



Editorial

On managing change

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I have been struggling to find something suitable to write about for this Editorial in the final issue of the *Australian e-Journal for the Advancement of Mental Health*. In part this relates to the pressure to complete a submission (due 20 November) for the April 2010 Senate Inquiry into Suicide and its Prevention in Australia, and another submission (due 30 November) to the Children's Commission in Queensland on how we can reduce suicide in young people in Queensland, where the rate seems to be much higher than other states of Australia. Prior to these I had been tasked by the Department of Health and Ageing to write a comparison of national suicide prevention strategies across the world to see what might influence our thinking. I wanted very much to have this one complete so that I could use parts of it for my arguments about suicide prevention in the two submissions. Were there some useful threads that came together? Of course, but in a broad sense they will not surprise many of you. What appears to have made change in successful strategies around the world is 'help-seeking'. Underpinning this is an educated and knowledgeable general public (including young people) allowing them to know when it is critical to seek help, and know how they might go about it. Second is an educated and relevant workforce, regularly updated about best practice in crisis work, clinical management, and prevention strategies that will reduce the likelihood of suicidal behaviour. Third is a critical mass of accessible clinical and support services in all communities, available to deal with help-seeking

appropriately as soon as it occurs. How we achieve all this in our massive country is perhaps for a future editorial after we have completed the Inquiries. Anyway that is not what I wanted to write about at this time.

Something else I do not want to write much about in this last and very special issue of *AeJAMH*, is to do with the content. While I have written about my extended family experience of children of parents with mental illness in the past, and continue to have clinical experiences of relevance to the area, I think I should leave it to the experts who have contributed to the issue. I owe a considerable debt to Andrea Reupert and Darryl Maybery who have worked hard as our guest editors (and under some uncertainty at times) to bring together a group of authors from around the world who have broad expertise in, and clear understanding of, the complexities. I thank them, the authors and those who have written editorials for this special issue. I know this will be a major contribution to our field and both reflect and drive advances in mental health.

What I want to write about is 'change'. Let me begin with some recent personal experiences, move on to two recent clinical cases, and then return to this journal.

My daughter has recently made changes in her career from being an actor with a singing voice 'to die for' to a Voice and Movement Therapist with a flourishing private practice, trained in Martha's Vineyard in the United States, and now completing her Masters degree. VMT¹ is one of the expressive therapies and incorporates work

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on the voice, with body awareness and movement, artwork, diaries, and aspects from a range of other therapies including cognitive behavioural work. Sophie has recently worked with our team at The University of Queensland and a small group of self-injuring young women. The results have been surprising and encouraging, and have given us enthusiasm and courage to do more research on what is a very integrative therapy, balanced between right and left brain ways of doing things. Thus far our previous experience (and our clients' experience) of proven therapies like CBT, applied to self-injury, has not been good (Hazell, Martin, McGill et al., 2009). The research on Dialectical Behaviour Therapy does seem quite good in this area (Linehan, Comtois, Murray et al., 2006), but young people find the commitment to a lengthy program of therapy, and the demands of the intensive nature of the therapy, too much and often drop out. Expressive therapies are more engaging and more fun, and may go some way to holding the young people in therapy for the requisite sessions needed to make consistent change.

We are already asking the question 'What makes change?' Our consensus is that expressive therapies seem more comfortable from the start, despite the presence of others, and the anxiety about sharing. Group cohesion occurs rapidly, and the acceptance by others of bits of the young person's story *and* their pain (as told through art or dance or song) provides early relief. So, is it the shared experience of a novel process supporting exposure of pain that leads to change, ('We are all in this together')? Or is it acceptance by others that leads to finally being able to box up the issues and store them, not allowing them the space to intrude into daily living? Certainly there are parallels in individual psychotherapy where the acceptance and 'holding' by the therapist, of the pain of personal experiences provides acknowledgement of 'OK-ness' and the ability to move on in daily life.

Sophie has just returned from two weeks in Kenya where she was working with a group of therapy colleagues in a program for severely abused women. 'Why go to Kenya', I ask, 'when you can find severely abused women in Australia?' to which of course the answer was 'Because I was asked'. Past this, and my relief

that she was home safe and sound, Sophie had an extraordinary set of stories to tell. What intrigued her most was that women could be so severely and repeatedly abused (and physically damaged), but have reached a point of acceptance and have moved on. 'That was in the past; I need to get on with my life'. And they did, leading as full a life as they could in the context of the slums outside Nairobi. And their spirit shone through.

My father has just passed his 90th birthday and we had a large, extended family celebration to mark the occasion, and honour a survivor. He is ex Royal Air Force (like his father and four of his brothers) and during World War II spent 15 months as a radio operator in northern France, in 1940 being chased and shot at by the advancing armies, and eventually rescued off the beaches of Dunkirk in the 5th wave. I cannot imagine the terror that must have existed in the exit from France, the ever-present danger, at the age of 23, of being killed. He has never spoken to me of his experiences until one night about four years ago when we were watching the movie 'Dunkirk' on the TV. He sat impassive with a tear trickling down the side of his face. I asked if he was okay. 'Yes, of course...it's stupid of me...but I was there'. When I asked him to tell me more he gave me the bare bones in three sentences, refused to discuss what happened to his colleagues, and then said 'Well, all of that is in the past...you just have to leave it behind...and get on with your life'. He has done just that. He has never suffered from psychosomatic illness, or post-traumatic stress, and is robust enough to have survived a recent severe bout of toxic shock from an infected gallbladder while travelling through the United States on holiday to see one of his surviving brothers. He had surgery, recovered over two weeks, then just got on a plane to the United Kingdom to see relatives.

Is it the shared experience of War that helped him to box it all up? I don't know. Is it that he worked the process through in the first few years afterward with colleagues over a drink? I don't think so. He was back at work after three days leave. I don't think he was ever seen for any sort of psychological assessment; the duties of war were all too consuming. He, like many others, just accepted the personal cost of war, and moved on. And his spirit shines through.

So how should people react to immense trauma and change at a personal or family level? Are some people just stoic enough to get on with life, if left alone? Should we be seeking to explore the events that changed their lives, then help them celebrate their ability to incorporate all those changes in their life and survive? Or do we just need to not make a big fuss, hold their story, hold their pain, and encourage them to get on with life?

I have assessed two young people in the last couple of weeks for whom the emotional pain must be intolerable at times; yet their spirit shines through. The first is 14 and the daughter of professional parents. She has had an insidious onset of dysthymia over 18 months, and is now in a full-blown first episode of major depression. She has all the neuro-vegetative features, and no relevant past or family history to suggest how she came to get this illness. Of note there is a quality to her nihilism that I have not seen for a long time in someone so young. In the middle of a rational conversation she will suddenly drop into: 'I am empty. I am not worth anything. I am never going to be anyone or do anything worthwhile. I have no skills. Why don't my parents let me just die?' She has self-injured, but so far not attempted suicide. She has been in regular therapy with a psychologist, and recently I put her on an SSRI, from which she got side-effects within two weeks. We switched to an SNRI ('What happens if that doesn't work? You see, my body is just useless!').

On the other hand there is an observing self which arrives with a wry smile ('I suppose I am just going to have to put up with this until *you* get the medication right. Perhaps I just need to do some extra sessions at work'). She has just completed the school year and not done too badly considering her cognitive processing and memory problems. One saving grace is the number of friends she has; she is well liked, even admired. The other is a guitar she plays regularly in a band. At one session she told me how bad she is at this – 'it's a useless heap of shit, and so am I'. Then the wry grin appeared, 'I suppose it *is* keeping me sane'. At the most recent session she admitted she wants to make music a career, go to the local conservatorium, can see herself playing professionally. She began for the first time to plan what sounds like a reasonable career

path; her parents have supported this. She is taking something that everyone else says she does amazingly well, and using it to stay on track, to cope. Her spirit shines through.

The second young person is a boy of roughly the same age. He is bright, academically doing well, but developing some delinquent traits, particularly at school where he has been 'on report'. The psychologist who treats him thought he lacked empathy, and was at times cold and distant, though engaged in an ongoing therapeutic alliance, and wanting to continue. At first he was not easy to interview, as is true of many 14 year old boys. He was edgy, fidgety, avoided eye contact, and responded with monosyllabic answers. When I suggested he tell me the worst delinquent thing he had done, a slow smile crossed his face, and he opened up. A long-term close friend had been abused at school by a teacher, and he and the friend had shouted rude words from outside her room, then run away (he laughed at the memory). We investigated several other episodes, none of them any worse (he smiled warmly with each telling). Then, gradually, the awful story emerged of an older brother suiciding last year after a very lengthy history of delinquency, violence, and drug abuse. It seems that the older brother had done some very nasty things to our young man over the two years before his death, and this had left him with awful memories, mixed feelings in his grief, and severe doubts about himself. He hates the brother, but feels guilt at his hatred. His 'naughtiness' could be seen as taking on the traits of his brother as a way of coming to terms with the loss, but I suspect the history of a very happy boy till the age of 11, the fact of achievement despite his complex grieving, the presence of close friends and that he is well liked by loads more, all mitigate against this becoming a long-term and dangerous pattern that might repeat tragic history. Once we broke through in assessment he changed and his bright spirit showed through. I was able to reassure parents and the therapist that he will be okay. He probably needs to work through some detail of the horrors over the two years prior to the brother's death. The therapist will need to acknowledge his courage and resilience, and will need to 'hold' his pain; then let him get on with his life.

Change is the only constant in our lives. That is both a truism, but also an oxymoron if you think about it. Heraclitus of Ephesus (535-475BC) is reckoned to be the first who said: 'All is flux; nothing stays still.' And it seems that this is increasingly true in our modern world. You can look for your favourite cordial in the supermarket, but the maker can't get the lemons; they are not in season. Or the maker of your favourite cereal has changed the box, and you just can't quickly find what you are used to. Or the supermarket has moved all the shelves around because the new manager thinks it is more logical. I live an hour north of Brisbane, and both the main and subsidiary roads seem to have been in evolution for years. Every time you drive, the barriers are in a different place, or there are flagmen waving you over here or there and slowing us all down. And then, of course, living on an island we are all anxious about the rising sea level and what this might mean for our homes. A report comes out that says it is only rising a little each year; another comes out saying that global warming is having a catastrophic effect on the ice at the South Pole and the sea level will rise a metre or so over the next 50 years.

The modern update is probably Isaac Asimov (1920-1992) who wrote: 'The only constant is change, continuing change, inevitable change, that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be.'

Given the purpose of this editorial, I quite like what Marcus Aurelius (121-180, Roman Emperor from 161) is reputed to have said: 'The universe is transformation; *our life is what our thoughts make it* [my emphasis].' We can react to change in so many ways; what we have to work out is how to get the best from life whatever comes along. At some level this is easy. If I know the lemons run out every year, and want my favourite cordial I can make a note to remind me to store enough to take me through the lean times. If I can't find something in the supermarket, then I need to have the confidence to be able to ask and get help, and not just feel stupid. I understand many stores change arrangements every few months to avoid shop-lifting; I guess we have to live with such things.

We have to learn patience around road rebuilding; it all comes good in the end. We have to have some faith in others (perhaps elected representatives) who are in a better position to influence our lives for the better. Hopefully the 2009 Copenhagen ('Hopenhagen') Conference will guide us individually, as a country and as spaceship Earth, toward solutions for global warming and its consequences. When something more serious happens to us personally we need a store of inner strength, we need to be able to ask for help, we may need patience, and sometimes we will need the indomitable spirit that is present (if sometimes hidden) in all of us as our human right, and we may need to trust that others at all sorts of levels will be there to do the best they can to help.

What do these stories tell us, and what is their relevance to this editorial? The demise of Auseinet had been on the cards for some time, particularly since suicide prevention was removed to a new host and a special program of its own (see <http://www.livingisforeverone.com.au>) with a loss of funding from the LiFe Strategy. Despite phenomenal success in raising the profile of Mental Health Promotion, Prevention and Early Intervention over many years, through an excellent communication program through newsletters, the journal, email alerts and the website, Auseinet has perhaps done the job we all hoped it would do. We have run that race, and we all need to move on, even if the principles and the practice need to be further developed. Many of our states have now made policy decisions, taken strategic action and applied more funding than ever to prevention in mental health.

The *Australian e-Journal for the Advancement of Mental Health* has been a very important part of that original communication strategy, and our thanks go to Jennie Parham and the Auseinet team for seeing its present and future worth and maintaining that part of the funding necessary for our three issues per year. We owe an immense debt of gratitude to Anne O'Hanlon who almost single-handed over all the years has provided dedication to a world-class product through clear vision, high standards, a supportive board, good choice of reviewers, and that eagle eye that editors develop. Not only have we been able to publish many excellent papers from those

at the forefront of this important field, sometimes in themed issues, but we also have been able to help and guide so many new authors to share their work with others. Sometimes clinicians or emerging researchers are reticent to publish what they do; they feel the planned resources were outstripped by the clinical demand, or the program was not quite fully developed, or the results did not quite work out as expected. Without knowing what people do at all levels, we are destined to repeat history. So we have always believed a key part of the work of a journal has been to develop the field as a whole, but within this, to develop the skills of those who might not yet have had the opportunity to publish.

Behind the scenes, of course, we have had a small army ensuring that the style continued (thanks to Jill Knappstein's superb editorial assistance), and that issues were translated to the internet allowing for smooth downloads of high quality PDF versions of papers. I would like to pay personal tribute to Steve Trickey and David Robley from Flinders University who have maintained the Auseinet site so well over so many years (on a shoe-string budget), but specifically have helped to drive the journal to a world-class product and have provided so much assistance in the current change environment.

So *AeJAMH* has to react to change, and after this last issue (Volume 8, Issue 3) becomes simply *Advances in Mental Health*. We have negotiated with James H. Davidson at eContent Management (<http://www.e-contentmanagement.com/>), where there is a stable of other world-class journals, to take on the journal and guide its commercial development. Yes, I mention that word 'commercial'... Thus far the Australian Government has seen the need for a journal as part of a communication strategy for prevention in Mental Health, and explicitly supported the venture. How often do governments fund journals over so many years? It has been an extraordinary journey, we have been well supported, and we owe an immense debt to the Department of Health and Ageing for holding faith and being prepared to fund us for so long. Even at this point, they have been prepared to provide some transition funding to enable us to keep back issues free to download for a time-limited period; commitment indeed!

If we are to go forward, continue to build the field, continue with our precepts about building the science of advances in mental health, then we need you. We need you to write for the journal, we need your comments and feedback; we need you to contribute (if you can) through encouraging professional writing, or perhaps agreeing to review articles. We will need you to get used to some very upmarket, online ways of managing your articles, consistent with international best practice (we have a great team of experienced people just waiting to help you at eContent Management). Most of all we need you to come with us on this journey. You or your service, or library, can subscribe to the journal per annum, which allows free download of articles. Or you can browse and pay per download for individual articles or for whole issues of interest.

Our promise to you is to provide a high-class product to continue *Advances in Mental Health*. We want you to consider it worth publishing in *AMH*. We do understand the need for international journal ranking systems, but this will never outweigh our passion to advance the field, and those working in it. Of course we will publish Australian articles, but equally we will be searching for international content of relevance to us here; we live in a global environment. The current special issue on children of parents with a mental illness demonstrates how well we can do. We will continue with the theming of issues, and will draw together guest editors as needed. Our planning cycle will extend so that you can see what we have coming up in future issues as you go online to browse.

So, change is inevitable. We had a good infancy and early childhood, and will survive this shift of attachment. We have a history of strengths, know who to ask for support, and have skilled people around us. We have a future, and an indomitable spirit to take us on the next part of the journey. Please stay with us.

Note

1. Voice and Movement Therapy was developed by Paul Newham (<http://www.paulnewham.com/>). Also see <http://www.iavmt.org/index2.html>.

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