



WHO CARES ABOUT CARATIVE FACTORS?

It was April, 2000. It was nightshift in an acute, adult in-patient unit in Auckland, NZ. I had just finished a paper as part of my Bachelor of Health Science (Nursing) on the subject of nurse theorists. My head was full of Benner's *Novice to Expert*, Christensen's *Nursing Partnership*, Orem's *Self-Care Theory*, Leininger's *Transcultural Nursing*, Neuman's *Systems Model* and Peplau's *Interpersonal Theory* (of course). And so it was that the conversation with my nursing colleagues that night was quite different from any other.

Instead of discussing how the All Blacks went in their latest game, who got the latest Charge-Nurse (NUM) position, or planning what we were going to do if John B.'s voices became too much for him again tonight, this particular night the conversation focussed on what it is that mental health (MH) nurses actually do? Somehow, quite unexpectedly, the topic got onto nursing theories and the nurses who created them. Ok, I confess I may have played a not insignificant part in steering the conversation in that direction.

You see, one particular nursing theorist had a very strong impact on me. It was Jean Watson, with her Theory of Human Caring. In all honesty, I will state that it wasn't exactly an epiphanic "AHA" moment. As I read the theory, two words had leapt out at me, quite simply because I had no idea what they meant.

Carative Factor number 10 in Watson's Theory of Human Caring reads "*Allowance for existential-phenomenological forces.*" And I remember how, as we unpacked Watson's *Theory of Human Caring*, all my classmates had frown-ridden foreheads, their eyes were glazed and distant and they were looking everywhere except at the lecturer, desperately hoping she wouldn't ask them for an explanation of existential phenomenology.

And so it was that Watson first caught my attention. So I read, re-read and re-re-read the *Theory of Human Caring*. And suddenly, it all made sense. It more than just made sense. It enabled me to make sense of who I was as a nurse and allowed me to describe my nursing care meaningfully. I should state at this time, I had completed 2 hospital-based nurse training programs. The first as a Psychopaedic Nursing, 1979 – 1983 (once known in Australia as Mental Retardation Nurse or Div IV), the second as a Psychiatric Nurse, 1986-1988. I was also nearing the end of my General Nurse bridging program which included several papers which gave me a BHSc (Nursing), 1999-2000.

So it felt like no small thing that after approximately 20 years, I was finally able to articulate what I meant when I told people I was "a psychiatric nurse".

Jump forward another 15 years. It's 2015 and the vexed question of what it is that mental health nurses do still echoes around the corridors of nursing, both clinically and academically. Anecdotally, a common reflection of Undergraduate Nursing students at the commencement of

their clinical placement in mental health is that they are anxious. They don't know what they are going to say or do on the ward. In the absence of drips, drains and dressings, the looming dark void of just "being" with someone they don't know and fear they aren't going to relate to easily seems quite enormous.

So let's have a look at Jean Watson's Theory of Human Caring and see if it shines any light on what it is that MH nurses do?

CARATIVE FACTOR 1:

This is the formation of a humanistic (one who is concerned with the interests and welfare of humans)-altruistic (unselfishly concerned for or devoted to the welfare of others) system of values; or put more simply, it's the act of intentionally putting someone else's needs first. MH nurses do this.

FACTOR 2:

Instillation of faith-hope; fairly self-explanatory? MH nurses do this.

FACTOR 3:

Cultivation of sensitivity to one's self and to others; sensitivity to others is pretty standard for all the nurses I know (who are still nursing!) Sensitivity to one's self... well, perhaps not so much. This takes quite a lot of what is often jokingly referred to as "navel gazing" and makes some uncomfortable. Some say it is unnecessary. I would disagree and say that GOOD MH nurses do this.

FACTOR 4:

Development of a helping-trusting, human caring relationship; again, pretty self-explanatory and MH nurses do this.

FACTOR 5:

Promotion and acceptance of the expression of positive and negative feelings; well, I'd say we're better at the acceptance of positive feelings. My personal experience is that when patients express negative feelings about the care and treatment they've received, it can sometimes trigger some really unpleasant reactions from some nurses, even moreso if the negative feelings are about a colleague. We take it on the chin more easily if it's about ourselves. Good MH nurses are better at accepting negative feedback.

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REFLECTIONS: AN ACTION LEARNING SET WITH A CONSUMER GROUP

In July 2015, the Centre for Psychiatric Nursing (CPN) offered a one day workshop on Action Learning Set Training (ALS) for consumers from across the mental health services in Victoria. The workshop was co-produced with Catherine Roper, Consumer Academic at the CPN who co-facilitated the ALS training.

The CPN has offered ALS training for mental health nurses for the last two years however; this was the first-time that the workshop was offered to a consumer group. Providing the workshop to consumers was an idea that developed in response to 'The Psych Action & Training group' (PAT). This group meets regularly at the CPN and they have a special interest in the development of consumer standpoint in research and education/training. The Chair of PAT, Catherine Roper invited me to give a short presentation on ALS which was well received. After that meeting a workshop on ALS for consumers was developed and marketed to a broad range of consumers.

Our reflections on the ALS training with a consumer group are informed by the way in which the consumers/participants engaged with the ALS process. Nearly all participants had no previous experience of ALS. However, from the beginning of the workshop they demonstrated confidence and trust in the process and in our roles as facilitator and co-facilitator.



Finbar Hopkins with the ALS group from July

The participants were apprised of each of the roles within the ALS process, Presenter, Supporter/Enabler and Facilitator. An experiential ALS was enacted and this gave them an opportunity to test the process and the roles. They engaged fully with the Socratic questioning and they were able to assist with problem solving as well as focus on their own learning and that of the Presenter.

The way in which the consumer group engaged with the content and the experiential aspect of the workshop facilitated new learning on AL process. The group discussed for example, the notion of ground rules. Ground rules are typical of the nomenclature that is used when speaking about boundary maintenance in ALS, however, for the consumer group it implied inflexibility and they suggested using terminology that could be more inclusive.

The workshop evaluations indicated that ALS is an effective and supportive process that could be

beneficial to their work particularly as consumer consultants, where their opportunities to test and explore problems with a peer group are limited. Furthermore, they requested that they would be open to taking part in an ongoing ALS group at the CPN and that they would also be keen to be supported to establish an ALS in their work settings.

The overall strength of ALS process is that it helps the participants to question assumptions, clarify issues, and explore the status quo. This process opens up new and creative possibilities for working relationships within organisations. In conclusion, introducing the ALS training to a consumer group was very powerful and constructive process both for the group and the facilitators.

Finbar Hopkins

Lecturer, Centre for Psychiatric Nursing

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FACTOR 5:

Promotion and acceptance of the expression of positive and negative feelings; well, I'd say we're better at the acceptance of positive feelings. My personal experience is that when patients express negative feelings about the care and treatment they've received, it can sometimes trigger some really unpleasant reactions from some nurses, even moreso if the negative feelings are about a colleague. We take it on the chin more easily if it's about ourselves. Good MH nurses are better at accepting negative feedback.

FACTOR 6:

Systematic use of a creative problem-solving caring process; most of the nurses I have worked with are good at this. It's the bread and butter of nursing, what we do day in, day out. And it's taught very well in nursing academia these days, in my opinion.

FACTOR 7:

Promotion of transpersonal teaching-learning; and now we're starting to get a bit touchy-feely again. Transpersonal (and I quote straight out of Wiki, if

you're looking for a reference) 'has been defined as experiences "in which the sense of identity or self extends beyond (trans) the individual or personal to encompass wider aspects of humankind, life, psyche or cosmos". SOME MH nurses do this, sometimes.

FACTOR 8:

Provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment; sounds somewhat controlling and domineering perhaps? But there are times when we say to patients "Well, actually, NO you just can't do that." Good MH nurses will try to find a way to do this without becoming the epitome of Nurse Ratched (One Flew Over...)

FACTOR 9:

Assistance with gratification of human needs; think Maslow - food, water, shelter, protection. In my experience all MH nurses who do their utmost to provide for the most basic of human needs.

AND FINALLY, THE AMAZING FACTOR 10:

Allowance for existential-phenomenological forces. I'm going to massively over-simplify here, for the sake of well, simplicity. This is the "Big

Picture" stuff. These are the questions we don't ask, because we don't know the answers to them. In fact, some of us don't even know if we WANT to know the answers to some of them.

More recently Watson redefined her theory to include application of more loving, more spiritual interpretations of caring and she called these "Clinical Caritas Processes". These new perspectives may or may not have had some effect on the credibility or general acceptance of her theory. Be that as it may, I remain convinced that Watson's original Theory of Human Caring is still relevant today. It continues to help me articulate what it is that I do as a MH nurse and when asked who cares about the carative factors, I will always reply "I do!"

James Houghton

Lecturer, Centre for Psychiatric Nursing

MONEY MATTERS



Larissa Limberis

Has it really already been three months since the last edition of the Carillon and two months since the Collaborative Conference? Thanks again to everyone who was involved on the day. Your efforts and

participation made it a really great event, although unfortunately the steady decline in registrations over the past 6 years has continued on its downward trajectory. The attendance has almost halved since 2010! Is this because prior to 2010 there was still decent support available for services to send their staff off to conferences and to other professional development activities? I welcome your thoughts and insights about this.

It's probably no news to you, but as someone unfamiliar with the area of mental health care, I've been quite unsettled to learn about the dwindling resources available to services and what this means for consumers, nurses and researchers. It seems that the major issue the industry faces and that Kim Ryan (Chief Executive, ACMHN)

pointed to in her recent interview on the ABC news, is that "there just aren't enough funds in the system."¹

Yet in a Nursing Review article, Professor Allan Fels (National Mental Health Commission Chairman) reported that the federal government is wasting a staggering \$10 billion a year on a mental health system that fails its patients². Perhaps the amount of money available is not the problem then, so much as how the money is being spent. Elizabeth Martin, a researcher from the Queensland University of Technology is specialised in this very topic and has some compelling arguments surrounding the cost effectiveness of healthcare budget rationing. In a recent Nursing Review podcast, she spoke about how most governmental decision-makers don't know what to look for when deciding which healthcare projects to fund. This, she argues, results in a great deal of waste and inefficiency.³

In mental health care this has meant not enough nursing staff and undertrained staff which has resulted in unsafe work conditions and less than optimal care for consumers (themes that were raised at the Victorian Chief Mental Health Nursing Planning Day in June; in a report on Dual

Disability that the CPN just submitted to the DHHS; at the VCPN conference; and in the recent media). It might seem absurd to compare poor conference attendance with these broader issues affecting mental health nursing in Australia, but the more I look at them the more they all seem to be interrelated. Major reforms are in order, starting with better allocations of money. The CPN has an important role to play in promoting these goals and the conference, the professional development workshops and the research activities that it undertakes are pivotal in moving these initiatives forward.

Larissa Limberis
Programs Officer, Centre for Psychiatric Nursing

- 1 Kim Ryan in 'Mental Health Nurses Say the System is Broken' in ABC New Breakfast, 15 April 2015 <http://www.abc.net.au/news/2015-04-15/mental-health-nurses-say-the-system-is-broken/6393644>
- 2 Professor Allan Fels in 'Govt Pays for Mental Health Failure: Fels,' Andrew Bracey Nursing Review August 27 2015 <http://www.nursingreview.com.au/2015/08/govt-pays-for-mental-health-failure-fels/>
- 3 Elizabeth Martin in 'Ration Roulette: Researcher says Australia Lacks Informed Processes for Allocating Funds,' Dallas Bastian Nursing Review March 10, 2015 <http://www.nursingreview.com.au/2015/03/ration-roulette-researcher-says-australia-lacks-informed-processes-for-allocating-funds/>

THERE'S AN APP FOR THAT

Mobile Applications (Apps) are becoming an increasingly popular option for mental health interventions and support – especially for prevention and early intervention. They're accessible to patients who struggle to attend face-to-face sessions, and can provide support to continue care between sessions. As a practitioner, looking at the evidence and choosing which App to start with can be a daunting task, but ReachOut has worked with a range of experts to develop two new Apps that bring evidence-based approaches to young people's smartphones.

ReachOut Breathe aims to help reduce the physical symptoms of anxiety. It's based on the established Cognitive Behavioural Therapy (CBT) technique of controlled breathing combined, with biofeedback to assist people to slow their heart rate and increase feelings of calmness.

Professionals using the App in care settings have found it a valuable asset, with one saying "For

those suffering panic attacks, it is a good way of practicing breathing retraining. It can be particularly helpful for young people you are trying to encourage them towards non-pharmacological or self-help forms of anxiety management."

ReachOut WorryTime is also based on a CBT technique for anxiety (scheduled "worry time"). It provides a place for users to set aside their worries so that they can get on with their day. True to the technique, the App then alerts the user when it's time to think about their worries.

Professionals have said "It utilises the worry time approach to reduce overall time spent worrying and encourage focus and problem solving instead. Highly recommended."

The ReachOut Professionals website (professionals.reachout.com) provides peer reviews of Apps and online tools that can be used in mental health settings. The reviews advise how

to determine which App suits which patient, and provide guidance on how to use them in conjunction with face-to-face support. However, it is still very important to use professional judgement when providing any therapy recommendations including digital forms of therapy like Apps and online tools - not all Apps are suitable for everyone.

To read the full review of ReachOut Breathe go to: professionals.reachout.com/reachout-breathe

To read the full article about ReachOut WorryTime, head to: professionals.reachout.com/reachout-worrytime

For more reviews of Apps and tools and professional development on using e-mental health tools in practice, go to: professionals.reachout.com

Noni Hollonds
ReachOut Professionals Coordinator
ReachOut Australia

THERE'S METH IN THE MADNESS: WHAT DO WE KNOW ABOUT ICE USE IN RURAL COMMUNITIES?

Madness? I'm not referring to the users of ice, but there is certainly a level of crazy in the media. Is there really an ice epidemic? Are our regional areas really awash with ice? Find out what the data tell us about what's really going on and what it means for responding. And why it matters that we understand what the real problem is.

Hear more on this topic from Assoc. Prof Nicole Lee, Director at LeeJenn Health Consultants during her keynote address at the 7th Australian Rural and Remote Mental Health Symposium, held 26 – 28 October 2015 at the Novotel Forest

Resort, Creswick, VIC located less than 15 minutes from Ballarat.

Assoc. Prof Lee is one of Australia's leaders in methamphetamine treatment and is internationally known for her research in this area. She will be joining several other highly regarded professionals in the mental health field who will be providing a keynote address including:

- Mr Michael Burge OAM, Consumer Advocate / Wellness Warrior Mental Health
- Mr David Butt, CEO, National Mental Health Commission
- Professor David Kavanagh, Director, eMHPrac – e-Mental Health in Practice
- Dr. Cathy Kezelman AM, President, Adults Surviving Child Abuse
- Hon Catherine King, MP, Shadow Health Minister, Federal Member for Ballarat

- Professor John Macdonald, Foundation Chair in Primary Health Care, Director, Men's Health Information and Resource Centre, University of Western Sydney
- Dr Louise Roufeil PhD FAPS MCHP, Executive Manager (Professional Practice), Australian Psychological Society

The program also includes over 55 concurrent sessions, 8 workshops, networking functions and much more so this important event is one not to be missed. To book your spot to attend, please visit <http://anzmh.asn.au/rmmh> or phone 07 5502 2068 for more information.

Tara Lemmon
Symposium Secretariat
7th Australian Rural and Remote Mental Health Symposium

HEARING VOICES AND SPIRITUALITY: UNDERSTANDING MYSTICISM AND MADNESS IN OUR CONTEMPORARY MENTAL HEALTH SETTINGS

‘Hearing Voices is a common human experience’ has been one of the fundamental underlying principles of the world wide social movement which the International Hearing Voices Network has been built upon. With the Australian and Victorian Hearing Voices Networks increasingly gaining recognition within the mental health sector and the wider community, we are currently seeing a very real and tangible shift in the discourse surrounding voice hearing experiences, and what it could potentially mean for our conventional understanding of ‘psychosis’ and other forms of mental illness, and how we respond.

Thanks to the work of pioneers within the broader movement, both internationally and locally, we now have a greater understanding of the links between trauma and what our mental health system has come to understand as hallucinations and delusions. As this understanding becomes more widespread however, we need to be mindful that ‘trauma’ and ‘voices’ do not become synonymous, or that they simply become yet another euphemism for the ‘symptoms of schizophrenia’. With the current, and rightful, focus on trauma as a major element in the lives of many people who experience voices, altered perceptions and extreme levels of distress, anecdotal reports from many other voice hearers in the community who do not identify with trauma experiences suggest that there is a growing concern for our sector assuming that all voice hearing experiences, altered perceptions of reality and other seemingly odd or unusual behaviours, must by default have their origin in trauma if it is not in biological causes.

The growing evidence suggests that not only do we need to rethink our understanding of voices, but that not all voice hearers are having the same experiences. In essence, while many voice experiences may manifest in correlation with well documented biological processes and appear similar in terms of outward appearance and behaviour, the idea that an individual who hears the voice of someone who abused them in the past is having the same experience as a person who is, intentionally or unintentionally, entering into altered states of conscious perception and engaging in dialogues with disembodied voices needs to be addressed. We often classify both of these general experiences as hallucinations, which can also lead to both types of experiences receiving similar, if not identical, diagnoses.

Throughout human history, countless cultures around the world have associated voice hearing experiences with the realms of the spirit, mysticism, religion and magic. Indeed, in our own systemic mental health context, the reverence that other communities might show towards a shaman, a psychic medium, or religious leader, for having the ability to hear voices is often cited when we discuss issues of stigma and discrimination in our culture towards people diagnosed with schizophrenia. In many cultures, strange behavior, random movements, talking to entities that others can’t perceive, dismemberment experiences, and even the sudden and rapid decomposition of self are often seen as indicators of spontaneous initiation crises. While world views and symbolic language systems vary in increasingly diverse

ways, concepts of spirituality, religion, magic and mysticism have proven to be a controversial and often polarising subject, particularly in mental health. In the interest of opening up discourse are we better served to perhaps shift the focus from questioning the existence of spiritual realms in order to more generally think of these crises as transformative experiences, with an emphasis on the individual’s ability to move through these states by engaging with them fully, rather than suppressing them?

In many cultures, a wide range of voice hearing experiences and other altered and extreme states are contextualised through worldviews which accommodate concepts of spirit. As symbolic constructs, these worldviews have allowed for a diverse range of communities to develop positive, integrated and inclusive ways of dealing with both the experience of hearing voices, as well as the individual community members who have certain types of voice hearing experiences.

Many voice hearers who have experienced similar states and identify with mystical or spiritual conceptual frameworks have found themselves getting caught up within the mental health system, being diagnosed with psychotic disorders with little to no recourse, and often going on to be subjected to compulsory treatments and other forms of restrictive interventions which could be construed as acts of structural violence when they have objected. In our current Victorian legislation, it is clearly stated that someone is not to be considered to have a mental illness because of their spiritual, religious or political beliefs, however one of the challenges we face in our system is adhering to this ideal when many forms of voice hearing are classified under the collective terminology of ‘hallucinations’. Compounding this issue for many voice hearers is when a person’s beliefs about their immediate experience which do not reflect a Westernised medical world view are often simultaneously interpreted through the lens of diagnostic labelling such as delusions, ideas of reference and anosognosia.

While there has been a limited amount of research conducted regarding the relationships and differences between mysticism and mental illness, is it actually possible to discern between legitimate spiritual emergence or religious experience and

genuine ‘mental illness’, or is the distinction purely one of culturally contextual perspectives? Much of the comparative research has been focused on areas such as phenomenology, ethnographies and drawing clear delineation between the madness of mysticism and ‘real mental illness’, however this has largely been constructed around preconceived notions of both spirituality and psychiatric diagnoses, and has generally ignored the very real dynamic which exists between human experience of the world, symbolic language and culturally relative world views. Even amongst cultures which deal with concepts of spirit possession, while it is true that many people revere voice hearers as integral members of the community, many other cultures which deal with similar conceptual frameworks and worldviews have been demonstrated to vilify voice hearers immensely. Anthropologically speaking, humans largely interpret and account for their experience of the world through symbols. Our culturally relative language systems shape the way we perceive the world, with our worldviews then further shaping our symbolic language in a dynamic and interdependent exchange. By taking a step back from our symbolic constructs of ‘reality’, both mystical and materialist, and focusing instead on the experiential qualities of voice hearing experiences which we then build our descriptions around as a way to make sense of them, it could be argued that any distinction we would make between legitimate spiritual experience and psychotic disorders which feature religious themes as part of their presentation is largely one of relative context.

In many cultures, a wide range of voice hearing experiences and other altered and extreme states are contextualised through worldviews which accommodate concepts of spirit. As symbolic constructs, these worldviews have allowed for a diverse range of communities to develop positive, integrated and inclusive ways of dealing with both the experience of hearing voices, as well as the individual community members who have certain types of voice hearing experiences. Communication with the community and exploration of voices, altered states and other forms of experience is often engaged with openly, and in many instances actively encouraged. By contrast, in our Western, secular culture, we lack any real context for voice hearing other than romanticised notions of psychic abilities and creative inspiration, and concepts of serious mental illness. Our language promotes a world view which sees voice hearing which doesn’t appear to be of immediate and beneficial value as the product of a diseased mind. Engagement with voice hearing experiences is actively discouraged, often even penalised through incarceration, forced compliance with psychiatric treatments, and coercive methods of behavior modification. In the Western world, voice hearing has become something to be feared as a sign of unwellness and deviance, with no opportunities provided by the wider community for people who receive diagnoses to explore alternative frameworks, let alone the possibilities or potential of their experiences.

With this in mind, how do we open up a dialogue with our largely secular, contemporary world view

about the experiential qualities and legitimacy of spiritual emergence and crises, particularly when people's beliefs are so often viewed as symptomatic of the very problem our sector is working to address? Perhaps the clues can be found if we keep returning to the concept and role of the shaman, not as a means of reducing stigma through well intentioned platitudes, but as an exploration of the diversity and potential of voice hearing experiences as a legitimate, even healthy form of human expression? We can possibly gain insight by focusing on the unique ability of the shaman to not only learn to cope with their voices, but to gain mastery and control over them; to access their voices and enter altered states at will, and to ultimately utilise their experiences as tools within their communities for healing and wisdom. Many of the experiential qualities of what our mental health system would classify as psychotic symptoms are also common to the experiential nature of culturally relative understandings of shamanic initiatory crises. While this in itself offers a glimmer of hope for many voice hearers cycling through the mental health system, the most encouraging aspect of exploring this line of thought is that an initiated shaman does not typically start out having mastery and control over their experience, rather it is something which must be learned through embracing their dangerous gifts and enduring the trials which spirit has brought to them. Often there will be other shamans within a community who will provide guidance and training for a newly initiated healer to develop their gifts and practice. Without necessarily invoking the existence of spirits, it could be argued that cultural worldviews which accommodate aspects of voice hearing within conceptual symbolic frameworks that not only explain voices, but also reflect the often numinous

and ineffable experiential qualities of the voices themselves, have developed ways to learn to cope with voices, as well as develop varying degrees of mastery, control and application. Within the context of this world view, people experience feelings of safety, acceptance, inclusion and respect, as well as the ability to actively engage with voices and extreme states at will, and as gifts; voice hearing as powerful, transformative tools which people utilise for healing and insight, and which also benefit both the individuals and the community.

We can already see a reflection of this type of symbolic worldview and community within our current consumer workforce. As we bare witness to the unprecedented growth of Peer Support Work in the mental health sector, we are also witnessing the establishment of a workforce which, much like the shaman, has the ability to straddle two worlds, to speak the language of the sector while also being fluent in the language of consumers. More importantly perhaps are the notions of story telling and reciprocal exchange as elements of best practice, and the sense of community which is often fostered amongst peer networks. In the effort to bridge the gap in our understanding of spirituality and mental health, the practice, discipline and expertise of the Mental Health Peer Support Workforce might be the key to initiating these important conversations. While we need to open up communication with disciplines and organisations outside of our mental health system, and with the wider community, about an important and enduring aspect of human experience, ultimately we need to communicate with those who have lived experience in order to even begin to negotiate the pitfalls of language which so often pose a barrier to meaningful dialogue about the relationship between mysticism and madness.

There is growing consensus amongst facets of the voice hearing community within the International Hearing Voices Network that the need for these discussions and shifts in thinking are becoming ever more vital. With mounting evidence highlighting the devastating impacts of involuntary treatments and lifelong medication use, and more and more voice hearers coming forward about not using medications while also refusing to identify with their diagnoses, it is crucially important that we begin to explore the alternatives. Approaches and paradigms which enable voice hearers to experience recovery and freedom to engage with their spiritual beliefs without fear, without reduced life expectancy, and without breaches of human rights, should rightfully be at the forefront of research and include perspectives from a range of disciplines within and outside of our mental health system, rather than forever drifting at the fringes.

Nathan Grixti identifies as a voice hearer. He has fulfilled a number of professional community support and advocacy roles, and has been actively engaged with the mental health consumer community and sector for over a decade. Nathan is currently employed as the Program Manager of Voices Vic, with Prahran Mission.

Nathan will be presenting a free public lecture, 'Hearing Voices: Spirituality, Mysticism and Mental Health' at the Uniting Church Cheltenham on Thursday 8 October 2015, with John Watkins, author of *Hearing Voices: A Common Human Experience and Unshrinking Psychosis: Understanding and Healing the Wounded Soul*.

For enquiries or bookings, please contact: Prahran Mission on 03 9692 9500

MEDIA RELEASE: THURSDAY 6 AUGUST, 2015

SIBLINGS OF CHILDREN WITH SCHIZOPHRENIA SHOW RESILIENCE TO THE CONDITION AS THEY GROW UP

Fundamental differences between how the brain forms during adolescence have been discovered in children with schizophrenia and their siblings, a new study shows.

The study opens up new avenues for researchers to explore when developing treatment for the illness, which can be hugely debilitating for children.

Researchers from the University of Melbourne and the National Institute of Mental Health in Washington DC used structural brain magnetic resonance imaging (MRI) to map the brains of 109 children with childhood-onset schizophrenia (COS), from ages 12 to 24.

They compared the images with scans taken of the participants' brothers and sisters without COS to see if similar brain changes took place over time.

The siblings without COS showed similar delays in brain connectivity while growing up, but these connections tended to normalise or 'catch up' to those of normally developing adolescents.

The findings are published in the July edition of a Journal of the American Medical Association Network, JAMA Psychiatry.

Lead researcher, Dr Andrew Zalesky is a University of Melbourne electrical engineer who lends his expertise to understanding the brain's wiring. He divides his time between the Faculties of Medicine and Engineering at the Melbourne Neuropsychiatry Centre.

Dr Zalesky says the ability of the siblings to catch up and develop important brain circuitry means there is a degree of resilience to their risk for schizophrenia.

"We've looked at the development of brain networks over the adolescent period, from childhood to early adulthood. Abnormalities detected early in the unaffected children normalise by age 16," Dr Zalesky said.

"The greatest risk for schizophrenia is family history, but the majority of siblings of individuals with the disorder are unaffected.

"So why are these brothers and sisters able to overcome the risk? Looking for these biological factors that protect a person from developing

schizophrenia opens up a new direction in the search for treatments."

Co-author, Professor Christos Pantelis, heads the Melbourne Neuropsychiatry Centre at the University of Melbourne. He treats patients with severe forms of schizophrenia.

He says examining the biological, social and psychological protective factors that can improve resilience to mental disorders will help researchers to develop new approaches to treatment.

"New generation medications can help young patients manage their symptoms, but can have significant side effects. Our work has the potential to open up avenues towards earlier intervention with fewer side-effects that improve a child's resilience to becoming ill," Prof Pantelis said.

"This is an interesting new direction, as it suggests the search for targeted psychiatric treatments for schizophrenia and psychosis requires following young people over time."

Download the *Delayed development of brain connectivity in adolescents with schizophrenia and their unaffected siblings paper here*.

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