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Mental health and substance use information you can trust

BC's Mental Health and Addictions Journal

visions

Vol. 11 No. 1 **2015**

treatments: what works?

complementary and alternative medicine

misunderstood medications

visions

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

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Subscriptions to Visions are free in BC to those experiencing a mental illness or substance use problem, their families, and any service provider. For those outside BC, subscriptions are $25 (Cdn) for four issues. Visions electronic subscriptions and back issues are available for free at www.heretohelp.bc.ca/visions. Advertising rates and deadlines are also online.

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Heretohelp is a project of the BC Partners for Mental Health and Addictions Information. The BC Partners are a group of seven non-profit agencies working together to empower people to improve their quality of life by providing good quality information on mental health, mental illness and substance use. We represent AnxietyBC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health, Family Services of the North Shore's Jessie's Legacy Program and the Mood Disorders Association of BC. BC Partners work is funded by BC Mental Health and Substance Use Services, an agency of the Provincial Health Services Authority.

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footnotes reminder

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we want your feedback!

If you have a comment about something you've read in *Visions* that you'd like to share, please email us at **visions@heretohelp.bc.ca**, or you can mail or fax us at the address to the right. Letters should be no longer than 200 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive. For full guidelines, please visit www.heretohelp.bc.ca/visions

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letters to the editor

I have been receiving *e-Visions* for about a year. I wanted to thank you and your team for producing such a high quality resource. I find something in practically every issue that helps me in my practice as a middle school counsellor. Please pass on my thanks and congratulations on a job well done.

— *Teresa Grandinetti, Port Coquitlam*

I must say that any chance I get to read a copy of *Visions Journal*, I find it well-written, helpful and informative. My younger brother is a chronic alcoholic with an underlying mental disorder so papers like this help me to understand the challenges he faces. I will look forward to receiving each one of them, and it will certainly be helpful and enlightening.

— *Diane, Vancouver*

caution

As in all issues of *Visions*, the views here are not meant to replace professional advice. You should never stop taking medications, for example, without first talking to your doctor. Also, talk to your doctor and pharmacist before trying new treatments to make sure there are no interactions. And do feel free to take all or part of this issue to your health care provider to have a discussion about treatment.

editor's message

This issue was voted on by *Visions* readers as our Recovery subtheme. It was an incredibly challenging one to produce, but now that it's here I think it will be read and referenced heavily. A major reason this topic area is so tricky, I think, is that people's views about treatments—part of what we need to get and feel better—are quite deeply held. Whether it's our positive or negative assumptions about electroconvulsive therapy or certain vitamins, our beliefs are influenced strongly by our culture and upbringing, our experiences, and our training.

On the cover of *Visions*, you'll see the group behind this magazine: HeretoHelp. Our tagline is "Mental health and substance use information you can trust." For too long, HeretoHelp has been pretty silent about many treatments beyond medications and approaches like cognitive-behavioural therapy. This issue is perhaps our first attempt, by engaging some researchers and clinicians in the field we respect, to get more in depth at what this buzzword "evidence-based" really means. After all, we know there are whole host of treatments that work and that people use and like. And what people use, what they like, and what works aren't always the same thing.

I welcome letters to the editor—and I expect I'll see some for this issue! Individuals and industries are very passionate about sharing with others what works for them or in their field. We did put a concerted callout for more personal experiences, but we were specifically looking for people who could share the benefits and drawbacks of complementary and alternative medicine (CAM) and mainstream treatments they tried. We found few people who were willing to share both.

This is not an issue devoted to CAM, though you'll find one article and parts of several others that explore CAM. I also don't pretend to depict a balanced view in this issue, as you'll see no articles from CAM providers. Good-news stories about CAM are easy to find. What you won't find as easily is more of an objective and plainer-language look at the evidence behind CAM as treatment. Even if this *Visions* doesn't provide a space for every perspective, I hope you find the ones that are here helpful in making more informed choices.

Sarah Hamid-Balma

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

Choosing Treatments That Work

WHAT DOES IT MEAN, AND WHY DOES IT MATTER?

Lloyd Oppel, MD, MHSc, CCFP (E.M.)

With any illness, patients and those caring for them want treatment that works. At first blush that seems a simple enough idea, but what does "works" mean? For a simple sliver in the skin, works may just mean taking the sliver out and using soap and water to clean the wound. That seems pretty straightforward and measurable.

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Dr. Oppel is a family physician who works in emergency medicine in Vancouver. For 20 years Lloyd has worked in the area of complementary and alternative medicine for both Doctors of BC (formerly BC Medical Association) and the Canadian Medical Association. He has a degree in public health and taught experimental design in the UBC medical school. For many years, Lloyd chaired the Doctors of BC allied health practices committee, which monitors public use of, and issues relating to, controversial medical therapies

But what does "works" mean when it comes to a diagnosis like depression? That isn't so easy. You cannot see depression on an X-ray or in a blood test.

To diagnose and monitor depression and prescribe treatments, most professionals use a series of questions that touch on areas like energy level, sleep pattern, enjoyment of life, a sense of feeling 'low' and appetite. But all of these areas can be affected by factors ranging from antidepressant medication, to living circumstances, to simply having a friend to confide in. Lots of things impact our mental well-being—only some of them involve treatments by professionals.

There is always more to the patient experience, journey and recovery from mental illness than just the specific mainstream professional treatments. While different kinds of non-traditional treatments can provide support, using them can also cloud our ability to know what treatments are actually effective in and of themselves, or which treatments add value for other reasons. The practice of meditation, for example, can make cancer patients feel less anxious, more energetic, and better able to manage symptoms

without medication—all things that would also go along with effective medical treatment.

In spite of the challenges of assessing what 'works' means for something like depression, we do have ways to gather and assess scientific evidence in a way that reduces biases.

Choosing treatment

People seek health treatments for a number of reasons. For many people, it's important to choose a treatment they understand, makes 'sense' and fits with their view of the world. For some groups of people, it's important that treatment matches their cultural or religious views, such as Aboriginal people turning to First Nations health practices. Teaching health professionals to offer "culturally safe" care is now an important part of medical training.

Patients also tend to value a sense of control when it comes to choosing treatments. Being given choices, and feeling as though they are partners in their recovery, can play a large role in the selection—and perceived benefit—of therapy.

For many people, if not all, it is very important to be offered hope. In emergency rooms, I've seen patients who leave the ER with medical problems that remain undiagnosed, but who are happy with the reassurance that their problem isn't life-threatening.

In cases where the outlook is more grim (or felt to be), it can be difficult to deliver bad news in a way that keeps hope alive, though health professionals have a duty to be honest with patients. As a result, patients may be drawn to therapies that exist outside the realm of proven treatment—if hope is offered there.

We all tend to seek the things mentioned above: hope, understanding and control. These are things that can be offered by many types of treatment—including those that don't actually work.

One article in this issue will deal with what it takes to prove that a treatment really works. Other articles explore the evidence for various treatments, including proven treatments that aren't as widely used and often misunderstood like electroconvulsive therapy or light therapy. And another large area on the health landscape that bears special mention is complementary and alternative medicine (CAM). This is not a *Visions* issue devoted to CAM but given readers' interest and my experience in this area, I'd like to provide more background below. Please also see my CAM article on p. 32.

CAM vs. conventional medicine

In the last 25 years, there has been a large increase in the numbers of CAM therapies—and in the number of people using these therapies. There are so many different kinds of CAM that asking people "have you ever used CAM?" will very likely be answered "yes." A survey done in 2006 by BC's Fraser Institute produced figures saying that three-quarters of people in Canada have used CAM during their lifetimes and half in the last year.[1]

So what is CAM? CAM is a loose collection of health treatments and diagnostic techniques that generally fall outside the realm of what is considered safe and effective by most doctors and scientists. These are generally unavailable in hospitals or health authority clinics, usually aren't taught in medical schools, and most often are considered to be unproven, or even disproven.

Some examples of CAM treatments include herbal remedies (e.g., St. John's wort, claimed to be useful for depression), homeopathy, Traditional Chinese Medicine, taking vitamins, massage, practising meditation, chiropractic and prayer.

CAM is often contrasted with conventional medicine. Conventional medicine is sometimes called "modern medicine," "mainstream medicine," "Western medicine," or "scientific medicine." It generally refers to a system of prevention and treatments of disease that incorporates the best available scientific evidence. Some examples of conventional medicine would be vaccinations to prevent infectious diseases, surgery, use of insulin to treat diabetes, medications to control high blood pressure, and cognitive-behavioural therapy to treat depression or anxiety.

Deciding what constitutes CAM versus conventional medicine can be tricky; grey areas exist.

For example, it can take time for new treatments to be tested to the point where they become accepted practice. Some people would argue that conventional medicine adopts any new treatment once it is proven safe and effective. For example, treating stomach ulcers with antibiotics was initially greeted with skepticism until there was evidence that a bacterium called *helicobacter pylores* was responsible for most cases.

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> We all tend to seek hope, understanding and control. These are things that can be offered by many types of treatment—including those that don't actually work.

Another grey area is in public policy. For example, people assume CAM must be as safe and effective as conventional treatment if they are covered in provincial-government or private insurance plans. Yet political priorities are actually not always tied to scientific evidence. There are economic and advocacy pressures to ensure that natural remedies do not need to meet the same standards of proof and effectiveness as pharmaceutical drugs. Provincial governments license practitioners of various forms of CAM where the evidence of effectiveness is far from clear. Government assurances that this offers the public access to more choices in 'quality' health care is hard to reconcile with the standards of safety and efficacy that apply in most realms of conventional medicine. The insurance industry understandably responds to public demand and offers plans that cover many forms of treatment—many of which fall outside the bounds of proven medicine. But popular doesn't always mean effective.

So why do people choose CAM?

There are a variety of reasons. As mentioned above, we all seek hope. CAM is often portrayed as safe and 'natural,' and many people feel that using CAM is less risky than using conventional medicine. People can often access it right away, which is enticing if there are long waitlists for conventional treatment. Also, it's comforting to get treatment in a way that matches our philosophical and cultural outlook. And many people want to feel somewhat in control of their recovery and treatment. CAM, like conventional medicine treatments, can offer these things regardless of whether the treatments are effective.

Keeping the public safe

It's important to consumers that their treatments are safe and effective. CAM is particularly in the spotlight here if only because the therapies falling under its umbrella do not enjoy the sort of proof that is more typical of conventional medicine.

In some cases, CAM treatments are innocuous, and one might say "what's the harm?" In other cases, the treatments may be very expensive, may interact with mainstream medications, and might even be directly harmful. Additionally, taking an unproven treatment might cause the patient to delay getting effective care or reject it entirely. For example, a decade ago headlines were made when numerous cases of people with serious mental illnesses reported harms after taking a vitamin supplement instead of their psychiatric medication.

What can be done ?

- Whether CAM or conventional medicine, consumers deserve to be protected by meaningful truth-in-advertising rules. For example, CAMs like homeopathy, Traditional Chinese medicine or Ayurvedic medicine that are considered "traditional" because of long-standing use within certain cultures do not have to provide any experimental evidence that they work to Health Canada if they are not claiming to help a serious disease. These rules need to change.
- We need to close the gap in provincial rules and regulations that allows CAM health practitioners onto the field without examining whether the treatments they offer are truly beneficial.
- Encourage patients to let their health care provider know all the CAM treatments they are using.

Where can CAM fit in?
The case for compassion

Even in a situation where a patient chooses a therapy that is ineffective, it may be useful to incorporate it into a treatment plan that will be acceptable for the patient. Doing so may make the patient more satisfied with their care, foster a sense of partnership with their physician, and allow patients to feel more in control of their situation.

The caveat? The mainstream health care provider has to realize that the complementary treatment being provided is being used alongside (as an adjunct) to more effective treatment. It goes without saying that medical treatments are just a part of the patient journey and recovery process. Just as a warm hug can make the day's worries seem less, the use of unconventional treatments may help patients cope with the illness at hand. V

Evidence of Treatment Efficacy

HOW DO WE KNOW WHAT ISN'T SO?

Paul Latimer, MD, PhD, FRCPC

Ever since the Internet age began, there has been an explosion of health-related information available to anyone, anywhere, at any time. Just open your browser and type in any kind of medical issue—including mental health issues—and you'll be inundated with thousands of pages of suggested treatments, advice and testimonials.

Dr. Latimer is a general psychiatrist with more than 40 years of clinical and research experience. He has been involved in more than 150 clinical trials and the development of many psychiatric medications available today. He practises in Kelowna and is the Chief Executive Officer of Okanagan Clinical Trials

This great amount of information can be very helpful. It gives anyone with access to an Internet connection the ability to research and learn about their mental health issues and can be very useful for gaining some perspective and health education.

Access to all this information, however, can also be overwhelming and confusing when information conflicts. It can even be dangerous when it isn't clear which information is accurate and evidence-based and which is not.

Is it enough to hear from friends or online advocates that a treatment has worked?

Although many people do make their decisions because of the testimony of others, this in itself is not evidence of a treatment's effectiveness. But what exactly is evidence when it comes to medical information?

Testing treatments in scientifically valid clinical trials (as explained below) can tell us whether a treatment is truly effective.

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The testimony of others, in itself, is not evidence of a treatment's effectiveness. But what exactly is evidence when it comes to medical information?

Testing medications— a clear-cut process

Research for medications involves evaluating and comparing the potential new medication against non-active compounds (placebo). It also compares it to other approved medications for the specific disorder. In a trial of antidepressants, for example, a new antidepressant might be compared to a sugar pill (the placebo) and to an established antidepressant.

Before a study is begun, it must first be evaluated and approved by an independent ethics review board. The purpose of the review process is to assure, both in advance and periodically throughout the study, that the rights and welfare of the subjects (i.e., people taking part in the study) are protected. It also ensures the subjects are properly informed about the potential risks and benefits involved in their participation.

Additionally, the review will ensure that the study uses proper scientific methods so the results will be valid. Proper scientific methods include such things as randomization and double-blind procedures. In a trial of antidepressants, subjects who have depression would be randomly assigned to receive one of the new drug, placebo or established medication and neither they nor the researcher would know which treatment they were receiving. This is called a "double-blind" study.

Most trials are double-blind. This is done to minimize bias. Because, for example, when either the researcher or the subject knows who is getting the placebo, the occurrence of side effects tends to be greater for the experimental treatment than for the placebo. However, in a double-blind study, side effects are actually quite common in subjects taking the placebo.

It's important to conduct the study so that placebo effects are minimized. A placebo effect occurs when a person perceives a positive effect from an inactive treatment. Many studies fail, not because the treatments are ineffective, but because the placebo effects are too large.

Proper scientific methods include adequate selection criteria for subjects. The goal is to choose subjects who have the disorder being studied but no other disorders that would complicate their treatment or put them at increased risk. For example, in a depression study, suicidal patients are usually excluded.

Proper scientific methods also include sufficient sample size (i.e., number of subjects) to show a statistically significant difference. The greater the difference between the effectiveness of two treatments, the smaller the sample size required to show a statistically significant difference. If differences between two treatments are likely to be small, a very large number of subjects is required to show that a difference between them is unlikely to occur by chance alone.

Preclinical research (i.e., research that takes place before the trials in humans) examines the chemical makeup of a new drug for general safety. Once the chemistry is understood, the compound is tested on laboratory animals to learn how it works in the lab animal's body, to further ensure its safety. A new compound will only be tested on humans after promising results in these preclinical stages.

Human testing on healthy volunteers is typically referred to as Phase I. These subjects don't have the disorder for which the treatment is intended. The goal of this phase is to determine a drug's toxicity, absorption, distribution and metabolism. This usually involves about 20 to 80 subjects.

There may also be attempts in Phase I to see how individuals respond to various doses of the medication. Even when there's good evidence a drug has the desired effects, it's still necessary to work out what doses are required; side effects often depend on the dose. An ideal dose will maximize the effectiveness while minimizing side effects.

In Phase 2, subjects with the disorder being studied are used but they are selected in quite a narrow way to reduce risk and maximize chances of success. Phase 2 subjects are less like typical patients seen in a clinic than those in Phase 3. Phase 2 will involve 100 to 300 subjects, and Phase 3, 1,000 to 3,000 subjects.

After Phase 3, the results from all the phases can go to the regulatory authorities to consider whether to approve the drug or not. In the US, it's the Federal Drug Administration (FDA), and in Canada, Health Canada has this mandate. It usually takes about 12 years to get to this submission stage.

The drug is approved for use only if it is shown to be both safe and effective and it will be approved only for the conditions that have been studied. Many potential new treatments don't get approved.

If the drug is approved there are then Phase 4 or post-marketing studies that might compare the drug to a competitor, study adverse effects or explore some other aspect of the use of the medication.

Any medication treatment prescribed by a doctor (MD) in Canada will have gone through this process.

Non-med treatments—for most, the evidence isn't there

Many therapies (e.g., naturopathic remedies) and products (e.g., vitamins or nutraceuticals) advertised and available in the community or on the internet have not met these standards. They are not subjected to rigorous testing and approval before being sold to consumers. This is why the medical profession may be skeptical of these products and therapies.

But how do we account for the many positive testimonies from people using unproven treatments? These could be accounted for by the placebo effect. Placebo effects are very common in most areas of medicine.

It's estimated in psychiatric drug studies that between 20% and 50% of participants taking an inactive medicine will report positive results.[1] Their psychiatric symptoms really do improve while on the 'fake' medicine. They also have many side effects. Things such as cost of the treatment, colour of the pill and what the subject is told to expect can also influence both the beneficial effects and the side effects of the placebo. This is a complex topic about which whole books have been written.[2]

Medications are not the only source of placebo effects. This kind of effect can also occur from interaction with a practitioner, from counselling or psychotherapy or anything else that is offered as a treatment.

Unfortunately, the placebo effect is usually fleeting and cannot replace an actual treatment for a medical condition. For example, a depressed person may feel better for a time while taking an inactive medication, but will often soon experience a recurrence of their symptoms.

If you look online for medical advice, be sure to look at who is sponsoring the information. If it's sponsored by a reputable source such as a provincial health board, professional organization or a university, it is likely to contain information that has been filtered with a scientific eye.

If you're unsure of the source, bring your findings or questions with you to your doctor. They have been educated on scientific method and current treatments for mental health conditions. They should be willing to assist you in evaluating health information and working with you to find an option that will be effective in your situation. v

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Informed Choices

Evaluating treatment options that work for you

Stephanie Wilson, BA

Finding a treatment approach to manage symptoms, improve quality of life and well-being, and start the recovery process is a priority when someone experiences a health problem or illness.

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Stephanie is Editorial Coordinator for Visions and a plain-language content developer for the BC Partners for Mental Health and Addictions Information

This article is informed by, and adapted in part from, two info sheets that Stephanie led the development of: Evaluating Health Information *and* Working with Your Doctor for Mental Illnesses. *Both are available at heretohelp.bc.ca*

Choosing a treatment—whether mainstream treatments, alternative treatments or a combination of the two—is not always straightforward. There may be a lot of information to consider, and you'll likely come across contradicting points of view or different ideas of the 'best' way to help yourself.

The key is learning to evaluate different sources of information so you can make decisions that support your goals and your own perspectives or values. Your doctor or other members of your health care team can provide good feedback and support around mainstream treatments and some alternative treatments. But if you pursue other alternative approaches on your own, you may not have this kind of professional assistance.

Evaluating information

There are countless news stories, articles, websites and blog posts about mental health and treatments for mental illnesses. It's up to you to determine what information is trustworthy and how deeply it should influence your opinions.

Here are good questions to ask when you're considering any information,

whether it's new research, a news story or an article on a website:

- Does the writer provide their own credentials?
- Are there footnotes or references so you know where the information came from? For example, is it based on published research, the writer's own research, an interview or personal opinions?
- What is the motivation behind the story, article or website? Is someone trying to sell a product or service? Does the source of an interview or story have something to gain by sharing their story?
- Does the information seem to accurately describe the problem or issue? Or does it make extreme claims or present itself as a secret nobody else knows?
- Does the information seem overly simple for a complicated problem?
- Does the information respect you and your experiences? Do you see stereotypes, prejudice, or discrimination?
- Is the information balanced? Does it recognize both sides to the issue? Do you sense bias or exaggeration? For example, does it discuss potential downsides? Most treatments have downsides, from cost to time-to-treat to side effects.
- Does the story offer any alternatives?
- Does it encourage you to think and to ask questions?
- How new is the information? Look for a date. If it's more than a couple of years old, it may be outdated.

It's also important to evaluate information in the context of your own situation. For example, there are people and organizations who claim


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mental illnesses like depression are caused by nutritional deficiencies, suggesting people take many supplements.[1] It's true that some vitamin deficiencies may be a factor in some mental illnesses—for example, there is evidence that vitamin D deficiencies may be a factor in depression.[2] The danger in the first example is that a single factor is presented as the *only* factor in treating a mental illness. For people who are medically tested to be deficient, vitamin supplements may greatly improve their symptoms. However, that doesn't mean all people who experience depression will benefit from the same supplementation. And it may not be safe for everyone—just because something is "natural" doesn't make it automatically safe. So, taking vitamin supplements is not necessarily a program you should try on your own without medical supervision and regular checkups.

Evaluating websites

When you evaluate the information you read on the website, also consider:

- Is this a credible (believable, trustworthy) website? Government, government-funded agencies, well-known health providers, universities or groups of medical professionals are usually the most reliable.
- Can you tell the difference between information and advertisements? While web ads are common, on credible sites ads are clearly distinct from information. On less credible sites, ads may look like part of the story or page.

Evaluating research

The most reliable research is found in academic journals. This research is "peer reviewed," which means it's looked at by experts in the field and must pass strict quality guidelines. However, not all research is created equal. The way a study is carried out (the methodology) can have a very big

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impact on the results. Also, human studies that look at large groups and studies that examine existing research (meta analyses and systematic reviews) may provide a better understanding of some of the issues. Research that studies a very small group of people and non-human research, like mice studies, may not be as helpful when you're thinking about different options. It's generally a good idea to consider several articles or review articles, rather than basing opinions or choices on a single article.

Evaluating personal stories

Personal stories can be a helpful tool when considering different treatment options and different paths in your own recovery. However, not all personal stories are equal. While some personal experience stories may lead people to helpful options, others may be less helpful, and may lead people away from a viable option.

It's important to think about personal stories as critically as you would about any other information. Writers may share a personal opinion that you disagree with, but this doesn't necessarily mean there's anything wrong with their story.

Here are general guidelines to help you identify personal stories that may not be helpful.

The writer:

- claims their individual experiences are scientific fact
- claims their thoughts or opinions are the most correct or only correct way to think about the problem (a special red flag if they say your current treatment is harmful)
- claims to have information that no one else has discovered; beware of the "miracle cure"
- offers detailed medical advice, even though they are not a doctor or relevant health professional
- is using their story to sell a product or service

Putting it all together

Consider your own preferences

When you think about treatments or approaches that might help you, it's important to take your own preferences into account. Everyone has opinions, and maybe even fears, around certain treatments. For example, many people worry about taking medications for various reasons (e.g., side effects, dependency). People may also prefer one approach over others because it better fits with their needs or goals.

Cultural or social values can impact treatment preferences. For example, what one culture calls an 'illness' may be considered an issue related to spirituality, relationships, or past events in other cultures. These values and preferences are important because people may be alienated by health systems when the explanation of their experiences or the prescribed treatments don't match with their own understanding of the concern.

Work with your care team

Your doctor and other members of your care team are an important part of your recovery—it's important that you work together to meet your goals. Bring up your concerns, ask questions and remember that you are an equal partner in your care.

caution

Avoid stopping or starting any treatment or therapy without talking to your health care provider. Remember that alternative treatments can interact with prescribed treatments. It's important to bring up everything you take, and have a conversation with your doctor if you'd like to make any changes.

related resources

Evaluating Mental Health and Substance Use Information info sheet: www.heretohelp.bc.ca/factsheet/evaluating-mental-health-and-substance-use-information

Working with your Doctor for Mental Illnesses info sheet: www.heretohelp.bc.ca/factsheet/working-with-your-doctor-for-mental-illnesses

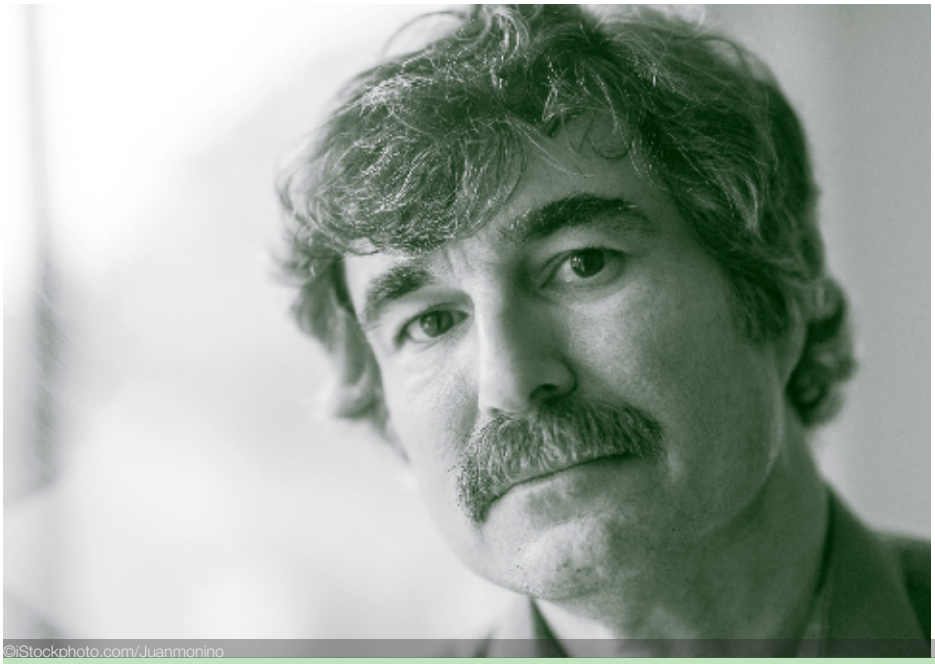
Mental Illness and Alcoholism

ODDS WERE AGAINST ME, BUT SURRENDER TO MY HIGHER POWER BROUGHT THE HELP I NEEDED

Mark V. Fernandes

Mental illness and alcoholism has run in my family for many generations. Fifteen years ago, at the age of 37, my brother Eric took his life. Eric's mental illness was undiagnosed.

Mark has 32 years of experience recovering from bipolar 1 and alcoholism. He now supports people with alcohol addiction, who are new to Alcoholics Anonymous, find sobriety. Mark has a long association with the Mood Disorders Association of BC (MDA), and refers AA members with a dual diagnosis to MDA



He did go to the hospital during an episode of mania, but the doctors didn't feel Eric was a danger to himself or others, so they sent him home. The next day his wife found him dead in the garage.

It was my mother's genetic makeup that carried the mental illness gene to both Eric and me. Six months after Eric died, my Aunt Nancy took her own life in the same fashion as Eric—she was found passed away in her garage. Aunt Nancy was a heavy drinker and had had bouts of mania and depression, but was never diagnosed with a mental illness. However, she did pass on the bipolar gene to one of her sons. My Aunt Alleen suffered mental illness and took her life 20 years ago—by driving at a high speed off the end of a pier. My Aunt Mary was severely inflicted with mental illness in the 1950s. Since there were no medications back then to treat manic depression, she spent a large part of her life in Riverview Hospital. She eventually died there.

*Queen Elizabeth Way (QEW) is a busy highway that connects Toronto to Niagara Falls and Buffalo, New York.

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I couldn't envision a life without alcohol. Every activity I did involved drinking copious amounts of beer, and when I began my career in business, scotch.

My struggle with bipolar illness and alcoholism began 32 years ago. Since then I've been certified against my will more than 20 times, each time spending six to eight weeks in hospital. This happened all across Canada—in Toronto, Montreal, Winnipeg, Calgary and Vancouver.

My journey started in Mississauga

During high school I made friends who were into playing competitive ball hockey and drinking beer—lots of beer! At the end of my first year at the University of Western Ontario, I only passed one course due to my budding alcoholism. So, I decided to make my mark in the business world.

Within two years I had a bright future as a salesman in a company that grew to become the largest business forms distributor in Canada.

In 1983, at the age of 23, I had my first manic episode. I'd never been late but suddenly started arriving at work late, obviously with no sleep and with signs of heavy drinking. My employer became concerned that I was overworked and suggested I take some time off. But I wasn't overworked—I was experiencing my first bout of psychosis (loss of contact with reality, typically including delusions, hallucinations and disorganized thinking).

There are many symptoms of mania and depression...these are the ones I experienced during my illness:

- I rarely slept—the mania kept me awake, and I also felt that if I fell asleep I'd die. Despite only a few hours of sleep, the next day I'd have lots of energy.
- I spent large sums of money.
- I had "delusions of grandeur"—I believed I was going to be the next prime minister of Canada, for example.
- My thoughts turned to an inappropriate quest for sexual encounters.
- I was irritable and hostile—I once provoked a fight with my brother for no reason.
- When depressed, I lost interest in doing things I normally enjoyed. I had no energy and rarely got out of bed.
- I heard voices.

There is no way to sugar-coat my first experience with hearing voices: A voice in my head said He was God. God told me to make my way to the QEW* highway in Toronto. So I did. Then He told me to look for a break in traffic and run to the middle of the highway. So I did.

God said, "I'm going to teach you a lesson in faith." He told me to start running with my back to the traffic. Then He said, "I will tell you when to run across the highway—without looking!" He then said, "Go now!"... But I didn't go. I turned to look at a stream of cars roaring by and said, "F-- you, God."

This was the beginning of my journey away from God.

That 'demon' alcohol

Because of our family history with mental illness, my parents suspected I was having a manic episode. They took me to the Clarke Institute, a psychiatric hospital in Toronto. I was diagnosed with bipolar 1 illness and spent six weeks in hospital.

Upon discharge, my psychiatrist explained that I had a very serious mental disorder called bipolar 1, and I would have to stop drinking. I said, "Surely you don't mean beer?" I couldn't envision a life without alcohol. Every activity I did involved drinking copious amounts of beer, and when I began my career in business, scotch.

We had an office in Montreal and Toronto, which required me to travel back and forth regularly. It was the perfect set-up—money was no object. I drank and dined in fancy lounges and restaurants at my leisure. After an expensive meal, my business colleague and I visited local night clubs in pursuit of women until 3:00 am. I would be insanely drunk.

In 1991, my employer did his best to keep me working, but eventually I couldn't meet the demands of a

busy printing company, and was let go. It was devastating not being able to work and live the high end lifestyle that I was accustomed to; CPP disability payed only $900 per month.

I was so sick that at the age of 33 I moved from Toronto back to White Rock, BC, to live with my parents. And not only had I lost my relationship with my business colleague, but I then lost the trust of my parents, who feared getting a call from the authorities telling them I'd died from an alcohol-related incident.

Sometime after moving home, my parents gave me a letter.

Here are a few highlights:
August 26, 1993

"Your mother and all of the family have asked you to seek professional counselling, but to date we have seen no evidence that you intend to do so. You must be made to understand the devastating and negative effect you are having on our lives—how much longer can we continue in this fashion? Should your next episode of illness be induced because of alcohol, you will be abandoned—get help now! ...go with God and maybe He'll help you—Love, Dad."

That day was the most important turning point in my life. The word "abandoned" shook me to the core—and I woke up.

I went home and called Alcoholics Anonymous (AA). Somewhere deep in my subconscious I knew people with a drinking problem went to Alcoholics Anonymous. That same night I went to my first AA meeting.

The 12 Steps saved my life

So, what is an alcoholic? An alcoholic is someone like me who, despite warnings from doctors, family and friends that I may die due to my mental illness and/or alcoholism, continues to drink. Aunt Nancy's son Jamie was diagnosed with bipolar illness and was told, like me, that he shouldn't drink. It was explained to him that if he mixed alcohol with medications, the doctors wouldn't be able to determine the best course of action to treat his bipolar illness. My cousin Jamie is not an alcoholic, however. When he became aware that he had a mental illness, he listened to the doctors—and just stopped drinking.

The 12-step program and fellowship of Alcoholics Anonymous saved my life. The only requirement for membership in AA is a desire to stop drinking. The basic premise of recovering from alcohol addiction is found in Step 3: "Made a decision to turn our will and our lives over to the care of God as we understood Him." When I asked my Higher Power to help me stop drinking, the help came. I no longer had any craving for alcohol. I found my way back to God.

Over the first six months of recovery, I had made a number of friends in AA who took the time to help me understand the AA program of recovery. It was recommended that, right from the start of getting sober, I work with a sponsor. A sponsor is an AA member who guides the newcomer on how to recover from a seemingly hopeless state of mind and body. My sponsor suggested I make an appointment to see an addiction doctor.

I took the suggestion and began seeing an addictions doctor who was also a recovering alcoholic. For some reason this was comforting to me. After six weeks of my assessment, this doctor recommended I sign myself into the Maple Ridge Treatment Centre (MRTC), where I did a four-week residential treatment program. At the time, MRTC offered a 12-step approach.

In treatment I had a profound mental shift: I no longer denied the fact that I was indeed in the late stages of alcoholism. I surrendered fully to my disease. I was ready to do whatever it was going to take to heal my mind, body and soul. For the last 22 years I have attended AA meetings, first in Vancouver and then in White Rock. I am extremely grateful for the Alcoholics Anonymous program. AA put me on a path of self-discovery. Today—I know who I am.

Other treatments and practices that have helped me heal my life

Over 20 years ago I started to see a well-respected psychiatrist who specializes in treating mood disorders. Because I was sober, he was able to begin the process of finding—through trial and error—which medications worked best for me. Over the years, he has been by my side guiding me through mania or depression. Currently, my medication regime includes mood stabilizers, antidepressants, antipsychotic drugs and dexedrine.

One of the things I did to augment my recovery was meet with a counsellor for two years. I was able to work through some troubling family-of-origin issues. Thanks to AA and counselling,

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It was recommended that, right from the start of getting sober, I work with a sponsor. A sponsor is an AA member who guides the newcomer on how to recover from a seemingly hopeless state of mind and body.

I'm free of the hellish addiction to alcohol. Ten years ago a friend invited me to try a form of meditation called Ascension. I've been practising ever since, including meeting weekly with other people (non AA) for group meditation. (If you're interested in knowing more about Ascension, go to www.thebrightpath.com.)

We have 50,000 thoughts per day swirling around in our head. Meditation has allowed me to slow my thoughts down considerably. When I meditate daily, I'm able to check my thinking. I ask myself, "Do my thoughts include any signs of mania or depression?" There was a time during one of my meditation sessions that I knew I was manic. I called my psychiatrist and we adjusted my medication. I caught the mania in time and avoided another trip to the psychiatric ward.

From receiving to giving: Support is crucial

The support of my family has been crucial in my recovery. Even in the darkest times—when they were at their wits' end and my dad wrote that ultimatum letter—they never gave up on me. My mother was involved in the grassroots beginnings of the Mood Disorders Association of BC (MDA) and helped me to access my psychiatrist. She also started an MDA support group in White Rock for me to attend. Over the last 30 years, I have been a good student of recovery. Healing mind, body and soul took time, but it has led me to a healthy and prosperous life. I'm now comfortably retired. I spend my time helping alcoholics who are new to AA achieve sobriety. I've found this to be extremely rewarding. Often, I give people who are dually diagnosed (i.e., mental illness and addiction) information about the Mood Disorders Association of BC. I've referred many who require the help of a mood disorder specialist. This too, is very rewarding. (Incidentally, MDA has a Group Medical Visits program that can really expedite access to medical help: www.mdabc.net/group-medical-visits.)

Many thanks to *Visions* for allowing me the opportunity to share my story. Mental illness and alcoholism is a part of the fabric of our society. Many suffer in silence. We need to educate families, friends and people in the workplace to speak out about the illness. Recovery is possible—I'm proof of that. V

Treatment

A QUAGMIRE OF APPROACHES AND ATTITUDES

Bob Krzyzewski

My encounters with the mental health and medical systems substantially confused my recovery path. Ten years ago, I experienced a number of losses. The worst was losing both my parents to sudden illness, followed by a close friend who committed suicide shortly after we had spent significant time together.

Bob is a Vancouver-based healer and conscious community networker. He performs with guitar at local events; facilitates workshops in yoga, meditation and dietary practices; offers personal sessions in foot reflexology, body and energy work, and addictions and transpersonal counselling; and writes on various themes for local publications

This article originally appeared in 2007 in Visions Journal, *except for the sidebar, which is a 2015 update*

I became severely depressed and suicidal. I didn't have a concrete plan to kill myself, but thought I'd better get professional help before things escalated to self-destruct levels.

Route 1: Addiction services

I had been in recovery for an alcohol addiction problem for some years, and didn't want to go backwards toward the chaos and pain of active consumption. So, I thought an addictions counsellor might best be able to assess my situation. Rallying my resolve, I went into my local addiction services outpatient clinic for an assessment.

A barrage of questions came at me from the intake worker there, who took notes "to determine the severity of my risk." She felt I needed continuing outpatient counselling, and wanted me to sign a service user agreement. This document outlined the parameters of counselling, including that I would not accept medications from any doctor, or

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outside referral source. I asked, "What if I had to go into emergency at a hospital in the middle of the night, for severe anxiety, or suicidal feelings?" She said that would violate, and therefore terminate, our service agreement.

I was shocked at her reply. "Well," I stammered, "where else could I go to get help?"

She suggested I go across the street to the mental health services office, and she proceeded to set up an immediate intake appointment for me.

Route 2: Mental health services

A little confused, I crossed the street and announced myself. Soon I was in a private office with a social worker. I went through much the same scenario as I had with the addictions intake worker—and received the same evaluation: I was "at risk," and should attend ongoing counselling sessions. Another service agreement contract was produced, only this time it required that I agree to inherently comply with the recommendations of the staff doctor, including the medications prescribed for, exactly as written. Feeling uncomfortable about this, I asked, "Do you have an addictions specialist on call as a staff physician?"

"Well, not really. They're trained psychiatrists; they know their medications really well. But medications only work if you take them as prescribed; otherwise, you're in non-compliance with his recommendations, and your counselling and all services will be terminated."

"Well, what if I feel I'm creating cravings for my street drugs by taking his prescription?"

"He'd give you another medication to deal with that symptom, then."
"How many medications does he have?" I naively asked.

"Oh, he's got lots," she said, "and you'd have to take them all if he wanted you to."

I really panicked at the authority this staff psychiatrist was going to have over me. I felt very confused and frustrated: all my feelings of rejection from my friend's suicide were now complicated with a feeling of being unacceptable to both these helping institutions.

"I think I'd better get a second opinion from a private psychiatrist," I replied, as I walked out of her office.

It felt like metal doors to rehabilitation were closing forcefully behind me. It seemed a great irony that these 'helping professionals' were asking me to give up my right to inform myself and make my own way through the treatment experience. My anxiety was definitely on the rise.

Route 3: Private psychiatrist

I put the word out that I was looking for a psychiatrist. A trusted friend recommended one she felt would understand my spiritual 'ravings'—I see visions, receive visitations and experience astral projection. I met this doctor in a comfortable office, in my neighbourhood. He was Indo-Canadian, and wore a silver wrist band, which looked the same as one my yoga teacher, who practises a form of Sikh yoga, wears. I asked the doctor if he practised this faith, and he replied that he did. This opened a whole area of conversation, and he seemed enthusiastic to discuss these spiritual matters. So when this psychiatrist prescribed antidepressants, I, keeping an open mind, was willing to comply. I started on a dose of a popular SSRI medication. After two days, I called and said I was experiencing side effects, including rushes, palpitations, hot flashes and tremors. He said, "These drugs don't take effect for two to three weeks. You must be mistaken."

I replied, "I never waited two to three weeks to get high on a street drug, and I know what it feels like to be getting stoned!"

"How am I supposed to help you then?" he asked.

"How about we sit down and talk to each other?" I suggested.

"I don't have time for that," he retorted.

So I said, "How about I read about the natural herbs, vitamins and other holistic alternative treatments for depression and report them to you, and you evaluate them according to your accepted medical criteria?"

"Affirmative, Einstein," he chuckled.

Route 4: Alternative treatments

Since then, I have spoken to many alternative health/healing practitioners and have explored many herbs, vitamins and other holistic treatments. Much has been very beneficial, and I

have managed to establish a recovery program of well-being modalities, including massage and reflexology, chi kung and yoga (kundalini, ashtanga and restorative), as well as singing and accompanying myself on guitar. This route has had its own issues. One thing particularly relevant to me has to do with a recommended practice of a holistic program: cleansing your blood and digestive tract of toxins. One of the components of an often-suggested kit for this purpose is a herbal formula in tincture form, which is taken internally. Tinctures, however, can contain as much as 70% alcohol. While there are tinctures without alcohol (glycerin based), they usually have to be special-ordered.

Luckily, I noticed the alcohol content before opening the box and asked for a refund or exchange. When the sales clerk asked why I was returning the kit, I told him that I had abstained from alcohol for 23 years and that I believed my system would be intolerant of any amount or form of alcohol.

The previously friendly and supportive clerk lashed into my remarks, stating that tinctures don't contain any "active alcohol" and "couldn't hurt a flea."

I replied that I wasn't worried about a flea, but about myself, and I wasn't going to take any chances at this stage of my recovery.

Words of wisdom

The well-being modalities that I learned and practise demand much more time and energy than simply taking medication does. They are active forms of self development and, in some cases, have thousand-year-old philosophies behind them, adding to their usefulness as a resource for daily living.

Preferably these practices would be combined with cognitive-behavioural therapy, or other forms of therapy, including medication regimes.

If you are taking medications, I would suggest that you do as much background research as you can, read labels carefully and ask questions fearlessly. It's not a perfect world, and rough spots, mistakes and even disasters still occur despite precautions taken. But it's better than sitting back and not looking out for your own well-being! v

bob today: updating the last eight years

Since I wrote this article eight years ago, I've moved into a more active mode of recovery. This has taken the form of two new and important streams.

The first stream has been the 'nutrition as medicine' perspective, kickstarted by viewing the movie Masks of Madness, which explores underlying nutritional problems that can worsen mental health problems. I felt encouraged to lower my carbohydrate intake as these foods (especially pastries, breads, rice, cookies, chips etc.) convert to sugar in the bloodstream quickly, causing a spike and then a rapid drop in blood sugar. This causes irritability, fatigue and a myriad of other unpleasant symptoms.

Another fairly well-known message is that caffeine in coffee, chocolate and sodas encourages the release of stress hormones. These hormones produce that racy feeling associated with anxiety. It's easy to mistake coffee as a source of water, but caffeinated drinks can lead to dehydration. The water also loses its benefits if these beverages are loaded up with sugar.

The second stream of treatment I've been pursuing has been post-traumatic stress disorder (PTSD) treatment for the underlying symptoms of my depression and anxiety.

The PTSD piece for me presented itself as a group-based therapy called Seeking Safety, available at some mental health teams and Pacifica, an alcohol and drug treatment centre. This therapy incorporates cognitive-behavioural therapy, energy practices such as breath work, eye movement desensitization and reprocessing, emotionally focused therapy, and neurophysiology (how the brain and nervous system works) presented in understandable terms. I was familiar with all these modalities through yoga, but the added social support was the crucial element for me. In a neurophysiology sense, I translated the compassionate, informed group leader as a positive parent and role model and I connected with the other participants too. Over eight weeks, Seeking Safety gave me a chance to rehearse skills and then apply them in my daily relationships.

I am not recommending anything unconditionally, you should consult with your doctor or psychiatrist as you do your research. Wherever your healing lies, I wish you hope and success in finding your personal path to recovery.

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Electroconvulsive Therapy

HOW IT HELPED ME IN MY BATTLE WITH DEPRESSION

Teri Doerksen

I was first diagnosed with clinical depression and given a prescription for antidepressant medication in 1985 at the age of 22. Since I was a teenager, I had been using alcohol to self-medicate, which made my depression worse.

After years of recurrent depression, Teri is now in remission. She began volunteering at the Mood Disorders Association of BC in May 2014, and recently started working there full-time. Teri enjoys journalling, reading and exercising

Six years later, my diagnosis had become more severe: recurrent refractory (i.e., hard to treat) major depression with a concurrent disorder (alcohol abuse). I experienced worsening depression and anxiety, suicide attempts, brief recoveries and repeated committals to psychiatric wards around the Lower Mainland, including five lengthy stays at Riverview Hospital. At Riverview, many different medications were tried and for the most part they failed.

After my first suicide attempt in 1988, doctors at Riverview suggested electroconvulsive therapy (ECT).

Initially, I believed electroconvulsive therapy was like the scene in the movie One Flew Over the Cuckoo's Nest where Jack Nicholson's character convulses violently after being shocked while still conscious. This used to be the case, and it was the only perception I had of ECT.

My doctors, however, explained very clearly to me how the procedure would be done, and my fear changed to a more educated awareness. Between 1988 and 2009, I had at least 10 courses of ECT, at several different locations, both while in hospital and on an outpatient basis. The courses

varied from six to 12 ECT sessions per course. My treatments were usually done on Monday, Wednesday and Friday mornings each week.

Knowing first-hand what ECT is like, I always try to reassure people who are about to have their first treatment. I tell them that the worst part is the IV insertion, and after that it's a 'piece of cake.'

So what is ECT like?

Here's what happens on an ECT morning: You get up around 6 a.m. and can't have any breakfast, coffee or even water until after the treatment. Also, morning meds are not taken until after the treatment. Your vital signs are taken by a nurse and, once you are on a gurney and covered with a warm blanket, an IV is inserted—unlike Jack Nicholson's character McMurphy, you are put to sleep for the procedure!

After the anesthetist puts you to sleep, the psychiatrist performs the actual ECT treatment (see sidebar). In five to 10 minutes, you wake up. Then you recover for a further 30 minutes before being brought back to the ward by a nurse. Finally, you can have breakfast, coffee and your meds at around 9 a.m.

The only downsides for me were some short-term memory loss upon awakening from the anesthetic; this usually only lasted for an hour or two. And I did have headaches after the treatments.

The upside of ECT for me

My experiences with ECT were definitely positive. ECT always helped to bring me out of my suicidal depressions—it provided a relief from the intensely destructive symptoms that nothing else could. After a few treatments in a series, I was usually able to begin to participate in ward activities such as occupational therapy or group outings—the first seeds of hope were planted. I guess that's what ECT always gave me—hope that I would once again be able to cope with my mental illness.

After a complete series of 10 or 12 treatments, I was always less depressed than when the treatments began. For

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is electroconvulsive therapy (ECT) safe and effective?

Ronald A. Remick, MD

Electroconvulsive therapy (ECT) has been, and continues to be, among the most effective treatments in psychiatry. Over 80% of those patients receiving ECT can expect significant improvement or recovery from their depressive symptoms.[1] In comparison, improvement rate with either antidepressant medication or a course of cognitive psychotherapy is 55% to 60%.[1]

It's unfortunate that ECT remains so misunderstood—so shrouded in fear. ECT is nothing like the frightening experience depicted in the movies! It's a modern medical procedure. It is administered under the supervision of a psychiatrist and anesthesiologist, with other health care professionals (e.g., nurses) available and present. ECT can be an inpatient or outpatient procedure.

The effectiveness of ECT is based on inducing a brain electrical seizure. Brain electrical seizures result in a number of neurochemical and hormonal changes in the brain. These chemical and hormonal brain changes from the ECT treatments are the likely cause in the improvement or resolution of depressive symptoms.

The procedure is quite safe and painless.[1] The patient is anesthetized and given muscle relaxants. With the use of anesthetic, the brain seizure doesn't cause the body to convulse.[2] Less electricity is used, and it's administered as a very quick pulse (up to 8 seconds) rather than a steady stream.[2-3] The equipment is computerized and has much improved control over the administration of the electrical current.[3]

In many ways ECT is very similar to the electrical stimulation given to restabilize the heart rate in people with heart rhythm irregularities. Indeed, the same anesthesiologist typically administers both ECT and the heart-stimulating versions on the same day in the same area of the hospital.

ECT should not be considered as a last resort in the treatment of depression. Rather, it is a treatment option for any patient with a chronic depression that is not improving.

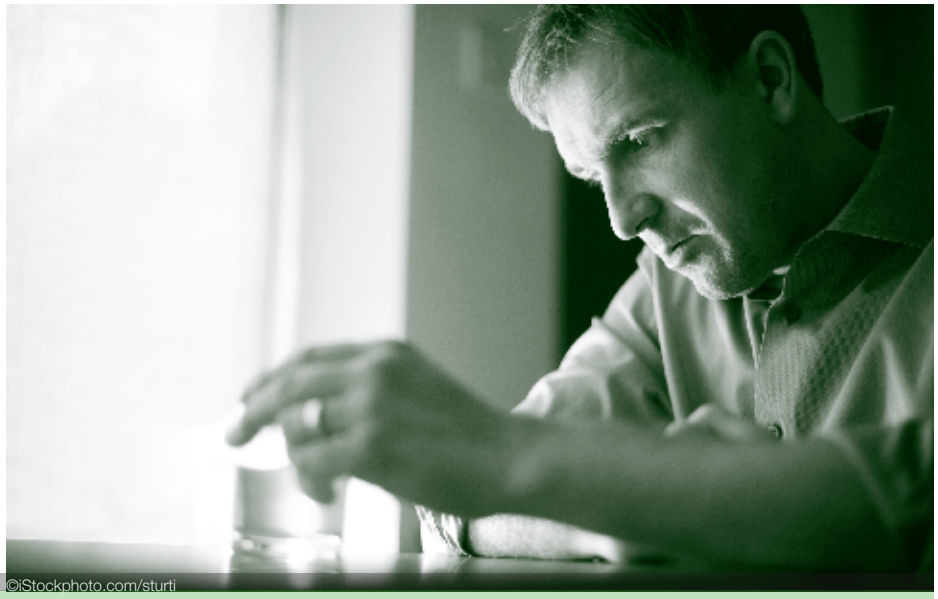
Ron is Medical Director of the Mood Disorders Association of BC's Psychiatric Urgent Care Program

Alcohol Treatments

WHAT DOES THE EVIDENCE TELL US?

Chantele Joordens, MSc

Alcohol is a widely available, legal and prevalent drug in our society. It is often present in the media, where the risks associated with alcohol use tend to be minimized.



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Chantele is a Research Associate at the Centre for Addictions Research of BC in Victoria. She has a master's degree in Social Psychology and has been at the Centre for over two years. Her main project has been a collaborative effort between CARBC and the BC Ministry of Health to estimate substance use treatment need in the province

A journal article by leading researchers on alcohol and public health estimates that 4% of the world's total burden of disease is attributable to alcohol.[1] Alcohol consumption is related to more than 60 different medical conditions, including breast cancer and coronary heart disease. Specifically, those who consume more alcohol than is recommended are at a heightened risk of developing an alcohol-attributable disease.

Looking at these statistics, we can clearly see that alcohol use is a substantial issue. This is why effective treatment of alcohol disorders is critically important.

Established treatments for alcohol use disorders

Problems associated with alcohol use can be thought of on a continuum—from no issues at one end of the spectrum to dependence on the other end of the spectrum. Because of this wide range of issues, alcohol use treatment must cater to an assortment of individual needs. Also, the type of treatment that works for one person may not necessarily work for another person. For this reason, it is important to offer many different types of treatment, accessible in many ways (e.g. inpatient, outpatient, support groups, etc.).

Some experts have categorized alcohol treatment into three broad categories: 1) brief intervention, 2) mutual help groups, and 3) specialized treatment programs (e.g., withdrawal management, medications, etc.).[1] Brief intervention is generally aimed at those people who have minimal alcohol dependency, or are just at the onset of experiencing any alcohol related issues.[1] Mutual self-help groups could include Alcoholics Anonymous, which is seen as a sort of substitute for more formal types of treatment, where clinicians are generally involved. Finally, specialized treatment programs aim to manage withdrawal and potential future relapse.

According to the Alcohol Use Disorders Identification Test (AUDIT)[2] instrument, a screening tool used to identify those with harmful and hazardous drinking, there are three distinct divisions of alcohol use: hazardous/risky drinking, harmful drinking, and alcohol dependence.[1]

Brief intervention

Brief intervention is aimed at individuals who score low in terms of alcohol dependence or are just beginning to show signs of alcoholism (i.e., hazardous/risky drinkers). Brief intervention is based on motivational interviewing where clients are presented with objective feedback from a general practitioner or counselor, for example that is based on the information provided by the individual. CARBC has developed a number of paper-based screening tools such as the Alcohol Reality Check questionnaire that asks such questions as how much alcohol you have had in the past week, how many times you have combined alcohol with other risky activities (e.g., operating machinery, mixing with other drugs, etc.). This feedback is given with the hopes of increasing a persons' awareness of their alcohol consumption and the associated risks. Rather than requiring abstinence, this method instead promotes clients to self-monitor their alcohol intake.[1]

Brief intervention is considered useful because it acknowledges that individuals enter treatment with differing levels of alcohol dependence and therefore differing levels of therapy needs. However, brief intervention is most appropriate for those clients whose alcohol use is characterized as "harmful" rather than full alcohol dependence.[1] Full dependence may require more intense forms of treatment, specifically specialized treatment programs covered later in this article. Brief intervention allows clinicians to make a positive impact in minimal sessions, therefore maximizing the effectiveness for clients who only attend one or two sessions.

Mutual help or self-help groups

Self-help organizations for problem alcohol use have been around for decades. The most widely known group is Alcoholics Anonymous (AA) and its 12-step group approach. The AA 12 steps centre around abstaining from alcohol use, admitting being powerless over alcohol, and relying heavily on belief in God/a higher power. Not only are clients following set steps with goals at each one, but the ongoing personal and emotional support through being a part of a group of non-judgmental and supportive individuals is also important. AA is inclusive such that anyone can join and it's a free-of-charge, ongoing program where you can choose to attend as many or as few meetings as you like. Furthermore, clients pair themselves with a sponsor who they feel they would be compatible with, someone who has also experienced addiction and can provide support and advice for the client between meetings, as addiction is a constant battle.

Due to the spiritual aspect of AA as well as the notion of participating in a group and sharing personal stories, the guiding principles of the AA program may not suit everyone. They do however cater to individuals at any stage of treatment or non-treatment; as well as the full spectrum of risky drinkers through to those with more serious alcohol dependence.

Of course, 12-step AA groups are just one type of mutual self-help group. There are also secular groups such as LifeRing or SMART, which are peer-run recovery groups for individuals who are either directly affected (i.e., the substance user) or indirectly affected (i.e., family member of substance user) by alcohol.

There is research that suggests participation in self-help groups (i.e., SMART Recovery, Secular Organization for Sobriety, and twelve-step groups such as AA and NA) may be associated with reduced alcohol consumption, fewer alcohol-related outcomes (e.g., Alzheimers, diabetes, obesity, cardiovascular disease, etc.) and better psychological functioning.[3] However, a more recent review of the evidence shows that AA groups may simply benefit individuals by encouraging them to begin or continue at a treatment program.[4]

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Specialized treatment programs

Withdrawal management (also known as "detox" or "rehab")

Withdrawal management can be either medicated or not medicated, inpatient or outpatient, depending on the severity of the withdrawal symptoms. If the client is experiencing symptoms such as seizures or delirium tremens, they will likely receive benzodiazepines such as lorazepam to moderate these effects of alcohol withdrawal.[5] Interestingly however, studies have found no difference in the effectiveness of inpatient (i.e., being formally admitted to a hospital) versus outpatient treatment,[6,7] even though inpatient treatment is much more costly. Generally, especially if the client is experiencing severe withdrawal symptoms, specialized treatment is most useful for those clients at the top end of the spectrum of alcohol use problems (i.e., alcohol dependence).

Prescription medications

Medication options have been shown to be beneficial in treating alcohol use disorders. Specifically, a 2014 study investigated the effects of two pharmacological drugs administered for 12-week periods: acamprosate (e.g., Campral) and naltrexone (e.g., Revia or Depade; oral and injection). The authors found that both acamprosate and oral naltrexone were related to reduced return to drinking.[8]

New online, mobile resources

Today, a very high percentage of people now solely access information from their laptops and their smartphones, so newer developments in treatment cleverly include online options for substance use intervention. This lets users access the information from anywhere, remain anonymous and integrate it into their everyday lives. Furthermore, the large proportion of people who would have experienced barriers to accessing treatment before, whether the barriers were physical, financial or motivational, now have the ability to receive online alcohol treatment.

Researchers investigated a Web-based personalized feedback intervention called CheckYourDrinking.net and found that participants were drinking less alcohol 3 and 6 months after the program had ended, however by 12 months post-intervention the participants had returned to their regular drinking habits.[9]

There are other online tools such as e-check-up-to-go, a personalized online prevention intervention app. While these online resources are accessible and relatively cheap for the average working person, it must be noted that in order to access them, one must have a computer or smartphone. Many people with alcohol use disorders experience concurrent issues such as poverty or lack of stable housing and/or food, thus these people would likely not have access to the online tools. Furthermore, these interventions and tools are designed to help individuals with less severe alcohol use much like the population that brief intervention targets (i.e., hazardous/risky drinkers), thus cannot replace more intense forms of treatment such as inpatient care.

As a whole, the multiple options for substance use treatment cater to a wide range of needs. Furthermore, treatments are not mutually exclusive and it is important to match your own values, needs and resources with your alcohol use treatment. The type of treatment that works for one person may not necessarily work for another person, and so offering many different types of treatment is important. V

Light Therapy

HELPING THE WINTER BLUES AND MORE

Dr. Edwin Tam, MD, FRCP

What in the world is light therapy? Don't we all get light all the time when we're awake? Why would anyone need that?

Dr. Tam is Clinical Associate Professor at the Department of Psychiatry, University of British Columbia, and UBC Hospital. He works with seasonal affective disorders in the UBC Hospital Mood Disorders Outpatient Clinic

Light therapy is one of the lesser known treatments in mood disorders, but one that has a very important role for a certain type of depression.

What is SAD?

Winter depression, or seasonal affective disorder (SAD), is a type of depression that mostly strikes in the winter (there is a very rare form that shows up only in summer). Patients with SAD get triggered into depression by the onset of fall, and get better in the spring.

What is the trigger? Scientists know that light is very important marker for seasonal patterns in nature. Light is how hibernating animals figure out the seasons are changing. They monitor how long the days are by when it gets dark; shorter days mean winter is coming, and it's time to hibernate.

Could the brain of a SAD patient be picking up on the changing seasons by measuring the length of days? If so, this brain certainly isn't being fooled by the indoor lights that make all our days longer.

And, could it be that very bright light closer to outdoor light would help in this situation?

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Light therapy: How might it help SAD?

There isn't one theory that fully explains the effects of light therapy on everyone, and it may work differently for different people. But it has been shown to work well for SAD, or winter depression—65% of people with SAD get a good response over four to eight weeks.[1]

Light therapy began, in 1984, with bright light from a light box with fluorescent tubes. The light box was used daily, for several hours in the morning and in the evening, to try to make the day seem like a summer day. It was used by patients with SAD... and their depression got better.[2]

How does light help depression? One theory is that depression in SAD patients is like hibernation in animals. Hibernating animals eat more, then sleep more as their body systems slow down. Depression involves low energy, and often in the case of SAD, eating and sleeping excessively. By switching SAD patients back into summer mode, light therapy may be snapping them out of this hibernation equivalent.

Another theory is that depression in SAD patients is like jet lag. When they get up on winter mornings, the darkness makes them think it's earlier than it actually is. Their body clocks become out of sync with the external clock time, and they end up feeling "jet-lagged," with tiredness, poor concentration and poor mood. Since bright light is a known factor in setting the body clock, light therapy in the morning would help sync up the clocks. In addition, there is evidence that light therapy works by increasing brain levels of neurotransmitters such as serotonin, noradrenaline and dopamine, which may be low in patients with depression.[3]

It's possible that it might work for non-seasonal depression. While this needs to be explored further, a collaborative Canadian study involving the University of British Columbia has just been completed (not yet published) showing that light therapy, either alone or combined with fluoxetine (Prozac), was effective and well tolerated by patients with non-seasonal depression.

Another use has been to help people adjust to shift work. Some small studies have also shown it helps with eating disorders (bulimia). This is not surprising as increased eating is often seen in SAD, and a seasonal pattern is noted in up to 40% of people with bulimia.[4]

Fine-tuning light therapy

Since the first use of light therapy, research has been focused on figuring out how to make it work as effectively and as efficiently as possible for people with SAD.

The first thing was to see if the time spent under the lights could be reduced. We've discovered that using it once a day gives about the same results as twice a day. In particular, morning light seems effective for more people than evening light.

Also, you can cut back on the hours if you use a brighter light. If indoor light is about 500 lux (lux measures how bright something is to the human eye), and outdoor midday light in the summer is 100,000 lux, then most light boxes come in around 10,000 lux, or about as bright as summer-morning outdoor light.

In terms of colour, white light seems to work as well as any other, if not better. White light is light that contains all the wavelengths of visible light at equal intensities. And you don't need ultraviolet (UV) for it to work, which is good because ultraviolet can be bad for the skin. UV light is not visible, so white light looks just as white with or without UV.

The standard treatment is now 10,000 lux of UV-screened white light from a light box for 30 minutes in the early morning for the duration of fall and winter. This can be increased as needed.

A further development has been to make the light box more portable. There is now a "light book" that uses LED lights, which seem to be

Light therapy has been shown to work well for SAD, or winter depression—65% of people with SAD get a good response over four to eight weeks.

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comparable in terms of results even though they aren't as bright. The cost of a light book is about the same as a light box (roughly $200).

Light therapy involves very bright light, and you can't get that from regular indoor lighting. Changing the light bulbs won't do it. A tanning salon light is bright, but your eyes are covered so it won't help with depression.

Light therapy can have side effects such as eye strain, feeling wired (like drinking too much coffee), headache, and in rare cases, mania. People with eye problems should have the ophthalmologist check their eyes before starting light therapy.

Patients who have a history of bipolar disorder should be extra careful of being switched into a high or manic state, and may need to be started on a mood-stabilizing medication first.

Although anyone can buy a light box without a prescription, I'd suggest that anyone with depression, seasonal or not, first go to a doctor for assessment and diagnosis, to rule out physical causes. I also recommend continuing under the care of a medical professional for follow-up and treatment, to monitor for side effects and optimize the therapy.

More detailed information is available in "Public Resources" online at ubcsad.ca. v

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Misunderstood Medications

Deborah Thompson, BScPharm, PharmD, BCPP

Three of the most misunderstood psychiatric medications are antidepressants, the antipsychotic clozapine and omega-3 fatty acids. Let's take a closer look at these...

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Deborah is the Clinical Pharmacy Specialist for the Fraser Health Psychosis Treatment Optimization Program. She has worked with clinicians in community mental health centres and dedicated psychiatric facilities. Deborah also provides education about medications and mental illness through presentations, workshops and articles to consumers, staff and programs

Antidepressants: Proper compliance is key

Depression is, in large part, a biological disorder. Changes occur in the brain of someone with depression. Imaging studies of the brain in depressed individuals show decreased brain activity, altered blood flow and disconnected circuits. These may be associated with changes in chemical messengers and other physiological functions.[1]

Early theories about depression suggested that symptoms were due to a lack of key chemical messengers in the brain: dopamine, norepinephrine and serotonin. Antidepressants work by increasing access to these chemical messengers, alleviating symptoms and enhancing brain activity.

All antidepressants have a similar response rate—it may take weeks for a patient to experience the full effect. But individual antidepressants differ in how they are used (i.e., form, frequency, scheduling), dosages given and possible side effects experienced. Some are activating and could be given in the morning, others are sedating so can be given in the evening, and some are sedating at low doses and activating at high doses, and vice versa.

Clinicians tailor treatment plans to an individual patient's needs. It's important to identify the right medication in the right dosage that will eliminate symptoms and produce few or no side effects. Some patients may require the addition of other

medications to achieve a complete resolution of symptoms.

All antidepressants manage depression. Approximately two-thirds of individuals improve with initial antidepressant treatment.[2]

Unfortunately, patients don't always take medications as prescribed. A lack of knowledge or a poor attitude about depression and antidepressants may result in patients not taking their medications as directed. This often results in poor response and negative outcomes. Studies indicate that older patients may have a more negative view of antidepressants.[3,4] Reviews of patients taking antidepressants reveal a number of false beliefs:[3,4]

- that antidepressants can change personality
- that a person could take less medication on days when they feel better
- that antidepressants are difficult to stop when taken for a long time

Effective antidepressants can have positive effects on indecision, memory, thinking and mood. They can also trigger medication-related effects such as activation, agitation, anxiety and restlessness. Individuals taking antidepressants should discuss all the effects they are experiencing—both symptoms and side effects—with their clinician.

Antidepressants work by stabilizing a brain system. It takes time for antidepressant medications to achieve the desired effect on mood. Taking less medication and/or 'drug holidays' will result in a drop in antidepressant levels, triggering a loss of response and resulting in a relapse. Abruptly stopping an antidepressant can result in rebound (re-emergence of symptoms that can be worse than the original symptoms) or withdrawal. Tapering off the antidepressant helps avoid withdrawal and allows the clinician to monitor for the re-emergence of mood symptoms.

Studies of adults and youth have identified that untreated depression is a reason that patients take their own life. Suicide is also more likely when individuals fail to take their medications. Most people who died by suicide hadn't taken any antidepressants prior to death. Only 4% of people who take their own life intentionally overdose on antidepressant medications.[5]

Depression is a significant global health problem. Antidepressants can provide an effective treatment option for moderate to severe depression. But the most effective medication is the one the patient takes!

Clozapine: Benefits outweigh risks

Clozapine was developed in the 1960s. It was believed to be an antipsychotic less likely to cause the type of movement disorders associated with other medications. Clozapine was used worldwide until 1975.

In 1975, clozapine was withdrawn in Canada and the United States, though other countries continued to offer the medication. The withdrawal was due to reports of a serious side effect: agranulocytosis. Agranulocytosis describes a significant drop in a patient's white blood cells. White blood cells fight infection, so a drop in levels puts the patient at risk of contracting infections. Only one to two patients out of 100 are at risk of developing agranulocytosis, and clozapine-induced agranulocytosis is reversed when the medication is discontinued.[6]

Clozapine was reintroduced in Canada and the US in l989 following studies that showed patients resistant to other antipsychotics may respond to clozapine.[7] Mandatory lab monitoring of the blood cell count was introduced to identify those at risk of developing agranulocytosis.

Patients starting clozapine have lab work done weekly for the first 26 weeks. More frequent lab work may be requested if there's a low count. Or, after six months, the frequency of lab work may be reduced to every two weeks, and after one year, to once a month. A decrease in the frequency of lab work reflects a decreased risk. After one year, the risk of developing agranulocytosis on clozapine is no greater than on any other antipsychotic agent.[8]

The longer psychosis is untreated, the greater the negative effects on patients. Individuals who fail to respond to two other antipsychotics should be considered for clozapine.[9]

Suicide is a major cause of death in patients with schizophrenia. Treatment with clozapine has been associated with a three-fold reduction in suicide for patients with schizophrenia.[10] Clozapine takes time to work. One study reported that almost two-thirds of their patients had responded to clozapine by 12 months.[11] Some

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> Perfect medications do not exist. Identifying the most effective medication, or medications, takes time and takes into consideration the individual's needs and response.

clinicians have observed that patients continue to improve the longer they stay on this medication.

Timely and appropriate use of clozapine requires communication and collaboration between the patient, care givers and clinicians. But, despite the need for ongoing monitoring, clozapine benefits continue to outweigh the risks. Patients completing a self-assessment questionnaire reported achieving better "mental health" compared to other antipsychotic medications.[12]

Omega-3 fatty acids: What role do they play?

Omega-3 fatty acids—EPA (eicosapentaenoic acid) or DHA (docosahexaenoic acid)—are considered essential fatty acids. This means they are necessary for normal development and health. The brain contains large amounts of omega-3 fatty acids. Omega-3 fatty acids are integrated into cell membranes and help maintain the integrity and function of neurons (nerve cells). An inadequate intake of omega-3 fatty acids results in depletion of stores with negative effects throughout the body.

Humans cannot make omega-3 fatty acids, so they must be obtained from our diet. The best source is fatty fish (e.g., halibut, mackerel, salmon). Canola oil, flaxseed oil, leafy green vegetables and nuts are also sources of omega-3 fatty acids, but they provide limited quantities and require more energy to convert them to usable forms in our body.

Evidence suggests that omega-3 fatty acids have beneficial effects in schizophrenia and depression. There is also preliminary evidence suggesting benefit in bipolar disorder.

The largest body of literature investigating the impact of omega-3 fatty acids in psychiatric disorders focuses on schizophrenia. Decreased levels of omega-3 fatty acids have been observed in individuals experiencing their first episode of psychosis. People with schizophrenia can present with low levels of omega-3 fatty acids in cell membranes.[13]

Benefits of adjunctive use (i.e., alongside the primary medications) of omega-3 fatty acid in patients with schizophrenia or schizoaffective disorder may include:[14]

- slowing the progression of psychosis in young patients
- decreasing psychiatric symptoms
- reducing the need for antipsychotic medications
- increasing the efficacy of clozapine in patients with persistent symptoms
- helping reduce medication side effects such as drug-related movement disorders

Inadequate stores of omega-3 fatty acids may also be a contributing factor for depression. Adding omega-3 fatty acids may help individuals on antidepressants who don't achieve an adequate response to their medications.[14]

However, using omega-3 fatty acids to supplement traditional treatments used for psychiatric disorders has produced inconsistent results in studies. Reasons for some of the less promising results may include:[13,14]

- the damage was already done by the time the illness was diagnosed
- benefits from omega-3 fatty acids may take longer to occur than the studies allowed for
- variations in the purity and consistency of omega-3 fatty acid products

There is also inconsistent information about the ideal dose. Suggested doses range from one to four grams per day of omega-3 fatty acids.

Still, omega-3 fatty acids do have psychiatric and medical (e.g., reduced cardiovascular disease, diabetes prevention) benefits, although these benefits may take time to occur. Omega-3 fatty acids are generally accepted and well tolerated by patients but should not be considered a replacement for traditional treatment options. Augmenting current treatment by the addition of over-the-counter herbal medications or supplements

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Complementary and Alternative Medicine

A LOOK AT SOME COMMON UNCONVENTIONAL MENTAL HEALTH TREATMENTS

Lloyd Oppel, MD, MHSc, CCFP (EM)

Complementary and alternative medicine (CAM) is often defined as a collection of various health treatments and diagnostic practices that generally fall outside of what most doctors and scientists would consider standard proven care.[1]

Dr. Oppel is a physician. For 20 years he has worked in the area of complementary and alternative medicine provincially and nationally. He has a degree in public health and teaches at UBC medical school. For many years, Lloyd chaired the Doctors of BC allied health practices committee, which monitors issues relating to controversial medical therapies

Some examples of CAM treatments include herbal remedies, homeopathy, Traditional Chinese Medicine, taking vitamins, massage therapy, chiropractic, relaxation and practising meditation or yoga. Many people use at least one of the products or services that fall under the umbrella of CAM.[2]

CAMs are incredibly diverse. For example, take two ingestible CAMs: homeopathy and St. John's wort. Homeopathy, which is said by some[3] to be effective for treating attention-deficit hyperactivity disorder (ADHD), uses remedies that are so dilute that they contain nothing but water. Most scientists agree that such remedies cannot have an effect beyond placebo. (The placebo effect describes benefits even after a research subject unknowingly takes fake medicine; studies[8] have shown that when people already believe the medication they are taking will work, they tend to report better symptoms in research studies.)[4] Another CAM therapy taken orally, like St. John's wort, actually contains a chemical (hypericin) that has biological effects that warrant clinical research to see if it can truly treat depression.

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There are many forms of CAM that are used in an effort to treat mental illness. Some of the more common ones are: St. John's wort, homeopathy, SAMe, acupuncture, valerian and exercise therapy. Let's look at the evidence for these as a primary treatment for mental health problems.

St. John's wort (SJW) for depression

This herbal remedy has been in use for hundreds of years.[5] Proponents say it's useful for treating depression. Sales of SJW are booming[6]—it's one of the most popular herbs for sale in health food stores.

A number of studies have been done to see if SJW works better than placebo. What does the research say? According to the National Institutes of Health, "the evidence is not definitive"[5] and there can be serious side effects from using the herb.[5]

Why isn't the evidence clear? A 2008 analysis of many research studies found that SJW was as good as standard antidepressants for people with major depression.[7] However, the herb only appeared to have this effect in people from German-speaking countries. This strange finding highlighted concerns about whether the studies had ensured a fair comparison was made between SJW and the comparison treatments (proper controls). Adding to this concern is the fact that two very well-controlled trials found no difference between SJW and placebos (sugar pills).[9,10]

As with any treatment, it's important for patients to let their doctors and pharmacists know what they are taking. If SJW is combined with antidepressant drugs, it can cause serious problems—like serotonin syndrome. Also, other medications one is taking may be less effective if they are combined with SJW: birth control pills, certain cancer medications, and blood thinners, for example.

Homeopathy for ADHD

Homeopathy is a very popular form of alternative medicine.[2] It is a system of practice where it is believed that very tiny amounts of an often harmful substance will act as a remedy for the types of symptoms that a large amount of that same substance would produce. Homeopaths often liken this approach to immunizations. Vigourous shaking and pounding of the dilutions is also said to "activate" the remedies. In the case of homeopathy, however, the preparation of the remedies involves so many repeated dilutions that there is usually not a single atom left of the original substance.[4] Despite this, homeopathy has been claimed to be able to treat a wide range of illnesses, including mental illness.

The treatment of attention deficit/hyperactive disorder (ADHD) with homeopathy is currently in the Canadian news. The University of Toronto is planning to conduct a study of homeopathy for ADHD.[11] Previously, three clinical trials have been performed on homeopathy for ADHD: two done by a practitioner of homeopathy were positive,[3,12] and another found that homeopathy had no effect.[13] This latter study, however, did find that all the patients felt better for having seen a health care provider, which is a very common phenomenon even with treatments known to be effective in their own right.[14]

The proposal has generated controversy because most scientists agree that homeopathy, due to its lack of active ingredient, is really just placebo treatment.[11] Proponents of the study feel that determining the placebo effect in homeopathy may, in itself, be useful.

SAMe for depression and ADHD

SAMe is about as natural a treatment as they come. SAMe is a modified amino acid and is found normally in the body.[15] It has been studied for potential benefits in osteoarthritis and liver disease, but what about mental health?

There have been a handful of clinical trials testing the effect of SAMe on depression and ADHD. Some are positive, but more and higher quality research is needed before solid recommendations for its use can be made.[15-19] For ADHD, not as much clinical trial information is available as for depression.[15]

SAMe does have some side effects. Most notable are increased blood pressure and lower blood sugar.

Acupuncture for depression

Acupuncture is a traditional Chinese practice where needles are inserted into the skin at special points believed to correspond to the flow of "chi" or "vital energy" in the body. Acupuncture has been claimed to be useful for treating a large variety of illnesses from migraines and nausea to schizophrenia and dementia.

While acupuncture does not fit with what modern science knows about how the body works, thousands of clinical trials have been performed to see if it may have some effect. Most trials that have tested traditional acupuncture versus needles inserted at non-acupuncture points ("sham controls") have found no difference in effect.[20] Acupuncture trials that don't use sham controls are usually positive – but this may simply be because of strong placebo effects. In such trials, unless the comparison group also gets needles inserted, both patients and providers will know who received the 'real' treatment. Many serious biases come into play unless both patients and evaluators are unaware of who is getting the genuine acupuncture treatment (this is known as a "double blind" study, see the article on p. 8).

Acupuncture has been studied for depression. The most recent and objective review of the evidence to date determined that there was not good evidence for recommending acupuncture for depression.[21]

Valerian for anxiety

Valerian is a plant that has been noted for centuries to have sedating effects. There isn't enough evidence to decide whether valerian can treat anxiety or depression. A number of trials have looked at whether valerian can be used to treat insomnia,[22] common in anxiety and depression, but an analysis of those trials found that objective proof of effectiveness was still lacking.[23]

Exercise therapy for depression

A growing body of evidence points to the enormous benefits of regular physical activity. Quite aside from the personal satisfaction one can gain from staying fit, exercise is credited with improving heart health, reducing blood pressure, controlling high blood sugar—and helping a host of other issues, including mental well-being.

Most of us have seen the benefit of exercise on energy and mood, but can it be used to *treat* clinical depression? A 2013 review of 39 trials found some indications that exercise was better than no treatment in reducing the symptoms of depression.[24] While it appeared that exercise was not as helpful as medication or counseling, the authors cautioned that better trials were needed.

That said, there are a number of advantages to exercising that make it well worth trying:

- it puts the patient in the 'driver's seat'
- it can be free
- it can be done safely alongside other treatments
- unless you overdo it, there are no side effects

Can CAM be a useful adjunct?

Adjunctive therapy is a term that applies to treatments that, while not the primary treatment, can make the healing process go more smoothly.

Exercise is an excellent example of an adjunctive therapy. Although the direct benefits on clinical depression might be quite small, for many people just getting out and being active is something they see as part of getting better. Exercising also gives the patient a sense of contributing to their recovery; of being an active partner in their health care—something that many people desire.

From the treatment provider's point of view, recommending a CAM therapy might be a good way to maintain rapport with a patient. It would be important, of course, to monitor the treatment for side effects or interaction with medications.

Some last words

Not all types of CAM are the same. Some—like homeopathy lie so far outside the limits of reasonable science that they can be considered disproven. Others—like relaxation, yoga and exercise therapy—may have limited symptom-reducing effects but certainly form part of an overall wellness plan.

Patients who wish to use CAM treatments need to speak with their mainstream health care provider about any CAM treatment they want to use. These health care providers will need to walk a fine line between the rights of the patient to choose and their own professional duty to offer the best advice and information possible. But foremost, they need to ensure their patients get the benefits of proven therapy. v

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Effective Treatments for Mental Disorders in Children and Youth

Christine Schwartz, MA, PhD, RPsych, Charlotte Waddell, MSc, MD, CCFP, FRCPC (Child and Adolescent Psychiatry), Jen Barican, MPH, and Daphne Gray-Grant, BA (Honours)

Mental disorders are the leading health problems that Canadian children and youth face from infancy onwards. In fact, at any given time, an estimated 12.6% of young people ages 4 to 17 years—or nearly 84,000 young people in BC—are experiencing these disorders.[1]

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Christine, Charlotte, Jen and Daphne all work with the Children's Health Policy Centre in the Faculty of Health Sciences at Simon Fraser University in Vancouver. The centre focuses on improving children's social and emotional well-being and on the public policies needed to reach this goal. For more information, please see childhealthpolicy.ca

As well, only 30% of children and youth with mental disorders are estimated to receive needed treatment services, and few prevention programs are offered.[1] And without effective prevention or treatment, disorders that emerge in childhood usually persist—leading to lifelong distress and symptoms, as well as impairment, or the reduced ability to participate in life, school and work.

These numbers are troubling. However, the good news is that effective treatments exist for all of the mental disorders affecting young people. Some of the most common disorders even have more than one effective treatment.

Which treatments help young people?

The table (see next page)[1] presents those treatments that have been found to be effective for young people. Each one has produced significant benefits according to at least two rigorous evaluations using randomized-controlled trial methods in children or youth.

Among the psychosocial (or non-medication) treatments, cognitive-behavioural therapy (CBT) shows particularly strong results. There is evidence that it is effective in treating seven of the 10 disorders listed in the table, including with children as young as six.

For anxiety—the most common group of childhood mental disorders—mental health practitioners have successfully delivered CBT to groups of children and youth in schools and clinics. This is a cost-effective way to serve many more young people. Children and youth have also had success using self-guided CBT for anxiety, for example, with telephone support from practitioners. With this latter mode of delivery, CBT has great potential to help young people who have traditionally been hard to serve, such as those living in remote communities.

Certain medications can also reduce symptoms. For bipolar disorder and schizophrenia, in particular, newer antipsychotic medications are supported by rigorous randomized-controlled trial evaluations in young people. However, for many conditions—including some that are very common such as anxiety, conduct and depressive disorders—medications should be used only after effective psychosocial treatments have been tried and young people have not responded. Whenever psychiatric medications are used, close monitoring is needed, since serious side effects can occur.

More resources are needed

Given that 70% of children and youth with mental disorders do not

effective treatments for child and youth mental health disorders[1]

Anxiety Disorders (Affects 3.8% or 25,300 BC children and youth)*	Cognitive-behavioural therapy (CBT), and antidepressant medication (fluoxetine; when CBT has not succeeded)
Attention-Deficit/ Hyperactivity Disorder (Affects 2.5% or 16,600 BC children and youth)	Behavioural therapy, CBT, parent training, neurofeedback, and medications (methylphenidate, dextroamphetamine and atomoxetine)
Autism Spectrum Disorders (Affects 0.6% or 4,000 BC children and youth)	Intensive behavioural intervention (IBI), and newer antipsychotic medications (risperidone and aripiprazole; when IBI has not succeeded)
Bipolar Disorder (Affects 0.6% or 2,100 BC youth)	Newer antipsychotic medications (risperidone, aripiprazole and quetiapine)
Conduct Disorder (Affects 2.1% or 14,000 BC children and youth)	Parent training, CBT combined with parent training and family therapy, and newer antipsychotic medications (risperidone and quetiapine; when psychosocial treatments have not succeeded)
Eating Disorders (Affects 0.1% or 300 BC youth)	Family therapy (for anorexia)
Major Depressive Disorder (Affects 1.6% or 10,600 BC children and youth)	CBT, interpersonal psychotherapy (IPT), and antidepressant medications (fluoxetine; when CBT or IPT have not succeeded)
Obsessive-Compulsive Disorder (Affects 0.4% or 2,700 BC children and youth)	CBT (exposure + response prevention), and antidepressants (fluoxetine and sertraline; when CBT has not succeeded)
Schizophrenia (Affects 0.1% or 300 BC youth)	Newer antipsychotic medications (risperidone and olanzapine)
Substance Use Disorders (Affects 2.4% or 8,400 BC youth)	CBT, family therapy, and motivational training

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currently receive effective treatments, it is imperative that we address this tremendous gap in services.[1] This gap would not be tolerated for childhood cancer or diabetes and it should not be tolerated for childhood mental disorders. The public resources going toward child and youth mental health therefore need to be dramatically increased—so that every young person with a mental disorder can receive effective interventions.

related resources

All produced by the Children's Health Policy Centre at SFU and available at childhealthpolicy.ca.

- *Child and youth mental disorders: Prevalence and evidence-based interventions* (2014)
- *Improving children's mental health: Six highly effective psychosocial interventions* (2014)
- *Children's Mental Health Research Quarterly* for free, online information on a wide range of prevention and treatment topics

As well as providing effective treatments for all 84,000 young people estimated to have mental disorders in BC at any given time, we need to prevent disorders where we can. There are effective programs for preventing the four of the most common conditions: anxiety, substance use, conduct and major depressive disorders.[2] Taken together, these four disorders affect an estimated 58,000 young people in BC at any given time.[2]

Successful prevention approaches include parent training and CBT starting in the early years—approaches that many practitioners are familiar with.[2] By adding prevention programs into the mix, we can begin to reduce the number of people who needlessly experience the symptoms, distress and impairment associated with childhood mental disorders—problems which then often continue over a lifetime.

* All numbers are estimates based on high-quality epidemiological surveys[1]

Psychotherapy—Choosing an Effective Treatment

Karolina Rozworska, MA

It is estimated that one in five Canadians live with a mental health problem that significantly interferes with their life activities.[1] Most of these problems can be successfully managed with appropriate treatment, but finding an effective treatment can be a daunting task.

Karolina is a PhD student in Counselling Psychology at UBC and recently completed the Canadian Institutes of Health/Michael Smith Foundation for Health Research Science Policy Fellowship at the BC Ministry of Health. Her work intersects clinical practice, academic research and public policy. She specializes in eating disorders and in psychotherapy research

In this article, I describe how psychotherapy reduces mental health problems and how to choose a psychotherapy service that is a good fit.

What is psychotherapy?

Psychotherapy is a treatment for mental health problems in which a mental health professional helps you change how you think, feel and behave using methods based on psychological, biological and social theories and research. Research shows that changing one's thoughts, feelings and behaviours reduces or eliminates symptoms of many mental health problems and improves quality of life. Psychotherapy is also used successfully to help people cope with or overcome life problems, such as adjusting to a health issue or overcoming discrimination, bullying or abuse, to name just a few. However, this article focuses only on mental health problems.

Psychotherapy is sometimes referred to as "counselling," sometimes as "talk therapy" and sometimes simply as "therapy." While these terms tend

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to be used interchangeably, the term "counselling" has also been used more broadly to describe supportive conversations between a health professional and the client. These might focus on regular medication intake, housing issues or helping navigate the health system. These types of counselling, while helpful, would not qualify as psychotherapy because they are not meant to treat mental health problems.

Psychotherapy is one of the best treatments for mental health problems. This statement is supported by 50 years' worth of research.[2] The question is not if psychotherapy works, but how.

How does psychotherapy work?

Researchers have different views about how and why psychotherapy works. The "active ingredients" in psychotherapy can be broadly grouped into *specific* and *common* factors. Knowing about these "active ingredients" can help choose a psychotherapy service that is a good fit for you.

Specific factors

Many researchers say that psychotherapy works because it offers carefully assembled interventions tailored for specific mental health problems. An example of an intervention would be when the therapist teaches the client how to challenge worrying thoughts by comparing them to facts. A different example is when the therapist and the client explore patterns in the client's relationships across time. Another intervention would be when the therapist teaches the client strategies to become more aware of their emotions.

These interventions are called "specific factors" because they differ from one psychotherapy to another. A "psychotherapy" is understood here as a group of interventions. Researchers who study specific factors compare different psychotherapies (e.g., cognitive-behavioural therapy, psychodynamic psychotherapy, etc.) to each other to find the most effective psychotherapy for a specific mental health problem.

Which psychotherapies might best help your mental health issue?

The table (see next page) shows psychotherapies that have the most research support for selected mental health problems. This is not a complete list and it is not meant to suggest that other psychotherapies cannot be effective. Research in this area grows quickly and many psychotherapies have not yet been tested. The combinations of specific psychotherapies and mental health problem pairs that could be studied are almost endless, especially when we take into account that some people have two or more mental health problems. However, the list can help you to make an informed decision about the psychotherapy that might be a fit for you.

Common factors

Other psychotherapy researchers believe that therapy works because of "common factors" that are shared across psychotherapies. According to these researchers, most psychotherapies can be helpful for most problems because the effectiveness lies in the art of how psychotherapy is done, not which interventions are used.

An example of a common factor is a positive, honest relationship between the therapist and the client, who are working toward the same goal. Another common factor is when the therapist and the client develop a shared understanding of the client's problem and the way it can be changed. Yet another is when the client is given an opportunity to practise and master new skills that help overcome their problem. Research supports the importance of common factors. For example, studies consistently show that a strong therapeutic relationship between the therapist and the client leads to better outcomes in various therapies and problems.[51]

In addition, some researchers have shown that, when some aspects of research design are improved, psychotherapies might not be as different from each other in their effectiveness as those who study "specific factors" believe they are.[52,53]

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psychotherapies for specific disorders*

Depression	Behavioural activation[3] Cognitive-behavioural therapy[4] Couples therapy Emotionally-focused couples therapy[5] Behavioural marital therapy[6,7] Systemic couples therapy[8] Emotion-focused therapy[9] Interpersonal therapy[10] Short-term psychodynamic psychotherapy[11]
Anxiety Disorders	Acceptance and commitment therapy[12,13,14] Cognitive-behavioural therapy[15,16,17] Partner-assisted exposure for panic disorder[18] Psychodynamic psychotherapy[19**]
Bipolar Disorders	Cognitive-behavioural therapy[51,52,53] Family-based therapy[51,54,55, 56] Interpersonal and social rhythm therapy[51,57]
Personality Disorders Cluster B (borderline, narcissistic, histrionic, antisocial)	Dialectical-behaviour therapy[20,21,22] Mentalization-based therapy[23] Schema-focused therapy[24] Transference-focused psychotherapy[20,25]
Personality disorders: cluster C (obsessive-compulsive, avoidant, dependant)	Cognitive-behavioural therapy[26] Short-term dynamic psychotherapy[26,27]
Post-traumatic Stress Disorder	Cognitive-behavioural therapy[28,29,30] Eye movement desensitization and reprocessing[31] Hypnotherapy[31] Interpersonal therapy[31] Narrative exposure therapy[32] Psychodynamic therapy[31] Stress inoculation training[31]
Eating Disorders: Bulimia Nervosa	Cognitive-behavioural therapy[33,34] Emotional and social mind training[35] Focal psychotherapy[36,37] Hypnobehavioural therapy[38] Integrative cognitive-affective therapy[39] Interpersonal therapy[40,41,42]
Eating Disorders: Anorexia Nervosa	Psychotherapy is an effective treatment and research does not support any one approach over another for adults[43]
Obsessive-Compulsive Disorder	Cognitive-behavioural therapy (exposure and ritual prevention)[44,45]
Schizophrenia	Cognitive-behavioural therapy[46,47] Family-focused therapy[48,49] Acceptance and commitment therapy[50**]

How do I choose a psychotherapy that works for me?

Choosing a psychotherapy service can be overwhelming at first. So it can be helpful to use a guide such as some approaches used by therapists. One approach therapists use to decide how to work with a specific client is called evidence-based practice (EBP). EBP specifies three types of information that can help decide on the appropriate psychotherapy: 1) client characteristics, 2) research evidence, and 3) therapist's clinical expertise. EBP has been recommended by the American and Canadian psychological associations[54,55] and is also used in the field of medicine, where it originated. Although the principles of the EBP were designed to help clinicians, they can also be useful for clients who are deciding on the best psychotherapy service to meet their needs.

Here are some therapist and client characteristics that, according to research, affect outcomes in psychotherapy. You might want to consider them when choosing a psychotherapy service that meets your needs.

The therapist

Research suggests that the person who is delivering therapy has an impact on the treatment's success. Most effective therapists are empathic, accepting, genuine, able to speak with you directly about any misunderstandings that happen between the two of you, and able to see strengths in your cultural worldview. They are also highly skilled, but not rigid, in the therapies that they provide.[56] They will challenge you or invite you to step outside your comfort zone.[57]

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glossary of therapies

For plain-language definitions of the 30+ psychotherapies listed on the opposite page, please see the Glossary prepared by *Visions* staff at the end of Karolina's article at www.heretohelp.bc.ca/visions

* Note: Psychotherapies are listed alphabetically within each disorder; they are not ranked by effectiveness.

**promising approach

You can monitor to see whether your therapist has these qualities. If you are not "clicking" with your therapist, it can be very helpful for both of you to have a conversation about this.

The client

You, as the client, are the most important ingredient of change in psychotherapy. You are the one who does most of the work. Studies show that clients with better outcomes understand their problems similarly to the way their therapist views them, but are also open to changing these understandings. They are motivated and have optimistic but not idealistic expectations toward therapy (unless they have depression, because negative expectations are part of the disorder).[57,58]

Reviewing your attitudes toward psychotherapy can help you assess if this is a good treatment for you.

Finding a 'fit'— It's worth making an effort

Psychotherapies and therapists vary in their styles of work—and your preferences in how you would like to work matter. You might meet with several therapists before you find a good fit. A good fit means that you feel respected and supported by your therapist and that you 'buy into' the psychotherapy approach enough to work hard and step outside your comfort zone. You might decide to choose a psychotherapy that was successfully studied with a problem like yours.

While choosing a service might not be easy, it is worth the effort—psychotherapy is, after all, one of the most effective treatments available for mental health problems. This is particularly true when you find a good combination of specific and common factors that match your needs. v

ECT - CONTINUED FROM PAGE 22

me, the benefits of ECT far outweighed the negative aspects, which were few.

The attitudes of others regarding ECT varied. My parents were incredibly supportive throughout my struggles with mental illness—they witnessed first-hand how ECT affected my mood in a positive way. They sensibly believed that ECT was a useful tool in combating depression.

Some people in my life didn't even know that ECT was still used. Other people thought and expressed to me that it was "barbaric"—why would I subject myself to such a thing? I have since been able to tell these people about the life-saving benefits of ECT and how it has helped me in my recovery.

From 'refractory' to remission

Today I am free of symptoms, taking care of my body and working full-time—things that I thought were not possible! My journey to wellness, however, has been a long walk on a very bumpy road.

In 1999 during one of many stays at St. Paul's Hospital, a cocktail of medications was found, through trial and error, which began to improve my mood—though I still had many hospitalizations after that. The doctor that succeeded in finding this effective combination of meds also used ECT to treat my chronic depression. This combination of meds and ECT gradually led to a more stable life, with fewer and fewer trips to the hospital.

My last hospitalization was in 2007, and my last ECT treatments were in February of 2009. To this day, however, I am still taking that cocktail, under doctor's orders. In 2010, also at my doctor's urging, I began exercising regularly. I had quit smoking in 2007 and was 60 pounds overweight. After many unsuccessful attempts at starting to exercise, I decided to take it seriously and joined a gym. I eventually lost the 60 pounds—and that regular exercise began my road to remission. My mood is always elevated after exercise, with those hormones, the endorphins, doing their work. Exercise is my reliable stress reliever.

If you're wondering whether ECT might help you, I'd suggest talking with your psychiatrist openly and honestly. For me, a combination of ECT and the right medications was the answer.

I hope, through sharing my experience with ECT, that I have made a dent in the massive wall of stigma that still surrounds mental illness in general, and electroconvulsive therapy in particular. v

MEDICATIONS - CONTINUED FROM PAGE 31

should always be discussed with the patient's health care provider prior to use. This discussion should include the goals of the proposed augmentation, side effects and interactions.

Perfect medications do not exist. Identifying the most effective medication, or medications, takes time and takes into consideration the individual's needs and response.

The risks and benefits of every medication should be discussed with the patient to address concerns. Once a medication is selected, patients should be monitored for efficacy and side effects.

If you have questions about your medications, your local pharmacist is available to help with your concerns. v

for footnotes go to www.heretohelp.bc.ca/visions

Antidepressant Medication and Antipsychotic Medication booklets

www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information

Antidepressant Medication and *Antipsychotic Medications* are two booklets from the Centre for Addiction and Mental Health that describe common classes of the medications, usage, side effects, and other important information. You can also find information on specific medications and therapies in the Mental Health and Addiction Information A to Z section.

Working With Your Doctor for Mental Illnesses info sheet

www.heretohelp.bc.ca/factsheet/working-with-your-doctor-for-mental-illnesses

When you are considering and using a particular treatment, it's important to work with your care team so you can make an informed choice about your treatment and monitor your results. The *Working With Your Doctor for Mental Illnesses* info sheet discusses strategies to work effectively with your health care team so you can set goals, make decisions, track your progress, and work together towards recovery.

Children's Health Policy Centre

www.childhealthpolicy.ca

The Children's Health Policy Centre at SFU examines different evidence-based treatments, prevention, supports, and other inventions in child and youth mental health and well-being. *The Quarterly* journal reviews and communicates the current evidence in bulletin form, and the Centre's research reports go into more depth. Learn more about the Children's Healthy Policy Centre and read its publication online.

National Institute for Health and Care Institute

www.nice.org.uk

The National Institute for Health and Care Institute, or NICE, is a UK-based organization that develops evidence-based guidance for health, public health, and social services. NICE Pathways at pathways.nice.org.uk is an online tool that helps you identify information based on an illness, treatment, population group, or factors of well-being.

Health Evidence

www.healthevidence.org

Health Evidence at McMaster University explores different public health interventions and publishes reviews of their findings. They also offer tools to help you find and use research, such as listing over 4000 summaries of systematic reviews and then rating the ones that are the highest quality. The database is free to use.

Cochrane Library

www.cochranelibrary.com

The Cochrane Library is a collection of databases from Cochrane, a global network of researchers, health professionals, patients, and care providers who review health evidence. Cochrane Library also provides a plain language version of the review. Cochrane reviews are among the most highly trusted systematic reviews. The website has sections on mental health and complementary and alternative treatments.

BC Guidelines

www.bcguidelines.ca

BC Guidelines are clinical guidelines for BC physicians. Mental health guidelines, found on the left hand menu, describe different diagnoses and effective treatments. While these guides are aimed at physicians, there are recommended resources for families and patients under each of the mental illnesses.

National Center for Complementary and Integrative Health, National Institutes of Health

nccih.nih.gov

The US-based National Center for Complementary and Integrative Health, from the National Institutes of Health, provides research on complementary and alternative medicine. They offer evidence-based information on treatments, and provide information and guidelines to help patients make informed choices and identify qualified practitioners.

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

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Mental health and substance use
information you can trust

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