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BC's Mental Health and Addictions Journal

visions

Vol. 13 No. 1 **2017**

recovery: stigma and inclusion

a journey to worthy

the three faces of stigma

we're in full colour now!

We've made changes to how *Visions* is printed so that it's both more engaging and costs us less money to print. We were able to do both and hope you enjoy the new look. We welcome your feedback.

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions.

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visions

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

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bc partners and heretohelp

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background

experiences and perspectives

alternatives and approaches

letters to the editor

The information was excellent and the timing fantastic for the 2016 Visions issue on Mindfulness. CMHA Vernon had just started our first pilot mindfulness group in the fall. Thirty clients participated and attended three 1.5 hour classes. The Visions article "Mindfulness myths and facts" by Dr. Mark Sherman served as an excellent introduction on a poster. People also received HeretoHelp Wellness Module #11 on Mindfulness and other resources. We watched and listened to guided meditations. Some feedback from participants included "I need it to help reduce my anxiety" and "A taste of what living mindfully is: it can bring such wellness, peace and overall health." Due to requests, we now offer a weekly drop-in mindfulness class. Fifteen CMHA staff also got a taste of mindfulness at a staff meeting with guided meditations and handouts. Feedback included "I need to do this more often" and "I really need to slow down." Thank you for your great work! In my humble opinion, Visions is the most important mental health journal! It includes an informative blend of articles from people living with mental health issues, writers, researchers and professionals.

—Marie-France Ladouceur, Vernon BC

have an opioid story?

An upcoming issue of our *Visions* magazine will be on Opioids.

If you would like to share your story, e-mail us at visions@heretohelp.bc.ca

editor's message

I'm sick of stigma. And sadly, those reluctant to seek help or continue treatment are too—they remain literally unwell because of stigma. Does anyone else feel like the mental health and addictions movement is stuck in the 20th century and everyone but us has moved beyond stigma to look at the conditions that create it? Because don't forget that stigmas are not inevitable: they can be created (think smoking) and reduced (think cancer). Other movements have embraced a human rights model and focused on anti-discrimination policies. After all, the transgender movement doesn't talk about stigma, it talks about social justice. Why has our field been so slow to do the same?

When I think of why stigma still lingers, I get it. There are parts of us that we cannot really change like age, race, gender identity, physical disability, and sexual orientation. But mental illness and addictions can and do change; they develop at some point and can get better or worse. But more than anything else, they affect what is arguably the core of our humanity: our thoughts, our emotions, our behaviours, and our interactions with the world. Anything that disrupts that, frankly, terrifies us. So better to keep "those people" over there and blame and fear them.

But I do see hope. The stories in this issue of *Visions* are incredibly moving and instructive about what helps and what hurts. Effective treatments are out there like never before and people are using them. There is an invisible sea of people across BC who are in recovery and live well (yet only a few of their nearest and dearest know it!).

If you are one of those in the invisible sea, consider these facts. Meeting people with lived experience is the best way to eradicate stigma against mental illness and addiction.[1] People who know a family member or friend who has sought mental health care are more likely to seek help themselves.[2] The most effective anti-stigma message is a humanizing one that communicates that mental health and substance problems are an understandable response to someone's unique situation.[3] You don't have to go on TV or shout it from the rooftops but if you sought help, consider telling at least one more person in your life your story. Just think of the power if our invisible sea were made visible.

SarahHB

Sarah Hamid-Balma

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

Stigma

MARK OF SHAME OR COMPLEX SOCIAL PROCESS?

Heather Stuart, PhD (Epidemiology)

Few medical conditions have been associated with as much negativity as mental illness. One *has* diabetes, cancer or a broken leg, for example, but one *is* mentally ill. How we talk about mental illnesses suggests that we have come to view them as something that dominates all aspects of an individual's personality.

Photo credit: ©iStockphoto.com/spfoto

Heather is a Professor and the Bell Canada Mental Health and Anti-stigma Research Chair at Queen's University in Kingston, Ontario. She is Chair and Co-founder and past Chair of the World Psychiatric Association's Scientific Section on Stigma and Mental Disorders. She has worked with various international and national agencies to develop best practices in stigma reduction, using her research to help policy makers and planners solve day-to-day problems and make evidence-informed decisions

In some cases, mental illnesses can even become an individual's identity. We might say, for example, "He is a schizophrenic" or "She is borderline"—even "They are addicts."

Mental illness–related stigma has a long history and is present in virtually all cultures. People often describe mental illness stigma as more difficult to live with than the mental illness itself. The stigma can be more long-lasting and disabling than the illness, often presenting a major barrier to help-seeking and recovery.

The term "stigma" comes from the sharp stick (or *stig*) that early Greeks used to tattoo slaves, criminals and undesirables. Thus, "stigma" is often defined as a mark of shame, and this is the definition you are likely to find in the dictionary. Recently, however, the United Nations Convention on the Rights of People with Disabilities[1] has encouraged us to think about stigma in broader terms, as an issue of social justice, and asks us to pay more attention to how social and organizational structures perpetuate inequalities for people with mental and physical impairments. From this perspective, "stigma" is not a mark of shame borne by the individual; rather, "stigmatization" is a complex social process that results in discrimination and social inequity.

The research literature describing mental illness–related stigma can be organized into three mechanisms of stigmatization: structural stigma, public stigma and self-stigma.

Structural stigma

Organizations may behave in ways that exclude, disadvantage or discriminate against people with a mental illness. There are many examples of this structural stigma. In the workforce, people with a mental illness may not be able to get a job, for example, or keep a job or be promoted. They may be stuck in low-paying positions that don't make full use of their knowledge and skills. In health care organizations, stigma may be expressed by not providing certain individuals with timely access to care. The media may also promote stigma through negative and stereotyped images. People who work in these organizations may be part of the stigmatization process (even if they aren't prejudiced), simply by virtue of their following organizational policies and procedures. Anti-stigma programs targeting structural stigma must change the way organizations behave.[2]

Public stigma

The negative and harmful views that members of the public have of people with a mental illness are collectively called "public stigma." Negative and prejudicial images and ideas may lead to unfair treatment and discrimination of people with mental illness. This can occur in the context of families and friends, and in day-to-day interactions.

Public stigma also has a way of "sticking" to individuals or things closely associated with the individual who has a mental illness. Families may be stigmatized (because they are perceived to have "caused" the illness or because they are thought to be harbouring a "dangerous" and "unpredictable" individual). They may lose the support of family networks and friends. Mental health providers are often devalued by their medical colleagues, and mental health treatments are frequently held in suspicion by members of the public. Finally, mental health research is underfunded, particularly when we consider it in light of the financial and other burdens caused by mental illnesses. Anti-stigma programs targeting public stigma must change the way members of the public think *and* behave.[2]

Self-stigma

Finally, self-stigma occurs when individuals who have a mental illness internalize negative public images and apply them to themselves. Self-stigma changes a person's perceptions of self: the individual sees him- or herself as less deserving, as blameworthy and powerless. People who self-stigmatize may experience embarrassment and shame. They may avoid social interactions and have difficulty managing their recovery process.[3] Anti-stigma programs must be developed to target self-stigma and change the way people with a mental illness think and feel about themselves.

Not all mental illnesses are stigmatized in the same way or to the same degree. Substance-use disorders and schizophrenia are more stigmatized than depression and psychological distress, for example. Members of the public think that people with substance-use disorders or schizophrenia are more dangerous and unpredictable than those who have depression or who are psychologically troubled. Members of the public are comfortable imposing more restrictions on groups that they think are more dangerous, and may support actions to limit civic or human rights.[4]

Because different disorders are stigmatized in different ways, a one-size-fits-all anti-stigma approach isn't the most effective way to combat stigma. The message may be too watered down, or it may miss the mark altogether. What we would want a police officer to know and do in order to combat stigma, for example, is not the same as what we would want an emergency room nurse or an employer to know and do.

For example, we may want a police officer to de-escalate a difficult situation involving someone with a mental illness by talking to them rather than using undue force. In the emergency room, we may want nurses to understand that people who have attempted suicide are in acute pain and crying out for help, and not simply monopolizing important health resources that could be otherwise used for people who want to live. We would want employers to provide appropriate accommodations and supports for employees with a mental illness rather than assuming that they are no longer competent to do the job.

Many anti-stigma programs provide factual information about mental illnesses in the hope that this information will change public attitudes and behaviours. Sometimes these programs can backfire and create greater intolerance. For example, decades of "sound-bytes" encouraging

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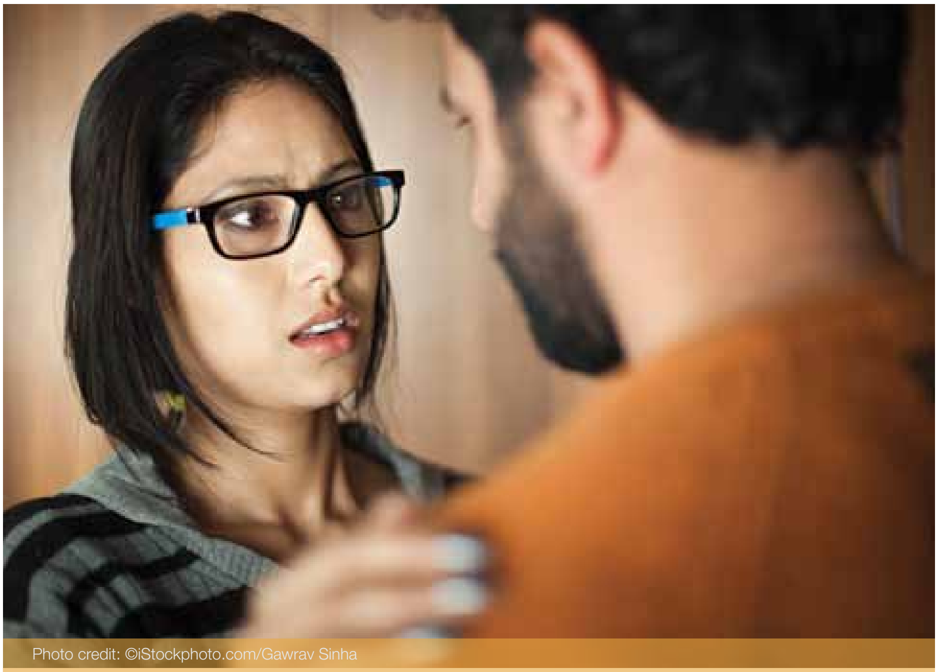

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Becoming more aware of how people with mental illness are stigmatized is an important first step in addressing this problem.

us to think of mental illnesses as “illnesses like any other” have increased our empathy towards people with a mental illness. At the same time, however, our feelings of social distance have not changed; in some cases, they’ve increased.[5]

The most successful anti-stigma programs include positive social contact with people who have had a mental illness. People with lived experience of a mental illness can dispel myths and provide a positive role model for recovery. This type of “contact-based education” has been used extensively in schools, health care settings, workplaces and the media—groups that the Mental Health Commission of Canada (MHCC) has noted are particularly affected by the negative and damaging impacts of stigma.[6]

In Canada and elsewhere, stigma has become a matter of public health concern. Many countries now have large national anti-stigma programs. MHCC’s *Opening Minds* anti-stigma initiative has been operating since 2009. It targets youth, health care providers, employers and the media in an effort to improve awareness and reduce discrimination towards people living with a mental illness. *Opening Minds* has partnered with programs across Canada to help develop best practices in stigma reduction, using contact-based educational approaches.[6]

Because stigmatizing views of mental illnesses are socially ingrained, we all have the capacity to stigmatize, even when we don’t intend to. We do it automatically, without being consciously aware of doing so. That is why becoming more aware of how people with mental illness are stigmatized is an important first step in addressing this problem.

Some simple things that we can all do are listed on the *Bell Let’s Talk* website.[7] These include:

- Paying attention to the words we use to describe people with a mental illness and avoiding words that are derogatory or demeaning
- Educating ourselves so that we learn and understand the signs of mental illness and know how to respond to them
- Remembering to be kind to people who are experiencing a mental illness. Small acts of kindness (like inviting the individual for coffee or sending a get-well card) can go a long way
- Making sure we listen non-judgementally to people instead of telling them what we think they should do or minimizing their illness. (Don’t say, for example, “What have you got to be depressed about?”)

Most importantly, we need to learn how to talk about mental illness so that we can break the silence and combat the stigma.

One in five Canadians will experience a mental illness this year. Stigma is a key barrier to their help-seeking and recovery. We all have a role to play in creating more inclusive social environments—at structural, community and individual and personal levels.

Many and One

MY LIFE WITH DISSOCIATIVE IDENTITY

Jen Callow

On the outside, I'm one person. On the inside, I'm many. The severe trauma I experienced growing up left me dissociative, the term I use for what's commonly called dissociative identity disorder. My dissociation helped me to survive at the time.

Jen lives in the Southern Interior of BC, where she creates a variety of art and spends time in nature. She's been dissociative all her life. Through sharing her experience, she hopes to create a greater understanding of what it can be like to be both many and one

Photo credit: ©iStockphoto.com/Copit

Being dissociative means I'm made up of many personalities, or parts. Most of my parts have fully developed personalities and are even different ages and genders. They have their own preferences, needs, worldviews and life experiences. They have unique gestures, behaviours and ways of speaking. Many have names, although that's not as important to them as it used to be. In this article, I use both "I" and "we": it's a collaborative effort by my parts, written as one voice.

As someone who is dissociative, I face stigma on a daily basis—not only the social stigma of being many parts in a society of individuals, but also self-stigma. My parts have internalized many of society's negative views about dissociation, and we frequently struggle with a sense of shame and a strong desire to hide our dissociation from others.

Even calling it "dissociative identity disorder" perpetuates stigma. "Disorder" means chaos or mess. It suggests the person who survived trauma by dissociating is the problem. In reality, it's the trauma that's "disordered" and the problem—not the person. My *parts* aren't a disorder—they're parts of me who've been through a lot of pain. They feel hurt and sad at the thought that they're a problem that needs fixing.

Although it's not perfect, I'm drawn to the word "injury."[1] "Dissociative identity injury" is more compassionate. It puts the focus back on the trauma.

Living together

Most of my parts have traumatic memories. They are often the age at which the trauma happened to them, the age when they dissociated. A few other parts existed solely to handle my daily life. These parts remembered little or nothing about the trauma. They are close to, or the same age as, our physical body. The adult part of me who spends the most time interacting with the world, and whom people know as "Jen," is one of these daily-life parts.

My younger parts aren't equipped to handle my adult daily life on their own. But they still participate—for example helping with chores or planning outings.

Big decisions are made communally whenever we can—much like in a large family. Often my adult parts mediate these discussions; we try to actively listen and address everyone's concerns. No part of me is more "me" or important than any other part—we are all aspects of "Jen."

In reality, it's the trauma that's "disordered" and the problem—not the person. My *parts* aren't a disorder—they're parts of me who've been through a lot of pain.

All my parts used to be very separate. Parts took over whenever they were triggered by a particular event or situation. Neither the triggered parts nor my daily-life parts had control over these switches. For many years, my parts weren't even aware of each other.

After years of therapy, we now naturally seem to have more continuity between our memories and experiences. We're more connected to each other. We love and look out for each other. I am never truly alone.

Overcoming stigma

I still get overwhelmed by emotions and memories from the past (though it happens less frequently now, after years of therapy). When an event sets off a flashback, it can be hard to tell what part of my experience is from my triggered parts and what's happening in the present; the past literally lives inside of me in the form of my parts.

It's easy to feel ashamed when I get triggered. My shame stems from the negative reactions I've received in the past, when I've switched in front of anyone other than a few trusted friends and therapists.

When I'm out in public, it can be embarrassing if people hear me talking under my breath to my parts, or see me nodding or shaking my head (indicating "yes" or "no"). Sometimes when I'm triggered I lose track of conversations with other people, or say something that doesn't quite fit the situation.

The adult parts of me are more aware of triggers and switches than we used to be, and I can usually work with my parts so that other people aren't aware a switch has happened. But a switch can still occur without much warning. What I need in those moments is for people to meet me where I'm at—most importantly, to honour whatever feelings I am expressing, even if they don't seem to make sense.

One of the most distressing triggers I experienced intensified because the other person involved was unable or unwilling to honour my feelings. When I was a teenager, I had to have a general anesthetic for some dental work. I freaked out in the operating room—crying, struggling, pleading for time to compose myself. In hindsight, I realize that I'd fully switched into one of my child parts, but at the time, I didn't know. The


Photo credit: ©iStockphoto.com/Wavebreakmedia

The love and acceptance I found with my therapist helped me develop the confidence and strength I needed to face both my internalized stigma and the stigma within my community.

anesthesiologist had no patience for my reaction; he pinned my arm to the dental chair, stuck the needle in and told me to act my age.

What I really needed was for him to have listened to me and worked with me to find things that would calm me. A few minutes of compassion would have made all the difference.

Healing ourselves

As a teenager, I became depressed and suicidal. The school counselor referred me to the mental health centre in my city, but the sessions did nothing to help my depression. I briefly tried antidepressants, but they made me feel sick and increasingly suicidal.

Not one of my medical practitioners realized I was dissociative. Some of them noted that I sometimes acted more childlike, switched moods quickly and seemed to be experiencing an ongoing conflict within myself, but no one suspected the truth.

When I was 20, I found the right therapist. I'd been invited to attend a group therapy session at the mental health centre. I felt a deep, positive connection with the therapist facilitating the group. Luckily, she agreed to take me on as a client.

After a couple of sessions, I remember telling her I felt like I had different "me's" inside of me. She started working directly with my parts as we trusted her more.

It soon became apparent that my parts were separate and distinct, and that I had hundreds of them. More parts kept coming forward in therapy, wanting her attention. We did our best to prioritize based on need. We worked with my parts over the next eight or nine years, healing the trauma and building an inner community (explaining we were all part of one person, encouraging and helping my parts to work together). I started to feel calmer, increasingly cared for and hopeful—I started to heal.

Realizing I was dissociative and not depressed gave me a sense of freedom. I finally knew what I was dealing with and had effective therapy. The love and acceptance I found with my therapist helped me develop the confidence and strength I needed to face both my internalized stigma and the stigma within my community.

In my experience, having parts isn't a problem. The problem is when my parts aren't communicating well, or when their needs aren't being met. In my early therapy, healing the trauma and creating a loving community amongst my parts were equal priorities. I still use this approach. Through this process, I have gone from having around 500 fully developed parts to having just under 100. Once a part's trauma is completely healed, that part merges with other parts, becoming a new part who's different and yet contains the traits and memories of all the merged parts.

It can feel much less chaotic having fewer parts. But it can also feel quiet and lonely if many parts merge at once. One day I may be "one";

however, that's not my priority. I experience life differently from a person who's "one," and my life still has joy and meaning.

Looking ahead

As I get physically older, I feel increased pressure to hide my parts and act my physical age. My body is that of a grown woman, and I feel society's expectations to act and dress in certain (adult) ways.

It can be hard for my younger parts to participate in my daily life. Playgrounds aren't made for adults, the child parts of me can't take part in kids' events anymore and dressing like a teenager feels less acceptable. I love spending time with kids and adults who are young at heart because it gives me permission to be silly and play. At times, I've joined activities where younger parts of me can participate without it being obvious, such as sports or choirs.

In the privacy of our home, we express ourselves more freely, through things like art, dance and music, or playing with toys. But what all of us really want is the freedom to be more *ourselves* in the outside world.

Learning to accept and love all of me is an ongoing journey—for all my parts. In many ways, I believe that our society is on a similar path: we are all learning to accept ourselves and others who are different from us. What gives me hope is seeing the ways our society is becoming more inclusive—from gender-neutral washrooms to starting the process of reconciliation with Indigenous peoples. And I draw strength from friends and therapists who embrace me as I am—so that I can increasingly embrace myself as I am. They see my strengths and struggles in the context of me as a person, not just someone who's dissociative.

I suspect that dissociative identity is more common than people think, perhaps misdiagnosed as other conditions, including schizophrenia or, in my case, depression. The hurtful assumptions I encountered outside my therapist's office are still evident in our society today. And many still claim that being "one" person is better than being dissociative, that someone who is dissociative is condemned to suffer, and that they are destined to be dissociative forever.

But I hope that one day there will be space for people like me to be all of our selves without shame or stigma. With this article, I am contributing to that space, encouraging people to think about dissociation differently. I am many and I am one. Though it's taken many years, "I" am proud of who I am.

related resources

For more on dissociative identity, see www.morethananidea.ca, www.aninfinitemind.com and www.sidran.org.

Fixing Your Flat Tire

RECOGNIZING AND RECOVERING FROM BINGE-EATING DISORDER

José*

In Mexico, food is the core of social life. Growing up in Mexico often meant eating—whether at a school celebration or a family gathering. I was a joyful, energetic kid who ate whatever was offered and indulged in the occasional extra piece of cake. I didn't have negative experiences with food until early adulthood.

José is a Mexican living in Vancouver. He is a postgraduate student at the University of British Columbia

** pseudonym*

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When I moved out on my own, I developed binge-eating disorder, or BED. BED is characterized by recurrent episodes of eating large quantities of food in short periods of time. It is like anorexia and bulimia in that it produces a great amount of anxiety in the individual and has an impact on physical health. But it is different in that it doesn't involve compensatory measures such as restricting and purging.

Some disorders have visible signs that people recognize as evidence of a health problem. With eating disorders, things aren't always what they seem. People with eating disorders may look nothing alike: they come from different cultural backgrounds and have different body types, despite having some of the same patterns and routines.

Many people occasionally overindulge and then feel bad about it, but that doesn't constitute a disorder. With BED, binges occur at least once per week over several months. People with BED often feel like they don't have the power to stop eating even what they know is an excessive amount of food.

After I completed my graduate studies abroad in theatre and moved back to Mexico, I became deeply unhappy. I had left behind like-minded colleagues and returned to a society that didn't appreciate my art or my research. I didn't like my job. I was living on my own in Mexico City and knew very few people. I was lonely and disappointed in myself and my country. My life didn't reflect my natural creativity. Food provided a refuge from my sadness.

At night, I would go to the supermarket and buy food as if I was buying for a party—a chocolate cake, a tub of ice cream, bags and bags of chips. Then I'd go home and eat everything myself, in front of the television. I'd start with the chips and eat my way through the desserts, by which time I felt sad, full and incapable of stopping. Bite after bite, I assured myself that this would be the last time—only to wake up and repeat the whole pattern. I knew I had a problem because not only did I gain 20 kilos in a few months but I wanted to be alone to binge, whether my day had been good or not.

I was seeing a therapist for my low mood, but I kept my bingeing hidden even from her. When I started to do some online research, I was shocked to realize that I was living with an eating disorder.

Having BED is like having a flat tire but continuing to drive. You know there's a problem, but instead of taking the time to fix the tire, you just keep driving, putting more and more strain on the car. When you continue binge-eating patterns, you're avoiding the opportunity to stop, check in with your mental state and fix the problem.

I finally decided to tell my therapist. She helped me develop some recovery strategies.

Photo credit: ©iStockphoto.com/baona

Having this disorder is like having a flat tire but continuing to drive. You know there's a problem, but you just keep driving, putting more and more strain on the car.

Reducing stigma

Today, many Western societies place a high value on what we have come to believe is a "healthy" (read: thin) body. But while we spend a lot of time thinking about the relationship between food and our bodies, we rarely discuss openly the relationship between food and eating disorders and other mental health issues.

The stigma attached to BED (and other eating disorders) is due partly to the fact that we d*on't* talk about it. By writing this article, I aim to make the disorder more visible—both for other binge eaters and for those who have told me that my binge-eating can be "cured" by "willpower," by sewing my mouth shut or by just "being healthy." These sorts of comments increase the sense of shame in the individual struggling with an eating disorder.

A positive aspect of starting conversations about BED and other eating disorders is that more people will realize that recovery is possible. The methods we use to become healthy are as varied and unique as we are. We develop eating disorders for different reasons, in distinct contexts. We must each find the method of "unlearning"—or of learning healthier patterns—that works best for us.

Some ideas for recovery

The recovery process doesn't happen overnight. But every action towards recovery counts, even when you fail to meet the objectives you've set. You are still moving forward, still getting better.

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Pieces of Me

REFLECTIONS OF A MENTAL HEALTH NURSE ON REDUCING STIGMA

Michelle C. Danda, MN, RN, CPNHM(C)

One of the first memories I have of my dad was when I was in Grade 5. My mom had gone to work—she was a licensed practical nurse who worked nights in a seniors' care facility—and my dad was up late, listening to jazz music.

Michelle is a Registered Nurse. She graduated from the University of Calgary nursing program in 2008. She has practised in the Lower Mainland, BC, and in Calgary, Alberta. Currently she works in the Vancouver area in adolescent and adult mental health and substance use, and in assertive mental health outreach

Photo credit: Carla Elaine Photography

Michelle C. Danda

I was trying to sleep, but my dad was blaring his music so loudly that even with my door closed and my bedroom on a different floor, I could hear it clearly.

My older brother and I begged him to go to bed, even directing him firmly to his room, but he kept going back downstairs and turning up the music. I stayed up for what seemed like forever, deep into the night, begging him repeatedly to stay in his room. I remember the movie that was playing on the television. I remember being so tired at school the next day, and having an intense feeling of shame in the pit of my stomach, knowing my dad had been so drunk the night before that he wouldn't go to bed, wondering if any of my classmates or teacher somehow knew.

I don't know if that was the first time I realized that my dad had a problem with alcohol, but it was the first time I understood how big the problem was, and the first time I remember feeling so scared and alone trying to manage him without my mom.

One of the final memories I have of my dad was when I was 23 and living in Vancouver. I was nearing completion of my second semester of graduate studies, prior to starting nursing school. I wasn't happy; I felt lost and lonely. I called my parents back home in Calgary. Without any hesitation, and without any interrogation or judgement, my dad told me he would immediately come out to Vancouver and help me move back home. All I needed to do was ask.

So I asked. And he came.

I remember anticipating how painfully long the car ride back to Calgary would be, 12 hours in a car with someone towards whom I still had so much anger and resentment. But I also remember that when we stopped for gas in Golden, BC, my dad looked at me and apologized for drinking too much when I was growing up. That was the first time I can recall him acknowledging to me that he had any issues with alcohol. In that moment, I realized that my dad loved me and was doing the best he could, despite living with persistent mental health problems.


Photo credit: ©iStockphoto.com/bowdenimages

> None of us is immune to making judgements. I constantly reflect on the value judgements that I make, reminding myself that we each bring our own experiences to our workplaces.

Today, I am a mental health and substance use nurse. Whenever I hear co-workers' judgements about a client family member's lack of insight or understanding into a loved one's mental health and addiction problems, I feel personally affected. In those moments, I think: "That was my family. You are judging me." I try to re-frame the situation, using it as a teachable moment to call out stigma and encourage reflection. But I rarely share my own story because I am still unsure how much of it I feel safe sharing with colleagues. I am constantly asking myself, "Would sharing be helpful at this particular moment? Am I sharing in order to help the person I am talking to grow and reflect or am I trying to shame them into doing something differently?"

In hindsight, I believe that my dad was doing the best he could, given the multiple challenges he faced. But even today, 11 years after my dad's death (which was identified clearly as being due to complications related to liver cirrhosis), my mom—who talks about the professional nursing care she has provided to people with alcohol addiction—will still not acknowledge that my father had any mental health or substance use issues.

Multiple factors contribute to insight. When people in our care are not acknowledging or talking about a problem, this does not necessarily mean they completely lack understanding about the circumstances. It might just be their way of coping. Approaching the situation from the perspective of the patient and the family (their experiences, not yours) can help build empathy and understanding.

None of us is immune to making judgements. I find that I constantly reflect on the value judgements that I make, reminding myself that we each bring our own experiences to our workplaces. I think that the key to being a caring, compassionate, empathetic and ethical mental health worker is understanding how our first-hand experiences impact the care we give.

Even though I have first-hand experience with some of the challenges

> Part of creating an inclusive, accepting, empathetic and compassionate workplace means disconnecting the terms “sick” and “well” from “them” and “us.”

faced by family members when a loved one struggles with mental health and substance use issues, my insight into my own experience, while it shapes my compassion and empathy, is not necessarily helpful to my clients. So, I go back to that first question: “Would sharing be helpful at this particular moment?”

My dad died shortly after I found out I was accepted to the nursing program at the University of Calgary. It wasn’t until I started nursing school that I began to reflect on the care my dad received as a patient in the emergency room, in the intensive care unit and in palliative care. I began to see the moral judgements and negative assumptions that many health care staff make, not only about people living with substance use problems but also about their families and loved loves.

I think that sometimes health care providers forget that the issues and problems our patients face are the same as those faced by our co-workers and loved ones. When we make implicitly or explicitly judgemental comments aloud, we may be sitting in a room with others who have experienced or are currently experiencing similar circumstances.

Mental illness and substance use touch all of us. When I hear off-the-cuff remarks by my co-workers about partying on the weekend or drinking in the evening, I cannot help but think, *Do you have a problem? Is this a cry for help?* Maintaining the status quo of the health care worker as “well” and the patient as “sick” perpetuates a culture of shame, stigma and silence. Part of creating an inclusive, accepting, empathetic and compassionate workplace means disconnecting the terms “sick” and “well” from “them” and “us.” Slight changes can help create a culture where our co-workers are not afraid to share their personal struggles.

When I started working in Vancouver, I found myself in a culture where the language used is deeply embedded in moral judgement. In my practice, I consciously use non-judgemental language when speaking about people living with substance use and mental health issues. For example, I talk about a “user of [specific substance]” or an individual who “currently has not used substances for [number of days/months/years]” rather than referring to someone as “clean,” which presupposes that the opposite is “dirty.”

I also use person-first language, which means that I put the person first rather than the illness.[1] For example, I say “[person], who lives with schizophrenia” or “[person], who lives with alcohol addiction” rather than referring to the individual as “a schizophrenic” or “an addict.”

When someone uses language that isn’t person-first language, I sometimes re-phrase their words in the context of our conversation as a way of normalizing and integrating these terms within my practice. Though these changes seem small, they have a powerful effect on the way those around me refer to mental health and illness and substance use, think about mental health challenges and, in turn, speak and act around people living with substance use and mental health issues.

My father’s issue was alcohol, a legal substance. But his substance of choice could easily have been any other mood-altering substance. The current opioid crisis has brought the issue of substance use to the forefront in everyone’s minds. When I turn on the radio today, I hear about “addicts” daily; the language used often makes me cringe. Using person-first language might seem like an insignificant change, but the result may be profound as we begin to see the people who are suffering from addictions issues as people—parents, friends, children, family—who have interests and have had and can have lives beyond their current addiction issue. Using person-first language can reduce the stigma of substance use and help create safe spaces for health care delivery, where those accessing care know that we see them as people, not addictions.

A Journey to Worthy

THE IMPACT AND STIGMA OF SUICIDE

Brittany Didrich

Mental illness has been a part of my life for almost 20 years—most of my existence. At the age of four, I lost my father to suicide. He was battling a deep depression and was struggling with recovery from his addiction to cocaine.

Brittany Didrich

Brittany enjoys reading, writing, cuddling with her cat and spending time with her family, partner and friends

From this event, I created an idea of myself, that I was not good enough for my father to want to continue living life with me. With the help of a counsellor, I have come to realize that I am doing a disservice to myself if I continue to believe that I am not worthy, not "good enough," simply because a four-year-old decided I wasn't.

It's been a tiresome journey to get the help I needed, as I never wanted to admit that something might actually be wrong with me. I looked at myself and said, "Other people have it worse than me," or, "I have nothing to be upset about; I'm just whining." It can be difficult being young and listening to an older generation say, "You haven't even lived yet. What do you have to be depressed about?" Hearing these words can cause young people and teenagers to retreat farther into themselves. Without knowing someone's struggle, we can't determine what someone is feeling or what someone might be affected by. It is always possible for someone young to "have something to be depressed about."

Growing up, I felt the stigma surrounding my father's suicide. I never spoke much about him, and when I was asked, I used phrases such as "He died," or "He passed away." I felt that nobody wanted to hear my sob story and I didn't want anyone's sympathy. None of my peers and none of the adults in my life ever spoke about suicide or its victims, and so when I started having suicidal thoughts of my own, I kept them hidden. Stigma is not always about what someone says. The less suicide is talked about, the more taboo it seems, particularly to people who have never been affected by it.

I knew that some symptoms of depression applied to me, but I had always thought the typical depressed person was so exhausted that they could not go to work or function in their everyday lives. I thought that depression always consumed you—that you couldn't do anything at all except lie in the darkness of your room with the covers pulled over your head, blocking out the world.

I have since learned that there is no such thing as "typical" when it comes to depression. Nobody fits into the categories perfectly because everyone experiences mental illness differently. The stereotypical "depressed person" is just that: a stereotype. My assumptions were based on a stereotype rather than on real experience.

I became interested in alcohol around the age of 15. Others among my peers were also beginning to drink—mostly the ones with parents who did so frequently. I hid my drinking from almost everyone I was close to. I would purposely hang out with acquaintances at school rather than friends. Among my acquaintances, I wasn't the only one using alcohol, so no one bothered to question me about it. Isolating myself from my true friends was the only way I could get away with it. My close friends would have been alarmed; acquaintances just thought I liked to "have a good time."

During high school, I worked a part-time job and kept my grades up to As and Bs—but I was also drinking straight vodka every day before 8 am. The only time I wasn't intoxicated was when I had to work on the weekends, when I had to write a test, or when there simply was no alcohol around. In hindsight, I realize I was self-medicating. I continued to wake up every day, poison my body with alcohol and then put a smile on my face. Anybody who asked me "How are you?" received the same answer: "I'm good, how are you?"

Obviously, I was not good. But when someone asks how you are, they don't really want to know how you *actually* are; they are simply greeting you, and the expected response is that you are, indeed, fine. I had everyone fooled, even myself—that I was a capable person living a successful life.

After high school, I quit drinking heavily in order to work full-time. Without the giddy weightlessness of near-constant intoxication, my depression became increasingly worse. At work, I chatted lightly and laughed with my co-workers, while inside my head I was replaying false statements about myself: *I am stupid, ugly, fat, worthless.* Often when I worked an early-morning shift, I would be the first and only one in the department for an hour or more. My thoughts rapidly became focused on ways I could end my life. I told nobody about the way I was feeling for fear of being judged, seeming weak or being talked about behind my back.

On the morning of July 22, 2016, I intentionally overdosed. I called my best friend and told her what I had done. I was immediately admitted to the hospital. My mother, my partner and my other family members and friends were in utter shock. That was the lowest point I have ever been, and I never want to experience it again.

But ironically, because my plan hadn't gone the way I intended, I considered my suicide attempt to be a failure rather than a second chance. The doctors told me that if I had waited another two hours before arriving at Victoria General Hospital, my liver would have failed and I would have died. When I heard that, it didn't matter to me that my closest family and companions were horrified and in tears. I was numb, and I still wanted to die. I wished I had never picked up the phone.

After my release from the hospital, I did not tell any of my wider social circle what had happened. The stigma surrounding my own father's suicide was still with me; I didn't want people to look at me as a poor, sad little girl or—perhaps even worse—be indifferent.

Even though I had left the hospital with a prescription for my first dose of antidepressants, I was still uncertain what the future would look like. The pills worked for a while, and I began to feel better. But after about three months, I started getting worse again. I was clutching my chest at night, my stomach in knots, as I cried myself to sleep. Suicidal thoughts began to resurface, and I became afraid; I'd had a glimpse of hope after taking medication and I didn't want to feel suicidal again. When I looked back at the person who had been admitted to the hospital, I felt I was looking at a version of myself that no longer existed.

I knew I needed to reach out. I was still hiding secrets, and I suspected the fact that I was keeping them secret was affecting my health. So, I took a big step: I disclosed to my mother that I had been through a horrific experience of sexual assault a few years previously, and that I continued to deal with the effects of that assault every day. I battled constant feelings of guilt, shame and disgust. After I opened up about my experience, a physician was able to diagnose me with depression and noted that I also had some symptoms of post-traumatic stress disorder (PTSD).


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> I am glad to say that I have crawled out of the hole I was stuck in. Stigma is the darkness which makes the hole seem deeper and darker than it really is.

I have a high-functioning form of depression. In times of emotional distress, I focus my energy elsewhere—on my work or, as in the past, on my studies. It is usually impossible for others to see that I am struggling.

But I also have days where all I do is lie in my bed while the tears fall, for I cannot stop them. There are times when I am too tired and sleep too much—hours when I don't feel like I am moving my own feet or even aware of my surroundings; I'm just going through the motions. I overthink conversations in my head, second-guessing myself and wondering at all times if I'm doing what I should be doing.

But I am alive, I am breathing, I am reading, walking, writing, talking. I am living. It's wonderful. I reached out, I am properly medicated now, in counselling sessions, and I am doing better. I am learning to enjoy life again.

Now that I have been completely honest with my family and close friends, I also feel free of my invisible bindings. The people I care about most have accepted me and everything I have been through; it feels like I can start anew. Keeping things bottled up was always how I dealt with any difficult scenario in my life; I was ashamed and I worried about how I would be treated or viewed if I let anyone know what troubled me. I was under the impression that my thoughts were a reflection of who I was. I am glad to say that I have crawled out of the hole I was stuck in. Stigma is the darkness which makes the hole seem deeper and darker than it really is.

I have come to accept that not every day will be a good day, even if I want it to be. The most important thing is to ask for help when I need it. I am grateful that it is increasingly acceptable to talk about mental health openly, though I never thought to share my personal story in this way. Writing and speaking freely on this topic has helped my recovery. I hope this piece will encourage others to share their experiences. v

On the Other Side of the Elevator Doors

A SISTER'S PERSPECTIVE ON STIGMA AND SCHIZOPHRENIA

Cindy Crane, BCS

I grew up with a beautiful younger sister who was my good friend, an honour student in high school and an accomplished pianist. But on an unforgettable day in 1977, she intentionally rolled her car on the Trans-Canada Highway. The accident left her badly scarred and unable to walk for several months.

After raising her two daughters and son, Cindy finished her degree and spent three years living in British Columbia's Fraser Valley, helping and advocating for her sister and niece and nephew. Now she lives in Coleman, AB, with the puppy she rescued in Mexico. She is writing a book about her travels in South America

Photo credit: Cindy Turnbull

Cindy Crane

In retrospect, I believe the car accident may have been the first indicator of mental illness. In the years that followed, our family tried unsuccessfully to help Sue* as she struggled with alcoholism, joined a cult, became anorexic, abused drugs and made other suicide attempts. As a teenager, she ran away from home more than once. As an adult, she was never able to hold down a job for more than a few months.

At every stage, family members have proposed theories: It's teenage angst. It's because she's pregnant. It's because she has a challenging marriage. Much later, someone even suggested it was because of menopause.

One night many years ago, when her two children were still young, Sue told me she heard threatening voices in her head. At the time, I dismissed her comments as a holdover from her cult

**pseudonym*

experiences. Later, I did some research and began to suspect she might have schizophrenia. When I shared my suspicions with family members, no one was willing to consider the possibility. My parents particularly refused to talk any further about it.

In hindsight, I believe the negative public perception of mental illness had an effect on how willing my family was to consider the possibility that Sue was truly ill. That stigma nearly divided our family. *We* couldn't be a family who had a member with a mental illness.

It would be a very long time before Sue was finally diagnosed with schizophrenia—more than three decades after that fateful car accident. If my 18-year-old niece hadn't called 911, Sue may never have been diagnosed at all. In fact, we might never have known where she and my niece and nephew were living.

This was because, in 2007, Sue had announced to our family that she would no longer be having any contact with us because of the abuse she had suffered as a child. We were stunned. We all knew her accusations were false. My parents had always provided a stable, loving home for us.

For the next six years, we had no idea where Sue or the children were. She kept them hidden not only from us but from their father as well.

Then, on August 1, 2013, we got two phone calls from two different hospitals in the Fraser Health system. My niece had called 911 because she was experiencing thoughts of suicide. After she spoke to medical staff, there was enough concern about the welfare of my sister and nephew that they were picked up by Car 67 and taken to Royal Columbian Hospital (RCH).[1] My nephew was sent home, but my sister was admitted.

We now know that many of the circumstances in the previous six years, including the break-up of Sue's marriage, were brought on by Sue's symptoms of delusion. When we went to the hospital to see my niece—for the first time since she was 12—she said that when Sue first insisted they disappear, it had been exciting to think they were on the run. But over time she had begun to think that either she must be crazy or her mother was.

Sue believed the neighbours in the next-door apartment were plotting to kill them. The three had "escaped" through their third-storey window, lowering themselves on sheets tied to the bed. Then they had lived on the streets of downtown Vancouver for a week without food. They had killed the family's pet cockatiels before leaving the apartment because Sue believed the world was ending and they had to protect the birds from later suffering.

When the three found housing again, Sue began to suspect that a nearby cell tower was tracking the electronic chip she believed had been put in her eye after the car accident. She pulled both children out of school and moved again. When we found them, my niece and nephew had only an elementary-school education.

The most gut-wrenching question my niece asked us was, "Why didn't you help me sooner?" We assured her that every attempt to find them had yielded nothing. This was hard to explain to her.

I experienced first-hand Sue's other symptoms—and the equally distressing signs of stigma—when I went to RCH to see her.

On the other side of those elevator doors, I entered a scene from *One Flew over the Cuckoo's Nest*. There were doctors, nurses and patients everywhere. None of the nurses made eye contact with me. It was complete and utter chaos. I finally got someone's attention and explained who I was.

At first, Sue refused to open her door. I said, "I don't understand why I can't talk to you … I have come all the way from Alberta just to see you." Through the door Sue said, "You say that as if you think I am crazy." There was that stigma again, hanging in the air between us.

Once she opened the door, I gasped—she looked like a wraith: lost and bewildered. The glimpse I got of her room sickened me. The walls were made of cement blocks and painted an anaemic yellow. The tiny bed looked like it had come from a hospital demolition sale. Later, I wrote in my journal, "she is my sister, not a prisoner!"

The next time I went to visit Sue, a staff member escorted me to a messy waiting area where the TV was blaring. When Sue eventually showed up, she quickly switched off the TV. She said the hospital staff and volunteers spoke to her as if she were a child, insisting she participate in activities that held no interest for her. In hindsight, I can't help but wonder if the residents of the psych ward are treated differently from the residents in other wards of the hospital—as if they don't require a pleasant space, as if they don't require the sort of respect that other patients receive.

At this point, we still didn't know much about Sue's treatment. Because Sue is an adult, no one would tell us her diagnosis, and we had to formally request to be involved in the continuity of her care—a request that was refused by Sue. Apparently, she'd informed her doctors that everything we told the medical team about her early life was a lie.

I cannot express strongly enough my distress at this dysfunctional system: when a loved one is suffering, a strong, caring family should be involved in the ongoing care plan. My journal entry at the time captures my despair: "Who on earth do they think wants to help Sue once she leaves [the hospital] if not us?"

The one saving grace in the whole process was discovering the BC Schizophrenia Society (BCSS). BCSS provided emotional support and counselled us on how to navigate the complexities of the mental health system. The organization has continued to act as a guide and resource throughout Sue's recovery.

On August 23, Sue was discharged from the hospital. She returned to the apartment that she shared with her children, promising to come back for her medication on a regular basis. I do not know if she kept this promise, but she did slowly begin to re-establish contact with the rest of the family. It was at this point that I moved to the Fraser Valley from Alberta, thinking that Sue could live with me. She refused, but my niece took me up on the offer and lived with me for several months.

Life for our family is certainly much better than it was. Sue is now speaking with all of us again. She seems to enjoy spending time with us. We have shared laughter and happy memories together.

In July of 2016, our parents set up a living trust for Sue so that she receives on a monthly basis the money they had set aside for her to inherit. She has gained weight and looks much healthier. At one point, she assured us that she was still taking medication, but I don't think that's true any longer. Perhaps the reduction of stress in her life and the reconnection with friends and family have been factors in her recovery. She no longer has the pressure of having to provide for herself and her children.

My niece is now in her second year at the University of the Fraser Valley and my nephew was able to complete his high school education. But they have little contact with the family and only sporadic contact with Sue.

I am not proud to say it, but over the years, I have often been angry with Sue, for how I felt she was harming her children, hurting her husband and our family. I have also gone through a lot of self-recrimination: *If only I had been more tolerant. What would have happened if I'd given her more support?* And after Sue's diagnosis, every time I had an unusual idea or heard a voice in my head, I would have the unwelcome thought, *What if I am affected, too?*

While I lived in the Fraser Valley, I continued to be involved with BCSS support groups, and my love, compassion and understanding for Sue grew. I learned that nothing we did caused Sue's mental illness. And I understand that all these years she has been battling an invisible foe, much like Tolkien's Frodo trying to fight the demon Shelob in a dark cave.

The hardest part for me now is the sadness I feel when I think that my sister was deprived of a promising life. Once I recognized that she had been robbed by schizophrenia, I could truly forgive her and myself.

My hope is that the experiences of our family can help facilitate more positive conversations about mental health issues and the difficulties faced by families when their loved one is dealing with a mental health crisis. If our experiences can do this, then I am grateful for every aspect of this challenging journey. And I hope that the next time those elevator doors open, they will open on a scene of healing rather than chaos. v

Am I the Only One Going Through This?

STANDING UP TO STIGMA, ANXIETY AND HERPES—ALL AT ONCE

Sanaz*

I have social anxiety and genital herpes. It's a doozy of a combination.

Sanaz completed her undergraduate degree in 2016 in Kelowna, and is currently living in Vancouver

**pseudonym*

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I am also a perfectionist. When I sat down to write this article, I was second-guessing everything I wrote. So, I decided to just do a free flow without stopping because I have been freaking out in my house all day trying to write the perfect sentence, the perfect paragraph, and it must stop.

My aim for this article is to share my story in the hope that whoever reads it will feel less alone in the experience of being a human.

I will write first about my social anxiety so you can see how my experience with anxiety shaped my experience with herpes.

Often, when I'm talking to a friend, I feel extremely uncomfortable because my thoughts move along these lines:

Does she know I feel like this? Is my eye contact too intense? What is wrong with me? Am I making this awkward? I am so insecure. I am so much less than … She can tell how insecure I am ...

As you can no doubt tell, these thoughts do not make me feel good. When they occur, I am no longer present in the conversation with my friend. Instead, I am bashing myself, while she thinks I am listening.

I started having these thoughts in high school. I would often feel like I was being ridiculed by my friends when they joked around with me, but I never said anything to them about it. I didn't want to make a big deal out of things. I also did not trust my own instincts and emotions. I didn't understand that I had a right to feel the way I did.

Similar thoughts and feelings followed me after I left high school; I found it hard to be on a bus, talk to a cashier or eat in front of others because of my social anxiety. At university, I made amazing friends—many of whom are still friends today—but it was a challenge to spend time with them because I acted how I thought I should act—like a confident person with no insecurities! Inside, I felt very differently.

I never told my friends or family members when I was upset by their treatment of me. For example, if a friend made what I considered to be a hurtful comment, I would get a tight feeling in my chest, like bees were swarming in it, but I would act like I was totally fine. I never expressed my emotions aloud; instead, the little bully inside my head would examine the situation and always conclude, “You aren’t looking at the situation right!” Or, “If you say something, they will hate you and think you are too sensitive.”

How could I ever open up to anyone when I had a bully like that in my head? Why would I want to open up to people if I thought they would reject me if I told them how I felt?

These experiences all took their toll. Finally, I realized I needed to talk to someone. First, I opened up to my best friend and to my dad about how much anxiety I was experiencing. I also started seeing a counsellor, an amazing woman who has helped me a lot. Most importantly, these people *validated* my feelings.

I also realized I was literally not alone. I say “literally” because I used to think that, in actual fact, nobody else was going through any sort of struggle, ever. I was certain that I was the only one who didn’t have my life together.

I had no idea that finding out I have herpes would change the way I see other people and myself—for the better.

Shortly after my 23rd birthday, in 2016, after a routine pap test, my family doctor informed me that I have genital herpes. At the time, I knew nothing about herpes except for the stigma associated with the virus. I freaked out in his office. I remember him saying, “So … your blood test shows that you have antibodies for herpes simplex virus 2.” And I yelled, *“I have herpes?!”* A rush of shame ran through me. I started questioning my doctor about the future, and I started questioning myself about my life choices.

My doctor was actually really helpful and compassionate, but I remember being confused by his reaction. I was freaking out, and he was saying, “Listen, *everyone* has herpes; about one of every four people has the same strain as you.” I was just sitting there thinking, “Everyone?! What is this guy talking about? No one I know has herpes. How can he sit there and not think this is a big deal?” Even though I am lucky to have supportive family and friends, all the way home on the bus, I ruminated on the horrible future of shame and rejection I thought lay ahead of me in my dating and social life.

As you can imagine, what I feared most was telling potential lovers that I have herpes. I thought I would get rejected by all men and that I would never have a love life. I felt like an outcast—and in my experience, it is always the worst to feel like you are separated from your fellow human beings. But when I shared these fears with my parents, my father told me bluntly that any man who thought my diagnosis was a deal-breaker wasn’t worthy of me, and that helped a lot.

This gave me the courage to open up about my diagnosis to family, friends, co-workers and men in my dating world. As soon as I started opening up, I understood what my doctor meant by “Everyone has herpes.” The majority of the people I opened up to either had herpes themselves or knew somebody close to them who did. But I also found out something else: everyone I talked to was going through his or her own struggles and everyone felt insecure at times.

I realize now that *everyone* has a story: the human experience is a shared one. The stigma surrounding social anxiety and herpes made me feel like I had to keep both of them secret. But in being open about my “secrets,” I became closer than ever to the people in my life, and I have proof that I’m not alone. I hope this article can be proof for somebody else out there!

related resources

On the topic of living with herpes, I found articles by online blogger Ella Dawson really helpful: https://ellacydawson.wordpress.com

Mental Health is a Laughing Matter

David Granirer, MPCC, MSM

Most people think you have to be nuts to do stand-up comedy. I teach stand-up comedy as a form of therapy. It's not as crazy as it seems.

David Granirer

David is a Counsellor, Stand-Up Comic, Author, and Founder of Stand Up For Mental Health, a program that teaches people with mental health challenges how to do stand-up comedy. David is featured in the VOICE Award–winning documentary Cracking Up *and the award-winning Australian Broadcasting Corporation documentary* Crack Up. *See www.standupformentalhealth.com*

Stand Up For Mental Health (SMH) is a program that teaches stand-up comedy to people with mental health challenges as a way for them to build confidence and fight public stigma.

In the mental health field, service providers talk a lot about restoring wellness by accessing people's strengths, but we don't tend to say to someone, "You have a great sense of humour—let's use it to build you up and give you confidence."

Unlikely as it seems, I got my start in comedy as a trainer at the Vancouver Crisis Centre. There, I had a captive audience for my jokes, and I thought I was getting pretty funny—that is, until I signed up to perform on amateur night at a local club and was greeted with five minutes of dead silence.

I decided to take a comedy course. The next time I went on-stage, I was prepared and had a great set. I knew from that moment that I just had to do stand-up comedy.

In 2004, I founded SMH in Vancouver, BC. Since then, I've trained approximately 500 comics in partnership with mental health organizations in more than 35 cities in Canada, the US and Australia. We've performed over 500 shows on military bases and for correctional facilities, Veterans Affairs, government

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departments, corporations, universities, colleges, medical schools and comedy and arts festivals.

The program was successful almost right away. There was great support from the Vancouver mental health community, and organizations began to book us for shows. Students often hear about us by word of mouth, but we also get referrals from the mental health community. In 2006, other mental health organizations started asking me to establish SMH in their cities. I train the SMH comics via Skype and then fly in at the end of the program to perform with them.

Funding was another matter. For the first 10 years or so, I donated a lot of my time to keep the program running. But in the past 4 years, the program has become so successful, it's been able to fund itself. In fact, even though I'm trained as a counsellor, Stand Up For Mental Health has been my main gig since 2004.

During the first class of the SMH program, I give the comics an overview of what stand-up comedy entails. We then look at some joke-writing techniques used by top stand-up comics. Subsequent classes are spent generating material and brainstorming jokes. In the last month or so leading up to the showcase, we practise our performance, including timing and delivery.

I got the idea for SMH by watching students in the Stand-Up Comedy Clinic course I was teaching at Langara College. Even though the Langara program has nothing to do with mental health, many of my students overcame long-standing depression and phobias over the course of the program, as well as increasing their confidence and self-esteem.

One student told me that she had always had a fear of flying, but that the day after our showcase, she got on a plane and found that her fear was gone. She said, "Once I'd done stand-up comedy, I felt like I could do anything!" I was inspired by her and by others who gave me similar feedback. I decided to offer this sort of opportunity to those with psychiatric disorders, mental illness and other mental health challenges.

One of my comics who has taken numerous street drugs, including crystal meth, said that doing comedy is the best high she's ever had—and performing is free, legal and has no side effects. Oh, yeah—and it's fun! It's the best kind of wellness activity I can think of.

Another comic who had schizophrenia found it extremely difficult to ride public transit. As she sat on the bus, her voices would say things like, "Everyone knows that you're a freak, they think you're crazy." After taking SMH, she realized that she had a wicked sense of humour; the next time she rode the bus, she started joking with the other passengers. It was a great ride. She now had a skill that leveled the playing field and allowed her to engage with all those so-called scary, normal people. In other words, she had achieved a state of wellness when it came to interacting with the outside world.

The same comic also came to class one day wearing a striped shirt. She said that the voices hadn't let her wear stripes for years, but now that she was doing comedy, she wasn't so afraid of them. Another student with schizophrenia said that for about a week after we did a show, his voices would either become quiet or actually tell him positive things.

I also had my own experiences to draw on. I myself have had depression, and in my view, there's no better medicine than laughter—both being able to laugh and being able to make others laugh. I believe that a key component to recovery is the ability to see humour in adverse situations. And when you have a mental illness, that often means being able to laugh at yourself.

Comedy helped me tremendously in my own recovery process. The fact that I got up in front of audiences all across North America and Australia and told my story gave me confidence and helped me to combat the negative feelings I had about my own mental health.

Watching comics with mental health challenges also enables an audience to see the individuals as human and relatable, which helps to counteract public stigma and the negative stereotypes often propagated by the media. The best comment I ever heard about one of my students was someone from the audience saying, "That guy on stage has schizophrenia and he was hilarious!" How often do you hear "schizophrenia" and "hilarious" in the same sentence?

Many of my comics face stigma on a daily basis, and some have even come to think of themselves as "screwed up" or "dysfunctional." But in comedy, the more screwed up and dysfunctional you are, the better your act is going to be! This axiom creates a cognitive shift in the comics. All of a sudden, the very things they are ashamed of become great comedy material. They can't wait to tell other people about the time they thought they were Jesus or when they maxed out their credit card and ran around naked!

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combating stigma: those with lived experience are our greatest allies

Laurie Edmundson, BA

Laurie has a bachelor's degree in criminology and psychology and is a Mental Health Advocate

People with mental health challenges face numerous negative outcomes of stigma on a daily basis, including discrimination, interpersonal difficulties, increased stress, the feeling that they are a burden to others, and poorer access to mental health (and even physical health) services.[1] Reducing stigma not only increases the quality of life for individuals with mental illness but also helps to create more inclusive communities.

It turns out that our greatest allies in stigma reduction are actually those with lived experience of mental illness.

As part of my university research, I conducted a review of stigma reduction programs. Though the review considered stigma reduction initiatives and mental illness generally, my research focused on the highly stigmatized borderline personality disorder (BPD). I found that contact-based stigma reduction programs are more effective than education-only approaches at reducing service-provider, self-, and public stigma.

Contact-based programs are delivered by people with lived experience of mental illness. They show that people with mental health challenges are normal human beings who can have a good quality of life and be contributing members of society.

Overall, the contact-based programs reviewed were successful in decreasing negative attitudes towards those with mental illness, decreasing stigma, improving mental health literacy, improving the well-being of the mentally ill individual and increasing his or her desire to seek help, and improving the coping skills of all participants.[1] Another positive outcome was that, by reducing stigma, participants in these programs were more willing to help people with a mental illness.

Showing that recovery is possible gives hope to those who may be struggling with a mental illness themselves. It also empowers the person with lived experience delivering the stigma reduction program.[1] Empowering those with lived experience may also encourage the more far-reaching advocacy that is necessary when it comes to highly stigmatized disorders.

The success of contact-based stigma reduction programs suggests that such programs should be readily accessible to everyone—not only to improve the lives of those with mental illness and to increase public awareness and understanding but to continue growing communities founded on human relationships rather than false assumptions.

For full findings and more information, please visit www.laurieedmundson.com.

The Three Faces of Stigma

Steven J. Barnes, PhD

Having lived with bipolar disorder for more than 20 years, I have had many encounters with the stigma associated with mental illness.

Dr. Barnes teaches psychology at UBC and is part of the Collaborative RESearch Team to study psychosocial issues in Bipolar Disorder (CREST.BD). His expertise is in psychiatric disorders and neuroplasticity. He is also an artist who produces both traditional and new-media pieces. Dr. Barnes lives well with bipolar disorder

Art credit: Steven J. Barnes (August 2016)

I know you are but what am I?

Sometimes the stigma can be quite in-your-face: a week seldom passes when I don't encounter a news article highlighting that a particular violent criminal had a form of mental illness. (In reality, people living with a mental illness are more likely to be the victims, rather than the perpetrators, of violent crime.[1]) On the other hand, stigma can also be quite subtle—like the wary look I got from the pharmacist the other day when I handed him my prescription for lithium, a drug commonly used for the treatment of bipolar disorder.

As is true for many people living with a mental illness,[2] the negative effects of the stigma I experience often outweigh those of my symptoms. That may sound absurd, but it is important to realize that there are multiple sorts of stigma that can impact an individual living with a mental illness.

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

Types of stigma

Researchers who study psychiatric stigma often talk about three different types of stigma (also see pages 5–7 of this issue).

Structural stigma refers to particular policies of large entities (e.g., governments, companies, schools) that place restrictions on the rights or opportunities of persons living with mental illness.[3] For example, in Lithuania, citizens with long-term mental health problems are excluded from home owndership.[4]

Social stigma is what most people think of when they think of stigma. In general, social stigma refers to supporting stereotypes about individuals with a mental illness. For example, I remember as a student telling one of my professors that I had bipolar disorder. She subsequently began talking to me more slowly and even subtly questioned my ability to complete a graduate degree. In essence, she was endorsing a common stigmatizing misconception: that having a mental illness makes an individual less intelligent or less capable.[5]

Stigma can impact recovery from a mental illness and one's ability to live well with a mental illness.[6] Based on my own experiences, as well as the research literature,[7] this is particularly true for the third type of stigma: *self-stigma*.

In a nut shell (pun intended), self-stigma is the internalizing of stigma (social or structural). Self-stigma can affect how you think about yourself and your relationships with others; it can even affect your motivation to recover[8] and your adherence to treatments.[9] For example, following my diagnosis, I came to believe that I was intellectually and artistically impaired.

Self-stigma also distorted my beliefs about what other people thought of me. For example, I often assumed that others thought less of me once they learned of my diagnosis. I thought that people talked about me, and my diagnosis, behind my back, and that people could see behavioural differences in me—that they could see my diagnosis! And I thought that many people were two-faced—smiling when they saw me but otherwise trying to avoid me. Regardless of whether those perceptions were true, the important point is that such self-stigma had a major impact on my sense of self-worth and my perceptions of my worth in the eyes of others.

> Certain strategies that would seem to be intuitively reasonable ways of battling social stigma can actually be ineffective.

Battling stigma on all fronts

So, what can one do to combat stigma? There are several approaches, many of which are specific to the type of stigma you are battling.

Structural stigma can be effectively tackled through educational programs for individuals in positions of power, such as educational programs for medical students and police officers.[10]

Social stigma has been effectively addressed using educational interventions, such as the communicating of positive stories about people with mental illness—which is not as easy as it sounds because changing how the media presents mental illness can be challenging. In addition, social stigma can be effectively battled through interventions that place a person in direct contact with an individual living with a mental illness.[10] Both of these approaches can have a positive effect on structural stigma as well; as individuals' attitudes and understandings change, so do the attitudes and understandings reflected in the organizations they participate in.

It is also important to realize that certain strategies that would seem to be intuitively reasonable ways of battling social stigma can actually be ineffective or even counterproductive. For example, simulations of mental illness (such as the simulation of the auditory hallucinations of an individual living with schizophrenia) and educational interventions that focus on the "medicalizing" of mental illness (that is, informing people that mental illness is just like any other illness or disease) are generally ineffective.[11]

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Embracing Differences on Both Sides of the Street
BUILDING BRIDGES IN VANCOUVER'S DOWNTOWN EASTSIDE

Ronna Chisholm, B.Comm., Leslie Wong Fellow (UBC)

Ever since I was young, embracing difference has been a theme in my life. When I was seven, we moved to a new house where our neighbours were the only East Indian family in our small town on Vancouver Island.

Ronna is Co-Founder of Dossier, a Vancouver design company that specializes in brand and innovation. She's also the Founder of Railyard Lab, a business and design intern venture. Ronna is passionate about cultivating a new generation of thinkers, aligning strengths and passions to create business and social innovations that bridge racial, cultural, and socioeconomic differences

Photo credit: ©iStockphoto.com/TommL

The community was not very culturally diverse, and I remember overhearing a visitor's concerns about my new playmates. I couldn't understand those concerns at all. As far as I knew, the four beautiful girls who lived next door were the friends who taught me how to play ping-pong and whose warm home smelled delicious.

I also have personal experience facing stigma and feeling different from other people. Having never quite reached five feet in height, I was forever teased about being small. My mother would tell me often that good things come in small packages. That helped somewhat … until I was 13. My first year of high school was the year that Randy Newman's "Short People" topped the pop music charts. And if Newman knew what he was talking about, then I wasn't just short: I also "had nobody to love and no reason to live."

Today, the idea of taking the song seriously seems silly, but at 13, I thought very differently. I remember the feeling I had walking down the school hallways, listening to other students taunting me cruelly with the lyrics of the song.

So, I fought back: I took the money I had made from my part-time job scooping ice cream and I had a t-shirt made. I waited anxiously over the next few days until I could pick it up. And then I walked down the middle of the school hallway in my new grey shirt with white felt letters ironed on the back: "Short People Make Better Lovers."

While I laugh now, I can also admit that I'm a little embarrassed about how I handled it. At the time, I didn't fully comprehend the message I was sending; I just knew I couldn't be silent and do nothing.

Decades later, I had a similar reaction when I heard disturbing comments and objections in the neighbourhood about a social housing complex being built across the street from the design office where I've worked for over 25 years in Vancouver's Downtown Eastside. I couldn't understand such a negative reaction. I wondered, Why such fear? Why are we afraid of our neighbours? What does it even mean to be neighbours?

I discussed these questions with a team of four young business and design interns working with me. I charged them to think about how we might bridge the diversity on the two sides of our street. They were excited by this challenge and began talking to community members and gathering insights.

Together, the interns and I created the Hello Neighbour campaign to welcome the 140 new residents to the neighbourhood. Several businesses contributed items and donated money to provide every new resident with a welcome bag, including a notebook, a picture frame, a keychain, a good-luck bamboo plant, a JJ Bean mug and a pair of Aritzia mittens. All the new residents received a personally addressed, custom-designed card welcoming them to their new home and to the neighbourhood; each card was signed by several neighbours. For the next few weeks, we greeted and welcomed as many new neighbours as possible. Many of our new neighbours had never before lived in a home of their own.

> I wondered, Why such fear? Why are we afraid of our neighbours? What does it even mean to be neighbours?

As we greeted folks, we heard stories of all types. Stories of happiness (finally, a home!), stories of fear and trepidation (the challenge of sleeping in a bed versus sleeping in a tent), stories of tragedy (childhoods spent in residential school), and stories of mental illness, disability, sickness and hardship. We also heard stories of love for all things good—food, music, plants, bikes, reading, dogs, bunnies, friends and family.

Our intention with the Hello Neighbour campaign was to begin an ongoing, positive relationship between the residents and the local business community—to help balance out the negative attitudes and social stigma we had observed. We had no idea how our project might unfold, but we were open to whatever opportunity might present itself.

Our first unexpected opportunity came along soon after our welcoming campaign. A local church offered to donate funds from an improv night to Hello Neighbour. The event venue was down the street a few doors, so we invited some of our new neighbours to join us at the event and then give us input on how to spend the proceeds. In no time at all, we'd agreed to purchase a snooker table for the lounge area of the new social housing complex.

Since that evening two years ago, we've played weekly snooker games with resident and master pool player Dennis Scott. A sharply dressed, 69-year-old self-professed pool shark who once dreamed of running his own pool school, Dennis now has provided lessons to more than 30 folks from the business community. He considers teaching pool to be his community volunteer activity! Recently, we made him a t-shirt to acknowledge his dedicated service—complete with a head shot of him in his signature shades and the words "Pool School" emblazoned beneath.

In the summer of 2016, a new intern group took up the challenge to continue to build community between our two sides of the street.[1] This resulted in The Faces of Alexander

Street, a portrait-photography and video project that brought together several community members on both sides of the street.[2] The project culminated in an end-of-summer barbecue bash.

But while our positive efforts have been acknowledged by residents and housing staff alike, the truth is, there are no easy fixes or solutions. Continuing poverty and the growing opioid crisis in downtown Vancouver make it all the more important for us to reach out and connect with those who may be struggling.

A number of years ago, my late friend and mentor Milton Wong lamented to me, "What is wrong with us, why do we walk past people on the street, why do we not *see* people?" This lament struck a chord with me. It brought to mind a saying I'm especially fond of:
A loveless world is a sightless world.[3]

Although they were only across the street, in some ways our neighbours seemed a world away from us in terms of our differences. But Milton's thoughts are a constant reminder to me that truly *seeing* others begins with a love for each other and for our shared humanity. We all have our stories, we all experience joy and struggle and we all have a need to be known and to be seen. When we shift our focus to embrace our differences—even celebrate them—then we realize that we are not actually so very different from each other. In fact, reaching out to the people on the other side of the street has reminded me how very much alike we are.

After all, we're in this world—and on this street—together.

THE THREE FACES OF STIGMA—CONTINUED FROM PAGE 29

Self-stigma can be improved using several approaches, including:

- altering one's stigmatizing attitudes and beliefs through educational interventions
- improving one's skills for coping with self-stigma by improving one's self-esteem, empowerment and help-seeking[12]
- self-disclosure[13,14]

Self-disclosure involves disclosing one's diagnosis to others. Self-disclosure can take many forms, from discreetly telling a close friend to broadcasting one's experience to a much larger audience. It is important to weigh the pros and cons before disclosing one's diagnosis in a particular setting. For example, in a work setting, the costs of disclosing one's mental health issues (for example, the potential for gossip) may outweigh the benefits (for example, not having to lie to one's supervisor when taking time off for appointments with your psychiatrist).[13]

In battling my own self-stigma, I took the self-disclosure approach. Because I was initially wary of the effects of self-disclosing, I began by disclosing my condition in a relatively safe environment: a peer-run support group called The Kaleidoscope. Feeling empowered by that experience, I next began disclosing my condition to students in the courses I teach, in my lectures on the topic of mental illness. Finally, I moved to sharing my experiences with mental illness more broadly—through my work with the Collaborative RESearch Team to study psychosocial issues in Bipolar Disorder (CREST.BD), in my psychology textbook[15] and through articles like the one you have just read.

related resources

1. For more on the peer-run support group The Kaleidoscope, see www.the-kaleidoscope.com.
2. For more information on the Collaborative RESearch Team to study psychosocial issues in Bipolar Disorder, see www.crestbd.ca.

Double Stigma, Double Duty

SUPPORTING ASIAN MEN TO BECOME MENTAL HEALTH AMBASSADORS AND ACTIVISTS

Rodrick Lal, MPA, MA, RCC, CCPC, CCC, PhD (Cand.)

Evidence suggests that the mental health needs for racialized communities are seldom met, especially for men. In particular, men from Asian communities (such as the Chinese, Filipino, Korean, South Asian and Vietnamese communities) are among those least likely to seek help for mental health problems in Canada.

Photo credit: ©iStockphoto.com/sanmai

Rodrick is a Registered Clinical Counsellor/Educator. He is a co-investigator for the Strength in Unity project and is completing his PhD in the Faculty of Health at York University. Sepali Guruge is the lead and Nominated Principle Investigator for the Strength in Unity Project. For more information about the study and the team, see www.strength-in-unity.ca

This avoidance is frequently attributed to stigma, the individuals' sense of shame and his perceived need to "save face."[1]

While mental health stigma cuts across all cultures and ethnic backgrounds, research suggests that stigma takes different forms in different communities and is compounded by cultural stereotypes surrounding ideas of masculinity and an individual's experiences of racism and discrimination. This combination is sometimes referred to as "double stigma." The Strength in Unity (SIU) project (2013–2017), funded by the Movember Foundation, is the largest intervention study in Canada aimed at developing individual and community capacity to reduce the stigma of mental illness among Asian men and youth.

From my personal experience, as a counsellor and as an Asian male, I know that for many Asian families, especially for men, a diagnosis of a mental health problem such as depression can bring shame to the family, often leading to denial and a breakdown in communication between the mentally ill individual and other family members. In Asian cultures, having control over one's emotions is considered to be very important. Men, particularly, are taught not to express their feelings. As a result, seeking help is sometimes equated with bringing shame on the family honour.[2]

In some Asian religious or spiritual traditions, families are taught to surrender to divine will, to accept their lot in life, to be thankful for what they have and to not feel downhearted about difficulties in their lives.[3] For many Asian men in Canada, religion is a central part of family life. For immigrants, worship has taken on an additional role—that of sustaining cultural identity and social ties within the community. For men experiencing mental health difficulties, religious leaders are often the first source of help, and yet religious leaders are not always well trained to respond to mental health concerns.[4,5]

The Strength in Unity project

Strength in Unity involved numerous community partnerships with key settlement, mental health and immigrant-serving organizations. Through a community-engagement process, the SIU study was able to include 1600 men and youth from Asian communities in Toronto, Calgary and Vancouver, with the aim of encouraging and supporting them to become ambassadors and activists for mental health in their communities. In Vancouver, the study involved participants from a wide age range (16-70 years) and from diverse ethno-cultural backgrounds. The vast majority of the participants (90%) were born outside of Canada. Of those, 30% were newcomers to Canada. Twenty percent of study participants were living with mental illness and 25% of study participants were family members of people living with mental illness.

The central focus of the SIU study was to examine the effectiveness of two intervention workshops in addressing internalized and social stigma. Acceptance Commitment Training (ACT) provides a series of experiential workshops that encourage participants to re-examine and challenge their preconceived, culturally influenced notions about mental illness and mental health care. The program nurtures self-awareness, mindfulness, living according to one's cultural values and compassion for oneself. Contact-Based Empowerment Education (CEE) is a program that deepens the readiness of people to engage in anti-stigma mental health advocacy. It provides education about mental health and mental illness, motivates people to speak out against stigma and discrimination, and teaches skills that will aid community engagement and encourage individuals and families to seek care and treatment.

Findings of the study

Prior to the study interventions, men exhibited stigmatizing beliefs and used stigmatizing language in relation to mental illness. For example, one focus group participant said, "It's shameful in not being able to handle [mental health problems] yourself, it's something that's really difficult to involve others. It's difficult to even admit it yourself. Just because the community has this kind of ideal, or this kind of belief that you can't show that side of yourself, that weakness. That's internal, that's not for everybody else to see. It's hard for yourself to even, you know, admit or kind of own up to it."

Post-intervention, the study's preliminary findings from the Vancouver site suggest that a combination of ACT and CEE interventions is the most effective approach to reducing stigma among Asian men living with mental illness and their family members. The ACT workshops helped Asian men improve their capacity to face current and future mental health challenges. For example, some men in the study adopted mindfulness practices and were more accepting of their own mental health challenges or those of others. The CEE workshops helped many men become more active in their communities in reducing stigmatizing beliefs, often through the use of social media and discussion groups.

All participants, regardless of whether they were in the ACT, the CEE or a combined intervention group, reported improved attitudes, intentions and behaviours in relation to social justice and anti-stigma activities. These activities included talking to family members and communities for the first time about their mental health challenges, speaking in public forums about mental health issues, using social and traditional media as venues to discuss and de-stigmatize mental illness and, in some instances, volunteering for mental health organizations.

Reducing stigma and becoming empowered to make a positive social impact are gradual processes that require ongoing support. Together, the ACT and CEE programs provided participants with the individual and collective support to achieve these goals. Currently, participants are using their new knowledge, skills and networks to encourage their families, friends and communities to engage in dialogue about mental illness and mental wellness. Through this process, we hope to see Asian men in communities across Canada become more receptive to seeking mental health supports. v

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

FIXING YOUR FLAT TIRE—CONTINUED FROM PAGE 13

I found group therapy helpful in my own recovery. The more I talked about BED with others who faced the same sorts of challenges, the less shame I felt. At the same time, I received support and empathy from others in the group.

Making a calendar of small but significant actions is also helpful. For example, mark on your calendar ahead of time the sort of meal that you will really enjoy, and then take your time cooking that meal or going out to eat it with friends and family who can be your support system. Savour the flavours and textures, and the opportunity to start a new relationship with food and—more importantly—yourself.

Another tactic is to carry a small journal and make note of any time you feel the urge to eat in a disordered way. Consider what sort of things triggered that urge (What were you doing? Where were you doing it?) and how you felt when it happened (Did you feel angry? Anxious? Sad?). Then, brainstorm some activities (like walking around the park) that might distract you from that desire. Call someone who can encourage you.

Re-establishing a healthy relationship with food

At times food has brought me pleasure and relief from sadness, but it has also brought me extreme stress. Recovering from BED is not like recovering from an addiction to alcohol or gambling. Many people living with these addictions choose to eliminate the substance or the action completely. I don't have that choice. But I've learned that by purposely focusing on activities and ideas that do not include food, my urge to binge decreases. I now try to exercise more, walk when I feel stressed and avoid supermarkets when I'm feeling triggered. When I visit Mexico now, I'm surrounded by friends and family; I enjoy food socially and without shame, and on most days, I don't feel the urge to binge.

Though I still have difficult days, BED no longer controls me. Now that I'm able to have a different relationship with food, I realize I did well in recognizing my problem and looking for help. I hope that others with BED can begin taking steps towards recovery.

Stop the car. Change the tire. Your drive will be smoother. v

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MENTAL HEALTH IS A LAUGHING MATTER—CONTINUED FROM PAGE 27

Here are a few examples of how my comics have taken their experience with mental illness and created some fantastic stand-up material:

I went to a support group for shy people; no one showed up. (Paul Decarie)

I wanted to go to Paranoids Anonymous but no one would tell me where the meetings were. (Paul Decarie)

When I was in the psych ward, the doctor said I wasn't ready to go home, so I tried to prove it to him by doing a complicated art project. It involved tying sheets together and letting myself out the window. (Joan Stone)

I take lithium but I'm coming off of it. I'd much rather be solar-powered. (Amanda Azzopardi)

I'm not saying that comedy is a cure-all or a magic bullet, but in certain cases it seems to aid people in their recovery journeys. All too often we see the process of achieving mental wellness as a serious and arduous task. But it doesn't have to be. As a matter of fact, it *shouldn't* be! And having a great sense of humour will help you make sure that it isn't.

In the Vancouver area, the cost of the SMH program is on a sliding scale according to the comic's income, but we *never* turn anyone away for financial reasons. Our website, www.standupformentalhealth.com, is also a great information resource. It contains dozens of videos of comics I've trained in Canada, the US and Australia and is a terrific source of humour and inspiration. Check it out! v

resources

Opening Minds (Mental Health Commission of Canada)

www.mentalhealthcommission.ca/English/initiatives/11874/opening-minds

Opening Minds aims to reduce the impact of stigma on Canadians who experience a mental illness so that they can seek help and work towards recovery. Learn more about anti-stigma approaches as well as the impact of stigma on Canadians.

Info sheet: *Stigma and Discrimination around Mental Health and Substance Use Problems*

www.heretohelp.bc.ca/factsheet/stigma-and-discrimination-around-mental-health-and-substance-use-problems

Learn more about stigma and how you can take action in your communities.

Not Myself Today

www.notmyselftoday.ca

A campaign from the Canadian Mental Health Association to improve knowledge of mental health at work, reduce stigma, and build healthier and more supportive workplaces.

SickNotWeak

www.sicknotweak.com

An initiative, started by Michael Landsberg, to help people seek help, build community, and counter stigma.

StigmaFree National Alliance on Mental Illness (US)

www.nami.org/stigma

A campaign to help people learn about stigma and its effects, challenge stereotypes, share their own story.

Mind Your Mind

www.mindyourmind.ca

For children and teens. Learn more about mental health and stigma, find help, read posts and articles, and find personal stories.

Stigma Magazine

www.stigmamagazine.com

A BC-based national magazine for people who experience mental health or substance use problems, caregivers, and everyone who would like to learn more and build more inclusive communities. Read back issues online for free.

From discrimination to social inclusion: A review of the literature on anti stigma initiatives in mental health

www.mhcc.org.au/media/5646/from-discrimination-to-social-inclusion-lit-review.pdf

From the Queensland Alliance for Mental Health (Australia). A review of anti-stigma and social inclusion strategies around the world, with recommendations and best practices.

This list is not comprehensive and does not necessarily imply endorsement of all the content available in these resources.

heretohelp
Mental health and substance use
information you can trust

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