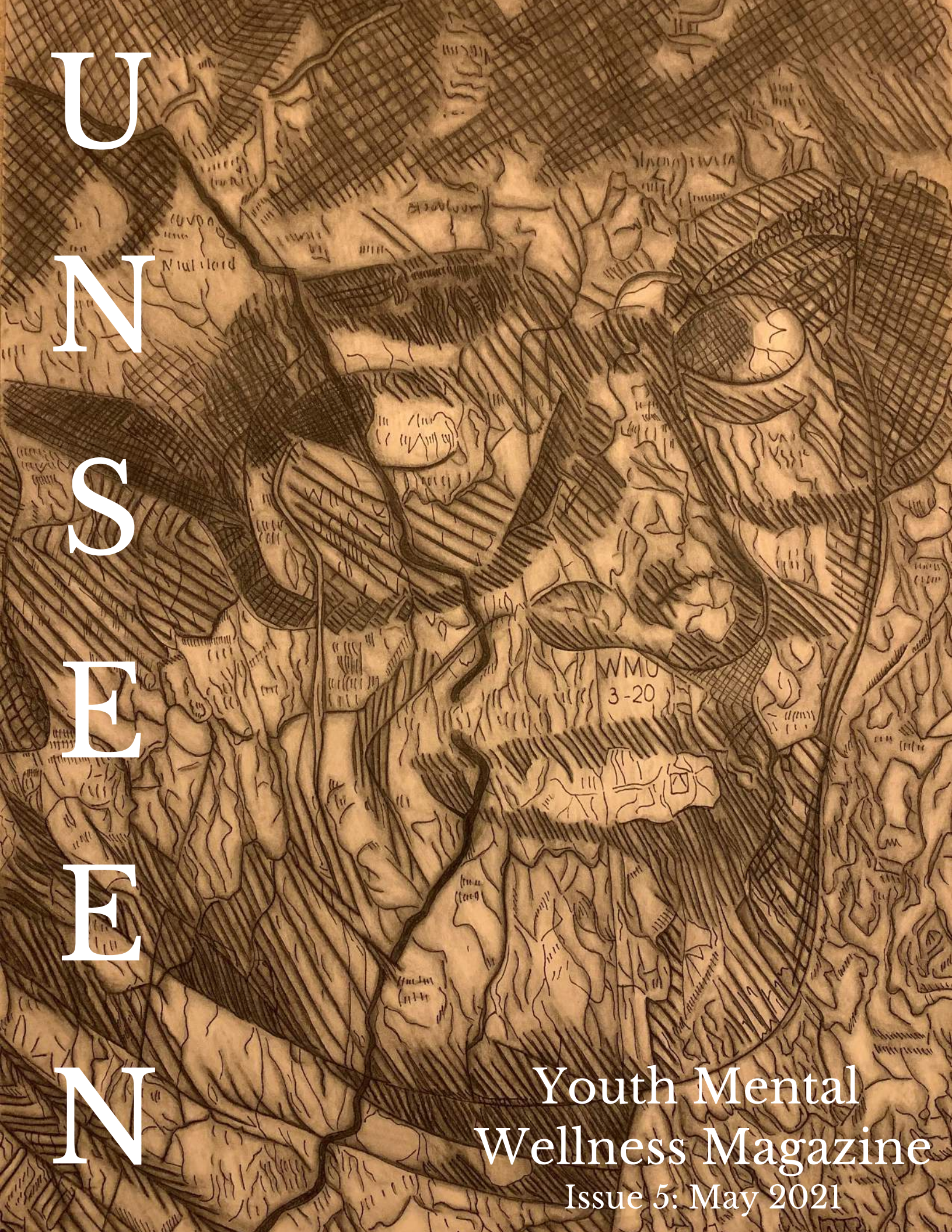


Youth Mental Wellness Magazine

Issue 5: May 2021

A note from the cover artist:

"This is my Granny, she passed when I was a baby. She and I have both struggled with Bipolar Disorder. Unfortunately she lost her battle. I am lucky enough to be born into a generation where mental health is more openly discussed and treated. Every day that I fight my battle I remember that I am not only fighting for me, but for everyone who didn't receive the support they needed, and especially for my Granny."

- Caty McInulty

TRIGGER WARNING

Thank you so much for picking up our fifth issue of *Unseen: Youth Mental Wellness Magazine.* This issue explores topics and experiences that are important to the CASA Youth Council (CYC). Some of the content addressed in this issue may be heavy, triggering, or difficult for some readers. When we put our magazine together, we think a lot about risk. It is really important for us to be able to share our experiences in a way that tells our truths without making our readers feel unsafe. We hope that by talking about difficult topics like assault, suicidal thoughts, and other challenging experiences, that young people who had, or are having, these experiences will feel that they are not alone. We want everyone to have the freedom and safety to talk about difficult experiences, and we encourage our readers to talk to someone they trust, or to reach out to professional services if they feel they need it.

There are, of course, also articles on mental wellness in this issue. All of our lives have both times of rain and sunshine. Thank you for coming on this journey with us.

Table of Contents

Letter From the Editors

First and foremost, thank you to our readers, old and new, for continuing to support us by simply reading and resonating with Unseen.

Welcome to our fifth edition of Unseen! Unseen is created by local Albertan youth, aged 13-25, who aspire to advocate and promote resilience in the mental health community. The following pages include personal stories, evidence-based articles, and hand-made art crafted by youth. These creative works are representations of each authors' unique perspective on mental health and illness, and serve to both reflect diversity and build a sense of community amongst those concerned with mental wellness.

Our previous Co-Chairs, Cadence and Rachel, have stepped-down from Unseen to pursue their unique passions and paths. We thank them both immensely for all they have done with Unseen, and wish them all the best on their new adventures. Our new Co-Chairs are Mykeala and Angella who, under the guidance of Cadence, will usher this and future issues of Unseen into fruition.

Secondly, COVID-19 events occurring in 2020, and the mental stressors that have accompanied it is the underlying theme of our 5th edition. This year has been an unprecedented and stressful time, to say the least, and we hope that you will find solace in the stories shared in accompanying pages. Together we will make it through.

We hope you all are safe during these times.

Sincerely,
The CASA Youth Council

Mental Health Apps We Love

Always There - Kids Help Phone

Live chat counselling. Can be used on iOS and Android

The Daily Difference

Modules to guide through mild anxiety, depression, bullying, and self harm. Can be used on iOS and Android

Calm Harm

Resist or manage the urge to self-harm. Can be used on iOS and Android

SuperBetter

Resilience training. Can be used on iOS and Android

MindshiftTM CBT

Relaxation, mindfulness, and CBT exercises. Can be used on iOS and Android

DiveThru

Guided journaling. Can be used on iOS and Android

Lyf

Support Forum. Can be used on iOS and Android

What's Up

Cope with anxiety, depression and more. Can be used on iOS and Android

notOK

Digital panic button. Can be used on iOS and Android

Coping in 2020

There have been many notable events of 2020, including rising unemployment, a shift to online education, the death of George Floyd, and the COVID-19 pandemic. In response to these events, members from the CASA Youth Council (CYC) were asked to answer the following question:

"How has your mental health been impacted by the numerous events of this past year and what methods have you used to cope?"

Being outside of school last year helped my mental health and it got better.

- Aislynn

Social distancing is such an important public health measure during COVID-19, however it has been hard on my mental health. As someone who is extroverted, interacting with others is energizing for me and helps me to feel fulfilled. Being a healthcare worker and also graduating from university this spring, this year has been undoubtedly difficult and disappointing. Not being able to see friends and family has been draining for me, especially during some tough personal times this year where I would usually rely on others for extra support. Despite the setbacks, I find hope in seeing how people have come together (at a distance) to support one another during these hard times. A kind text message, a window visit, or a quick video call with a loved one has gone a long way in keeping me grounded and connected. I have big hopes for 2021, and I think that living through this year will make us all more appreciative of the shared moments and experiences that we may have taken for granted in the past.

- Isabella Rees

At the beginning of the pandemic, I was working in healthcare and experienced how drastically the work environment changed as a result of pandemic related policies and procedures. Not only learning to adapt my work and personal life put a strain on my own mental health, I could see that it also negatively impacted the mental health of the patients that I cared for in the hospital. I can only begin to imagine how difficult it must have been for patients to connect and communicate with their health care providers as a result of physical barriers and personal protective equipment policies (such as having to frequently interact with multiple masked individuals, or only seeing 1 member of the health care team to reduce crowding). Additionally, many were unable to have family and friends visit them in hospital during a time they likely needed the most social support. During those times, it was especially useful to have patients utilize video calling devices to be able to communicate with their loved ones.

I also went back to university this year and have now learned to adapt to a solely online learning environment. This has also been a challenge to my mental wellbeing as it prevents me from interacting and engaging with my peers and professors in the same way as I would have with classes on campus. I have gone months without seeing friends and family in person and although it feels that online meetings cannot compare to that face-to-face interaction, I do still find that it is helpful to schedule regular virtual visits with my closest family and friends. A few other things that I have done to help cope with stressors during the pandemic is taking up a meditation routine, learning yoga online, journalling, ensuring I continue to be physically active, and getting out into nature and the outdoors as much as possible. Although, the pandemic has resulted in many disruptions to our lives, I would encourage others who may also feel their mental health has been negatively impacted to reach out to their support circle, and find ways to safely integrate the things they love to do into their day.

- Anonymous

As a university student living with severe general and social anxiety, going to campus was one of the only times I got out of the house. Due to classes being moved completely online, my mental health has taken a downturn due to a sense of isolation from those my age. I've found my social anxiety has increased, as well as feelings of depression resulting from loneliness.

Living in an era with bombardments of negative news, albeit vital to report on and bring awareness to, can exasperate symptoms for those already living with mental illness. Allowing myself to take time to not check media and instead check in with myself has been a very useful coping mechanism in these confusing times.

- Victoria

I've been fortunate enough to stay working, which has really helped. However, the last month of school being online was difficult, and being mailed my degree wasn't quite as fulfilling as attending a grad ceremony. On top of everything happening in the world, I had a very awful personal matter occur in June which left me feeling extremely depressed. I didn't eat for 3 days, skipped work, and overall was not doing well.

Coping has been hard, but my biggest help has been a strong support circle. I have so many incredible people in my life that love me, so many people reached out to me during my difficulties and really made me feel supported and like I didn't have to go through anything alone.

- Tiana Warner

I lost my job due to COVID-19, so this is the first time in a while that I have had such an open schedule. In some ways its good, but in other ways I don't like it. For example, I have more time to think about things that make me anxious, such as finances, my upcoming graduate program, and the future in general. To help with this, I picked up drawing, something I have wanted to be good at for years but have been too lazy to try. I found that I was actually decent at it, and it really increased my self-esteem! I also have been reading a lot of books using my kobo app, which has been nice since I don't have time to do that while in school. I also have way more time for family and exercise, so for that I am very grateful.

- Mykaela Holt

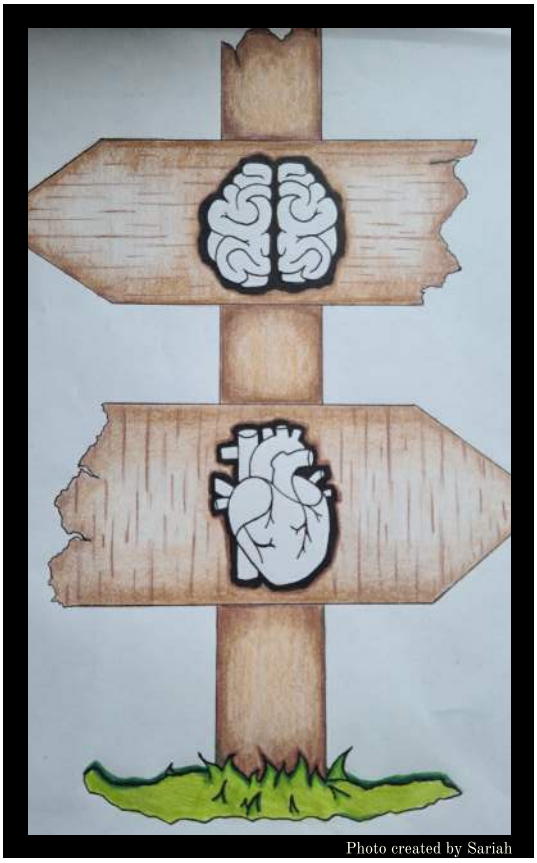


Photo created by Sariah

At the beginning of this year my mental illness was in remission, but the pandemic changed that. Many of the things I had worked so hard on like getting out of the house more and building up my social life were squashed. Experiencing social isolation and adjusting to online classes have been detrimental to my mental health. I have been going to therapy virtually and I was voluntarily hospitalized in a psychiatric ward during the month of November. I have learned the importance of keeping on a schedule and getting outside when I can.

- Anonymous

Although I was lucky to be able to keep my business up and running, to be able to have a good home life, and to have a good support network, I still struggled with the challenges placed on us throughout 2020. Since I have had mental health difficulties in the past, I had to stay proactive! For me, keeping a running list of things I was grateful for helped me keep positive. I was also able to keep my mind busy by creating a series of mini challenges and goals for myself, like walking a large chunk of the river valley system, reading a certain amount of books, hiking every mountain on a curated list, etc.

- Cadence Rolfson

Your brain is part of your body so your mental health is always going to be affected by things that affect your body and your routines. Living in a constant state of alertness - have I washed my hands? Do I have the virus? How am I going to pay for university? has made me feel trapped and alone at times. It seems like I'm constantly looking for a threat that I can never see, and in the absence of a visible enemy, I'm creating them in my mind. On the bright side, I've been luckier than most. I have a stable home and both my parents are employed full-time. The virus has brought tragedy, but tragedy that's removed from me. My immediate family is safe. The best thing I've found is taking control of my immediate environment by redecorating my home. By creating a safe environment around me, I can tell my brain that I'm not in danger and have a hope of being understood.

- Anonymous

COVID-19 has affected my mental health greatly. I am constantly worried about what is going on in the world each day. The uncertainty of everything brings my anxiety to a whole new level. The struggle between living scared and trying to adapt to the new normal is tough. Most people are learning to adapt, where if you are anything like me; you're trying your best to avoid anything negative about COVID-19. Yes, I may be living in an ignorance is bliss lifestyle, but this is what I need to be able to function from day to day without going into a panic attack. By blocking out certain feeds I have been able to just see all the positive things going on in the world again. Do not get me wrong, throughout the tragedy of all this there has been great things going on, I am talking with friends that I haven't seen in months.

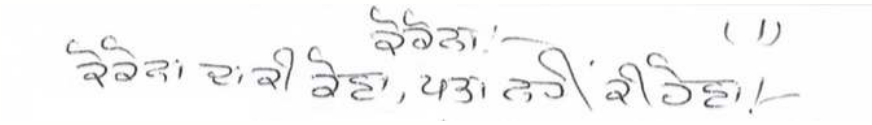
The isolation that COVID-19 has brought is difficult for me. I have been having more bad days then good, more times than I care to admit. But it helps me to say that I do need support and can't do it alone. Just like so many others not seeing friends and family. Putting a halt to what brought me the most joy in my life. My anxiety has some days gotten the best out of me. What my tendency to do is fight the anxiety, try to avoid it, distract myself, and ask for reassurance from family and friends. I am sticking to the hope that this soon will be over, and we can go into living another new normal. Where I get to hug and be within 6 feet of the people that I love. When I can go back to driving crazy distances to see my favourite artists perform live again. When I can go buy a bunch of junk food and have a movie night. And where I can just breathe. I know that as the world around us begins to change and adapt to the new normal, I will find my way to adapt as well.

I have become very thankful for the people around me that have helped me get through this.

We all need to keep in mind, we are never given anything in this world that we cannot handle.

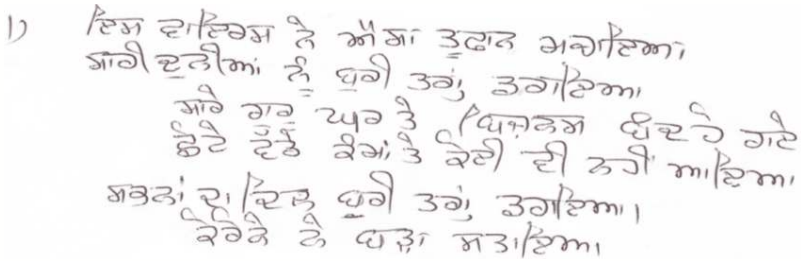
- Kelsey W.

WHY CRY ABOUT CORONAVIRUS BECAUSE WE DO NOT KNOW WHAT WILL HAPPEN

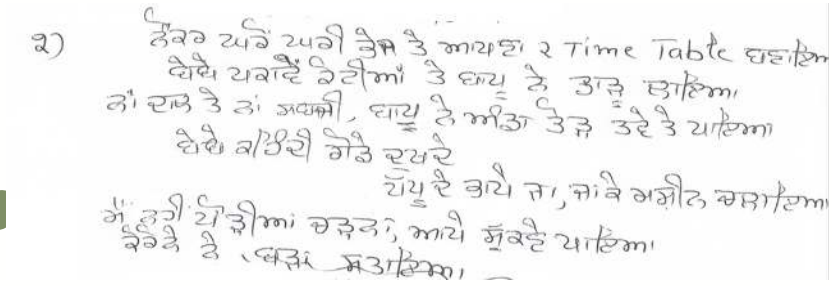


Written By: Baljeet Hundal
Translated by: Jasmine Gill

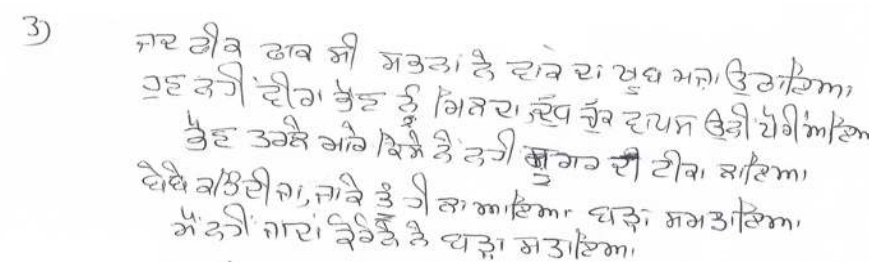
Preface: This poem was written by my grandmother in April 2020 shortly after the Coronavirus pandemic was declared by the World Health Organization. During this time, my grandmother and grandfather were on a trip to visit family members in India and had been living there for a few months. In late March 2020, India was placed on lockdown by local authorities as a measure to prevent the spread of the virus and travelling outside the home was extremely restricted.



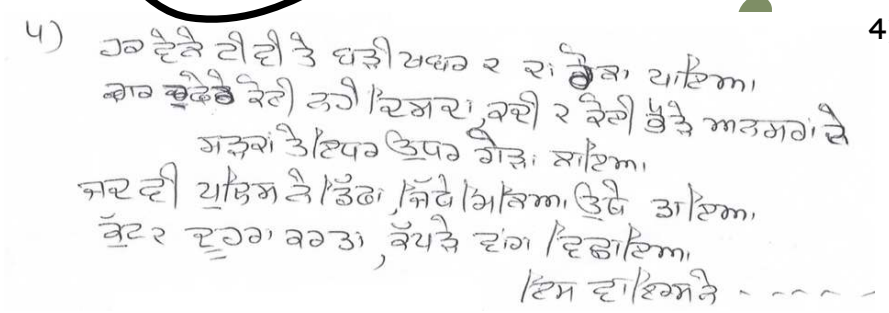
1) This virus has created a storm. It has terrified the whole world. All places of worship, and businesses are closed. No one can go to work; whether or not they work for small or large businesses. It has struck fear in everyone's heart; Corona* has upset everyone.



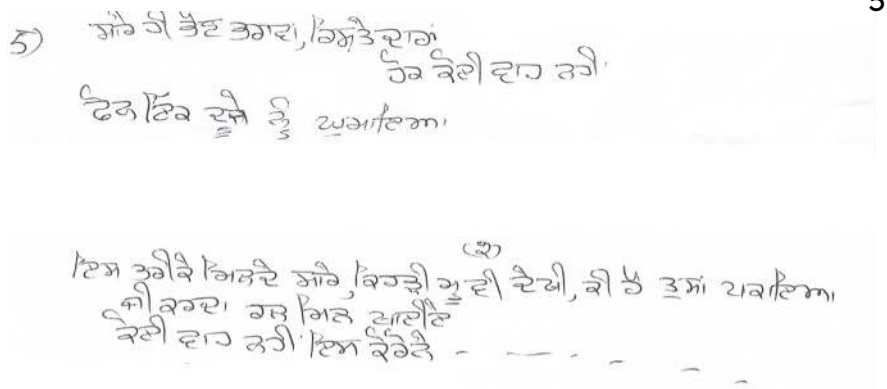
2) Maids and servants have been sent home. Everyone has made their own timetable. Mom will do the cooking, and Dad will sweep the floor. There are no prepared dishes for supper, so Dad has broken an egg into the pan. Mom says her knees are hurting. She tells her husband to turn on the washing machine. Then she says, "I cannot climb the stairs, go hang your wet clothes to dry." Corona has upset everyone.



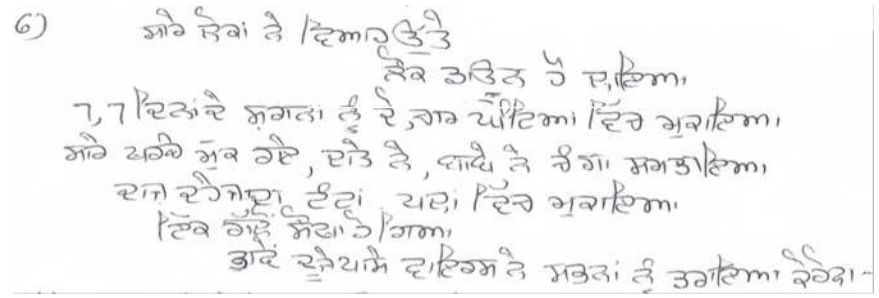
3) Before the pandemic, everyone enjoyed walking outside. Now Brother does not go visit his Sister, instead he picks up the milk jug that she left in her doorstep. Sister begged for help; no one was helping her with her insulin injection. Mom tries convincing her husband to help his Sister with the injection. He says, “I will not go.” Corona has upset everyone.



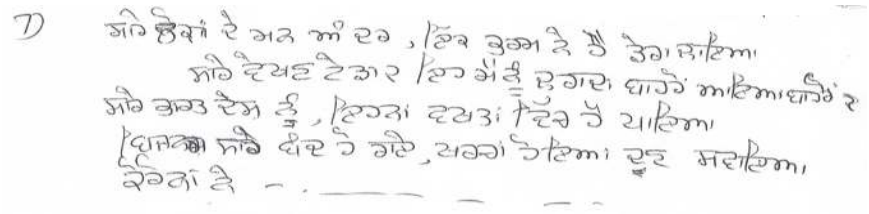
4) All the time, there is breaking news on the TV. In all four directions, there is no one to be seen in the vicinity. Sometimes, there are disobedient people roaming the streets. Whenever the police see this, they reprimand them. This virus has upset everyone.



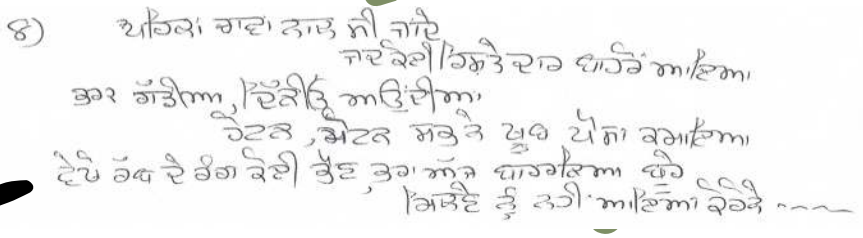
5) Brothers, sisters and relatives have nothing else to do. They dial the phone to each other. This is the way they visit each other, asking questions like “What movie did you watch? What have you cooked?” They feel helpless and wish to sit down and share a meal together. Corona has upset everyone.



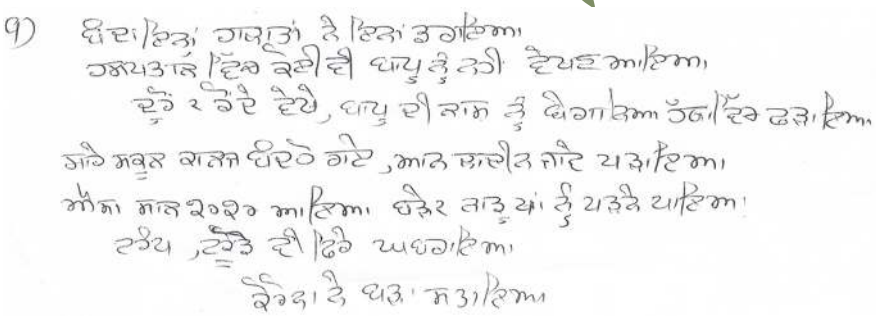
6) Weddings have been postponed. Seven-day-long wedding ceremonies have been shortened to two to three hours. Expenses are no more. God has taught a good lesson. The dowry system has instantly disappeared. On one hand, things are easier; on the other hand the virus has frightened people. Corona has upset everyone.



7) Fears and doubts have set in inside everyone's mind. People peer from the side of their eyes at each other, "It seems like they are foreigners..." All of India is in jeopardy. Businesses are closed; expenses have doubled. Corona has upset everyone.



8) Before, people were excited if a foreign relative was visiting. Cars packed with visitors came from the Delhi airport. Hotels and motels made a lot of money. Look at God's ways. Now, brothers and sisters do not come to the doorstep of their foreign relatives. Corona has upset everyone.



9) These circumstances have scared people so terribly. They do not visit the hospital to see their dad. From afar, they cry as their dad's body is carried away by strangers. Schools and colleges are closed. Teaching is done online. The year 2020 has arrived and humbled great leaders and boasters. Trump and Trudeau are also nervous. Corona has upset everyone.

Photo taken by Jasmine Gill

Photo taken by Jasmine Gill

Living With High-Functioning Mental Illness

Anonymous

High-functioning mental illnesses are rarely talked about, possibly because they are not often seen or acknowledged. High-functioning mental illness describes an illness that is often undetectable. Someone who has a high-functioning mental illness may be employed, study at a university, have a wide social group, have a healthy romantic relationship, and be involved in a sport. In sum, they function in all areas of their life, but they are still mentally ill.

For example, every day I wake up at 6:00 am after sleeping a healthy 8 hours. I take a shower, I make my breakfast, and I drive to work. Once I am home, I study for my courses, and afterwards I may hang out with my friends. My life appears normal, and, to other people, I appear to be functioning quite well. What is not often seen or acknowledged by others is that I am severely mentally ill.

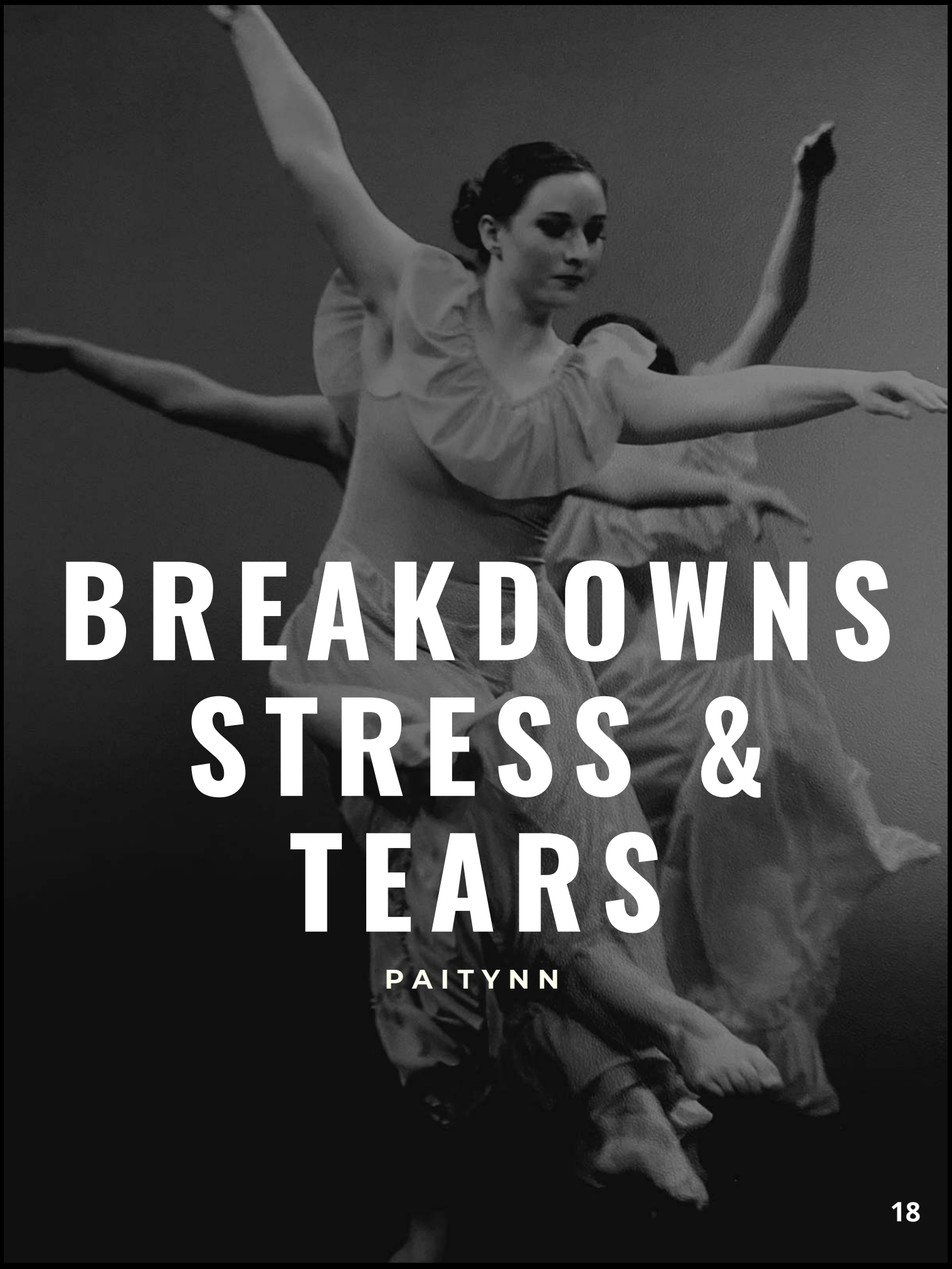
On a typical day, my body feels weighed down by an invisible heaviness, as though I am carrying an anchor around with me. From over my shoulder, I feel that I am

always being watched by an invisible figure. My mind often feels so scattered that I cannot even connect two thoughts, like I am putting together a puzzle while blind-folded. On the worst days, my hallucinations truly manifest. People's faces blur until all I can see are two black eyes bulging from their heads. Sometimes, I forget hours of my day, and I am left with this throbbing ache in my head that something is missing. I experience vivid self-harm imagery that replays in my mind for hours. Unseen voices - like a dull mumble - bubble up in my mind. Worst of all, I feel that everyone is watching me through cameras - from my friends, to my family, to my coworkers, as though I am being surveilled, judged, and picked apart by everyone that I love.

Despite these symptoms, I wake up at 6:00 am every day, I go to work, I study for my courses, and I spend time with my friends. My symptoms make everyday activities extremely challenging, but I do them anyways. I am "high-functioning" because I do not give myself any choice but to function. I have even developed the ability to deal with my symptoms in ways that coincide with "normal" everyday functions. For example, I go to the gym because it helps me feel energized enough to plough through my depression. When I hear mumblings inside my head, I turn on some music. I study for hours each day because it distracts me from the intrusive and delusional thoughts. I make fun of myself sometimes, because honestly, how weird is it to believe that your friends are spying on you through the camera in your phone? I am lucky because I have the energy and the support systems in place to manage my symptoms in such a way that I appear to be "high-functioning." Appearing "high-functioning" may include hiding the symptoms of an individual's mental illness. If someone seems high-functioning, this does not mean that they are not really mentally ill, it just means that they are functioning in spite of their mental illness. You may have a friend confide in you that they have major depressive disorder, and when you see them laughing with friends and succeeding in their career, you may think, "where did their depression go?" What could be difficult to understand is that the depression is still there - that individual is just managing their symptoms in a way that makes them appear high-functioning. This goes for any mental illness: someone acting in ways that do not make them appear mentally ill does not mean they are not ill. It just means they are managing their illness in ways that are not externally seen, whether that be with internal coping mechanisms, medications, or the **cycles** that their mental illness takes. When I refer to the cycles of being mentally ill, I mean the days when someone with a high-functioning mental illness may no longer be able to function at a high-level. From my experience, it is exhausting to keep your symptoms managed for long periods

Cycle of High Functioning Mental Illness

of time. For this reason, I sometimes burn-out and lose my ability to function. It is these times when people who only see me as high-functioning say, “but I thought you were finally better?” I cannot blame them-- I play the part of “high-functioning mental illness” so well. When someone close to you who is typically high-functioning becomes low-functioning, this is when they require the most support. If you are a friend or family member, reach out, and ask them what they need to feel supported. If needed, encourage them to meet with a therapist or psychiatrist, and help them find the resources to do so. Accept that the days of low-functioning go hand-in-hand with the high-functioning; accept them for who they are, what their mental illness is, and encourage them to seek help. What is important to understand is that being high-functioning does not make being mentally ill any easier, it just changes the way that we are perceived by others. For many mentally ill individuals, it can take years of therapy and medications to become high-functioning. For us, our mental illness is still there, and we deserve to be acknowledged for the challenges we face daily to survive in a world that demands high levels of functioning from us.



BREAKDOWNS STRESS & TEARS

PAITYNN

I was standing in the second row in a room of 17 seamlessly manicured ballet students, each donning our canvas ballet slippers, pink tights, and the required burgundy bodysuit, our hair pinned in perfectly formed buns, with a hairnet of course—no wispies allowed. We were working our way through the syllabus center work, sweat starting to form on our brows as we moved through each exercise. Our teacher, a plump woman with greying orange hair, was going over corrections when she said to me "you look like a potato." At first, I laughed. All the girls around me were laughing. It was funny, I guess, at first. The teacher wasn't laughing though, she was serious and looking right at me. I looked like a potato. I remember staring down at my adolescent body. I was short and yes, a little fluffy. My cheeks were burning with embarrassment and I felt tears swelling into my eyes as my classmates continued to giggle. The teacher called my mom a few days later to speak to me and apologize. She felt like the comment had become too focused on body image, but it was too late. The damage had been done. To this day, I look in the mirror and tell myself that I look like a potato—fat, shapeless, and dull.

The inner workings of the dance world have long been an intrigue to the outward eye. From the gracefulness of the principal ballerinas, to the celebrated display of a balance between flexibility, strength, and storytelling, and to the countless little girls worldwide who prance around gleefully in pink cap-sleeved bodysuits. You know the ones I'm talking about, right? I started out that way too. I was 4 years old with bold freckles, ginger hair, the same pink body-suit, and eager excitement on my face. The early days aren't so clear now, but I still remember the smell of the snack bar tucked in beside studio 5, and the cups of candy we would fill for 5 cents apiece. I remember the parent watch days and the junior grades examination days and the butterfly-like nerves that came with both. I still think about my earlier teachers, whom I adored, working on our arabesques with us late into the evening. I cherish those early memories, back when all I wanted to do was dance and before anyone ever made me feel small and insignificant.

In dance, submission is key. There are rules to be followed, regulations to be obeyed, and a required display of utmost respect to anyone above you. In my ballet school, the culture of submission began with how we were to present ourselves. Color coordinated bodysuits based on level always to be paired with pink tights free of holes or runs. Hair pulled into a tight,

slick bun with a hairnet, hairspray strongly recommended. No jewelry- however- small stud earrings were acceptable. Oh, and no nail polish. That was the ultimate sin. These requirements don't seem so bad when I type them out, but I remember being so afraid to break them at just seven or eight years old that when my mom bought me a pink knitted ballet wrap sweater, I couldn't bring myself to wear it, or to even put it in my dance bag, because I knew my teachers wouldn't approve.

Once we had mastered the presentation rules, the rules progressed and were called etiquette: an unspoken list that set out how we were to behave. Always pay attention, even when it's not your turn; be so on time that you are early; never sit down or lean against a wall or the barre; don't yawn or look at the clock; no talking or whispering; don't get frustrated with yourself because it's a disrespectful attitude; bow to and applaud the instructor after each lesson (just imagine if football teams or gymnasts did this). Rules were so important, and submission so valued, that when my teacher told me I looked like a potato it didn't even cross my mind to stand up for myself and tell her how much the comment hurt me. I thought I was strong enough to take it, so I stood there with a stinging pain in my chest but a loopy smile on my face. I was keeping the code of silence before I even knew what it was.

The code of silence, in the traditional sense, is the act of withholding information in order to protect oneself from being labelled a traitor, or to protect a group from being criticized. In dance, it's a bit different. It's the group mentality that keeps us from speaking out about our own negative experiences, or those of our peers, because we have been conditioned to be docile and fear ostracization for being weak. We may not even feel that wrongdoings should be reported or confronted because we have been taught to do as we are told without question—to obey without thought. We keep our mouths shut even when we have grounds to demand an apology. We are taught to take the cruelty and justify it by telling ourselves that it is simply a part of dance culture.

We can't talk about dance culture without discussing body type. Described by the artistic director of the Vaganova Ballet Academy in 2009, the ballerina physique is "ideally…a small head, long neck, long arms, long legs, and slender figure." Dancers such as Misty Copeland, with her unapologetically muscular body, have the

world convinced that this ideal is changing for the better, to be more including. I am unconvinced. The ballet world upholds a standard that prefers tall, lean, and thin dancers, to carry both the physical requirements of the technique as well as for aesthetic purposes. Girls who don't fit this standard are told by their teachers that they are too fat for ballet, that they have the wrong body type because of their muscular thighs or developed chests, and continually take hits that are meant to convey the message that their body is incorrect. I remember being 13 or 14 years old and hearing a beloved male ballet teacher tell another student, who was tall with broad shoulders, that she looked like a football player. We all felt her pain, but still, none of us said anything. The damage these types of comments do are almost irreparable. I think about that girl and wonder if she looks in the mirror and repeats the comment over and over. Does she tell herself she looks like a football player? Does she feel less worthy because of her shoulders? I wonder if the girls who were told they were too big stare at themselves and their perceived flaws and continue to hear the words. Do they still feel they are too big? I bet they do. I know I still do.

Costume fittings always confirmed just how wrong my body was. We would have to line up shortest to tallest. I would always be second or third in line. The costumes would hang on their rack in order of smallest to largest sizes. The wardrobe lady would work her way down the line, handing the smallest sizes to the shortest people and the bigger sizes to the tallest people. But there was me; short, solid, and not a size extra small as my height would indicate according to this system.

The result was that I would stand in line, without a costume to try on, until the tallest girls received their costumes and the wardrobe lady could circle back to me to give me a size that fit. It was painfully humiliating, to be the only girl without a costume as all the others slipped theirs on and reveled at their beauty. I would catch whispers from my teachers and the seamstress talking about having to find a size for me, to not forget about me. I always felt detached from myself in that room. My body would be present, standing still in line, while my mind floated elsewhere so it wouldn't be so uncomfortable. In fact, most of my days in dance class were spent pretending to be somebody else—anybody but the short chubby ginger hiding in the back row.

I spent many years feeling blunted. Inside I was angry, deeply hurting and constantly exhausted from the stress and embarrassment I felt about being me. Outside, I hardly smiled, I found it hard to engage in conversations and groups, and always planned out how I would secure a spot in the back corner of the room during center exercises. My teachers routinely called me out for these behaviors in front of my class. I can't count the amount of times I was told to smile, chided for never speaking, and told that they could still see my desire to hide in the back row. It was humiliating to be mocked in front of the girls I was trying to fit in with. They would giggle when the remarks were made, or turn to stare as my face turned to a tell-

tale red. I couldn't bring myself to smile and laugh, or to be exuberantly happy and present in every class. What I was feeling inside wouldn't allow me that freedom. I felt numb most of the time and disconnected from myself. I felt empty—hollow. Despite my clear uncomfortableness with my quietness being discussed, my teachers continued to make comments up until I graduated, and even in private.

Parent-teacher-student interviews: the most dreaded time of the year for me. Once a year, the ballet school organized mandatory meetings between select teachers, our parents, and us in order to formally discuss corrections, concerns, or praise. My classmates never expressed much disdain for them, but after my first experience with the interviews, the very mention of them would make me feel incredibly uneasy.

I was in grade 7, 13 years old, and in a burgundy bodysuit level. One of my teachers who was in the room for the interview wasn't one of my favorites, but I still tried my best in her class. The beginning and middle of the interview was uneventful, but the ending devastated me. It was the first time I ever understood what the term "heartbreak" really felt like. The teacher, with her straight honey blonde hair and sharp nose, stood up as I approached the door to leave and said something that I still tell myself almost 10 years later. She informed me, without much emotion, that in a room of my classmates I slipped below the radar and went mostly unnoticed in my classes. I remember leaving the room, graciously of course, beelining to the changeroom with its blue brick walls and neat rows of tan lockers, collapsing to the floor, and sobbing. You slip below the radar. I still tell myself that. When my friends go out without me, when I'm in a group of people and no one hears me when I speak, even when I'm home alone by myself. You slip below the radar.

Later on, in my final year, during the same painful interviews, a teacher that I cherished told me something similar. She sometimes didn't notice if I was in class or not, but that a "burning fire" within me would remind her that I was there. I spent years wondering what she meant. What kind of fire burned in my soul so strong that it reminded people of my presence, that I existed? I think now it was all the pain I was in manifesting itself on the outside, even if I couldn't or wouldn't talk about it. I left my studio 4 years ago and it's taken me just as long to process and reflect on my time there, and to be able to finally talk about it.

In a positive light, dance is painted as both a sport and an art form that can lift moods, strengthen memory and balance, improve muscle tone, and relieve stress. In a negative light, it becomes much more sinister. Perfectionism is instilled at a young age. Constantly given corrections, spending countless hours in front of mirrors, and training in a place where flaws are highlighted and praise comes by rarely, young dancers are used to the pressure of not measuring up. Overemphasizing perfection can lead to psychological inflexibility. Individuals with psychological inflexibility struggle with 6 main processes: fantasizing about the future or the past; rigidity in thoughts, attitude or beliefs that prevent mindful experiences; avoidance of painful thoughts, emotions, or memories; an attachment to a conceptualized self; a lack of clarity about ones values; and repeating actions that are mpulsive, avoidant, and self-defeating. (1) I have noticed many of these behaviors both in myself as well as in fellow ex-dancers, which goes to show just how taxing dance can be on mental health. This rigid mindset is often linked to anxiety and depression—issues that are very prevalent in dancers. Eating disorders are also very common in the dance world. With such a worshipped and seemingly unattainable body type being sought after by dance teachers and companies, it is impossible to feel like you wouldn't do absolutely anything to attain it, even if the risks are known. Dancers push their bodies harder than they are capable of and still must look effortless and poised. They dance when they are sick, injured, and of broken heart. They continue dancing when their teacher mocks them, or yells, or throws things. This resiliency, even in harshest environments, conditions dancers to internalize everything in order to maintain a near-perfect image on the outside, despite anything they feel inside—accepting both emotional and physical suffering.

As a society, and the dance world in particular, we have accepted a culture that habitually damages young participants. Change is needed—desperately. Youth sports programs need to be restructured in order to properly support mental health and to create an environment that is conducive to a well-balanced and healthy life. This transformation has to begin with coaches. At the head of an athlete's circle, instructors need to be more aware of just how tremendous their impact is on the youth under their leadership. They shape how their students act, behave, and think. Instructors have the ability to change, for better or worse, how an individual sees

themselves. Coaches must look introspectively and be hyperaware of how their words, actions, and attitude could present to their students, and how greatly it can influence them.

Beyond coaches, athletic environments should have readily available mental health resources. Having easily accessible nutritionists, sports psychologists, or counselors available for students to easily access would do remarkable good. Classes or seminars could be offered to discuss mental health, covering important topics and offering knowledge, education, and understanding about how to handle stress, how to build healthy coping mechanisms, and how and where to get help if needed. Learning and emphasis in these environments should not only be geared towards physical health and achievement but also towards mental health and how to improve it. Mental health is just as, or even more important than physical health and should be treated accordingly- especially in youth.

In my studio, mental health was very rarely discussed or mentioned. I want that to change for young dancers. I want them to continue to love dance well into adulthood, and even into their golden years. Unfortunately for me, the damage had been done, and it never really healed. I still feel invisible some days- still tell myself that no one notices my presence and that I slip under the radar. I have many days where I look in my full-length mirror and tell myself that I look like a potato, although it makes me laugh now, truly laugh, because it's just so ridiculous that a well-educated teacher would think they were justified in telling a student that. My love of dance was stolen, and I wish I could say that I was strong enough to take it back. It's been years since I've left the rows of seamlessly manicured ballet students with their slicked back hair and spotless uniforms. In the late hours of the night, when no one is looking and I'm in the kitchen waiting for my nightly toast with peanut butter, I steal back a few pirouettes, and for now, that's enough.

Works Cited:

(1) Levin, Michael E., et al. "Examining Psychological Inflexibility as a Transdiagnostic Process across Psychological Disorders." *Journal of Contextual Behavioral Science*, vol. 3, no. 3, 2014, pp. 155–163. *PubMed*, doi: 10.1016/j.jcbs.2014.06.003

what does that make me

Aislynn

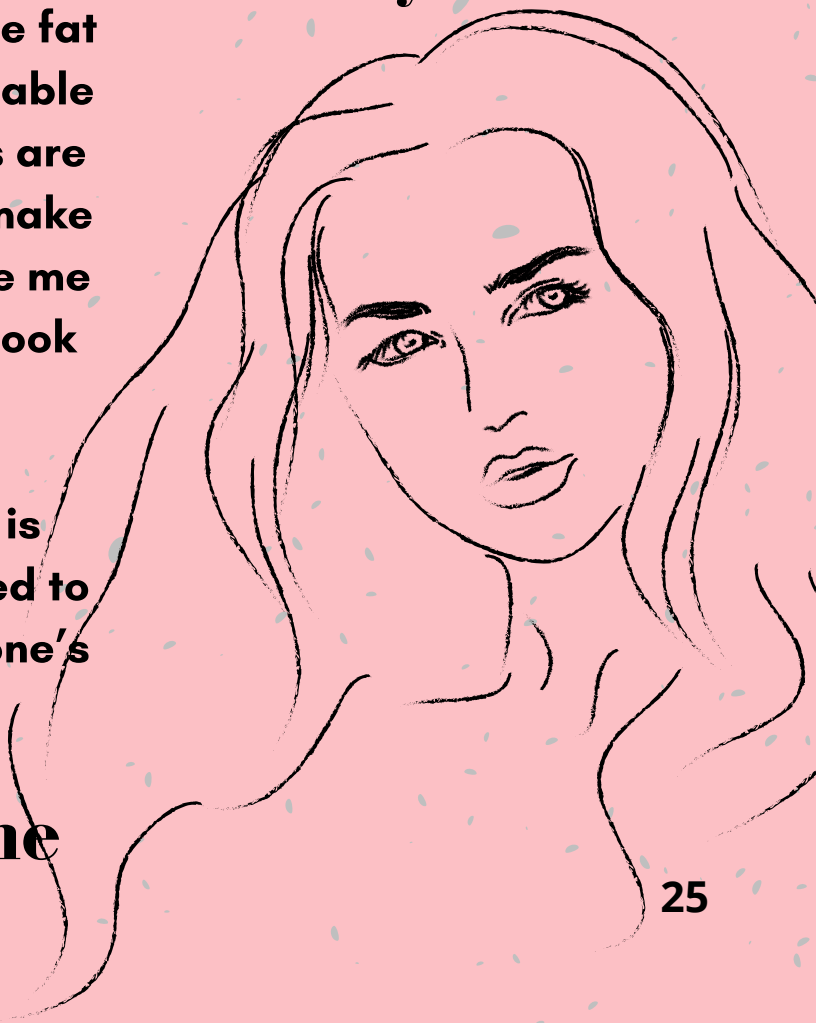
Society always gets to judge, decide, and normalize bodies. Society judges people's appearances and the way they dress.

Models are what society sees as perfect and flawless. They're skinny, beautiful, and appear to be confident.

They drill what we should be like, and what we should look like, into our heads until we believe it's true. If we don't look like them, we stand in the mirror criticizing ourselves.

But what if I don't look like what they say is perfect? Does that make me fat and ugly? What if I'm not comfortable and confident in the clothes girls are "supposed" to wear? Does that make me unattractive? Does that make me worthless? Does that make me look ugly?

Society needs to change what is represented as perfect. They need to normalize every body and everyone's beauty.



-you're beautiful the way you are

Colonization and Indigenous Mental Health

Sheher-Bano A.

The Colonialism of Indigenous peoples is an ongoing phenomenon that began in the 17th century. (1) There is evidence that Canadian Indigenous communities underperform drastically in determinants of health and mental wellness. (2) One explanation of this finding may be because Indigenous perspectives on mental health are swallowed up in the current Eurocentric model of mental health treatment. (2)

What are traditional Indigenous mental health practices, and how can we incorporate them into the current system? To answer this question, we consulted with Carrie Avveduti, a member of Alexander FN and Program Manager for Indigenous Services within CASA Child, Family and Adolescent Mental Health. “Wholism,” she says, “is the basic principle behind Indigenous mental health practices.” Wholism is the idea that healing can only come through addressing all the wellness needs of an individual: physical, emotional, spiritual and mental. (3) This is opposed to the current psychological practices in our system, which emphasize focused treatments meant to alleviate a specific set of symptoms. (4)

Photo created by Sheher-Bano A.

Thus, traditional Indigenous treatment methods are not given the respect they deserve in the current healthcare system, resulting in Indigenous peoples needs not being met by current interventions. (5)

Compounding the problem is that the framework used to recognize and treat mental health issues, the DSM-V, is often inaccurate when it comes to Indigenous patients. (6) The DSM-V is a manual used widely in the psychiatric profession to assess and diagnose patients, created by the American Psychiatrists' Association, and widely used throughout Canada and the United States. Critically, the DSM-V is based on observations of largely white, middle-class families in the United States. This means that culturally-specific factors, which may be relevant in the prevalence of a mental health issue in a certain population, are often ignored. For example, the effects of cultural assimilation policies, such as residential schools, on the mental health of Indigenous populations are not addressed in the DSM-V. These practices had overarching intergenerational effects which must be addressed in order to treat Indigenous individuals. Ignoring the culturally specific causes of mental health issues means that treatments are ineffective at best and actively harmful at worst. (6)

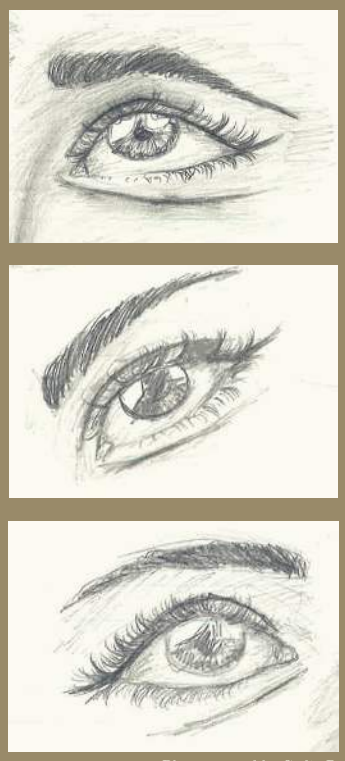


Photo created by Sadie B.

Photo created by Sheher-Bano A.

Another barrier to treatment is the deep distrust that Indigenous communities have for mental health and counselling services provided by the Canadian government. (2,7) This mistrust is rooted in the historical treatment of Indigenous people by the Canadian government, from the breaking of treaty agreements to residential schools and the sixties scoop, all of which have bred significant mistrust between Indigenous communities and the Canadian government.

Photo taken by Jasmine Gill

This historical mistrust means that many Indigenous people will not seek out the services they need, leading to lower mental health outcomes. (2,7) Furthermore, many mental healthcare professionals attempt to provide care to Indigenous clients the same way they would in a non-Indigenous community, and do not consider the individual's culture. (8) This approach has the potential to re-traumatize Indigenous clients and slow their recovery. (7,8)

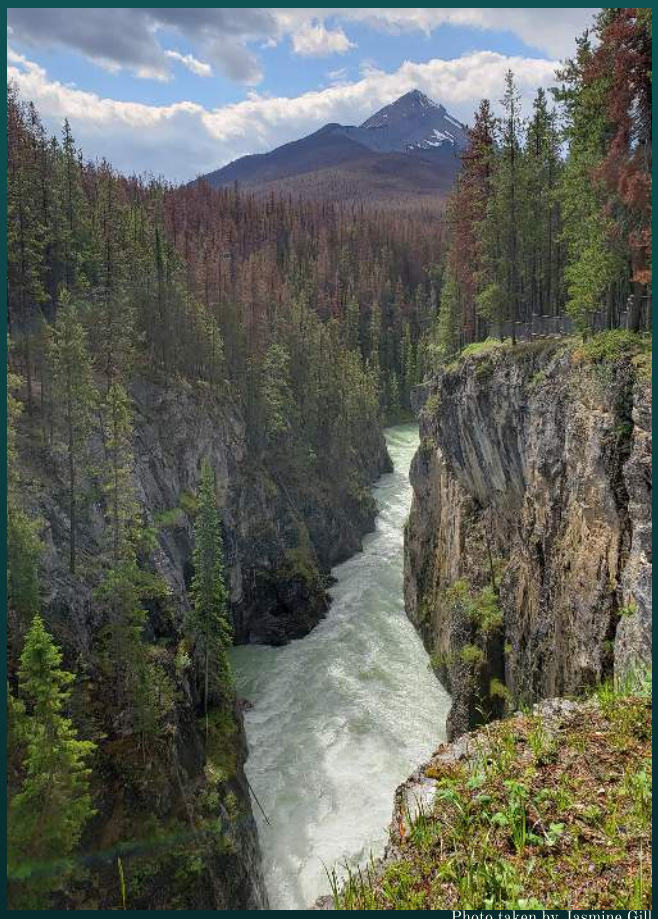


Photo taken by Jasmine Gill

Indeed, it can be said that state intervention in Indigenous affairs constitutes 21st century colonialism. Government policies towards Indigenous peoples are widely created on the principle that they are "for the good of the people", which implies that Indigenous people are unable to manage their own affairs, that the state must act as a "guardian" to protect them from their inherent "deviation". (7) That is, Indigenous beliefs and culture are predisposed to be inferior, and this inferiority must be guarded against by adopting "Canadian" values. This mentality reinforced the treatment of Indigenous peoples as "childlike" or "inferior" throughout Canadian history. When Indigenous treatment methods are ignored or considered "add-ons" to conventional

treatment methods, the message is that the Indigenous method is “inferior”, a continuation of the same colonial attitude exhibited during the writing of the Indian Act. (7)

When this historical mistrust is continued by the actions of mental healthcare professionals, the result is an even greater alienation of Indigenous people within the system (2). What is needed is a greater understanding of the cultural and historical factors that lower mental health outcomes, as well as a greater respect for traditional Indigenous ways of healing within the system. Indigenous healers with Indigenous healing strategies should be given the same respect that is afforded to other mental healthcare professionals, as well as the resources to help their communities. (9,10)

Photo created by Sheher-Bano A.

Works Cited:

(1) First Nations in Canada. Government of Canada, 2 May 2017, www.rcaanc-cirnac.gc.ca/eng/1307460755710/1536862806124. Accessed 19 May 2021.

(2) Allan, Billie, and Smylie, Janet. First Peoples, Second Class Treatment. Wellesley Institute, 2015, www.sac-oac.ca/sites/default/files/resources/Report-First-Peoples-Second-Class-Treatment.pdf.

(3)Absolon, Kathy. “Indigenous wholistic theory: A knowledge set for practice.” First Peoples Child & Family Review: An Interdisciplinary Journal Honouring the Voices, Perspectives, and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews, vol. 5, no. 2, 2010, pp. 74-87. erudite, doi.org/10.7202/1068933ar.

(4)Barudin, Jessica., and Zafran, Hiba. “Introduction to Trauma-Informed Rehabilitation with Indigenous Clients.” physiotherapy, vol. 19, 2019, www.researchgate.net/profile/Hiba-Zafran/publication/339513551_Introduction_to_trauma-informed_rehabilitation_with_Indigenous_communities/links/5e56f1e1a6fdccbeba056d87/Introduction-to-trauma-informed-rehabilitation-with-Indigenous-communities.pdf.

(5)Nuttgens, Simon, A.. and Campbell, Allan, J. “Multicultural Considerations for Counselling First Nations Clients.” Canadian Journal of Counselling, vol. 44, no. 2, 2010, pp. 115-129. Google Scholar, https://files.eric.ed.gov/fulltext/EJ890430.pdf.

(6) Langa, Melanie, E., and Gone, Joseph, P. “Cultural Context in DSM Diagnosis: An American Indian Case Illustration of Contradictory Trends.” Transcultural psychiatry, vol. 57, no. 4, 2020, pp. 567–580. SAGE journals, doi.org/10.1177/1363461519832473.

(7)De Leuw, Sarah., et al. “Deviant Constructions: How Governments Preserve Colonial Narratives of Addictions and Poor Mental Health to Intervene into the Lives of Indigenous Children and Families in Canada.” International Journal for Mental Health and Addictions, vol. 8, 2009, pp. 282-295. SpringerLink, journals-scholarsportal-info.myaccess.library.utoronto.ca/pdf/15571874/v08i0002/282_dchgpcicafic.xml.

(8)First Nations Health Authority. FNHA Policy Statement on Cultural Safety and Humility, 2016, www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf. Accessed 19 May 2021.

(9) Lavallee, Lynn, F. and Poole, Jennifer, M. “Beyond Recovery: Colonization, Health and Healing for Indigenous People in Canada.” International Journal for Mental Health Addiction, vol. 8, 2010, pp. 271-281. SpringerLink, 10.1007/s11469-009-9239-8.

(10) Stewart, Suzanne, L. “Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada.” International Journal of Health Promotion and Education, vol. 46, no. 2, 2013, pp. 49-56. Google Scholar, doi.org/10.1080/14635240.2008.10708129

Indigenous Mental Health Resources

Edmonton and Area

Bent Arrow

Bent Arrow Traditional Healing Society is “committed to building upon the strengths of Aboriginal children, youth and families to enable them to grow spiritually, emotionally, physically and mentally so that they can walk proudly in both the Aboriginal and non-Aboriginal Communities.” Founded in 1994, Bent Arrow strives to serve the Indigenous community in a culturally relevant, authentic, and sincere way. Programs include employment, housing, culture, youth, and families. Social service and foster care resources are also available.

11648 85 St NW, Edmonton, AB
780-481-3451
bentarrow.ca

Poundmaker's Lodge

Poundmaker’s Lodge Treatment Centre is an Indigenous addiction treatment centre between Edmonton and St. Albert. Poundmaker’s Lodge, established in 1973, accepts “all people from all walks of life.” All programs are CARF-accredited. Programs focus on the root cause of substance use disorders and empowers those in recovery. Concepts are based in the cultural and spiritual beliefs of First Nations, Métis, and Inuit peoples in combination with abstinence-based recovery. Poundmaker’s Lodge is “a place for healing, wellness, and spirituality.”

25108 Poundmaker Rd, Sturgeon County, AB
780-458-1884
poundmakerslodge.ca

Canadian Native Friendship Centre Edmonton

Canadian Native Friendship Centres strive to “better the lives of the Aboriginal community and educate the non-Aboriginal community in cultural awareness since 1962.” The CNFC was organized to help Aboriginal newcomers to the city with referral services, and social and recreational programs. CNFC improves the quality of life of Aboriginal people in an urban environment by supporting self-determined activities, encouraging equal access to and participation in Canadian society while respecting Aboriginal cultural distinctiveness.

CANADIAN NATIVE FRIENDSHIP CENTRE

11728 95 St, Edmonton, AB
780-761-1900
www.cnfc.ca

Edmonton Native Healing Centre

Our goal is to journey alongside the urban Aboriginal population reconnecting people to culture and ceremony.” ENHC serves parents, youth, professionals, those of low income, and those living on the streets. ENHC empowers individuals to grow stronger and creates vibrant community relationships while honouring culture. ENHC operates on principles of accountability, reliability, openness, honesty, and trust. ENHC values integrity, respect, reciprocity and nurturing. ENHC hosts frequent events, which can be found on their website calendar.

EDMONTON NATIVE HEALING CENTRE

11813-123 Street Edmonton, AB
780-482-5522
e-nhc.org

Aboriginal Psychological Services

“Aboriginal Psychological Services is a group of Psychologists and Knowledge Keepers who work together to provide services to those in need. It is a collaboration of culturally informed Psychologists, Counselors, and Knowledge Keepers that provide quality of services towards the counseling process. Our traditional principles of kinship help us to support one another as well as supporting our clients.” Alberta Psychological Services employs professionals who self-identify as Indigenous. Their fees do not apply to those with treaty status.

11440 Kingsway NW, Edmonton, AB 780-594-9855
www.aboriginalpsychologicalservices.com

Native Counselling Services of Alberta

“Native Counselling Services of Alberta’s mission is to promote the resilience of the Aboriginal individual and family, through programs and services that are grounded in reclaiming our interconnectedness, reconciliation of relationships and self determination.” For 45 years, NCSA has assisted Aboriginal people gain fair and equitable access to the justice, children’s services and corrections systems in Alberta. Programs include family services, housing, education, corrections, and court systems.

14904 121a Ave NW, Edmonton, AB
780-451-4002
www.ncsa.ca

CASA Indigenous Services

CASA's First Nation Program is a partnership with several Edmonton Area First Nation Communities. “With our partners, we work to remove community identified barriers to mental health supports and services for children and families, while providing community-based access to such services.” Children, youth and families living in or actively connected to the Alexander, Alexis, Paul and Enoch First Nations are eligible for services. The services provided by CASA Indigenous Services are publicly funded. There is no additional fee for services.

10645 63 Ave NW, Edmonton, AB
780-400-2271
www.casaservices.org/indigenous-services

Red Road Healing Society

Red Road Healing Society offers a variety of programs that are delivered from a cultural grassroots perspective. Their vision is “To walk with all our relations on the Red Road of life by remembering, renewing and restoring our traditional roles and values that bring life.” Drop in resources such as employment, health, education, social and telephone services are available. Appointment based resources such as counselling and home support are also available. Red Road Healing Society strives to Remember, Restore, and Renew while removing the initial barriers of generational trauma by providing professional services for Aboriginal people by Aboriginal people. There are no fees for services and programs, and the Red Road Healing Society welcomes everyone to access their services.

10045 156 St NW, Edmonton, AB
780-471-3220
redroadjourney.ca

Ben Calf Robe Society

Ben Calf Robe Society's mission statement reads "Our Children Are Sacred. Our work will strive to protect and enhance that sacredness by providing Aboriginal children and their families with holistic education, supportive social services, and programs of high quality and cultural relevance." Initially, Ben Calf Robe Society worked primarily in schools, tackling the 80% rate of Indigenous youth dropping out of high school. Today, services are provided to the larger community through a wide range of programs. Programs include in-home family support, family health and parenting, group care, foster care, and Indigenous awareness.

12046 77 St NW Edmonton, AB
780-477-6648
www.bcrsociety.ab.ca

Spirit of Our Youth

Spirit of Our Youth provides services and programs for Indigenous children, youth, and families based on cultural respect and trauma informed support. "We encourage building cultural connections as a path to personal healing. All our services include access to a Cultural Resource Coordinator or an Elder as well as the practice of sweats, smudging, pipe ceremonies, feasts, dances, traditional healing, language and customs." Spirit of Our Youth is based in Edmonton but accepts referrals from across Canada. Spirit of Our Youth values teamwork & support, integrity, resilience, and cultural involvement. Programs for supported independent living and group care are available, as well as one-on-one youth worker support.

10534 106 St NW, Edmonton, AB
780-474-7140
spirityouth.ca

AHS Indigenous Health Program

"The Indigenous Health Program partners with Indigenous peoples, communities and key stakeholders to provide accessible, culturally appropriate health services for First Nations, Métis and Inuit people in Alberta." The AHS Indigenous health program is guided by the advice of their Wisdom Council, a group of First Nations, Métis and Inuit Albertans. The goal of the Wisdom Council is to ensure Indigenous Albertans receive the best possible care. Edmonton zone services include Indigenous cultural helper services, Indigenous Wellness program, and Indigenous Community Health Representative services. More information can be found on the Alberta Health Services website.

Alberta Health Services

We Are One

www.albertahealthservices.ca

Addresses are zone specific
Phone numbers are service specific
www.albertahealthservices.ca/info/page11949.aspx

If You Are In Crisis

- CMHA Edmonton Region Distress Line
  - 780-482-4357
- Kids Help Phone
  - 1-800-668-6868
- Children's Mental Health Line + Response Team
  - 780-427-4491
- Adult Crisis Response Services
  - 780-342-7777
- Family Justice Services
  - 780-427-8343
- Mental Health Helpline
  - 1-877-303-2642

Call 911 or visit an emergency room if there is immediate danger

Sabre-Toothed Tiger

By Isabella Rees

I am a product of survival
my ancestors lived on the balls of their feet
quick to react
to the pang of hunger or thirst
to the snap of a twig in the forest
to the ominous sensation of eyes
watching them from the shadows
their amygdalas were primed and ready
to confront the next threat to their survival
their fight or flight saved them from predators
so that I could be here
Living

This quality
that conserved my ancestral line
that allowed
them to survive and prosper
persists in me, too.
my predators may not be the same
but they still have teeth

An inexpressive text from a friend
a dreaded assignment's deadline looming on my calendar
awkward small talk with a distant acquaintance
the laugh of a stranger as I walk by
my bathroom scale
the sunday scaries

The realization that total
and complete control
is an impossibility.

My brain remains sharp as ever
though it's
idea of a sabre-toothed tiger
is a little different these days
the daily dealings of modern life
still make my jaw clench
my heart race
the hair stand up on the back of
my neck.
but like my ancestors before me,
here I am,
Surviving.

Manifestations of Anxiety

By: Angella R.

Anxiety is thought to be the body's natural response when one encounters a dangerous situation, as it heightens the senses and prepares one to face the current situation they are in. (1) This may be evolutionarily true, yet in modern times people who experience anxiety are often not in life-threatening situations.

Many individuals have had some sort of experience with anxiety and/or stress. The triggers for anxiety and stress are numerous, and may be unique to the individuals who experience them. For example, if a person previously suffered a traumatic event, current situations that remind them of those past events may provoke anxious thoughts or tendencies. The feeling of anxiety itself is not necessarily a bad thing, however, the prolonging of anxious feelings may lead to an anxiety disorder.

The symptoms of stress and anxiety-related disorders are not mutually exclusive. I will elaborate about the similarities and differences, as well as how they tend to present within individuals.

Stress

Many experience anxious thoughts in response to stressful events, such as studying for a test, or an upcoming job interview. While potentially stressful events are too abundant to list, the physiological symptoms that stem from them are quite similar. These tend to include (2):

- Accelerated heart rate
- Rapid breathing
- Difficulty sleeping
- Feeling tense or restless
- Feeling panicky
- Difficulty thinking or concentrating
- Increased worrying

Anxiety-Related Disorders

There are a number of anxiety disorders that exist. One example is agoraphobia, defined by a person avoiding certain places or situations as they may cause the person to panic. (3) A second disorder is generalized anxiety disorder, where a person experiences excessive anxiety that can interfere with daily living. (4) A differentiating factor between the symptoms of stress and anxiety tends to be the causative triggers, and the emotions derived by these triggers. (5) For example, stress may be the result of an external event, such as an exam. When this external event disappears, the stress tends to as well. On the contrary, anxiety may remain present even when the external event is no longer there. Another important differentiating factor between stress and anxiety is the severity and impact on a person's quality of life. Anxiety has shown to have an increased severity of duration and impact on quality of life than stress.

The physiological symptoms presented tend to be identical to those listed above. However, the implications of these symptoms may lead to a variety of outcomes, such as (2):

- Impending sense of danger or doom
- Anxiety and/or panic attacks
- Excessive amount of worrying that interferes with daily tasks
- Avoidance of certain situations that may lead to an anxiety and/or panic attack
- Avoidance of places that may lead to an anxiety and/or panic attack
- Avoidance of social situations that may lead to an anxiety and/or panic attack

The above lists are not exhaustive, and any individual may experience any one or a multitude of symptoms. It is important to know that an anxiety disorder may be diagnosed when a certain number of symptoms are present. The manifestations of anxiety appear to be extensive and intertwined. Despite the complex network that defines and characterizes anxiety, there are a number of treatments that are available to those who suffer from extreme levels of anxiety. These treatments include psychotherapy, such as cognitive behavioural therapy or talk therapy, as well as medications if needed. (5) Lastly, it is imperative to check in on yourself. If you feel like you are experiencing levels of anxiety that is interfering with your day-to-day life, it is okay to ask for help. Know that you are not alone in feeling this, and with time and effort, it will get better.

Works Cited

(1) *Anxiety in Youth*. Anxiety Canada, n.d., www.anxietycanada.com/learn-about-anxiety/anxiety-in-youth/. Assessed 10 Aug. 2020.
(2) *Anxiety Disorders*. Mayo Clinic, n.d., www.mayoclinic.org/diseases-conditions/anxiety/symptoms-causes/syc-20350961. Assessed 10 Aug. 2020.
(3) *Agoraphobia*. Mayo Clinic, n.d., www.mayoclinic.org/diseases-conditions/agoraphobia/symptoms-causes/syc-20355987. Assessed 10 Aug. 2020.
(4) *Generalized Anxiety Disorder*. Mayo Clinic, n.d., www.mayoclinic.org/diseases-conditions/generalized-anxiety-disorder/symptoms-causes/syc-20360803. Assessed 10 Aug. 2020.
(5) *What's the difference between stress and anxiety?* American Psychological Association, 28 Oct. 2019, www.apa.org/topics/stress-anxiety-difference. Assessed 10 Aug. 2020.

“I’ve got this! Wait, do I? I don't think I can do this.”

Kelsey W.

If I pause for two seconds, I can feel my head spinning and wanting to take me in so many different directions. My palms are sweating, and I cannot move, my body feels numb…this is what I experience when I have an anxiety attack.

Anxiety is more than just these feelings;
it’s the need to control everything because you feel that if you don’t, it will fall apart.

It’s having a busy schedule so that you always have something to look forward to.

Anxiety is the feeling that you will never be good enough. You doubt yourself wondering if you have made the wrong choice.

It’s the constant fear that in any relationship you create you shouldn’t get too close to the person because they will end up leaving you.

Photo taken by Kelsey W.

Anxiety is struggling to find the right thing to say. So, you write, delete, and re-write a post or message before you send it- just in case you worded it wrong.
It's always wanting to help everywhere you can, with anything possible. Anxiety is struggling just to make sense of your thoughts, and not knowing which ones to believe.

It's the constant battle between your head and your heart.
Anxiety is living in a space where you feel like you have no control.
It's needing to have answers to all of life's problems.
Anxiety is having a severe case of FOMO (fear of missing out) - you must be a part of everything.
It's overthinking every situation, because it would be too simple for something to just go right for once.

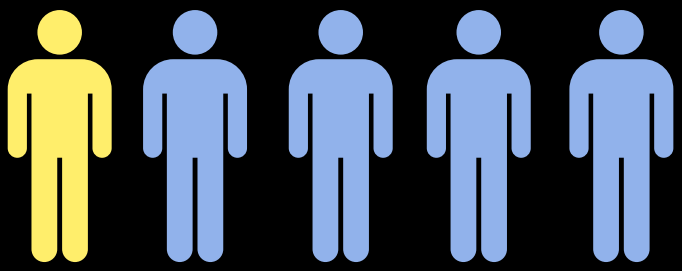
Anxiety is finding it hard to say goodbye, because you don't know if or when you will see them again.
It's wanting to do everything just right but apologizing for things that you didn't even do.
Anxiety is the nights that you spend awake, thinking of every little detail in your life.

My days are spent trying to perfect my every move and hiding the fear from the people around me. I have become so used to fearing my anxiety and not knowing how to cope with it. I feel like the last few months I have been in a constant state of panic; not knowing what days will be good, and which will be an ongoing battle.
Over the last while, I have been able to learn some tools and tricks that are helping lessen the intensity of my attacks.
It's an ongoing commitment that I am hoping in time will help me be better able to cope with my anxiety.
Keep in mind that in this world we are never given anything that we can't handle.
Whatever you are struggling with right now, I know you can get through it. I believe in you!
Even when it seems like the world has come crashing down, we must remember…
"It's just a breakdown before a breakthrough, and tomorrow's another day.[1]"
We all have tough and struggling moments in our lives, but we can all get through it just one step at a time.

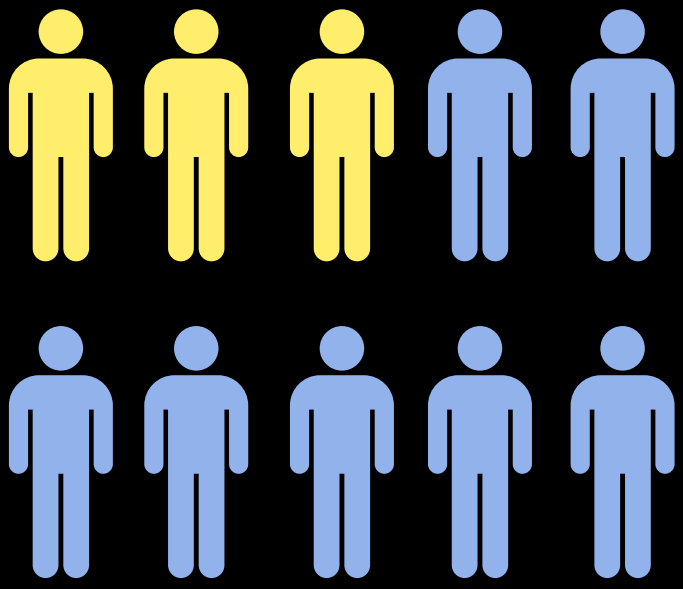
[1] Dream On - Written by Maureen Ennis and Perry Chafe

MINORITY MENTAL HEALTH

Jasmine Gill
Mykaela Holt
Cadence Rolfson



More than 1 in 5 people in Canada are a visible minority (~ 22.3%) [1].



Of the visible minority population, 3 in 10 were born in Canada.

Because Canada is a diverse country, it is important to understand how the unique challenges ethnic minorities face can impact their mental health. The following article discusses how various barriers, prevalent racism, individual contexts, and culturally sensitive therapy practices impact the mental health of ethnic minorities in North American communities.

Please note that these studies report the population average; as such, not everyone within a certain culture or ethnic group will have the same attitudes and behaviors regarding mental health.

Barriers for Ethnic Minorities Seeking Mental Health Services

Canada is home to a diverse population of individuals from multicultural backgrounds, representing over 200 ethnic groups with more than 200 languages spoken as a first language. (1) Approximately 20% of the population identifies as being a member of a racialized group, and a vast proportion of these individuals are of South Asian, Chinese and Black origin. (1)

Despite Canada's aim to provide equal access to healthcare for all residents, ethnic minorities in Canada continue to face challenges in accessing mental health treatments and services. This is a particular concern for ethnic minority youth, who may not be accessing mental health services they need despite their possible increased susceptibility to mental illness. (2) The Canadian Mental Health Association (CMHA) reports that only 1 out of every 5 Canadian children who need mental health services receive them. (3) A Canadian study published in 2010 reported that Black participants experiencing an episode of major depressive disorder were 60% less likely to seek treatment compared to Caucasian participants, while South Asian and East Asian (Chinese, Japanese, Korean) individuals were 85% and 74% less likely to seek treatment, respectively. (4) The discrepancy in services being used by ethnic minorities may be due to several interconnected factors that are listed below. (3) Notably, many risk factors for the development of mental health problems in addition to barriers to accessing mental health services disproportionately affect ethnic minority groups. (3)

When addressing discrepancies in health care use and treatment, social determinants of health help individuals better understand various factors that can influence a person's life. Social determinants of health are described as "the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life". (11) These social determinants not only influence the risk of developing mental illness, it may also affect the ability to access mental health care resources.

Social determinants of health include:

- Income and social status
- Social support networks
- Education and literacy
- Employment or working conditions
- Social environments
- Physical environments
- Personal health practice and coping skills
- Healthy child development
- Health services
- Gender
- Culture
- Age
- Migration
- Discrimination
- Language
- Food security
- Caregiver burden or health of a family member
- Safety from or exposure to victimization or violence
- Parent's mental health or substance use problems

There is evidence to suggest that immigrant, refugee, ethnocultural and racialized populations are more likely to be exposed to the negative impacts of the last 4 social determinants of health listed above. (11)

Overall, ethnic minority groups may face several obstacles in seeking and accessing mental health services. These may be due to internalized or self-perceived barriers, societal influences, limitations in service availability and delivery and financial constraints. As a result, individuals from ethnic minorities may be accessing formal mental health services at relatively lower rates compared to the rest of the population.

Facilitators to mental health care access include support from family and friends, established networks to health care providers, affordable treatments, flexible appointment times, and reduced transportation barriers. (12) Religious institutions can also facilitate mental health care as some individuals may be more comfortable seeking support in their religious group. (9) Additionally, culturally competent care providers may also encourage ongoing use of services among ethnically diverse individuals. (2)

Though our current healthcare system focuses on equality for all residents, there continues to be discrepancies in access to care among different ethnic and cultural groups. (13) Findings from the literature suggest that a focus on equity may better serve the needs of marginalized groups. Equity involves providing additional support to ethnic individuals who face the greatest barriers to access and care. (14) Further research on barriers that affect specific ethnic groups and sub-groups as well as enablers to receive care can help inform strategies to improve access to mental health care services. Consultation with youth in the community, along with a concerted effort to incorporate youth perspectives in research studies would be beneficial. Additionally, integrated cultural competency training for health professionals, and effective communication between patient and provider can facilitate an awareness of these barriers. By prioritizing the need to better understand challenges that ethnic minorities face in accessing and using services, efforts can then be directed towards finding opportunities to better support the unique mental health needs of ethnic minorities so they can access appropriate services. As stated by Cauce and colleagues, "culturally competent mental health services quickly become irrelevant if ethnic minority adolescents do not find their way into them." (9)

Racialized "acknowledges race as a social construct", and is a term that may be used instead of racial or visible minority. (11)

Ethnocultural refers to "a group that shares a common ancestry and cultural characteristics". (1)

Statistics from the United States (US) in 2015 report that among adults with mental illness, only 31% of Black and Hispanic individuals and 22% of Asians received mental health services compared with 48% of Caucasians who received services. (5) Furthermore, different types of services (inpatient or outpatient) are used by different ethnic groups. In particular, individuals from ethnic minority backgrounds may access alternate pathways to care. A 2010 US study found that Black, Hispanic and Asian youth diagnosed with depression were significantly less likely to receive mental health care in an outpatient clinic compared to Caucasian youth. (6) A 2014 meta-analysis of studies from Canada and England examining pathways to care at the first episode of psychosis found that Black patients were less likely to have a family physician involved in their care and there was a trend towards an increased likelihood of police involvement and relative to Caucasian patients. (7) Similarly, a Canadian study published in 2015 concluded that Black-Caribbean and Black-African patients experiencing first-episode psychosis were less likely to have a family physician initially involved in their care, and were more likely to initially visit an emergency room compared to White-European patients. (8) These lower rates of mental health service use and use of alternate pathways to care among ethnic minority groups may be attributed to multiple factors, some of which are described below.

In summary, barriers for ethnic minorities to access and utilize mental health services include the following: (2, 9, 10, 11)

Systemic barriers:

- Geographical barriers, lack of transportation, and long wait times
- Language barriers between patient and provider, which may contribute to misdiagnoses
- Lack of cultural diversity among mental health care providers
- Lack of culturally competent providers
- Inadequate support of mental health services for those with low income and/or on income support; Lack of insurance
- Stigma surrounding mental illness, which may be greater among ethnic minority populations
- Cultural presentation of symptoms may vary from classifications found in validated tools and resources
- Distrust in the health care system
- Racism

Service-related barriers:

- Racism, and discrimination from health care providers
- "Eurocentric" programs (programs that focus on European and Western culture and history) may fail to address the unique and complex needs of youth from various cultural backgrounds.
- Lack of organizational support, difficulty putting anti-racism into practice, and challenges in uptake of innovative programs
- Restrictions in funding
- Primary care physicians play a large role in identifying and managing mental health however, they may have limited resources to meet the demand of providing mental health care services

Photo taken by Jasmine Gill

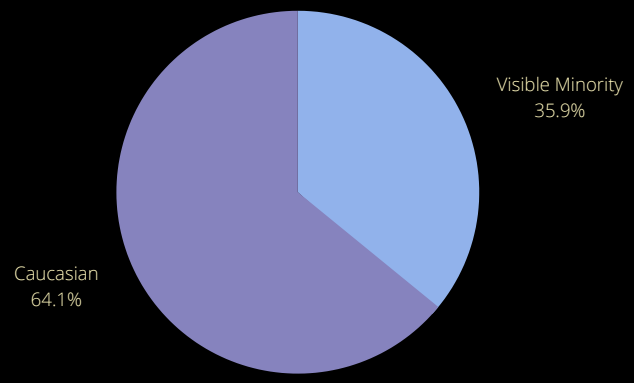
Personal and community related barriers:

- Reluctance to access services, reluctance to acknowledge signs and symptoms
- Fear of judgement from friends and family
- Neglecting signs and symptoms
- Internal and external stigma (including from society and health care providers)

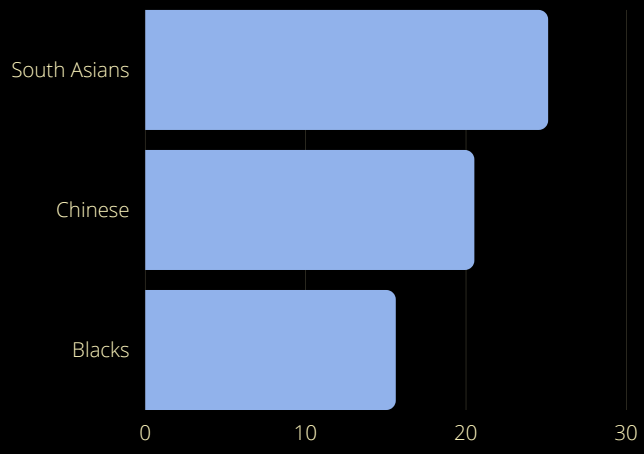
Effect of Racism on Mental Health

Racism—a prevalent social construct problem in our society today—is the marginalization and oppression of a group of people based on their phenotypic colour of skin, and/or their belonging to an ethnic group. In acting racist, one assigns values to another individual based on their ethnicity. This also includes the structuring of opportunities, systems, and institutions to serve a socially constructed racial hierarchy that favours one race over another. Regrettably, as Canadians, we are not immune to acts of racism. It sneaks in at every level: from daily interactions when you mistake an individual for someone else of the same race; to teachers and peers assuming a person of colour is an expert of all people of the same ethnicity; to dealing with negative (or even positive!) stereotypes. It undeniably happens on the larger playing field as well. Often, through social media we hear plentiful examples of racism, particularly from the US. But, as Canadians, it is our responsibility to recognize examples which occur here. For instance, the "story of Canada" is still chiefly taught from a European/ Western perspective- sometimes with the perspective of Indigenous people added in as a supplement, and the phrase "go back home" is a commonplace insult hurled across supermarket parking lots.

Not only is racism a social problem- it is also a mental health problem. Regardless of the type of racism - systemic, institutional, internalized, personalized, etc.- the experience of it is correlated with poor mental health. (15)



The percentage of visible minorities in Canada is growing, with a projected 31.2-35.9% of the population being a member of a minority group by 2036.



Among Canadian ethnic minority populations in 2016, the largest percentages in descending order are: South Asians (25.1%), Chinese (20.5%), and Blacks (15.6%).

https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025b-eng.htm?indid=14428-1

Some of the mental health effects from experiencing, witnessing, and/or internalizing racism include: (16,17)

- Increased risk of depression or suicide
- Increased levels of anxiety including GAD and social phobia
- Post-Traumatic Stress Disorder (PTSD)
- Substance abuse problems
- Intergenerational racism and trauma
- Hypervigilance and fear
- Shame and guilt
- Self-blame
- Negative internalized beliefs
- "Racial battle fatigue"
- Feeling helpless or worthless
- Avoidance behaviours

In fact, the after-effects of racism also include physical health deterioration, including: an increase of stress-related illnesses (high blood pressure, cardiovascular disease, heart disease, nervous system ailments); chronic inflammation from long-term survival through the "fight or flight" system; headaches; poor sleep; coronary artery calcification; and altered cortisol (stress hormone) patterns. (15,16) The list goes on. The cumulative effects of racism on mental health also seeps into other domains such as home life, school, and work, as well as across time and generations. (15)

Interestingly, although experiencing or witnessing a large demonstration of racism can cause obvious mental health concerns, small, incremental, and aggregating experiences of racism are consistently the cause of negative long-term effects on mental health. (15) As defined above, these "small" instances of racism occur continuously. For example, in a study of 101 black teens in the USA, it was found that each teen faced an average of more than five instances of racism per day, or more than 70 over two weeks! (18) Within these daily experiences, people of colour may experience microaggressions from others, in which they are discriminated against subtly, indirectly, or unintentionally. These microaggressions can include asking someone where they were born/ from, saying they don't see colour, or assuming a person follows ethnic, racial, or cultural stereotypes. In addition, the pervasivity of racist events leads to decreased feelings of control, a reflection of rejection by society, and an increase in psychological damage. (17) Furthermore, the fear of racism- including feeling unsafe or avoiding spaces where racism may occur- had the largest effect on the mental health of visible minorities. (15) Since racism occurs continuously, people of colour may not only develop the mental health problems and stress responses described above, but also unhealthy coping strategies. (17)

Photo created by Sheher-Bano A.

Effects of Context and Culture on Mental Health

Context refers to an individual's unique social environment, physical environment, cultural environment, and institutional environment (i.e. what services are available). Culture has been defined as a "social context in which people share social norms, beliefs, values, language, and institutions". (19) Ethnicity is typically used to separate one culture from another, although culture and ethnicity are not interchangeable terms. (9) Both context and culture affect how youth seek and participate in mental health services.

An article published by Cauce and colleagues. (9) outlined a help seeking model of three interconnected stages that ultimately lead to an individual using mental health services.

The model focused on the processes and barriers involved when minority youth seek mental health help. These stages, which may occur in any order, include the following:

1. Problem recognition
2. Decision to seek help
3. Service selection

How an individual uses and navigates mental health services depends not only on cultural beliefs and practices, but also on an individual's family and friends, service availability, referrals to mental health services, personal belief systems surrounding mental health, and their coping strategies. (9)

Photo taken by Jasmine Gill

Problem recognition and definition

Context influences how mental health symptoms are interpreted and perceived, as social norms vary depending on the community. These norms can influence perceptions of what is thought to be undesirable, deviant or concerning behaviour in youth. For example, if a child lives in a rough environment, then a parent may not consider a child's aggressive behavior towards others to be unusual, whereas a parent living in a higher income neighborhood may consider the behavior to be uncommon and a cause for concern. (20)

Culture also plays a large role in the recognition and interpretation of mental health, with some cultures defining symptoms of mental illness differently from Western cultures. For example, some groups of Russians and West Indians often perceive mental health to be a result of stress, whereas people from West Africa, Japan, Central and South Americans, South Asians, Ethiopians, Eritreans, and Somalis believe mental health to be a cause of evil spirits, witchcraft, or the "evil eye". (21)

The "decision" to seek help

There is a difference between identifying a need for mental health services and actively seeking help for those problems. (9) Individuals from certain cultures and backgrounds may not seek help even when a problem is recognized. For example, some groups of West Indians and Cambodians view mental health as a weakness, whereas individuals from Korea, China, South Asia, and Vietnam view mental illness as a source of shame that should be ignored. (21) African American youth are often encouraged to overcome difficult times using willpower, which can lead to increased confidence that they can overcome the issue. (14) Interestingly, the mental wellbeing of parents can influence their likelihood to seek services and acknowledge the psychological concerns in their children. Parents with high levels of anxiety may be more likely to seek support for their child's mental health problems than those with lower levels of anxiety. (11)

Service selection

While White people are more likely to seek help from outside sources (i.e. counselling, medication, and other related services), many ethnic minority cultures encourage individuals to overcome challenges on their own without the use of outside resources, including African Americans, (22) Russians, (21) and Arab groups, who view mental health as within their control. (21) Furthermore, many cultures are not comfortable discussing family conflicts with outsiders, including Vietnamese and South Asians.(21)

Individuals from ethnic minorities tend to seek support from their immediate and extended family, friends, and traditional or religious healers.

The support they receive from this extended network can either prevent or facilitate an individual's decision to seek other mental health services. Stigma and uncertainties regarding the role of mental health professionals may also be a contributing factor when deciding whether to seek services. For instance, Takeuchi and colleagues (23) found that African American's were less likely to seek medical help due to fears of losing their child to institutionalization. For some Asian American families, seeking mental health treatment is a last resort and efforts are directed towards managing these problems within the family environment. (9) In other cases, families and/or youth may be simply reluctant to seek out formal services. Thus, officials from schools, churches, and community agents can play a role in helping connect these youth to formal services.

Interestingly, on average individuals from Cambodia and China have been known to identify psychological problems as physical problems (i.e. getting a stomach-ache when anxious), and will primarily turn to physicians for help. (21) Although there are numerous cultures that may be uncomfortable with Western medicine, many other cultures embrace the integration of Western medicine (or at least accept it), including Arabians, Colombians, Ethiopians, Eritreans, and Russians. (21)

It may be challenging for youth to navigate which treatment center to choose and/or who to ask for help. Minority youth may seek help via informal supports such as family members or friends or turn to more formal services such as school counselors, psychologists, psychiatrists and pathways in the juvenile system. (9)

Frameworks to Improve Services for Ethnic Minorities

There is evidence that mental health treatments may be less effective for ethnic minorities when compared with the rest of the population. (24) To address this, therapists are advised to become aware of cultural issues the individual may be facing, such as stigma, racism, prejudice, stress, and stereotyping. Aspects of the individual's culture during treatment should also be included. The therapist can also help immigrant and refugee youth work through potential feelings of anger and confusion, find a balance between their cultural heritage and their current cultural environment, and increase their self-esteem and self-worth that generations of racism may have harmed. (24)

One of the organizations involved in improving services to ethnic minorities is Multicultural Health Brokers Co-op (MCHB). MCHB is an Edmonton facility that helps immigrants and refugees integrate into their new community, while at the same time advocating for the acceptance of Canadian diversity and celebrating the different cultural strengths that come from each individual. Many of their programs address the mental health concerns of minority youths and their families, aiming to promote youth health and well-being. To learn more, visit their website at **http://mchb.org/** and view the MCHB interview discussed in the following pages.

Photo taken by Jasmine Gill

Works Cited

(1) National Household Survey Dictionary. Statistics Canada, 2011 [Internet], www150.statcan.gc.ca/n1/en/daily-quotidien/130508/dq130508-eng.pdf?st=ZbflfvXX. Accessed 29 Oct 2020.
(2) Fante-Coleman, Tiyondah, and Jackson-Best, Fatimah. "Barriers and Facilitators to Accessing Mental Healthcare in Canada for Black Youth: A Scoping Review." Adolescent Research Review, vol. 5, no. 2, 2020, pp. 115–36. link.springer.com/article/10.1007/s40894-020-00133-2
(3) Mental Health Commission of Canada. Making the case for investing in mental health in Canada [Internet]. CMHA National, 2013, cmha.ca/fast-facts-about-mental-illness. Accessed 29 Oct 2020
(4) Gadalla, Tahany, M. "Ethnicity and seeking treatment for depression: a Canadian national study." Canadian Ethnic Studies, vol. 41, no. 3, 2010, pp. 233-45. muse.jhu.edu/article/482297. Accessed 29 Oct 2020.
(5) Agency for Healthcare Research and Quality. National Healthcare Quality and Disparities report [Internet], 2014, https://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html. Assessed 29 Oct 2020.
(6) Cummings, Janet, R., and Druss, Benjamin, G. "Racial/ethnic differences in mental health service use among adolescents with major depression." Journal of the American Academy of Child & Adolescent Psychiatry, vol. 50, no. 2, 2011, pp. 160-70.
(7) Anderson, Kelly, K., et al. "Pathways to first-episode care for psychosis in African-, Caribbean-, and European-origin groups in Ontario." The Canadian Journal of Psychiatry. vol. 60, no. 5, 2015, pp. 223-231. journals.sagepub.com/doi/abs/10.1177/070674371506000504
(8) Anderson, Kelly, K., et al. "A meta-analysis of ethnic differences in pathways to care at the first episode of psychosis." Acta psychiatrica scandinavica, vol. 130, no. 4, 2014, pp. 257-68. onlinelibrary.wiley.com/doi/full/10.1111/acps.12254
(9) Cauce Ana M., et al. "Cultural and contextual influences in mental health help seeking: a focus on ethnic minority youth." Journal of Consult Clinic Psychology. vol. 70, no, 1, 2002, pp. 44–55. ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=yrovfte&NEWS=N&AN=00004730-200202000-00004.
(10) Wallace, Stephanie, et al. "Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom." American Journal of Public Health, vol. 106, no. 7, 2016, pp. 1294–300.
(11) Mental Health Commission of Canada. The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized populations: report to the Mental Health Commission of Canada, 2016, madgic.library.carleton.ca/deposit/govt/ca_fed/mhcc_casefordiversity_2016_eng.pdf. Assessed 29 Oct 2020.
(12) Planey, Arrianna, M., et al. "Barriers and facilitators to mental health help-seeking among African American youth and their families: A systematic review study." Children and Youth Services Review, vol, 101, 2019, pp. 190–200.
(13) Mental Health Commission of Canada. Mental Health in Balance: Ending the Health Care Disparity in Canada [Internet], 2018, cmha.ca/wp-content/uploads/2018/09/CMHA-Parity-Paper-Full-Report-EN.pdf. Accessed 29 Oct 2020.
(14) Northwestern Health Unit. Equity vs Equality, 2014, www.nwhu.on.ca/ourservices/Pages/Equity-vs-Equality.aspx. Accessed 29 Oct 2020.
(15) Wallace, Stephanie., et al. "Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom." American Journal of Public Health, vol. 106, no. 7, 2016, pp.1294-1300.
(16) Simcoe, C. Racism and Mental Health, 11 Sept. 2020, cmha-yr.on.ca/learn/news/racism/. Accessed 2 Dec. 2020.
(17) Woo, Bongki. "Racial Discrimination and Mental Health in the USA: Testing the Reverse Racism Hypothesis." Journal of Racial and Ethnic Health Disparities, vol. 5, no 4, 2017, pp. 766-773.
(18) Harmon, Amy. How Much Racism Do You Face Every Day? The New York Times, 20, Jan. 2020, www.nytimes.com/interactive/2020/us/racism-african-americans-quiz.html. Accessed 02 Dec. 2020.
(19) Guerra, Nancy, G., and Jagers, Robert. "The importance of culture in the assessment of children and youth." Studying minority adolescents: Conceptual, methodological, and theoretical issues, 1998, pp. 167-181.
(20) Paradise, Matthew., et al. "The role of relationships in developmental trajectories of homeless and runaway youth." In B. R. Sarason & S. Duck (Eds.), Personal relationships: Implications for clinical and community psychology, 2001, pp. 159–179. John Wiley & Sons Ltd.
(21) Kongnetiman, Linda, and Eskow, Elaine. "Enhancing Cultural Competency: A Resource Kit for Health Care Professionals." Alberta Health Services, Feb. 2009, www.multiculturalmentalhealth.ca/wp-. Accessed 11 Oct 2020.
content/uploads/2013/10/Enhancing_Cultural_Competency_Resource_Kit1.pdf.
(22) Broman, Clifford, L. Coping with personal problems. In H. W. Neighbors & J. S. Jackson (Eds.), Mental health in Black America, 1996, pp. 117–129, Sage Publications, Inc.
(23) Takeuchi, David, T., et al. "The referral of minority adolescents to community mental health centers." Journal of Health and Social Behavior, vol. 34, no. 2, 1993, pp. 153-164. JSTOR, doi.org/10.2307/2137241.
(24) Comer, Ronald, J. Abnormal psychology (9th ed.). Macmillan, 2015

Interview with Dr. Heather Boynton on Minority Mental Health

Dr. Heather M. Boynton is a Registered Social Worker and a Mental Health Consultant on CASA's Community Geographic Team. She has worked in mental health for over 30 years as a Child and Family Therapist, and a Manager of Adult Services. She is an Adjunct Professor at Lakehead University in Kinesiology, Faculty at the Northern Ontario School of Medicine, as well as the University of Calgary in Social Work, in addition to being a sessional lecturer at Dalhousie University. She teaches with a strong focus on spirituality, cultural humility, and interprofessional education and collaboration. Her research interests include children's mental health, spirituality, trauma, grief and loss, postpartum depression, stigma, integrative and holistic health and wellness.

What are the different perspectives on mental health in minority cultures?

"I think it depends on the culture itself. I think in some cultures there is still a lot of stigma attached to mental health; especially Eastern and Middle Eastern cultures, from my experience. As clinicians we aim to help them understand mental health from more of an overall health perspective. It is quite broad, from my experience. Some of it has to do with society and culture, and some has to do with the perspectives of someone's own family or the culture of the family. It has been my experience that even with Canadian cultures there is stigma. There have been advancements like the Bell Talks project that have helped reduce stigma. I wouldn't label it as an issue for just one culture, I think it can be in any culture really.

Although, in some cultures, there seems to be more of a stigma still than there is in other cultures. There are varying degrees of stigma in different cultures. It is so complex, and it is not fair to generalize to a certain culture or cultures."

"What stigma or stereotypes do minorities face that affect mental health?

"Some cultures have a different understanding of mental health aspects. There are some cultures that view some types of mental health as spiritual aspects, for example feeling impacted by negative spiritual energies. Those cultures may seek out a more spiritual approach to resolve it rather than, say, going through a mental health approach. There may be some cultural groups that find this approach valuable or helpful and there may be others where the mental health issue may be more extreme. For example, someone who we would diagnose with schizophrenia. Going to a spiritual healing may not be able to really truly heal the full range of that disorder, but maybe someone who is having more anxiety or depression, may actually find some benefit from spiritual counselling."

What are the barriers to minority populations trying to access mental health treatment?

"Access definitely a barrier. As health care providers we need to be more proactive in opening up avenues of access where people can get into services rather than traditional ways. There needs to be more on the ground and in the community intakes for different cultures. I think language can be a barrier, and right now access to technology is a barrier. Even that stigma or shame - to have the courage to come forward to say that they need help can be difficult. Some of it is socially constructed belief systems that get in the way of people accessing services. Even when they are in service they may not be comfortable sharing things, they may not even be comfortable sharing their worldview and spirituality. Although, I believe it is becoming more and more acceptable to discuss spirituality. Spirituality is something that people want to have as part of their mental health and treatment, however that is not something that is typically asked about or incorporated... or even traditional therapies and healing for different cultures that have different traditional healing."

What challenges do minority youth specifically face in regard to mental health?

Dr. Boynton identified several barriers that were previously discussed including access, transportation issues, language barriers and stigma from an individual's family or community. She explained that different provinces have varying definitions for the minimum age of consent to receive mental health treatment. She believes that the ability of the individual to identify a need to seek out and receive services should be considered alongside these legal requirements. *"A lot of things we previously talked about. Including access, transportation issues. Language and interpreter services may be needed. There might be barriers around the family. If the family found out they were getting services it may be shameful, and there may be future ramifications should that be known. There are a lot of people that have the capacity to feel they have a need and actually receive services without their parents saying so. Addressing the age of consent for services is definitely an area of need."*

Photo taken by Jasmine Gill

"As health care providers we need to be more proactive in opening up avenues of access where people can get into services rather than traditional ways"

What are the most important factors in stimulating mental wellness within minority populations?

Dr. Boynton spoke about opportunities for individuals, and youth from minority communities to be "champions" of the cause and help reduce stigma and barriers by implementing strategies to promote mental health and wellness. *"I often wonder if there is a role for youth, because youth can make change for themselves. If we can get some youth champions that might be a way of moving things from a ground up. Educating kids at the school level or youth groups or church groups that may be open to preventative education [may be helpful in stimulating an understanding of mental wellness. Ways to promote awareness about mental health include via social media, pamphlets, flyers, posters, billboards, bus signs."* Further research can also help promote a better understanding of the populations being served in various communities, and whether those individuals belong to a minority group. *"There needs to be more people from those communities who are educated to be the champions to help them reduce stigma and barriers. The more that we can reach out to different communities and multicultural groups to introduce strategies can definitely be helpful. For example, why are the demographics in Edmonton and individuals accessing services in CASA different, why are there less minorities accessing services?"* Dr. Boynton believes there may be multiple reasons or factors.

What is the number one thing we should take away about minority mental health?

"I think the number one thing is really learning and understanding. The second would be advocacy and support."

How is CASA working towards supporting minority mental health?

"A research grant has been given for Participatory Action Research to be conducted within CASA and will be in partnership with several researchers from the University of Calgary. The goal is to enhance and further develop cultural competence at CASA through involving staff, clients, and stakeholders to inquire about current strengths, and areas of need. It will look at programs and policies as well as access, resources and supports. There is also a second grant being submitted focusing on the training needs for staff. CASA leadership has identified cross cultural understanding with a strong focus on Indigenous ways as a strategic priority, and a cultural advisory council will be overseeing a work plan to address all of these things."

Photo taken by Jasmine Gill

Interview with Multicultural Health Brokers (MCHB)

Yvonne Chiu, Jwamer Jalal, and Carlos Salegio

What is MCHB?

MCHB is a workers cooperative that is legally registered. It was created 28 years ago by 14 minority women who were natural leaders, and has now expanded to include 104 natural leaders from the minority community. MCHB is part of 30 different ethnic cultural communities; it focuses on holistic support by validating, nurturing, and alleviating individual and family struggles. Individuals at MCHB wear the name "broker" very proudly, as the term describes a mediator or peacemaker, someone who comes between two or more people or an entity. As brokers it is their job is to nourish good relationships, cultivate understanding, and work collaboratively with formal systems and within communities in order for individuals to receive more care. In other words, MCHB is an organization for the people by the people.

What stigma or stereotypes do minorities face that affect mental health?

While Canada is multicultural and multilingual, it still does not fully embrace diversity in all aspects of life. Because many minorities experience systemic and interpersonal racism, the term **racialized minorities** is used at MCHB. Many Canadians (minority and non-minority alike) have an implicit (and sometimes explicit) belief that being Canadian is looking and acting a certain way, something that can be challenging for minority youth to cope with. This can lead to **existential suffering,** which is when individuals feel as though they don't belong. As a result of existential suffering, minorities lose their sense of self, their sense of meaning and purpose, and their sense of connectedness to others. Identity loss and existential suffering occurs not just in youth, but also in parents, seniors, and second-generation immigrants.

Canadian culture is subconsciously a white culture, as racialized minorities are consistently othered. For example, Joey (who has Kurdish ancestry) explains how almost everyone he meets will ask him where he is from. "*When you are asked where you are from consistently and from everyone that you meet, you are constantly reminded of the fact that you are other, you are from somewhere else. To make things more confusing you don't always have a response to the question that is correct for the person asking it. For example, if a Canadian asks you where you are from and you say 'Canada', they will then respond with 'but where are you actually from?'. When I went to Kurdistan, the people would ask me from where I was from and I would say*

'Kurdistan', and they would then ask, 'where are you actually from'". As such, racialized minorities are constantly reminded of their ethnicity, the color of their skin, and the fact that they are other. It can feel as though people are defining them before they even say anything, as though their identity does not extend beyond their ethnicity.

Carlo's, who has a Latino father and a Canadian mother, explained his sense of not belonging: *"Because I am biracial, here [in Canada] I am asked where I am from because I don't look like I belong in a white society. But when I visit El Salvador (where my dad is from) I am a lot paler, it does not look like I belong there either. There is always a sense of not belonging"*

What are the barriers to minority populations trying to access mental health treatment?

Barriers include poverty, language, and the lack of understanding and commitment within formal systems to address the barriers and inequities racialized minority youth and families experience. As a result, relevant funding is limited and fluctuates depending on what the government can find and secure at a particular moment in time.

How can the stigma and barriers be lessened?

Lessening stigma is the responsibility of formal systems, broader society, and racialized minorities. For instance, formal systems could actively identify and remove barriers and facilitate true social inclusion by promoting the rights of individuals coming into Canada, stopping the cycle of poverty, creating programs that assist with longer-term adjustment & transition to life in the new home country, and improving optimal access to education. Furthermore, the challenges with one's identity that many racialized minorities experience, including adopting hybrid identities (combining their past identity with their adopted identity) should be an area of knowledge that is broadly shared and understood by educators, counsellors, serve providers, program designers and policymakers.

Social inclusion involves two sides of the same coin. The first side addresses actual barriers that minoritized community members and youth face. It is essential that these barriers are recognized and removed in order to stop the spiral of poverty and marginalization. The flip side of the coin is recognizing the unique strengths, languages, and cultural wealth of racialized minorities and incorporating it into everyday life. Having an intercultural society (rather than a multicultural society) where we all speak each other's languages and incorporate the most precious side of our culture into each other's life would allow different cultures to interweave into society, reducing stigma. True interweaving would break down the current "dominant and subordinate cultures" scenarios into a more egalitarian scenario, which is what society should be striving for at a grander scale.

Stigma and barriers can also be reduced by appreciating each other's cultural wealth and cultural capital. Cultural capital refers to the cultural "resources" & tools (cultural wealth) that racialized minority students have inherently within them that allow them to succeed without the financial and cultural advantages that those from the dominant society have.

There are 6 aspects of cultural capital

Aspirational Capital

The hopes and dreams that parents, grandparents, and those surrounding an individual embed within them. Joey explained that *"When I went to the U of A my parents were extremely excited, whenever I achieved anything in academia my parents were extremely excited"*. As such, aspirational capital is the ability to maintain hopes and dreams for the future, even in the face of perceived and real barriers.

Linguistic Capital

The intellectual and social skills obtained from communicating in two different languages. People who speak two different languages are often able to conceptualize things in different ways. For example, in Kurdish the phrase "I walk to go to the park" directly translates to "there's a park that I would love to go to" in English.

Navigation capital

Maneuvering through social institutions and being able to navigate different parts of society. Navigational capital is similar to playing different sports. For instance, different sports contain different rules of play that individuals use to help them succeed. When traveling to a different country, the same strategy is applied. To succeed in a different environment, individuals need to learn the customs and rules of the country. The more environments an individual goes, the more their navigational capital grows.

Resistance capital

The knowledge and skills fostered through opposition, challenges and inequality. There is embedded inequality built into Canadian society. Resistance capital draws on the concept of resilience, as individuals need to be able to adapt and deal with conflicts and injustices, which can only really happen when an individual is supported. The saying "pulling yourself up by your bootstraps" is not a reliable concept, as social support is needed to succeed. Resilience building often starts in the family and community, as cultural wealth provides individuals with the love, care and support needed for resilience. However, institutions and government are also required to build resilience, as family members do not know how to get involved in all things, such as university.

Family Capital

Cultural knowledge that is nurtured among families, including stories past down from an individual's ancestors. Joey explained the meaning of family capital using an example from his own life. *"My dad is a poet...for me that is family capital, I'm able to look at poetry and love it in a different way"*. Appreciating family capital within one's own family allows one to appreciate family capital from other cultures.

Social capital

An individual's network of people and community connection and resources. Social capital refers to the people an individual can access, talk to, and learn from.

Stigma can be lessened if minorities are no longer "othered" by the dominant culture. It is important to remember that everyone has a sense of self, as well as relationships with nature and family. Although there are differences across cultures, as humans we are the same. Othering could be decreased if people more intentionally shared their unique cultural capitals, such as music, poetry, and other artistic expressions that are part of their culture's way of everyday life. This intentionality would increase enjoyment across communities.

Yvonne explains that food is one way cultural diversity can be appreciated; however, often people don't know the story, the history and the social/cultural significance behind the food. If individuals place more emphasis on sharing stories and explaining the cultural significance of things, then people are put in a position where they can develop relationships and discover commonalities with those from other cultures. With the pandemic so many families are at home a lot together. Families have been taking the time to remember and reincorporate what kept them joyful in their original culture (the dancing, singing, sharing of stories and poetry and the games they used to play). The pandemic has given some people an opportunity to reconnect with their roots and share these cultural activities with others in the community.

What Youth Programs does MCHB offer?

Photo taken by Jasmine Gill

The Youth Programs at MCHB seek to nurture three kinds of relationships. The first addresses the need for youth to nurture bonds in their own ethno-cultural communities. To do this, MCHB groups youth together who speak the same language and immigrated from the same region. For example, Syrian youth are grouped together, and Spanish-speaking youth are grouped together in order to share and learn together. These programs encourage bonding, but to stop there would run the risk of groups being considered as "other". The second kind of relationship is called bridging, and it is designed to create change together. Bridging fosters relationships between groups and across cultural/ethnic divides. It encourages sharing and creating change together. The third relationship relates to policy, referring to the relationship between the common folk and those who make decisions everyday (usually those in the government or in schools who control policies). They work together to create a system that is designed to serve minority youth.

MCHB's Youth Programs have been supported since 2006 and are listed below:

Immigrant and Refugee Youth Mental Health Program (funded by Alberta's Safe Communities Initiative Grant): Youth who are embedded in the community are chosen as group leaders, as these youth are well positioned to identify relevant strategies to bring young people together. Youth leaders are matched with groups who have the same language and culture as them. For example, Spanish leaders are placed with Spanish youth groups. Education, recreation, and art are activities used to rebuild identities and bring a sense of belonging in settings that are safe and affirming, that celebrate individual strengths, and that respect individual culture and origins. The program offers a safe space for youth to speak their first language with others and express shared pride for their culture, reducing any feelings of shame that may be felt for not being part of dominant Canadian Western culture. Youth groups work with their leaders to develop strategies to deal with racism, and to build academic capacity with mentors who can relate to their experiences (i.e., understanding how to build a resume and apply for college, tutoring). Incorporating educational mentors is important, as the school system has gaps that many minority youths fall through. For example, a 13-year-old minority may not be ready for the academic challenges that other Canadian 13-year-olds are facing because they don't have a grasp on the dominant language yet. To address this, MCHB will pair these children up with peers that speak their language and understand their struggles. Mentors will offer homework help, enroll them in social support, and engage them with social activity. Youth groups usually meet once or twice a week, with one meeting during the week being academic support, and the other meeting focusing on social support).

Youth Brokering Program (funded by Public Health Agency of Canada): Offers a one-on-one support for minority youth. The program is embedded in three communities (Syrian, Oromo, Eritrean, and Ethiopian). Brokers are chosen straight from these communities to ensure minority youth's unique struggles are understood. As such, brokers are able to offer one on one support, help youth find work and a possible career path, as well as act as a bridge between youth and support systems (such as their families and to mainstream institutions). They can also connect youth to psychological help if needed.

A Wrap-Ed Program: This program is in collaboration with other agencies in Edmonton, including You Can Reach Edmonton (provides employment opportunities); John Howard (provides housing for youth who do not have stable housing), and Edmonton Police Services (to address any judicial issues minority youth may be facing). This program is the same as MCHB's PHAC Program, but it gives youth more access to other Edmonton resources.

Youth led Researching opportunity at the U of A (currently not a fully developed program): Youth led research examining suicide, self-harm, and substance abuse in 6 or 7 ethnocultural communities in Edmonton. Youth look at risk factors and pathways that lead to self harm. Youth also explore mental health topics they are interested in.

What can minority youth do to further promote the mental health of minority populations?

Youth can promote the mental health of minority populations by being cognizant of the 6 forms of cultural wealth discussed above and not taking them for granted.

CASA FAMILY ADVISORY COUNCIL

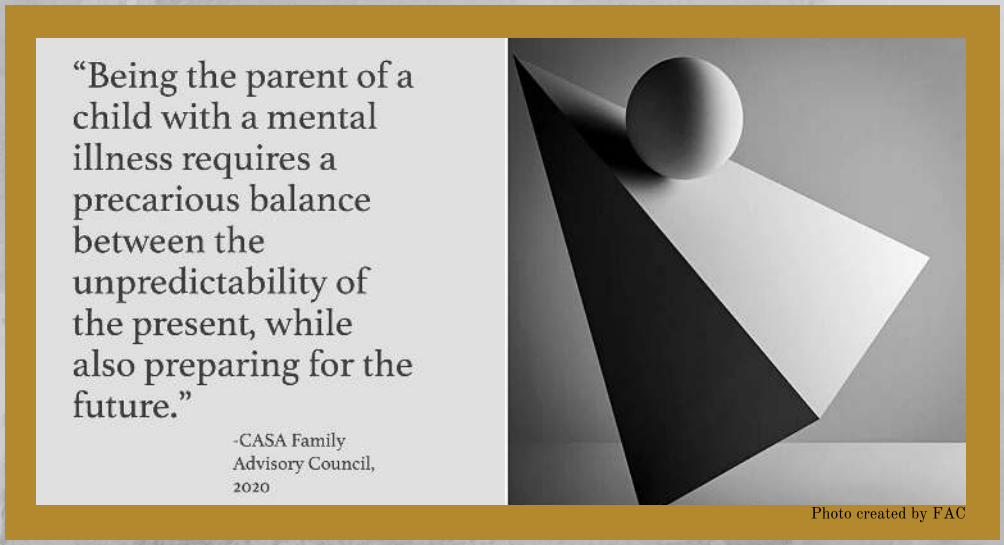
CASA's Family Advisory Council (FAC) was established in June 2014, by a group of dedicated parents seeking validation of their lived experiences, within Alberta's child/youth and family mental health systemic care interventions. Additionally, our council commits to sharing our personal journeys and the barriers, stigmas and judgements we have encountered, or continue to encounter, as families. Our hope is that by sharing our vulnerabilities as parents, we will in turn impact and inspire other families to support one another; to ensure families know they are not alone.

Secondly, the sharing of our personal journeys empowers us to collaborate with organizations, such as CASA. The FAC also feels that utilizing our voices collectively within other correlated systems, (ex. AB government, AB school systems, AHS) we can impact all facets of our current mental health systemic intervention resources, available to families, impacted by mental health crisis.

The FAC is a diverse group of parents and caregivers who risk vulnerabilities of our selves so that we may ensure others know they are not alone and that there is no 'one-size-fits-all' approach to individualized mental health care interventions. What we have found is that the more we can understand our journeys, the more we can unpack our concerns and be validated thus, the more we can support each other, the more we heal.

Simply put, the FAC recognizes that mental health systemic change is undeniably needed. Our policies must reflect and address the current needs of Albertan families, as we battle the overwhelming mental health pandemic in our province. We recognize the commonalities in our stories, themes of disbelief and despair but if you listen closely, there are also stories of personal growth, hope, genuine support and genuine love.

Perceptions will always differ, even within a home. Our families are imperfectly, perfect and as parents, so are we. The FAC invites anyone of interest to view our most recent initiative, 'Am I Enough? – CASA FAC



Photovoice Research Project, 2020'. This photovoice project uses our personal still image pictures to capture our parental struggles and successes, throughout our mental health systemic care journeys (please see links to project below).

We invite any and all feedback, as the FAC believes there is much to be gained by open and meaningful conversations about mental health, in any manner.

Lastly, a sincere 'thank you' to CASA's CYC for inviting our submission into their magazine. We express immense gratitude for years of collaboration and we are excited to continue to impact our communities together! We believe in change!

Sincerely,
Candace Fehr
CASA Family Advisory Co-chair

https://www.facebook.com/CASAFamilyAdvisoryCouncil/

The Highly Sensitive Person:

WHO THEY ARE, HOW THEY LIVE.

Victoria

For years I've described myself as an overanxious introvert, perhaps even bordering on neurotic. While these labels seemed to explain some of my thoughts and behaviours, I knew they did not encompass all I was experiencing in my everyday life. Very recently in a session with my therapist, I was introduced to the concept of "Highly Sensitive People". After taking the self-assessment quiz and scoring 27/27, I took a large interest in exploring Dr. Elaine Aron's research and the intricacies on what it means to be a Highly Sensitive Person (1).

Through my readings I began to connect the dots between what I was learning and how I was living. Small things, like my inability to watch horror movies or any media with extreme violence, were placed as a symptom of being a Highly Sensitive Person rather than just being "sensitive". I found comfort in knowing I'm not the only person who is easily overwhelmed by loud noises and bright lights, and that I'm not alone in being hyper-aware of the facial expressions and body language of those around me. Of the world's population, 15-20% identify as Highly Sensitive People (2). We often do not recognize high sensitivity in each other as we have perfected the ability to "chameleon" ourselves; we are able to blend in with whatever environment surrounds us. The high responsiveness to subtle changes in our surroundings allows us to adapt swiftly and respond accordingly, subsequently camouflaging us from appearing bothered or hyper-aroused. We will do whatever it takes to fit in with our environments.

The name of the Highly Sensitive Person (HSP) is sensory processing sensitivity. Unlike many traits, HSP's do not exist on a continuum; there is no middle ground of sensitivity, you either are an HSP or you are not. The HSP trait is highly associated with neuroticism, and those identifying as HSP's are found to have lowered levels of serotonin in the brain (2). HSP's with troubled childhoods are at an increased risk of becoming depressed, anxious, and shy than non-sensitive individuals with similar childhoods (2). However, HSP's with relatively good childhoods are at no more risk than others. Dopamine is tied closely to the HSP trait, as dopamine is necessary for the transmission of information to certain areas of the brain. Research has found the HSP scale associated with 10 variations on 7 dopamine-controlling genes (2). Genetics, then, is what separates the few with the HSP trait, from those without it. It is what occurs internally, concealed, that sorts the HSP minority from others.

Highly Sensitive People are often thought to be inhibited, shy, fearful, and introverted. This is a common misconception, as 30% of HSPs are extraverts (2). Also, the majority of introverts are not HSPs. The trait is a result of evolutionary adaptation and is found not only in humans but in countless species across the planet. Processing sensitivity is a survival strategy; the ability to pause, perceive, and reflect on what has been noticed before choosing a course of action has allowed for the thriving of numerous species. Which reactions and behaviours will be exhibited is entirely species dependent. Unfortunately, sensory processing sensitivity is not always an adaptive trait, and can be unhelpful in certain contexts. The increased attention to detail and subsequent use of this information to act in one's environment may at times be unnecessary and a waste of energy. The nervous system in a HSP is easily overstimulated; this is a result of increased attention to detail and constant hyperarousal. Because such small details are processed in the HSP brain, individuals may avoid novel scenarios if they even fractionally resemble an unpleasant past experience. This overgeneralization is another example of how this evolutionary HSP trait can be maladaptive in everyday life. The best way for an HSP to recover from overstimulation is to engage in downtime and practice self-care. Taking a chance to reduce unnecessary stimuli allows the HSP brain to slow down and regulate.

While the sensory processing sensitivity trait is not new, it has just begun to be observed and researched in the psychological field. Like many domains in psychology, the behaviour is difficult to observe and research processes can be slow moving. Dr. Elaine Aron has studied Highly Sensitive People extensively, providing explanations for why HSP minds work the way they do. She has also stressed the importance of not forgetting individuality in the midst of discovering this new misunderstood minority group; not everyone is hyper-aware and responsive at all times, and that's okay. Personally, my life has not been changed with this new information, rather I have been able to accept certain aspects of who I am and adapt my mental health care accordingly. Learning about Highly Sensitive People has allowed me the opportunity to reduce some heavy-handed self-stigma, while validating my experiences and behaviours as adaptive rather than destructive.

*For more information on Highly Sensitive People, visit https://hsperson.com/. Here you can find summarized research, self-assessment quizzes, and general resources. I hope this article and website helps bring insight to any other HSP's out there, as it did for me.

Works Cited

(1) Aron, Elaine N. The Highly Sensitive Person, n.d., hsperson.com/. Accessed 10 July 2020.
(2) Aron, Elaine N. Author's Note, 2012, for The Highly Sensitive Person, 6 Sept. 2012, pp. 1–13.

DOES

Dr. Elaine Aron has created the “DOES” acronym as a simple comprehensive description of the sensory processing sensitivity trait. These 4 areas are key to understanding the intricacies of being a Highly Sensitive Person.

- **D - Depth of Processing:**
  - HSPs observe and reflect before taking action, whether consciously or subconsciously, we process everything more than other people. HSP’s have more brain activation in the insula, which is responsible for integrating moment to moment awareness of body states and emotions, outer events, and bodily positions.

- **O - Overstimulation:**
  - HSPs are easily overstimulated. Paying increased attention to surroundings at all times exhausts the nervous system more rapidly. Social situations also contribute to overstimulation and may result in an HSP avoiding intense social situations more than a non-HSP would.

- **E - Emotional Reactivity and Empathy:**
  - HSPs give emphasis to emotional reactions and empathy, which helps them to notice and learn. HSP’s are thought to have a larger capacity for empathy. Emotional reactivity allows HSP’s to respond not only to negative stimuli, but to appreciate good outcomes and plan how to increase their frequencies.

- **S - Sensing the Subtle:**
  - HSPs are sensitive to all subtleties present in an environment; these subtleties are often the small details overlooked by others. Sensing the subtle permits an HSP to craft appropriate responses based on awareness of nonverbal cues regarding mood and trustworthiness (no matter if an individual is aware that they are exhibiting these cues).

Let's Talk about Schizophrenia

Balraj Malhi

What is Schizophrenia?

According to the World Health Organization (WHO), schizophrenia can be defined as a psychosis or type of mental illness that is characterized by distortions in thinking, perceptions, and emotions and many other symptoms. (2) These distortions can be manifested in combination with hallucinations and delusions, which can result in the individual suffering in terms of daily function. (2)

Symptoms

Schizophrenia involves deficits in a wide range of traits such as cognition, behavior and emotions. (2) As such, the symptoms of the illness are also quite variable. However, some of the most commonly seen symptoms in individuals with schizophrenia can be broken down into two major categories: positive psychotic symptoms and negative symptoms. (3) Positive symptoms can include hallucinations such as hearing voices and paranoid delusions such as believing you are famous, or that you are being spied on. Negative symptoms commonly include a decrease in ability to initiate speak, to express emotion, and to experience pleasure. For example, they may stop showering, have trouble staying on schedule, and may have a hard time holding conversations. (3)

Causes

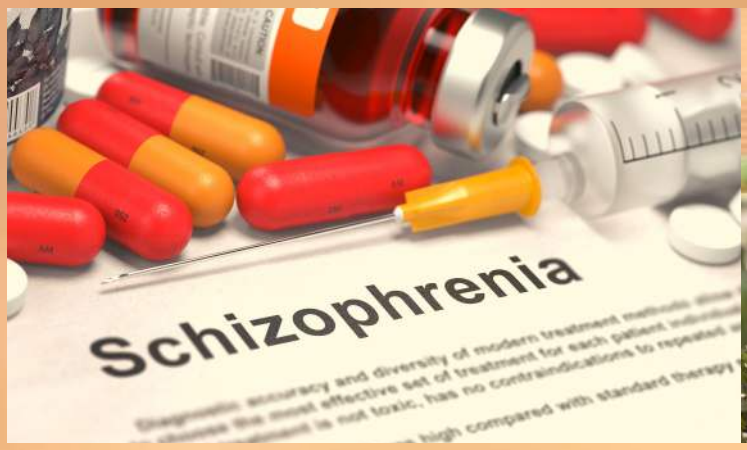
Much research has been conducted in terms of discovering the cause of schizophrenia. Some of the latest research suggests that multiple factors are involved, including genetics, brain chemistry, and environmental factors. (3)

Key Facts

- Schizophrenia is a severe mental disorder that affects more than 20 million people worldwide. (1)
- Schizophrenia is treatable. Combinations of medication and psychosocial support has shown to be effective. (1)
- Studies have shown that immigrant and lower socioeconomic populations have a greater than average chance of being diagnosed with schizophrenia than the general population. (1)
- The estimated costs of schizophrenia in Canada due to hospitalization, disability payments, and lost wages approach 2 billion dollars annually. (4)
- Schizophrenia occurs most often in the 16 to 30 year age group. (5)

Management of Illness

Medication can be prescribed to those with schizophrenia. The majority of these medications have a direct impact in reducing the positive symptoms experienced by an individual. (6) Some antipsychotics may also improve negative symptoms, while some may have no or a negative affect. Through continued usage of medication, individuals can resume their normal lifestyle. In addition to medication, various therapies and supports are available that help people learn social skills, as well as strategies on how to cope with stress. (3)



Works Cited

(1) *Schizophrenia.* World Health Organization, n.d., www.who.int/news-room/fact-sheets/detail/schizophrenia. Accessed 02 July 2020.
(2) *Schizophrenia.* Mayo Clinic, n.d., www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443. Accessed 02 July 2020.
(3) *What is Schizophrenia?* American Psychiatric Association, n.d., www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia. Accessed 02 July 2020.
(4) *Schizophrenia Facts.* Schizophrenia Society of Saskatchewan, n.d., www.schizophrenia.sk.ca/what-are-the-facts-about-schizophrenia/. Accessed 02 July 2020.
(5) *Facts about Schizophrenia.* Canadian Mental Health Association, n.d., toronto.cmha.ca/documents/facts-about-schizophrenia/. Accessed 02 July 2020.
(6) *Schizophrenia: Management and Treatment.* Cleveland Clinic, n.d., my.clevelandclinic.org/health/diseases/4568-schizophrenia/management-and-treatment. Accessed 02 July 2020.
(7) *Schizophrenia Treatment and Self-Help.* Help Guide, n.d., helpguide.org/articles/mental-disorders/schizophrenia-treatment-and-self-help.htm. Accessed 02 July 2020.
(8) *Schizophrenia.* Canadian Mental Health Association, n.d., cmha.ca/mental-health/understanding-mental-illness/schizophrenia. Accessed 02 July 2020.
(9) *What do you want to know about Schizophrenia?* Healthline, n.d., www.healthline.com/health/schizophrenia. Accessed 02 July 2020.
(10) *Schizophrenia.* Schizophrenia Society of Alberta, n.d., www.schizophrenia.ab.ca. Accessed 02 July 2020.
(11) *Schizophrenia.* My Health Alberta, n.d., myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=aa46937. Accessed 02 July 2020.

Activity Anorexia:

An Alternative Explanation to Self-Starvation

Mykaela Holt

There are few things more terrifying than watching someone you love starve themselves to death, a phenomenon that is not uncommon for individuals with the psychiatric disorder anorexia nervosa. (1) Symptoms of anorexia nervosa include extreme weight loss, restricted dieting, fears of weight gain, and a distorted perception of self. Although not listed as a primary symptom of the disease, approximately 80% of individuals with the disorder engage in some form of excessive activity, expressed either through athletics or extreme restlessness. (2,3)

Anorexia nervosa includes two subtypes: restricting-type, which involves excessive dieting, exercise, and/or fasting to achieve weight loss, and binge-eating/purging type, which involves individuals eating an excessive amount of food after a period of fasting that is then purged using laxatives, vomiting, or some other method of removal. (1)

Anorexia nervosa may be caused or maintained by a process known as activity anorexia. Activity anorexia was first introduced after a series of rat experiments, in which researchers severely restricted the rat's access to food to approximately 1.5 hours per day, while providing the rat with unlimited access to a running wheel. (4,5) The shocking result was that the less the rats ate, the more they ran, and the more they ran, the less they ate. When allowed to continue in this manner, the rat's self-destructive behavior resulted in death. Interestingly, when the rats were given a restricted diet but

denied access to the wheel, or when the rats were provided with the wheel but were fed a regular diet, activity anorexia did not occur. The rats only suffered the disorder when both excessive dieting and limitless exercise were presented together. (6)

Although the two models contrast in that anorexia nervosa is studied in humans and activity anorexia is studied in rats, interesting parallels between the two disorders have been drawn. (6,7) Most obvious is that both disorders involve extreme food restriction and accompanying increases in exercise. (2,3,7) Additionally, just like adolescent humans, adolescent rats are more likely to contract the disorder than their adult counterparts. (1,8) And finally, females of both species experience disturbances in their reproductive cycles, with amenorrhea (absence of menstruation) occurring in female humans. (6)

Interestingly, some researchers report that rats with activity anorexia develop an obsession with food during mealtimes despite their refusal to indulge. For instance, rats with activity anorexia have been observed to nibble on their food and then immediately spit the pieces back out during mealtimes. (9) In comparison, humans with anorexia will also obsess over food, as they will frequently offer to prepare meals for family members. Additionally, those with anorexia have been known to turn the process of eating into an almost ritualistic experience. (10) For example, one individual diagnosed with anorexia explained that when eating pizza, they would meticulously dissect it layer by layer, eating first the toppings, then the cheese. Next the sauce would be carefully scraped off, and then finally the bread would be attacked, a process that also managed to be broken down into several layers. As such, it would take them over 20 minutes to eat a single splice of pizza.

There are some obvious differences between the two models of anorexia. Firstly, even if the rats desired access to more meals, they would not be able to obtain it, whereas humans have unrestricted contact with food. (11) Furthermore, while activity anorexia is easily reversed in a rat by removing both the wheel and restricted diet (6), it is much harder to cure anorexia nervosa in a human, even when the individual is force fed and prevented from participating in physical activities. However, it has been suggested that humans—while not physically restricted—may by psychologically restricted from food due to the social pressures of coaches, peers, and society to remain thin and achieve the perfect body image. (7) As individuals with mental health know, psychological boundaries can be just as powerful as physical ones.

Secondly (and perhaps more importantly) rats are not humans. They engage in different behaviors than humans and their anatomy is not very comparable. Rats, for example, are significantly less likely to develop activity anorexia when meals are provided during the night (a time when they would typically behave in food searching behavior). (12) Furthermore, it is impossible for a rat to vomit. As such, only individuals with restricting-type anorexia (and not binge-eating/purging type anorexia) can be examined using the animal model.

Despite the limitations of the rat model, there are reasons to consider that activity anorexia extends to the human population. For instance, one study reported that 75% of individuals hospitalized with anorexia nervosa decreased their food intake after increasing their exercise levels, a percentage that compares with the development of activity anorexia in the rat population (80%). (13) These individuals with anorexia explained that while exercise was originally voluntary and enjoyable, it eventually turned into something uncontrollable, obsessive, and ritualistic. In one participant's own words, "the lower my weight got the more energy I had", while another participant explained that "nothing would prevent [them] from exercising". Even for individuals without an eating disorder, sudden increases in exercise can lead to reduced calorie intake and vice versa. (14) Additionally, athletes under pressure to maintain a low body weight (such as dancers, gymnasts, and amateur wrestlers) have a greater likelihood of contracting the disorder than those in the modeling industry—a corporation that demands excessive dieting without harsh exercise. (15)

But how can the risks associated with athletics and dieting be decreased? Research shows that rats who began both intense dieting and exercise at the same time were more likely to contract activity anorexia than rats who had access to the wheel before being introduced to the severe diet, or who had a restricted diet before being introduced to the wheel. (4,12) Furthermore, rats that had several small meals throughout the day rather than one large meal were less likely to develop the disorder. (7) And finally, rats who were denied wheel access approximately four hours prior to their meal (12) and rats who had indulged in a normal protein diet verses those who consumed low protein meals (18) were also less likely to contract the disorder. As such, prevention tactics include increasing activity gradually rather than abruptly, allowing a time period between when exercising and dieting is initiated, and consuming multiple small meals throughout the day that are well-balanced nutritionally rather than eating a single large meal. (11) These steps could go far in reducing risks associated with sport, recreation, and dieting practices.

For individuals who already have anorexia, dieticians can play a crucial role in helping an individual regain healthy consumption behaviors, as they educate individuals on what a balanced diet looks like, how much food they should eat, and how to identify hunger cues. Most importantly, they consult with the individual to develop a realistic meal plan. For example, one individual with anorexia explained they would snack throughout the day and consume a large meal at night. The individual noticed that the constant hunger made them feel exhausted and irritable throughout the day, and they were less efficient in their work. When they consulted a dietician at an outpatient clinic, the dietician suggested they reversed the order of their meals by eating their large meal first and leaving their snacks for later in the day. The individual found that this not only lead to improved mood and energy levels, but also resulted in enhanced work performance. The above example indicates that maladaptive habits formed in anorexia can be broken, and a lifestyle that encourages health can be restored.

Works Cited

(1) American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th Ed), 2013.

(2) Casper, Regina, C. "The 'drive for activity' and 'restlessness' in anorexia nervosa: potential pathways." *Journal of affective disorders*, vol. 92, no. 1, 2006, pp. 99-107. *ELSEVIER*, doi.org/10.1016/j.jad.2005.12.039.

(3) Kron, Leo., et al. "Hyperactivity in anorexia nervosa: a fundamental clinical feature." *Comprehensive psychiatry*, vol. 19, no. 5, 1978, pp. 433-440. *ELSEVIER*, doi.org/10.1016/0010-440X(78)90072-X.

(4) Dixon, Deann, P., et al. "Development of, and recovery from, activity-based anorexia in female rats." *Physiology & behavior*, vol. 80, no. 2-3, 2003, pp. 273-279. *ELSEVIER*, doi.org/10.1016/j.physbeh.2003.08.008.

(5) Routtenberg, Aryeh, and Kuznesof, Abby, W. "Self-starvation of rats living in activity wheels on a restricted food schedule." *Journal of Comparative and Physiological Psychology*, vol. 64, 1967, pp. *APA PsycNet*, 414-421.doi.org/10.1037/h0025205.

(6) Barbarich-Marsteller, Nicole, C. Activity-based anorexia in the rat. In Avena, N.M. (Ed.), *Animal models of eating disorders*, 2013, pp. 281-290. Springer.

(7) Epling, W. Frank, and Pierce, W. D. *Solving the anorexia puzzle: A scientific approach.* Toronto, Canada: Hogrefe & Huber, 1991.

(8) Woods, Donald, J., and Routtenberg, Aryeh. "'Self-starvation' in activity wheels: Developmental and chlorpromazine interactions." *Journal of Comparative and Physiological Psychology*, vol. 76, 1971, pp. 84–93. *APA PsycNet*, doi.org/10.1037/h0031047.

(9) D. P. Boer, personal communication, 2000.

(10) Bruch, Hilde. *The Golden Cage: The enigma of anorexia nervosa.* Cambridge, MA: Harvard University Press, (1978).

(11) Powell, Russel, A., et al. *Biological Dispositions in Learning.* In Powell, R.A., Honey, P.L., & Symbaluk, D.G., Introduction to Learning and Behavior (pp. 453-483). Cengage Learning, 2017.

(12) Dwyer, Dominic, M., & Boakes, R. A. "Activity-based anorexia in rats as failure to adapt to a feeding schedule." *Behavioral neuroscience*, vol. 111, no. 1, 1997, pp. 195–205. *APA PsycNet*, doi.org/10.1037/0735-7044.111.1.195.

(13) Davis, Caroline., et al. "The role of physical activity in the development and maintenance of eating disorders." *Psychological medicine*, vol. 24, no. 4, 1994, pp. 957-967. *Research Gate*, doi.org/10.1017/S0033291700029044.

(14) Epling, W, Frank., & Pierce, W, David. *An overview of activity anorexia.* In W.F. Epling & W.D. Pierce (Eds.), Activity anorexia: Theory, research, and treatment. Mahwah, NJ: Erlbaum, 1996.

(15) Garner, David, M., and Garfinkel, Paul, E. Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine*, vol. 10, 1980, pp. 647-656. *Semantic Scholar*, doi.org/10.1002/eat.22095.

(16) Wheeler, Garry. *Exercise, sports, and anorexia.* In W.F. Epling & W.D. Pierce (Eds.), Activity anorexia: Theory, research, and treatment. Mahwah, NJ: Erlbaum, 1996.

(17) Li, J. B., et al. "Effects of exercise on the levels of peptide YY and ghrelin." *Experimental and clinical endocrinology & diabetes*, vol. 119, no. 03, 2011, 163-166. *Thieme*, doi.org/ 10.1055/s-0030-1262790.

(18) Wasse, Lucy, K., et al. "Influence of rest and exercise at a simulated altitude of 4,000 m on appetite, energy intake, and plasma concentrations of acylated ghrelin and peptide YY." *Journal of applied physiology*, vol. 112, no. 4, 2012, pp. 552-559. a*merican physiological association*, doi.org/10.1152/japplphysiol.00090.2011.

(19) Vander Tuig, Jerry, G., and Beneke, William, M. "A low-protein diet blocks development of hyperphagia and obesity in rats with hypothalamic knife cuts." *The Journal of nutrition*, vol. 126, no. 6, 1996, pp. 1713-1721. *OXFORD ACADEMIC*, doi.org/10.1093/jn/126.6.1713.

Edmonton Resources

Counselling Services

ACCESS Open Minds
Walk-in youth addiction and mental health clinic (Ages 11-25)
Bill Rees YMCA, 10211 – 105 Street NW, Edmonton
780-887-9781

Cornerstone Counselling
Faith-based counselling services (All faiths welcome)
Sliding scale fee structure
#302, 10140 117 Street NW, Edmonton 780-482-6215

Pilgrim's Hospice Society
Grief and bereavement services and counselling
#104, 15023 123 Avenue NW, Edmonton
780-413-9801

Sexual Assault Centre of Edmonton
Trauma-centred therapy for those that have experienced sexual violence, assault, abuse or harassment
No fee
14964 121a Ave NW, Edmonton
780-423-4102

Photo created by Teaghan N.

Support Groups and Community Resources

Mental Health Co-pilots
Assistance with navigation of local mental health supports

Parents Empowering Parents Society
U-Turn for Youth: Drop-in support meetings for youth and young adults involved in substance use
2001 Sherwood Drive, Sherwood Park
780-410-8516

Photo created by Audrey S.

Crisis Lines

Alberta Health Services
Child and Adolescent Addiction and Mental Health Crisis Line (Ages 5-17)
8:00am-11:30pm
780-407-1000

Alberta Health Services
24/7 mental health help line
1-877-303-2642

Sexual Assault Centre of Edmonton
9am-9pm Support Line
780-423-4121

Canada Suicide Prevention Service
24/7 help line
1-833-456-4566

Canadian Mental Health Association
24/7 distress line for short-term crisis intervention
780-482-HELP (4357)

Phone Supports

Within Edmonton
211
Outside Edmonton
780-482-4636

Edmonton Resources

Culturally-Relevant and Faith-Based Supports

Aboriginal Counselling Services Association of Alberta
Circle of Safety program: Teaching circles for children impacted by family violence
780-448-0378

Africa Centre (Council for the Advancement of African Canadians in Alberta)
Six-month mentorship program to support Albertan youth of African descent aged 15-24 with their emotional and mental health
780-455-5423

Physical Health and Basic Needs Supports

Hope Mission
Youth Shelter
10014 105A Avenue NW, Edmonton (Male youth)
9908 106 Avenue NW, Edmonton (Female youth)
780-422-2018

Youth Empowerment and Support Services (YESS)
Nexus Overnight Shelter
9310 82 Avenue NW, Edmonton (8pm-11am)
780-468-7070

LGBTQ2S+ Supports

The CHEW Project
Counselling, crisis intervention, and social services for LGBTQ2S+ youth
11725 Jasper Avenue, Edmonton
780-665-5220

Pride Centre of Edmonton
Support groups, programs, information, and referral for people with diverse sexual orientations, gender identities, and gender expressions
2nd floor, 10618 105 Avenue NW, Edmonton
780-488-3234

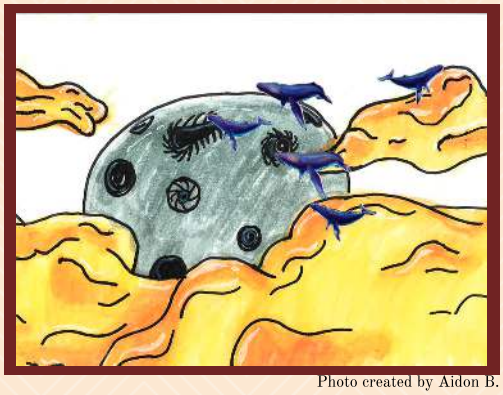


Photo created by Aidon B.

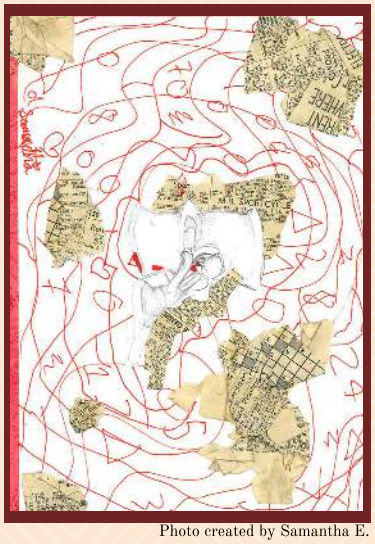


Photo created by Samantha E.


Photo created by Jaymie H.

We would like to thank the Edmonton Community Foundation (ECF) for funding Edition 5 of UNSEEN.

We would like to thank CASA Child, Adolescent and Family Mental Health and the CASA Foundation for their generous support of the CASA Youth Council

CASA Youth Council
Social Media

As you can see here in the pages of Unseen, we share our voices in many different ways. Follow us on social media, where we post about our experiences and the mental health issues that matter to us.

CASAYouthCouncil

@CASACYC

casayouthcouncil

Art & Photo & Design Credits

Caty McInulty
Cover page

Jasmine Gill
Why cry about corona virus becuase we don't know what will happen (p.14)
Colonization and Indigenous Mental Health (p.28)
Minority Mental Health (p.45, 48, 50, 53, 53, 58)

Sariah
Coping in 2020 (p.9)

Sheher-Bano A.
Colonization and Indigenous Mental Health (p. 26, 27, 29)
Minority Mental Health (p. 47)

Sadie B.
Colonization and Indigenous Mental Health (p.27)

Kelsey W.
"I've got this! Wait, do I? I don't think I can do this." (p. 40)

FAC
CASA Family Advisory Council (p. 61)

Aidon B., Audrey S., Jaymie H., Samantha E., Teaghan N.
Edmonton Resources (p. 73-74)

Angella R., Cadence Rolfson, Caleb (Morgan) Chomay, Kelsey W., Mykaela Holt
Magazine Layout

Unseen Contributors

Aislynn, 13

Unseen Magazine Subcommittee Member

Music enthusiast. Sassy gymnast. Hoodie lover.

OBJECTIVE: To bring a younger perspective to real-world problems that affect youth in their day-to-day lives.
HOBBIES: When I'm not training for gymnastics competitions, I enjoy long-boarding, biking, hanging with friends, and playing or practicing music.

Angella R., 23

Unseen Magazine Subcommittee Co-Chair & CYC Member

Science nerd. Coffee addict. Tattoo collector.

OBJECTIVE: To emphasize the importance of empathy and awareness for those suffering with mental health related illnesses, and helping to cultivate environments where these individuals can reach out for support and learn tools that can help them overcome whatever they are experiencing.
HOBBIES: Strength training, reading books about the human mind, and watching psychological thrillers.

Baljeet Hundal

Grandmother of CYC Member Jasmine G.

Baljeet was born in a small village in Punjab, India and immigrated to Canada in the 1990s with her husband and children. As an active member of The Royal Women Association in Calgary, she is passionate about promoting women's rights in the immigrant community. She enjoys writing poetry, singing traditional songs, sewing, meditating, and spending time with her 10 grandchildren!

Unseen Contributors

Balraj Malhi, 21

Social Media Subcommittee Co-Chair & CYC Member

Psychology nerd. Thrill seeker. Lifelong Oilers fanatic

OBJECTIVE: To raise awareness for youth mental health and to help foster a community in which individuals can freely express themselves without concerns of stigmatization. I want to able to assist others in expressing concerns regarding their mental health and promote awareness throughout society. I hope to assist in eliminating the stigma that surrounds mental health so that one day society will accept and support everyone for who they are.
HOBBIES: Learning new languages, reading, playing hockey, listening to all kinds of music.

Cadence Rolfson, 24

Unseen Magazine Subcommittee Co-Chair & CYC Member

Book-obsessed. Lover of all things furry. Injury-prone.

OBJECTIVE: To bring awareness to the reality behind mental health concerns. To build hope in individuals, families, and communities facing these issues. To bring forth education about, form better practice to treat, and to reduce the stigma towards problems with mental health.
HOBBIES: I love to do an overabundance of hiking, running, flipping, and anything involving puppies or books.

Isabella Rees, 22

Community Education Subcommittee Co-Chair & CYC Member

Student. Healthcare worker. Clinical researcher. Pasta enthusiast.

OBJECTIVE: To eliminate the stigma surrounding mental illness through education and advocacy. I envision a world where every child and youth feels fully supported in their mental health. I believe that educating youth about mental health is key to creating a more empathetic, caring, and supportive world for all.
HOBBIES: Drinking coffee, blogging, podcasting, snuggling my dogs, snowboarding, hitting the gym, brunch, travelling.

Unseen Contributors

Jasmine Gill, 24

CASA Youth Council Member

Cultural Enthusiast. Aspiring Globetrotter. Health Advocate.

OBJECTIVE: To raise awareness for youth mental health and spark conversation in the hopes of reducing stigma to foster engaged and inclusive communities. By working with the CYC on various initiatives, I hope to create an environment where individuals living with mental illness feel empowered and supported.
HOBBIES: Reading Stephen King novels, playing soccer and tennis, and hiking in the Rocky Mountains.

Kelsey W., 29

Unseen Magazine Subcommittee Member

Twin. Cultured appreciation for the arts . Always working to be the best version of me.

OBJECTIVE: I want to help give a voice and a platform for youth and young adults that are struggling with their mental health. I want to be a part of a place where they could turn to, that may help them feel just a little less alone. We need to change the way society views mental health. Why should I have to feel like I can't be myself just because I struggle with mental illness?? I shouldn't feel this way, but I do. Society has put such a stigma behind mental illness that people don't want to talk about it. This is where the change needs to happen, break down the walls and open up the means for conversation.
HOBBIES: Volunteering for Soul Sisters Memorial Foundation, Co-Founder of Harvey's Army, as well as photography, and photo editing.

Mykaela Holt, 23

Unseen Magazine Subcommittee Co-Chair & CYC Member

Hiking fanatic. Book lover. Occupational Therapy student.

OBJECTIVE: To foster feelings of empathy towards one another. I hope Unseen offers some insight on mental health and shows people they are not alone. It is my goal for Unseen to be a safe space where people can discuss their concerns, share stories and experiences, and develop understanding.
HOBBIES: Reading, hiking (especially mountains!), repelling, drawing, skiing!!, swimming, exercise in general, hanging out with my family, friends, and dog.

Unseen Contributors

Sheher-Bano A.

Victoria, 20

Unseen Magazine Subcommittee Member & Community Outreach Co-chair

Psychology Student. Tattoo devotee. Mental Health Advocate.

OBJECTIVE: To let youth know that they are not alone in their journey with mental health. I aspire to help create change in the area of mental health systems, so they are better suited to be helpful rather than harmful to adolescents. Creating an overall stigma free environment of understanding and support for mental health is something that has and always will be extremely important to me.
HOBBIES: Netflix binging, baking, playing guitar, exercising, daydreaming, cuddling my kitty.

Caleb (Morgan) Chomay

CASA Youth Council Member

Paitynn

Unseen Magazine Subcommittee Member


CASA
Child, Adolescent and Family
Mental Health


CYC