a socio-spiritual treatment. Often, people will seek a religious figure or do a "puja" — a ritual which is dedicated to a certain god or goddess. She says India has a pluralistic system, in which beliefs like astrology — which is like therapy —are practiced with Western medicine.

In East Asian cultures, often a mental health problem may be seen as a disharmony between yin and yang, she says.

In some African communities, she says, there is more of an emphasis on the community. "If someone is mentally ill, there is something wrong with the whole group. They will try a form of trance and all kinds of sacrifices. The belief is if the person is sick, the community is sick," says Das.

Hanna agrees. "Many of the family members from various cultures, South Asia and Haiti, speak about turning to spirituality and the belief of a higher power as the only existing being who could understand their suffering."

Das believes that the Western-based medical model often claims a superiority that it does not have. If Western-based medicine were to learn from cultural views, she says, it would be more effective. Das has been looking at Brazil and Zimbabwe and says that other treatments can heal more effectively. "[Health providers] have somewhat learned to respect that other people have cultural differences. But ultimately, when it comes to what kind of treatment health care workers will use, they are sticking to the Western model. They are not willing to use the wisdom of other knowledge systems of other cultures.

"I once knew of a Haitian mother who had her son in hospital for several months and they did not know what was wrong. They kept doing tests. After a couple of months, she said, 'I'll bring him to see a healer.' But the hospital wouldn't let her do that. If the doctors don't know what is wrong and it is the mother's wish to try something else, it's in the son's interest. It shows the arrogance of the medical practice."

Hanna says that while many look to their own spiritual value systems to heal from mental health problems, they may not look to their own communities. In large, extended families, a mental health disability is still shameful. "In different ethnic groups, there is a strong, strong desire to keep mental illness quiet in the family," says Hanna.

But Hanna points out that the stigma in North America is no better. And positive portrayals do exist. Das says that while my mother may have used "pagal" when she was angry, it's not necessarily a negative word. "Pagal is also used to describe many mystics. They are pagal, but everyone knows that there's truth in there."

Sujata Dey is a freelance writer and disability rights activist living in Guelph, Ontario. Her article is exerpted from abilities *magazine, Winter 1997.*

How's Your Personal Wellness?

Dr. Ian Pike

How healthy are you? Many people think that if they are not sick, then they must be healthy. To these people a definition of health might be freedom from disease. They see health and illness as a straight line called a health continuum, with ill health at one end and perfect health at the other.

←Ill — Neutral — Perfect→
Health Health

The difficulty with this linear consideration of health is that illness and health cannot overlap. That is, at some point one stops and the other begins. In the figure above, this is represented by the neutral point at the centre, where there is no discernible health or illness. To the left of the neutral point are varying degrees of illness, while to the right are varying degrees of health.

Today, many people reject the idea that health is defined by this linear continuum and is merely freedom from disease. Health is nowadays understood to be much more than just "not sick". People know that health consists of several dimensions: social, emotional, intellectual, occupational, spiritual and physical. And, they know that health is the result of balance among these dimensions, which is achieved through conscious and deliberate efforts to improve health on the part of the individual.

This notion was described by Halbert Dunn in the mid-1950's in a deliberate attempt to focus on the positive aspects of health, and to differentiate from the realm of illness and disease. He coined the term Wellness, meaning, a conscious and deliberate approach to an advanced state of physical, psychological and spiritual health. Achieving wellness, or optimal health, requires personal choice and commitment on the part of the individual to a way of life which, ... permits or facilitates human excellence, high energy levels, and optimal functioning.

This approach cannot be reconciled with a linear definition of health. Health is conceived of as a balance among the various dimensions and can be represented by a circle. In turn, the circle could be imagined to be the wheel on a bicycle. The more balanced the wheel is, the smoother the ride. The same is true of health. The greater the balance among the dimensions of health, the smoother the ride through life.

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Survival of the unfittest

George Merle

Eight years ago, a nervous breakdown ended with a trip to the Regina General Hospital, Psychiatric Ward.

A drugged sleep after a shot of Demerol in each buttock. A series of shock treatments for good measure. And Modecate which turned out to be my wonder drug.

I also discovered a typewriter in the Activity Therapy Room. I decided I would write my way out of that place. After supper every night I'd go down to AT [Activity Therapy] and type what I had written the night before.

There were no secrets; my life up to that point was all down on paper. Amazing, the frustration and the guilt were there, but these seemed to wane and die as it all came out one letter at a time on that typewriter in AT

I purged my soul of all wrongdoing. I wrote poems and stories as if I could be a writer, with different ideas. Looking through my eyes or even someone else's eyes, I could see that I could become anyone with any point of view. What a discovery! I could mould and shape my future simply by putting words to paper.

I moved into the Rosecrest Apartments after my release from the hospital. I also got my own typewriter. Anytime the world got to be too much I'd lock myself in my apartment and type.

Once, I stayed in that apartment for a week. The landlord tried the key in my door because he was concerned, and found me asleep. I awoke and showed him the poem I had finished the night before.

Pisces people are hopeless romantics. I am no different.

Shortly thereafter, I was elected by my peers at By Ourselves to serve as their coordinator. It is a most interesting and rewarding position. It's great. All I have to do is be myself, and I am paid for being a friend and confidant. I know almost every member on a first name basis. We help each other out during the tough times and share the joy of the good times.

Speaking of good times, I met a vision of loveliness named June at a CMHA convention. I got up the courage to ask her out for a drink! I suspected something different about this girl when she ordered orange juice from the bartender.

As it turns out this girl is refreshingly different. She is quiet and unassuming and a great companion.

June and I have the main floor of a house. We have a Pekinese puppy we call Ming. We are happy now that Ming is house trained.

I get a shot of Modecate every three weeks. It's a hassle, but the Normal Shots as I call them work for me. The medication combined with a certain maturing have kept me out of the hospital for eight years.

George Merle's story is excerpted from Transitions, CMHA, Saskatchewan Division's quarterly magazine. Reprinted with permission.

Stigma: The Greatest Barrier To Mental Health

Charmaine Stevens

Stigma thrives within all classes, segments, and groups in society, and even in mental health worksites. It feeds on the myths and misperceptions that the mentally ill are violent, lazy, stupid, blameworthy, untrustworthy, and volatile. In 1994, the Ontario Division of the CMHA did a study on misconceptions about people with a mental illness. They discovered that 88% of respondents believed that the mentally ill are violent or dangerous; another 40% believed they lack intelligence; 24% believed they are weak or lazy and 20% believed they are to blame and should shape up. This same study found that many mental health consumers said the stigma associated with having a mental illness is more difficult to live with than the mental illness itself.

Stigma places significant barriers in the way of achieving mental health. It prevents people from getting the help they need. A recent survey shows that nearly half of all Canadians feel that stigma is the main impediment to seeking help for a mental health problem[1]. People living with a mental illness tend to isolate themselves because of stigma, and so do their families. They worry about what people will say about them, or how they will act towards them. They fear losing a job, a reputation, or an important relationship. Instead of looking outwards for support, they may withdraw, making it difficult to get the help they need. In fact, less than one third of people with depression seek help, yet 80% of those who do seek help are treated succesfully[2]. Not looking for approporiate help or support when we need it places our mental health at greater risk.

If stigma compromises our efforts to optimize our mental health, what can we do about it? In the last couple of decades, there has been a shift in public policy that places greater emphasis on including people with mental illness in their communities. Research in Britain on two supported houses for people with mental illnesses showed that the social contact between residents and their neighbours lessened rejecting attitudes[3]. However, public education still needs to be part of the inclusion process.

The way we use language can influence attitudes. Using terms that label, judge, or patronize people living with a mental illness reinforces stigma. The media has a significant impact on the public perception of mental illness, and on the formulation of public policy. It is therefore also important to advocate for the elimination of negative images of the mentally ill within all different forms of the media. Above all, we can remind others that someone living with a mental health problem most likely has the same hopes and dreams that we all do, and that their illness is not the summation of their personhood.

Charmaine Stevens is a consumer and family member who facilitates the BC Division public education project called Open Mind: The BC Resource Centre for the Elimination of Stigma.

[1] COMPAS Survey, Canadian Mental Health Association and Canadian Psychiatric Association, 1992.
[2] Ibid
[3] Public Education For Community Care. Wolff, G. et al. Journal of British Psychiatry. 168(4):441-7. April, 1996.

A Sound Relationship

Charmaine Stevens

"Some people around here tell me I should go out with Floyd. But...I don't know. He's..." my colleague furtively whispered to me, tapping her finger against the side of her head. I was puzzled. "He's what?" I said. I had never met Floyd. "He just got out of the psych hospital." she replied. I realized then that she doubted his 'mental soundness.' "What do you know about him?" I enquired. She reflected for a moment before answering: "He's a good guy, very thoughtful and kind-hearted. But who knows what he's capable of - he's been in the nut house."

Martha (not her real name) and I were team-mates in a psychiatric facility. It was my first job as a psychiatric nurse and she was a health care worker. She was referring to a fellow health care worker who worked on another ward. He had just returned to work after three months of treatment in a hospital acute psychiatric ward for a major depressive episode. It was not his first experience with major depression, nor was it to be his last. Martha was a fine person: a hard worker, conscientious, reliable, and outspoken. I liked her. But I found myself staring at her, uncertain of what to say. Where could I start? She thought we were talking about her dating prospects; we were actually talking about stigma.

I was startled to encounter stigma in a fellow caregiver in the mental health field. Martha did not realize that stigma had infiltrated her unconscious thought. She had allowed stigma to prevent her from getting to know a decent and kind person who may have been a good friend - if not more - to her. I'm glad she overlooked him though; *I* married him.

Physician's Barriers to Seeking Mental Health

Some of the most difficult patients are doctors. But Dr. Michael Myers, a psychiatrist who specializes in working with doctors, says doctors are asking for trouble if they don't have their own doctor. Many doctors suffer from 'MD' says Dr. Myers: Massive Denial. The very people we expect to know and understand the signs and symptoms of emotional or psychological breaking points often don't reach out for help. The stigma of reaching out for help which exists among the general public is amplified within the medical community.

Myers believes the medical profession has a long way to go to educate and reduce stigma among physicians. "We need to be able to acknowledge the realities of our humanness," he says. Doctors internalize the idea that they are above and beyond illness, especially when they're working with illness around them every day, while they remain well. That concept of wellness ('I'm well, you're not') can have the psychological effect of making the doctor feel impervious to illness. It can stay with them, even as they are becoming unwell.

The internalized stigma that keeps doctors from getting help also comes from the ideas and experiences formed during medical training. Dr. Myers says medical students look at their psychiatry professors as 'wackos' and many take their psychiatric internships less than seriously. Doctors carry these attitudes with them into therapy (if they get that far). And at that point, Dr. Myers says his doctor-patients are surprised to find that Myers is not only not a weird write-off-of-a-character, but that he's also helpful.

Myers is a member of the Board of Trustees of the American Psychiatric Association, and is involved with the BC Medical Association's Psychiatric Section. When Myers speaks to these groups, he often stresses the importance of doctors and psychiatrists having their own doctor. "I tell them to clear out their cupboards. They shouldn't have any samples in their homes. I name all the anti-depressants they get samples of at their offices, and their eyes look away from me," — an indication that he's hitting home. Instead of self-medicating, Myers wants to see doctors work with their own physician, who can help them decide what's working best for their mental health.

Another barrier to doctors' mental health is the fear that a doctor's community will find out they're not well. Since they believe that to be mentally unwell is a weakness and that their patients and the community will view them differently, they don't want anyone to know. If a local doctor, pharmacist or nurse finds out that a doctor might be on a psychiatric medication, for example, they fear their practice and relationship with their patients might suffer.

In one case where the public found out, some patients were thrilled to know; some ran the other way. In Maple Ridge, BC, psychiatrist Dr. Britt Bright not only works with people who have mental illness, but she also works around her own mental illness. In order to maintain her mental health, she is careful to monitor her workload and her personal responsibilities. From experience, she knows to expect changes in her mental health as the seasons change and as her personal responsibilities increase.

"If it's fall, and the days are getting shorter, I might do less public speaking and keep the number of patients I see at a reasonable level for me." Dr. Bright has been instrumental in providing public education about depression and manic depression, and 'came out' publicly on cable television, telling people about her own life with bipolar illness, two and a half years ago. After that show, Dr. Bright received calls from people all over the Lower Mainland and beyond, asking if she could be their doctor. "I think patients appreciate the idea that a doctor could really understand what they're going through," she says.

In general, she says her psychiatrist colleagues have been very supportive. And in her observation, a person's favourable attitude toward mental illness really depends on their experience of knowing someone who is well, and living with an appropriately-treated mental illness.

In other words, it's how well we can be while living with a mental illness that shapes our attitudes toward mental illness. Dr. Bright's experience reinforces Dr. Myers' belief that doctors must reach out and get help when they need it (and to find their own doctor now, in case they need help further down the line).

First, however, Dr. Myers wants to eliminate the bureaucratic barrier to doctors' getting help. He has been advocating continent-wide for changes to physician's health insurance plans. In BC and other jurisdictions, many doctors are denied disability insurance if they have accessed psychiatric services in the past. Myers is advocating language changes on insurance forms from, "have you ever sought help for emotional/psychiatric issues" to "in the past year, have you suffered from emotional, mental health or chemical dependence issues, of a severity that you missed work. If so, please explain." This acknowledges the episodic nature of mental illness and leaves lots of room for doctors who are taking steps to protect their mental health — **before** their mental health deteriorates and their work suffers.

Myers sums up the need to attend to doctors' mental health in a common sense fashion. "It may seem selfish, but I have to take care of my own mental health first." Myers gets regular exercise, and keeps commitments with his family and appears to take life with a lot of laughter. His large sense of humour is what puts his patients at ease. And along with the treatment he provides, Myers believes that it's his example that really gives his patients another way to understand what mental health means.

Authors note: Dr. Michael Myers teaches part time at St. Paul's Hospital in Vancouver and also specializes in treating physicians and psychiatrists. Recently he has been working to make changes to medical insurance to end discrimination against physicians who have a mental illness, and has produced two videos: one about physicians living with depression; the other about families of doctors who have committed suicide.

The Mental Health of Community Mental Health Workers

Catharine Hume

How well does our mental health system promote the mental health of community mental workers? A recent CMHA, BC Division conference which brought CMHA Branch service providers and people who have received mental health services together to explore the areas of recovery and rehabilitation, highlighted the fact that we rarely even ask the question. We had initially brought front-line service providers together because we had heard from them that they were feeling isolated and disconnected from one another and CMHA as a whole. As the conference went on, it became clear that we need to think much more about the mental health of mental health workers and find better ways to support them to be open-hearted within an often inhumane mental health system.

Patricia Deegan, who has both received and provided service, suggests that a fundamental problem of mental health systems is their tendency to "break the human spirit" by putting both staff and clients in situations where the most basic human responses are thwarted.[1] During the conference, a number of people spoke out about when they had been penalized for responding from their heart.

One front line worker spoke about being told by other professionals that she had crossed a boundary and become too close to a person she was working with when she cried about the person's suicide. Another front-line worker talked about her experience of being kicked out of a psychiatric nursing program because she spoke out: "I couldn't stand to see what was happening - I kept thinking to myself, 'this is wrong' the way people are being treated - somebody's not noticing - maybe if I just point it out..." These examples struck a chord both within other service providers and within people who have received mental health services themselves.

Our mental health system continues to encourage front-line staff to maintain clear, professional boundaries. While boundaries are necessary, they can also become "an excuse to maintain attitudes that people with psychiatric disabilities are somehow a "breed apart."[2] Our keynote speaker, Amy Long, suggested that we need to bridge the connection between caregivers and the cared for and distinguish between healthy and unhealthy boundaries.

People enter helping professions to help others and when the system they work within restricts their ability to help and penalizes them for building relationships with people, it is not surprising that they become frustrated and disempowered. This frustration, over time, can lead to burn-out. Burn-out is often the result of a dedicated person trying to help one individual at a time within a system that does not effectively support those efforts. A part of the solution is to develop an outlet for staff's frustrations and ways for staff to advocate about system issues while continuing to provide services.[3]

The more general mental health needs of mental health workers are also often overlooked. Talking about mental health issues within mental health professional groups is generally frowned upon. People with mental illness who work within the system are often silent about their mental health histories fearing that they will be labeled, lose their job, be monitored differently or lose the respect of their co-workers.

Rather than negating mental health issues among mental health workers, Patricia Deegan suggests we must build healthy ways for workers to acknowledge and address their mental health issues. "Staff members must be helped to recognize the ways in which they, too, are deeply wounded. To embrace and accept our own woundedness and vulnerability is the first step toward understanding the experience of persons with disabilities. In so doing we discover that we share a common humanity with them and that we are not 'worlds apart'."[4]

Our mental health systems have a long way to go to create healthy working environments. Bringing mental health workers together to learn from each other and discuss these issues is one place to start. Creating environments where people are rewarded rather than penalized for showing vulnerability is another. As more and more front line workers meet and work with people in their homes and communities rather than in more formal clinical settings, we, in the community mental health system, need to look at how healthy boundaries can be maintained while allowing and encouraging the development of real healing relationships. The complexity of the roles of front-line workers needs to be acknowledged. Front-line workers, themselves, need to acknowledged and, as one conference participant noted: "people need to hear 'well done, good job,' and if we spend a lot of time doing that for people it will make such a difference."

[1] Deegan, Patricia E. (1996). Recovery as a Journey of the Heart. *Psychiatric Rehabilitation Journal, 19 (3)*, 91 - 97.

[2] Carling, Paul. (1995). Return to Community: Building Support Systems for People with Psychiatric Disabilities. New York: The Guilford Press.

[3] Carling, Paul. (1995). Return to Community: Building Support Systems for People with Psychiatric Disabilities. New York: The Guilford Press.

[4] Deegan, Patricia E. (1988). Recovery: The Lived Experience of Rehabilitation. *Psychosocial Rehabilitation Journal, 1988 11(4)*, 11-19.

Emotional Intelligence

Daniel Goleman

(reviewed by Eric McKechnie)

From time to time, we all find ourselves in situations where our emotions prompt us to act in ways that we did not anticipate. Tragically, the inability to understand, express and control our emotions not only undermines our interpersonal lives, but takes its toll on society as well. For example, author Daniel Goleman in his book Emotional Intelligence notes that a couple married in the late 1990's faces a staggering 67% chance of having their marriage end in divorce. Such a disturbing figure represents a social as-well-as a personal tragedy.

In the first, more technical, part of his book, Goleman discusses the various structures of the brain. His basic premise is that" ... we have two minds, one that thinks and one that feels." He argues that the emotional mind is run by a primitive part of the brain called the limbic system, while the rational mind is associated with the neocortex, a comparatively recent addition to the brain. In effect, our emotions are "older", and hence more powerful, than our thoughts. The evolutionary advantage of this situation is clear in an extreme situation, too much deliberation can mean the difference between life and death. However, in the modern world, the opposite is the case, and we no longer have the luxury of allowing the limbic system to constantly override the neocortex.

Regrettably, we live in a society preoccupied with the rational mind and almost completely ignoring the emotional mind. This preoccupation is exemplified by our unbridled enthusiasm for IQ testing. Goleman demonstrates that IQ contributes to no more than 20% of our success in life. The other 80% is attributable to other factors, including our social skills and our emotional maturity. This observation is backed up by a remarkable study in which it was demonstrated that "how popular a child was in third grade has been shown to be a better predictor of mental-health problems at age eighteen than anything else - teachers' and nurses' ratings, school performance and IQ, even scores on psychological tests." The word "popular" may be misleading. In this case, it was used to describe children who were confident, positive and comfortable with themselves and others (in other words, emotionally intelligent).

In the second, more readable, part of the book, Goleman moves away from biology and focuses on the importance of accepting and channeling our emotions. Although many people confuse emotions with feelings. Goleman points out that the word emotion comes from a Latin verb (motere) which means 'to move.' Seen from this perspective, emotions are not feelings but rather "impulses to act". This is a crucial distinction because it protects us from two common mistakes. The first mistake is to feel guilty about our feelings, over which we have no control.
The second mistake is to simply surrender to our feelings and to act on them indiscriminately, which is obviously unhealthy and dangerous.

In conclusion, Goleman's book has many strengths. His style is easy to read and he is able to explain highly technical concepts in a simple, yet non-patronizing way. Comprehension is reinforced by the copious use of everyday examples. There is some practical advice for achieving emotional growth, although there could have been more. However, the real highlight of the book is its optimistic outlook. The author avoids the popular, deterministic belief that almost all behavior is genetic. "There is a range of possibilities even within genetic constraints." He also constantly emphasizes that old habits can be replaced by newer and better ones: "Our emotional capacities are not a given; with the right learning, they can be improved." He even points out that severe trauma, such as that associated with Post Traumatic Stress Disorder, can be eventually mitigated and healed by emotional growth. Goleman has written a challenging, inspiring and, at times, touching book; the last word belongs to him: "... emotional lessons - even the most deeply implanted habits of the heart learned in childhood - can be reshaped. Emotional learning is lifelong."

Eric McKechnie is a health care worker at Riverview Hospital and is studying psychosocial rehabilitation.

Grieving Mental Illness: A Guide for Patients and Their Caregivers

Virginia Lafond

(reviewed by Jane Duval)

Virginia Lafond's book, Grieving Mental Illness, is written for those who suffer mental illness first hand, and for those who give care. It is based in part on her experience as a mental health professional. It also springs from her own experience with mental illness.

Chief premise of the book is that grief—along with attendant feelings of doubt, sadness, anger, guilt, fear, and shame—is an inevitable partner to mental illness. Another is that grief's presence is rarely acknowledged by anyone. However, as Virginia Lafond points out, "The bottom line is this: Those of us whose lives have been touched by mental illness have something to grieve about, and we need to get on with the business of doing that."

When someone develops a serious physical illness, most of us understand that grief will be experienced, not only by the person directly affected but also by their family members, and, from time to time, by their professional caregivers. But until recently, no one has paid much attention to the fact that the same grief occurs in the face of mental illness.

In Grieving Mental Illness, Virginia Lafond reaches beyond the illness itself and talks about the subjective experience that accompanies it—what the inner person feels when mental illness becomes a part of life's reality.

She also offers engaging and helpful advice on how to move forward from the suffering associated with mental illness. By consciously grieving, we can help

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Broken Brains or Wounded Hearts: What Causes Mental Illness?

Ty C. Colbert, Ph.D.
(reviewed by Byron Fraser)

'Madness is not necessarily a dysfunctional stratagem.'
- Thomas Szasz

Who says there is no progress? After having initial widespread success and significant impact in the late 60s and early 70s, the "new psychiatry" - biopsychiatry - heralded by the likes of E. Fuller Torrey and Nancy Andreasen, et. al., came to the fore. Now all that has changed and the antipsychiatry movement is back bigtime with a host of new literature attacking every aspect of the medical/disease model and the institutionalized coercion that goes hand in hand with it.

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bring healing and wholeness to our lives—resulting in new ways of coping, reduced stress, and greater self-esteem.

As Dr. Barry Jones notes in the book's Foreword, "This is much more than a self-help book. It offers an important theoretical marriage—a marriage that joins the acknowledgement of what mental illness means to the person with an educational model for understanding and using the grief that accompanies mental illness. The offspring of the marriage is a developmental model of grieving, a model that shows how grieving can be a lifeline when mental illness enters our lives."

Jane Duval is the Policy Development and Communications coordinator at the British Columbia Schizophrenia Society

Significant recent works in this movement include Alvin Pam and Colin Ross' *Peudoscience in Biological Psychiatry* (1995) and Herb Kutchins and Stuart Kirk's wholesale demolition of the DSM-4, *Making Us Crazy* (1997). The book that probably really turned the corner was Peter Breggin's 1991 best seller *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace The Drugs, Electroshock, and Biochemical Theories of the 'New Psychiatry'*. And, of course, Thomas Szasz has steadfastly continued to plant vital thought-seeds in our world which, after a seemingly delayed gestation period, are now experiencing a real outing all over the place.

As a result the whole question of whether or not this 'thing' we call the 'mind' is or is not distinct from this 'thing' we call the 'brain' - - or whether or not the medical categories 'health' and 'illness' can be meaningfully scientifically applied to 'mind" (a subject which Thomas Szasz explores in his recent (1996) book, *The Meaning of Mind: Language, Morality, and Neuroscience"*) — remains as much an open and pertinent question as ever.

What has been missing from the anti-biopsychiatry critique, however, to make its scientific revolution complete, has been a dynamic, coherently articulated alternative paradigm to counter the long-standing medical/disease model. We now have this in the wonderful new (1996) work of Dr. Ty C. Colbert and his Emotional Pain Model.

Space does not permit more than just the briefest sketch of the theoretical substance of *Broken Brains or Wounded Hearts* but hopefully this will serve to stimulate readers to consult this vital source. The book consists of three sections outlined in a little over 300 pages. The first deals with an overview of and update on the latest research pertaining to the medical model: the truth behind psychiatric medication, twin and adoptive inheritance studies, the search for defective genes, and brain imaging studies, etc. The second explains **The Emotional Pain Model** and its applications for understanding multiple personalities, addictions and compulsions, hate and self-hate, and violence toward self and others — and much more. And the third points to **A New Direction** away from failed bio-psychiatry and toward the new non-drug centers, feeling level therapies, consumer-run self-help organizations, and low-cost alternative treatment clinics.

Dr. Colbert's most relevant conclusion with respect to the medical model is that " ... the truth is that researchers have never discovered a single defective gene or accurately identified any chemical imbalance that has caused an emotional disorder; nor have they ever proven that brain abnormalities are responsible for even one emotional disorder." Furthermore, he quotes prominent psychiatrist, Ken Barney, who says, "The idea that 'schizophrenia' is a hidden disease entity, with a soon-to-be-discovered biogenetic 'cause' has been thoroughly debunked."

A quote which gives the essential idea of The Emotional Pain Model is as follows:
"All emotional or so-called 'mental' disorders, whether they be schizophrenia, depression, mania, panic attacks, or compulsive behaviors, are defense mechanisms that the mind creates to deal with an overload of pain. This is the central difference between the medical model and the emotional pain model. The medical model presents the brain as broken or defective. The emotional pain model declares that nothing is wrong with the brain and, in fact, shows that the brain is often working brilliantly as it helps create strategies to deal with the emotional pain of an investing heart."

Finally, one instance of Dr. Colbert's **New Directions** comes from the San Joaquin Psychotherapy Center. In five years of working with 20-to-30 year veterans who bio-psychiatry has failed to help — even ones formerly considered untreatable — without medication, shock, restraint, or seclusion - the hospital readmission rate is zero, and there have been no suicides or assaults.

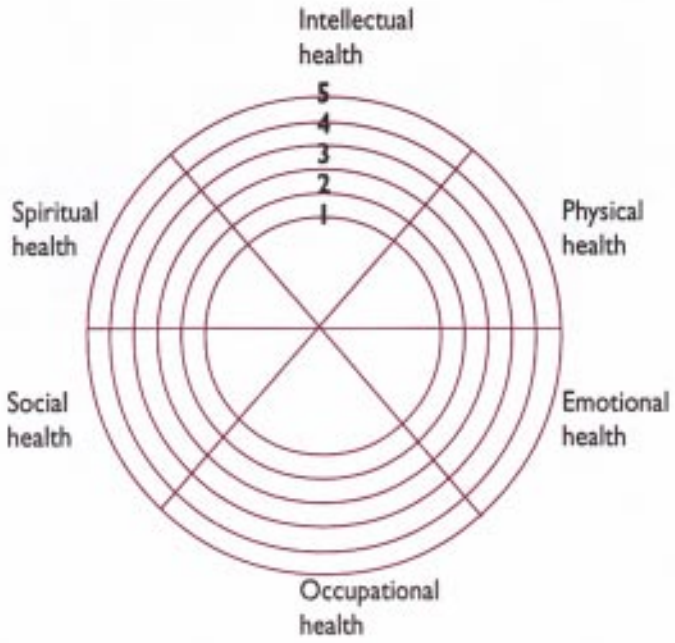
Of course, there is much, much, more about the therapeutic implications spelled out in the book.

(Available from Support Coalition, PO Box 11284, Eugene, OR 97440, USA, for $26.45 U.S. add $3.00 for a sample copy of their magazine, Dendron).

Byron Fraser is a member of the Board of MPA (Mental Patients Association) and lives proudly drug-free, in his community, after being "incarcerated" at Colony Farm (a forensic psychiatric institute) for over 4 years.

The Personal Wellness Profile quiz: How balanced is your life?

The Personal Wellness Wheel



Using this blank Wellness Wheel, and the descriptions of each dimension of health from the Personal Wellness Profile, shade in each segment to determine the overall balance of wellness in your life.

KEY:
5 - At Full Potential
4 - Doing Well
3 - Needs Some Fixing Up
2 - Needs Major Fixing Up
1 - Not Acceptable

The Personal Wellness Profile allows you to draw on your own wisdom to assess the degree of balance among the dimensions of health in your life. In each dimension you will find listed a series of words which are to be used to trigger your thoughts about your behaviors and level of satisfaction. For each word, consider whether you are currently satisfied or concerned about your behaviors and give a numerical value (between 1 and 5) that best fits. When you have completed the words in each dimension, look at the number pattern and decide on an average description about that dimension of health, ranging from 1 – Not Acceptable, to 5 – At Full Potential. Continue to assess each dimension of health in this manner until you have completed and described all six.

When all six dimensions are complete, you will be able to gain some understanding of the degree of balance among them by completing the Wellness Wheel. For each dimension review the summary description ranging from 1 – Not Acceptable to 5 – At Full Potential) and complete the segment by shading from the centre of the wheel out to the number corresponding to the description. When all six segments are shaded, you will see the degree of balance among the dimensions of health. This image may provide insight to your ride through life, as well as areas where you may wish to make improvements and personal growth.

Physical Health

The ability to meet the physical demands of daily life, and leave sufficient reserves to deal with emergencies.

Smoking
Caffeine Intake
Alcohol Use
Medication Use
Body Weight / Body Image
Physical Pain
Physical Activity / Exercise
Energy and Stamina
Eating Habits
Sexual Satisfaction
Sleep Patterns
Strength

On average, I would describe my physical health as (A number between 1 and 5: 1=very concerned, 2= somewhat concerned, 3=neutral, 4=somewhat satisfied, 5=very satisfied):

Intellectual Health

The ability to learn, understand, comprehend and problem-solve. Also, the ability to make oneself understood

Alertness
Poetic Vision
Memory
Enthusiasm
Curiosity
Creativity and Novel Thinking
Know my field / Knowledgeable
Wisdom
Stimulating
Logical
Open-minded
Clear Thinker and Speaker

On average, I would describe my intellectual health as (A number between 1 and 5: 1=very concerned, 2= somewhat concerned, 3=neutral, 4=somewhat satisfied, 5=very satisfied):

Emotional Health

The ability to control emotions so that one feels comfortable expressing them when appropriate. It is also the ability not to express emotions when it is inappropriate to do so.

Depressed
Often Anxious
Happiness
Stability
Sensitivity
Express Feelings
Grieving
Contentedness
Self-Control
Accept Feelings
Independence
Self-Security

On average, I would describe my emotional health as (A number between 1 and 5: 1=very concerned, 2= somewhat concerned, 3=neutral, 4=somewhat satisfied, 5=very satisfied):

Social Health

The ability to interact well with people and the environment. Having satisfying friendships and inter-personal relationships.

Friendships
Handle Conflict
Affectionate
Intimacy
Polite
Social Graces
Conversation Ease
Respect / Honesty
Loyal / Trusting
Responsive
Express Needs
Forgiveness

On average, I would describe my social health as (A number between 1 and 5: 1=very concerned, 2= somewhat concerned, 3=neutral, 4=somewhat satisfied, 5=very satisfied):

Spiritual Health

The ability to find personal meaning and purpose in the world. For some, this may come through belief in the laws of nature, science or a God-like higher being.

Hope
Positive View
Commitment
Meaning
Comfort with Death
Feel Forgiven
Purpose in Life / At Peace
In Touch with Higher Force
Worship Life
Values and Beliefs
Prayer / Contemplation
Faith / Thanksgiving

On average, I would describe my spiritual health as (A number between 1 and 5: 1=very concerned, 2= somewhat concerned, 3=neutral, 4=somewhat satisfied, 5=very satisfied):

Occupational Health

The degree of satisfaction, happiness, productivity and sense of contribution from one's chosen occupation or vocation.

Priorities / Goal Setting
Trying too Hard
Going too Fast
Change
Handle Money Well
Decision Making
Job Enjoyment / Satisfaction
Able to Relax
Courageous
Time Management
Able to Play / Humor
Comfort with Aging

On average, I would describe my occupational health as (A number between 1 and 5: 1=very concerned, 2= somewhat concerned, 3=neutral, 4=somewhat satisfied, 5=very satisfied):

Using the blank Wellness Wheel, and the descriptions of each dimension of health from the Personal Wellness Profile, shade in each segment to determine the overall balance of wellness in your life.

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
BC Division.
Suite 1200 - 1111 Melville Street
Vancouver, BC V6E 3V6