BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

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Laurynas Naviauskas

background

experiences & perspectives

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, Awareness and Networking around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to the Provincial Health Services Authority for providing financial support for the production of *Visions*

alternatives & approaches

regional programs

It seemed so much easier at the brainstorming table. Men's and boys' mental health is something that has never had its own *Visions* issue before. Yes, there are arguments that all mental health services and research are implicitly based on men, but if a gender lens reveals inequities for women then it also has the ability to reveal areas of concern for men. The problem is, it seems, that men don't think they are a gender. Luckily, there is an emerging field of scholarship looking at masculinism and how it affects men and boys. This area of research is identifying some important conflicts between health-seeking behaviour and men's socialization.

In reality, putting this issue together was harder and more interesting than we thought. Men's difficulties expressing themselves in a masculinist society is repeated in many of the articles in this Issue. Most of the articles have an undercurrent of the stereotyped, strong, silent male secretly dealing with his own issues. For the health of men and of boys, we must challenge this idea.

While we have captured a variety of experiences, services, research and background information, there are always things that are left out, unavailable, or simply missed. We would love to hear about those things. Noticeable by their absence are articles on men's housing issues, men and their relationships, ADD/ADHD in boys and men, issues of poverty, the criminalization of mental illness and substance use (or in many cases, pathologizing of criminal behaviour), and issues for men with other disabilities alongside of mental illness. I am sure that this does not exhaust the things that impact the lives of men and boys.

Listening to the voices of people living with health issues balances the dominant words of the health industry, but it is not easy. These articles challenge our personal beliefs and may even offend us. The voices of these brave authors must be heard alongside the research and the service descriptions. They are, after all, the sole reason that many of us work in this field. They are also graphic in detail, as you will see in a couple of the following articles. So take a deep breath. Dive in. Let us know if these articles challenge you, open up new ways of looking at the issues, or simple affirm for you something you have experienced.

Christina Martens

Christina is Executive Director of the Canadian Mental Health Association's Mid-Island Branch. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria

subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge. You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website at www.heretohelp.bc.ca/publications. Contact us via any of the means listed to the right to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online.

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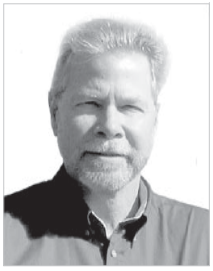
At the Intersection of Biology and Culture

Aaron White, PhD



Aaron is a school psychologist and counsellor for students with mental health and behaviour disorders for the West Vancouver School District. He is also an adjunct professor in UBC's Department of Educational and Counselling Psychology, and Special Education. Research interests include sexual harassment, sexual risk taking, and teen Internet use. Aaron has facilitated men's counselling and support groups and has taught anger management and violence prevention skills to young men

Just as the Winter 2004 *Visions* issue examined mental health and addictions issues facing women, this edition looks at these issues from the male perspective. Men live at the intersection between biology and culture, and the resulting predispositions, societal pressures, and cultural expectations create mental health challenges unique to their gender.

There are physical differences in brain structures and hormonal patterns between the sexes. The male neurological and biochemical makeup results in men having greater risk for certain neurological disorders, including autism, mental retardation, learning disabilities, and ADHD. However, there is another factor that is critical to consider when attempting to understand the male experience. That factor is what William Pollack, in his books on growing up male, calls the "Boy Code."[1]

The Boy Code is a set of expectations about how males should think, feel and act. Those expectations are: "be tough," "don't cry," "go it alone," "don't show any emotion except for anger." This is not to deny that there are variations in the way masculinity is experienced and expressed across cultures and social strata, but there is no doubt that most men growing up in North America have been exposed to similar expectations about what it means to be a man. Thus, whether straight or gay, working class or middle class, of South Asian or European descent, men have grown up knowing there are certain 'masculine' characteristics they are expected to adopt.

Understanding the Boy Code and other gendered sociocultural patterns helps to explain how it is that being female is a risk factor for internalizing disorders such as anxiety and depression, while being male is a risk factor for suicide completion, for alcohol and drug dependency, and for externalizing disorders such as antisocial personality disorder.

There are many characteristics of traditional masculinity that are positive and beneficial: being strong, courageous, willing to work hard and willing to sacrifice oneself to protect family and society in times of danger. And many masculine characteristics appear to be protective factors that help men to be at reduced risk for developing anxiety and depressive disorders. Most men do not over-focus on feelings. They tend to be more action-oriented, have higher self-esteem and more self-confidence, and do not over-analyze things, thus avoiding the paralysis of analysis. As well, most men appear to be able to compartmentalize well, a skill necessary for keeping things in perspective.

When these good characteristics become overemphasized or distorted, however, they can contribute to mental health and addiction problems for men. Being *too* action-oriented may cause men to ignore feelings. Too little analysis leads to not dealing with subtleties in relationships. Being too self-sufficient and believing that they must go it alone makes men unable to ask for help when they need it. Men who avoid experiencing or talking about 'unmanly' feelings such as sadness or fear may be at increased risk for using alcohol or drugs to mask those feelings. And finally, men who are primed to expect quick solutions to problems may not have the patience to stick with a program of therapy. Thus, balance is needed.

On the whole, boys show weaker language skills and lag in the development of emotional regulatory capabilities, putting them at greater risk for developing externalizing disorders in childhood.[2] And there is evidence that as boys move through adolescence, they experience a decrease in their ability to appropriately handle emotions such as fear or sadness.[3] As a result, by the time older adolescent males are getting ready to enter into serious relationships, they are actually less able to identify, talk about and appropriately share their feelings than they were when they were young adolescents.

Balance is the key. Too much or too little of an emotion like anger can be a problem. We all have seen the negative effects of male rage. But a stifling of anger can also be a problem; an unhealthy inhibition of anger has been found to be associated with increased risk for cancer.

What is needed is a healthy feeling of, and a healthy expression of, anger: feeling the energy of anger, but calmly deciding how to act it out, and most important of all, separating out the feelings that usually precede anger, especially anxiety and frustration. Men who flash quickly to irritation or anger often overlook, and thus do not deal with, their anxiety.

A significant challenge for those of us working with or living with males is to demonstrate that we are trustworthy, that we will not ridicule or shame them. We can do this by emphasizing the positives of being a male while also finding ways to assist boys and men in getting any help they need. Part of this is assuring them that we do not consider them less masculine by having a failing or weakness, or by needing to ask for help.

It is fear that hamstrings many of us men. Fear that admitting we can't go it alone will trigger outside ridicule by women and other men. Fear that admitting we need assistance will cause us to feel like less of a man on the inside.

This issue of *Visions* is an indication of the work yet to be done to encourage men to utilize both the mental health and medical systems in BC and elsewhere.

footnotes

1 Pollack, W. & Shuster, T. (2001) *Real Boys' Voices*. New York: Penguin Group.

2 Crick, N.R. & Zahn-Waxler, C. (2003). The development of psychopathology in females and males: Current progress and future challenges. *Development and Psychopathology, 15*, 719-742.

3 Polce-Lynch, M., Myers, B.J., Kliewer, W. et al. (2001). Adolescent self-esteem and gender: Exploring relations to sexual harassment, body image, media influence, and emotional expression. *Journal of Youth and Adolescence, 30*, 225-244.

Thank you for including personal stories of women's experiences with eating disorders—voices that are often unheard. Stories of self-starvation, of feeling fat, of binge-eating or purging are all meaningful cues to women's and girls' deeper internal struggles with how they experience themselves and how they are seen to experience themselves in the world. Controlling the body is a viable arena for controlling and regulating one's self, especially when other aspects of one's life feel unmanageable. Most women and girls who live with anorexia, for example, know that they are not "too fat": indeed, they usually know they are dangerously thin. What is most important is that they *feel* "too fat." Feeling fat is often conflated with feeling for example, bad, unworthy, or out of control. Many women and girls are more comfortable framing such emotional experiences as feeling fat. The shift away from difficult emotions to a focus on feeling fat offers more tangible possibilities. Fatness is something that can be overcome, something that they can do something about. A harm reduction philosophy in treatment (as opposed to focusing on bodily management) may be more effective and more compassionate to help them decode their "body talk," in order to uncover how they may displace their struggles about existing in the world into struggles of the body. This involves actually dealing with the feelings of vulnerability, uncertainty and fear which make women question their capacity and worth in the world. We might ask: what suppressed story is the body telling? What does her problem reveal to her and others about herself that is not usually known? Often, women and girls are afraid of their own voices and the possible consequences of them. Women and girls become very skilled at convincing themselves and others that all is well, when too often this is not the case.

—Catrina Brown, PhD, Halifax, NS
School of Social Work, Dalhousie University, and Co-Editor of
Consuming Passions: Feminist Approaches To Weight Preoccupation and Eating Disorders

I picked up a copy of *Visions* for the first time at my methadone clinic today, the Outreach Services Clinic in Fernwood, Victoria. I didn't have time to read it all, unfortunately, but I was amazed at what I saw. There was even a piece about the Seeking Safety group that I had attended, and it was written very accurately and with respect. Wow. Where have you guys been all these years? I am a recovering IV drug addict, and a mother of two young children. I am apprenticing in acupuncture, specifically detox acupuncture. What you are doing is wonderful, keep up the good work—we need it!

—Katherine, Saanich, BC

It was great reading the last issue of *Visions*. The edition covers a number of important issues affecting women. However, I'm having considerable difficulty understanding how a whole edition on the topic of "women" could overlook older women. There is a paragraph on page 11 and it talks "the elderly," somehow lumping older women and men into an amorphous, genderless lump. Mental health and addiction issues go across the lifespan; they don't magically end at age 35 or 40. By overlooking older women and treating them as invisible, you are also affecting the future of today's younger women as they age. There are very special mental health and addiction issues affecting older women in BC, and in some places there is good work being done to reach out and help them effectively. In most communities, it continues to be a major service gap. Women are worth the effort at any age. Let's start to recognize that.

—Charmaine Spencer, Seniors and Addictions Researcher
Department of Gerontology, Simon Fraser University

I am usually quite impressed with *Visions*—so many perspectives. I have learned so much. Thank you so much for this journal. But I was disappointed that the recent edition on Women didn't include anything on PMDD: Premenstrual Dysphoric Disorder. Speaking from experience, hot flashes are a walk in the park compared to PMDD. The incredible roller coaster mood swings and irritability drive you and your family crazy; you blow up at work, you can't trust your emotions. I wonder how much of a factor PMDD is in the suicides of women this age? Need I say more? And PMDD often occurs when you have teenagers—so you are at your worst just when your parenting skills need to be at their best. My baby sister is going through it now. I now realize that PMDD is probably what I was going through when my son died by suicide in 1994. I know there are many factors leading up to suicide, but the PMDD meant I certainly wasn't at my most effective parenting-wise, and because I was so "off the wall," my husband dismissed what turned out to be my very valid reading of my son's distress. Including PMDD in a future *Visions* might help more women get appropriate help—and thus help everyone!

Again, thanks so much for *Visions*.

—P. Bonny Ball, Vancouver, BC
Project Leader, Vancouver Suicide Survivors Coalition
Acting Vice President, Canadian Association for Suicide Prevention

we want your feedback!

If you have a comment about something you've read in Visions that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3

Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence

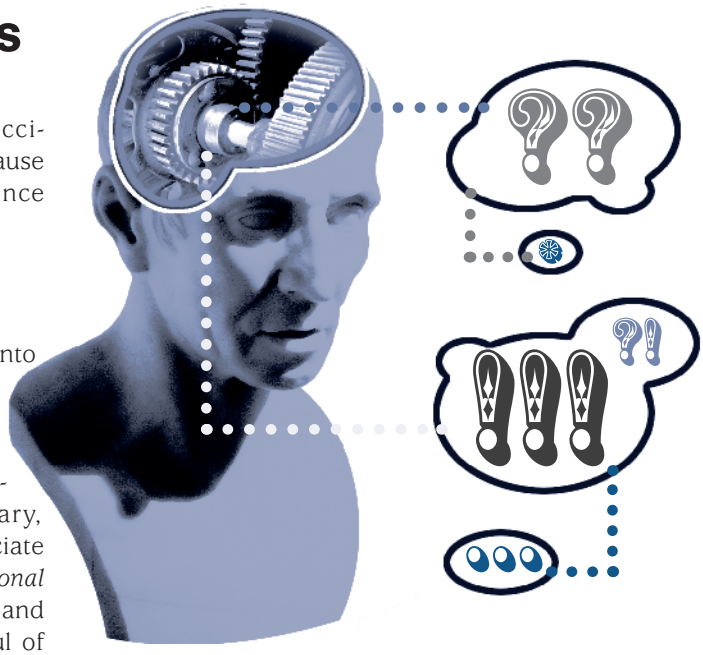
All letters are read. Your likelihood of being published will depend on the number of submissions we receive

Men's Mental Health

A silent crisis

Frances Bartlett

Frances is a Canadian journalist and prepared this article in 2004 for the Canadian Health Network. Reprinted with permission



It's being called a silent crisis, a sleeper issue. But there are signs that this sleeper is at last awakening. Around the world studies, surveys, web networks, journals and newspaper articles are shedding light on a shadowy subject: men's mental health.

Among the findings is the revelation that new fathers are also vulnerable to postpartum depression. In Canada, young and middle-aged men are being hospitalized for schizophrenia in increasing numbers. The gender gap among people with mental illness is much narrower than might be suspected. The StatsCan Canadian Community Health Survey on mental health and well-being found that 10% of men experienced symptoms of the surveyed mental health disorders and substance dependencies, compared to 11% of women. In the United Kingdom, studies of depression show a major shift in the traditional gender imbalance, with depression rising among men and decreasing among women.

The greatest evidence of male vulnerability is in suicide statistics. Among Canadians of all ages, four of every five suicides are male. In the UK, men are around three times more likely to kill themselves than women. In New South Wales, Australia, suicide has overtaken car accidents as the leading cause of death in males since 1991.

Barriers to seeking help

According to the Toronto Men's Health Network (TMHN), even the concept of "men's health" is relatively new in Canada. Dr. Don McCreary, co-chair of TMHN, associate editor of the *International Journal of Men's Health* and one of a small handful of men's health researchers in Canada, says there are a number of reasons for this.

One reason is the low priority given to men's health issues in the research community. More funding and more specialists in this area will encourage ongoing research into male mental health.

Male and societal attitudes have fostered the silence. "The women's health movement was very self-directed," says Dr. McCreary. "Women banded together to work on problems with health delivery. Men don't want to do that. We have inculcated a culture in our society that men have to be tough, men have to be strong. Our society is very good at punishing gender deviation in men. Weakness is not considered to be masculine."

The "code" governing men's behaviour is one of the prime barriers preventing men from seeking help. According to UK-based MaleHealth.com, men may feel it's "weak and unmanly to admit to feelings of despair." Because it's easier for men to acknowledge physical symptoms, rather than emotional ones, their mental health problems can go undiagnosed.

Beliefs about masculinity also encourage men's general lack of interest in health issues; many men simply don't believe they are susceptible to depression, so why bother learning about it? Similarly, risky behaviour, seen especially in younger men—including abuse of alcohol and/or drugs and violence—can mask their emotional problems, both from themselves and their physicians.

Western society's view of the value of men is seen as an important factor affecting men's mental health. An Australian study suggested that "there is a strong element of negativity in our culture about men which cannot contribute to positive mental health."

Greater recognition of the significance of men's roles as fathers and partners would help men cope with the difficult feelings that accompany a breakup and the loss of full access to their children. The social isolation experienced by many men at such a time is believed to a factor in the high rate of suicide amongst divorced men.

Men and depression

What do a firefighter, police officer, US Air Force First Sergeant, college graduate and publisher have in common? They are all male and they have all suffered from serious depression. They told their stories for the National Institute for Mental Health (NIMH) "Real Men. Real Depression." campaign.

It's estimated that up to six million American men have depression each year—about half the figure for women. But this gender disparity is being questioned, in the US and elsewhere. In focus groups conducted by the NIMH, "men described their own symptoms of depression without realizing they were depressed." They made no connection between their mental health and physical symptoms, such as headaches, digestive problems and chronic pain.

Dr. Michael Myers has noted the same thing, saying, "I couldn't do my job as a psychiatrist if I didn't listen to women describe their concerns about men." A psychiatrist and clinical professor in the Department of Psychiatry at the University of British Columbia, Dr. Myers says, "In men, mental illness can be masked. We've known for decades that women are more apt to recognize illness of any sort and go to their doctor. This doesn't mean women are healthier, but that some men just repress it. We believe a lot of somatization [symptoms] in men, for example, migraines, back pain, irritable bowel syndrome, is rooted in depression."

The consequences of masked depression can be devastating. "Too many men out there are suffering," says Dr. Myers. "They're acting out the depression." Acting may take the form of hostility and irritability; verbal violence and abusiveness; drinking to excess; or womanizing."

"In cases of marital breakup, there is a very important link between the man's mental health and how the divorce goes," continues Dr. Myers, who is the director of the Marital Therapy Clinic at St. Paul's Hospital in Vancouver. He says that when children are involved, and an ongoing relationship is maintained, the father better adapts to his changed circumstances. "If there's a complete severing, then men can become suicidal."

Along with genetics and stress, MaleHealth.com points out that social and psychological factors can contribute to men's depression. Men's focus on competition and feeling powerful can be adversely affected by unemployment and the presence of women in the workplace. Physical illness, in particular a life-threatening condition, is another trigger for depression, since it directly impacts a man's sense of strength and status.

Moving forward

Raising awareness about men and their vulnerability to depression is a rising trend and "may help in terms of reducing the stigma attached to mental health," says Dr. McCreary.

Some focused steps are being tested. A study in Australia reports that a men-only prompt list for physicians and patients, designed to overcome male reticence and low mental health literacy, assisted 60% of male patients in raising issues with their doctor.

National men's health organizations in the United States, Australia, the United Kingdom and Europe are growing focal points for men's health research. The acknowledged lack of data on male health is leading to calls for a needs-driven rather than a gender-based approach to health care.

Promotional campaigns, web sites, journals and networking groups targeting men and their mental health awareness are breaking the silence that has long surrounded this topic. But there is a long way to go before the depth and breadth of knowledge about men's mental health issues approaches that relating to women. **i**

web resource

See the Canadian Health Network article on healthy fathers at **www.canadian-health-network.ca** Under Groups, just click on Men.

A Snapshot of Seniors' Lives

Depression, suicide darken the later years

Chris Johnson

Reprinted with permission from The Vancouver Sun, *June 10, 2004, p. B1*

A farmer in his 70s had been working in his Aldergrove field on a sunny day last week.

His neighbour of 30 years noticed nothing wrong. A few hours later, when the farmer's wife came home, she found him hanging in the barn.

Talking to a reporter this week, the neighbours shook their heads and held back tears, trying to figure out why he killed himself. *The Sun* has decided not to publish the names at the family's request.

The man's family and his neighbours are not alone in grieving the loss of an elder or wondering what caused him to take his life.

But a Health Services Ministry study released this week reveals that contrary to popular belief, seniors, not teenagers, are the most likely age group to kill themselves.

Titled *A Profile of Seniors in British Columbia*, it says men over 65 are three times more likely to kill themselves than males between 10 and 24, which is often considered the most suicide-prone age group.

Elderly men, especially widowed, divorced, or single males, are five times more suicide-prone than women of their age. The suicide rate for women varies only slightly across age groups.

In total, seniors account for about 12% of all suicides in Canada, at a rate of 26 per 100,000 in British Columbia, according to 2002 statistics, the report says.

"We often think of teenage men dejected over their girlfriends," said Suzanne Germain, communications manager with the Ministry of Health. "That's not really the profile."

Researchers and suicide counsellors say the bad news also has good news within it.

They say suicide rates are high among the elderly because people are living longer, making them more vulnerable to illness leading to depression, a leading cause of suicide. But they say they're not surprised by the report's findings.

"It's a serious problem that often gets overlooked," said Jennifer White, a mental health therapist at Vancouver's Safer Counselling Service, which helps potential suicide victims.

"The media often pay attention to teenagers. But we need to do something about seniors as well. There's almost an attitude of acceptance, that they've lived a long life."

Gloria Gutman, director of gerontology at Simon Fraser University, says suicide rates are higher for men than for women, especially among retirees.

"They [senior males] have farther to fall than women. The vast majority of men have been in the labour force [longer] than women, at least until recently."

Gutman, who is also president of the International Association of Gerontology, says retirees sometimes can't cope with losing income, status—and self-esteem—after ending their careers.

"In our society, there is a tendency to stigmatize retired people. You're at the top of your prowess and profession at age 64 and three-quarters, but when you cross the line, somehow your value drops, particularly for people who define who they are by what they do."

Gutman says society can help by prohibiting mandatory retirement at 65.

The real picture could also be worse than the statistics. The report admits that it's hard to know precise suicide rates because many families will report other causes of death rather than saying a loved one took their own life.

Sadly, many people could have been saved. Up to 90% of victims struggled with depression, substance abuse or a disorder that could have been diagnosed, says the report.

White says family members can help troubled elders, especially those who have lost a spouse, by looking for telltale signs of depression, including social withdrawal, disruptions to sleeping and eating, difficulty concentrating, and persistent feeling of sadness and worthlessness. ...

isolation and loneliness

(adapted from www.agingincanada.ca)

Researchers in Manitoba published a report in January this year, looking at social isolation and older men. Here are some highlights from the Manitoba report:

- Older widowed men don't maintain self-care practices such as taking medications, may resist accepting Meals-on-Wheels services, and resort to unhealthy coping strategies such as alcohol and gambling.
- Older men are particularly vulnerable to isolation and loneliness when they experience difficulties adjusting to retirement (farmers retiring, in particular may find this transition difficult.)
- Social isolation and loneliness can cause other health problems for older men, in addition to depression—isolated men tended to have four and more chronic illnesses.
- Being alone leaves the person with more time to reflect inward and dwell on problems, making one more resistant to change, as there is no one to make suggestions or share ideas, and no opportunity to observe what steps others are taking relative to health.
- The degree to which an older man feels lonely is influenced by widowhood, poor life satisfaction, chronic illnesses and feeling that seniors always receive negative treatment.

Mirror, Mirror on the Wall, Men Are Dissatisfied After All

Todd G. Morrison, PhD

Todd is a social psychologist at the National University of Ireland in Galway. His research interests include male body image (specifically, the drive for muscularity), as well as stereotyping, prejudice and discrimination. Correspondence about this article may be sent to todd.morrison@nuigalway.ie

Research suggests that women's dissatisfaction with their bodies appears to be the norm in Western culture. Women's desire to 'improve' their physical appearance and their efforts to accomplish this goal through diet and exercise, as well as through more invasive means such as plastic surgery, are so commonplace that those having the temerity to express contentment with how they look appear abnormal or, at best, egotistical.

Despite awareness of the prevalence of women's dissatisfaction with their bodies—which manifests itself primarily, though not exclusively, in terms of the desire to be thin—for many years, social scientists blithely assumed that the topic of body image was of little pertinence to men. It was believed they didn't really care about whether their arms were muscular or their stomachs flat. A spare tire around the midriff, a double chin and sagging buttocks were irrelevant in terms of how they saw themselves physically. They were men, damn it! They had important issues to focus on—dare one say weighty issues?—and aesthetic considerations vis-à-vis the body were definitely not one of them.

In hindsight, it would appear that the notion men are disinterested in how they look physically was more a product of researcher bias than a case of genuine detachment from matters of their own flesh. Many social scientists appeared to use, as a framework for their research, the assumption that concerns about the body were the dominion of women but not of men. Consequently, they were more likely to use female participants in their studies on body image. They also were more likely to create and utilize measures of body satisfaction/dissatisfaction that targeted women, and were more likely to develop theories that possessed dubious applicability to men. One should not be surprised that such research efforts merely bolstered the view that male body image was a topic worthy of little consideration.

Over the past decade, however, as researchers began moving away from the narrow view that dissatisfaction with one's appearance was tantamount to perceiving oneself as overweight, and as they began to use measures that were appropriate for both men and women, a new picture emerged. Large proportions of men were unhappy with their appearance; however, the locus of their concern typically differed from women's. While females expressed a near uniform desire to become thinner, men's concerns were split between wanting to gain and wanting to lose weight.

The obvious conclusion was that neither sex had a monopoly on body contentment or lack thereof; dissatisfaction was rampant among both sexes. While this conclusion isn't good news—the desire to achieve a better body is not something to derive satisfaction from—it is important news. Why? Because it suggests men's attitudes toward their bodies, and the behaviours that may be a consequence of those attitudes, warrant research attention.

The 'drive for muscularity'

When looking specifically at the topic of male body image, current findings indicate that, irrespective of whether they want to gain or lose weight, most men express a desire to increase the muscularity of their bodies. For example, in one of my research studies, my colleagues and I found that almost 75% of male participants agreed with the question, "I intend to become more muscular in the future," and 70% felt that they "should work out more to increase muscle mass." As well, approximately 75% of these individuals reported doing weight training at least once a week. While it is important to note that these findings cannot be generalized to Canadian males as a group, they do reveal that, among the men surveyed, a strong desire for enhanced musculature was evident. With this pattern of results, it is little wonder that we concluded:

> The fixation on musculature and the ceaseless determination to be 'buff' are no longer restricted to the world of body building but, rather, appear to be widespread. Indeed, men who are satisfied with their appearance and do not subscribe to the cult of bigness have become atypical.[1]

This desire to 'bulk up' and achieve an idealized muscular body shape—well-developed pectoral (i.e., chest) muscles, arms and shoulders, and a narrow waist—has been labelled the *drive for muscularity.*

Over the past five years, this construct has generated considerable interest among researchers, many of whom are attempting to answer one or more of the following questions. Why do men appear to be concerned about, and driven to enhance, the muscularity of their bodies? What sorts of attitudes and behaviours are associated with the drive for muscularity? And, finally, is this drive associated with body disturbance?

Why do men want to be more muscular?

A number of explanations have been forwarded; however, they remain speculative rather than conclusive.

Some researchers contend that, as men and women have become more equal in Western society, the indicants traditionally used by men to define themselves as masculine have vanished. For example, in the past men and women could be differentiated on the basis of whether they worked outside or inside the home. In contemporary society, however, this distinction has largely disappeared. In the absence of traditional indicants of maleness, men are now required to use their bodies as literal representations of masculinity. Of course, the most obvious way in which the body can be used to connote maleness is through enhanced musculature.

It should be noted that this explanation also has been used to understand women's pervasive desire to lose weight. Stated simply, men expand and women contract; men get big and women get small; men become more muscular (i.e., stronger) and women become thinner (i.e., weaker)—therefore, these variations in body shape are used to maintain the traditional distinction between maleness and femaleness.

A far less abstract explanation for why men appear to be more preoccupied with muscularity focuses on mass media (primarily television and print) and the way they depict the male body. According to this explanation (which is formally called Sociocultural Theory), mass media present idealistic representations of the male physique: representations that feature sculpted biceps, well-developed pectoral muscles, and the all-important "six-pack" abdomen (which also connotes an absence of body fat). Men compare themselves to these images (a process known as social comparison) and, of course, perceive a discrepancy between their own bodies and those of the images they see. The drive for muscularity could be perceived as a motivational strategy that attempts to bridge this gap between reality and fantasy.

While intuitively appealing, Sociocultural Theory, when applied to men, has received mixed support. Certainly idealistic representations of the male body have become more commonplace since the 1980s and are now a ubiquitous element of mass media. However, it is unclear whether men actually compare themselves to these images and, if so, whether these sorts of comparisons necessarily produce decreases in body satisfaction and/or increases in the drive for muscularity.

What variables are associated with this drive?

A number of attitudinal and behavioural variables have been correlated with the desire to become more muscular. Not surprisingly, those higher in the drive for muscularity are more likely to weight train and to consume protein bars and other supplements designed to increase muscle mass.

As well, the stronger one's drive for muscularity is, the lower one's level of appearance self-esteem (i.e., satisfaction with how one looks) and global self-esteem (i.e., overall satisfaction with oneself). Individuals evidencing a stronger drive for muscularity also report higher levels of vanity and depression, and are more likely to contemplate using steroids.

While this sort of research does not permit one to identify cause and effect (i.e., one cannot assume that higher levels of the drive for muscularity necessarily cause, for example, lower levels of self-esteem or higher levels of vanity), such findings suggest that further investigating the drive for muscularity will be helpful in better understanding men's psychological and physical well-being.

Is this drive associated with body disturbance?

We don't know. The drive for muscularity has emerged only recently in the scientific literature. As more studies are conducted, we should be able to specify if, and in what ways, this drive is associated with body disturbance.

Of particular relevance to this question is muscle dysmorphia, a psychiatric condition characterized by a distressing preoccupation with the size and/or definition of one's musculature. Individuals suffering from muscle dysmorphia are preoccupied with their physical appearance and engage in self-injurious behaviour (e.g., steroid use and excessive weight training). Due to perceptions of inadequate muscle size, they may avoid mirrors and attempt to camouflage their bodies by wearing bulky clothing and avoiding situations that necessitate display of one's physique (e.g., swimming). Given the serious nature of muscle dysmorphia, it is essential that researchers explore the possible linkages between this condition and the drive for muscularity.

In conclusion

Researchers have abandoned the false view that men place little importance on their physical appearance, are content with whatever shape they possess, and impassively witness the "ravages of time" as they unfold. With the advent of constructs such as the drive for muscularity, we now realize that, sadly, men and women appear to be quite comparable in the discontent they experience regarding their bodies. The direction of the dissatisfac-

tion may differ—thinness for women and muscularity for men—but the end result is the same: a desire to escape from one's own skin and become something else, something better; to achieve an ever-illusive state of corporeal 'perfection.'

The argument that individuals engage in various body modification practices in an effort to "feel good about themselves" underscores the need to discover means of reducing both men's and women's dislike of their bodies. i

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Are Men Self-Medicating?

Exploring the relationship between alcohol use, depression, anxiety and gender

Sarah Hamid-Balma

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Self-medication: the theory

One of the theories I always expect to hear in discussions of how non-help-seeking men cope with depression or anxiety is "they self-medicate with alcohol." The self-medication theory—that people use substances (alcohol, tobacco, other drugs) to relieve some of the distress associated with symptoms of an underlying mental illness—is a popular one among media, academics, service providers, mental health consumers and families. I wanted to look at what some of the research has to say about this theory in the particular area of alcohol use, gender, depression and anxiety.

Problematic use of alcohol occurs frequently among people with mood and/or anxiety disorders—that is certainly not in dispute. In a Canadian survey, 15% of men meeting the criteria for 'alcohol abuse' or 'dependence' had a co-existing mood disorder and 32% an anxiety disorder; for women, the numbers rose to 40% and 54%, respectively.[1]

This strong relationship (what researchers call a correlation) has been found in both clinical (treatment) and community (non-treatment) settings. The self-medication theory attempts to explain the relationship by saying that the depression or anxiety came first and the alcohol use was a direct coping response to the symptoms of the depression or anxiety.

But self-medication theory does not explain all cases, nor does it provide a water-tight explanation, because of the complex interactions involved. In addition to direct self-medication with the aim of alleviating mood, there are at least five other possible 'pathways':

- For some people, mood and anxiety disorders can be consequences of problem drinking, dependence and/or withdrawal
- Even if mood and anxiety disorders precede alcohol use, it may not be self-medication at work, but rather the mood and anxiety problems may have occurred at an earlier age (often in childhood and younger adolescence), before alcohol entered the picture
- Alcohol may be used to cope with other physical symptoms of these disorders or their treatments (e.g., sleep problems or bodily complaints such as headaches) rather than to self-medicate feelings of sadness or anxiety
- A common factor such as a personality disorder or trait may lead a person to be vulnerable to both alcohol use and depression or anxiety
- In some cases, the issues may occur independently and then interact with each other later on

State of the evidence

Evidence of self-medication has, to date, been indirect at best. In both community and clinical settings, research strategies make it easier to demonstrate *correlation* (condition A and B occur together) than they do *causation* (condition A causes condition B). For example, it's easier to show that depression coexists with alcohol use than it is to show that someone with depression clearly chooses to drink alcohol because they are feeling 'down'—as opposed to some other reason.

A further complexity is that people who consume

alcohol are not a homogeneous population. Some use alcohol in beneficial or non-problematic ways, while others engage in patterns of use that are clearly harmful. The social, emotional and contextual influences for a person in the first group may be very different from the characteristics and risk factors of an individual in the latter group.[2] To be meaningful, research must distinguish between these influences and anxiety or depression as causative factors in drinking behaviour.

Another issue is that studies depending on self-reported data may overstate the case for self-medication. In one study, for example, most of the male patients reported that they used alcohol to cope with lower-back pain, implying that self-medication was the cause of their alcoholism. When carefully examined, however, 82% of the patients had alcohol use disorders *predating* the onset of their pain.[3] One can't self-medicate a condition that doesn't yet exist.

An anxiety connection

Research published in 2000 by French and American researchers Swendsen, Tennen, Carney et al.[4] explored the self-medication theory as it applies to depression/anxiety (states, not diagnoses) and alcohol use. They studied the brief cycles of mood and anxiety states, patterns of drinking of alcohol (and desire to drink) and the effects of alcohol use on mood and anxiety states. Novel strategies were used to attempt to separate out risk factors other than mood that may also influence alcohol consumption. (The full methods and procedures for running the study, selecting participants, and limitations of approaches and findings are described in the published article.)

The study found that only anxiety-related states (not sadness or other negative moods) were found to predict increases in alcohol consumption. It also showed that the higher the anxiety scores, the higher the effects of alcohol on lowering levels of nervousness. The authors state that the study does not discount a potential relationship between negative mood and alcohol use, but rather that the nature of the relationship may be different than for anxiety. (One piece of the depression-alcohol relationship we do know is that depression can be a consequence of problem drinking.)[5]

One must remember that the Swendsen et al. study looked at "states" and "behaviours," not disorders. Feeling depressed or anxious and choosing to drink are all like distant cousins of, respectively, major clinical depression, anxiety disorders or alcoholism; they're related, yet significantly different.

The Swendsen et al. results—even with the focus just on states—do mirror those of an earlier international study that looked at these three phenomena when they were diagnosable; that is, they studied mood and anxiety disorders in relation to alcohol use disorders. In that study of six countries, including Canada, the onset of anxiety *disorders* was more likely to precede that of substance *disorders* in all countries[2]—whereas such a timeline for mood disorders was not found.[2,6,7]

Timelines are important given that the self-medication theory cannot work unless alcohol use problems or disorders occur *after* the development of the mental disorder.

Two other researchers who examined those with anxiety disorders found that the self-medication theory is particularly relevant for those with phobias or social anxiety and those suffering from traumas such as sexual molestation.[8,9] Their findings indicate that individuals coping with these types of anxiety problems may be at higher risk for later substance use problems.

Gender differences

The other major finding of the Swendsen et al. study was that the rate of men self-medicating nervousness with alcohol was higher than for women. Men were more likely than women to use alcohol after a rise in anxious states. Men were also more likely to report that they could have "really used a drink" when they had previously been nervous. The authors state that the findings don't indicate a lack of possible self-medication in women, but that "the effect size is larger or more consistent for men, a finding similar to past investigations."[4]

While the reasons for the gender differences are complex and more research needs to be done in this area, the authors point to both biological and psychological factors. For example, alcohol is, in fact, less consistent in reducing anxiety in women,[10] and men may have greater expectations for having tension reduced through alcohol use.[11,12] Another study found an opposite pattern for depression: men perceive alcohol as providing less relief for depressive symptoms than women do (56% vs. 89%, respectively).[13]

Conclusions

As just one of the mechanisms that could explain the high rate of co-occurring mental disorders and substance use, the self-medication theory is surprisingly pervasive in the academic literature. This article has summarized a few findings in just one small slice of that literature: alcohol and depression/anxiety. But much more study is still needed.

For numerous reasons, it appears that self-medicating, in general, has much less scientific support overall than would be predicted from the lay media, but that there is a

what do clinicians in Canada think?

Based on opinion research by the Centre for Addiction and Mental Health: [14]

- Social workers and counsellors view self-medication as a significantly more relevant issue in alcoholism than do physicians
- Non-psychiatrist physicians tend to view most psychopathology (i.e., psychological and behavioural problems) in alcoholics as the direct result of using alcohol as opposed to a possible coexisting mental illness
- On treating alcohol use problems, all clinician groups agree on the value of cognitive-behavioural treatment, the need for medications to be combined with psychosocial interventions, and the importance of teaching self-monitoring and coping skills

Sexual Abuse and Addiction in Men

Beginning to See the Light

Almost 70 % of men who develop alcohol and drug problems also have a history of sexual abuse.[1] Until recently, however, little attention was paid to the relationship between sexual abuse and addiction among men.

The majority of investigation and practice discussion has revolved around the concerns of women as survivors of sexual abuse. This oversight has begun to be addressed through more rigorous study of this dual occurrence in men—though no recent major Canadian research has been initiated to address the problem.

The current research raises questions of how men's issues of addiction and sexual abuse are being addressed in the practice setting, including how addiction counsellors normalize and validate these experiences in a way that supports and allows men to be comfortable in disclosure. Consequently, service providers are beginning to confront these issues in their practices. ►

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more solid base of support for self-medicating with alcohol following anxiety states, particularly for men. The evidence does not appear to be there for a similar relationship to depression.

And just to complicate things further, the Swendsen et al. study also found that for both men and women, feeling pleasant or happy was also predictive of alcohol consumption,[4] showing that social reasons play an important role even if self-medication is true some of the time for some people.

It behooves the practitioner to look at timelines and motives and to test the claim of "I'm drinking to cope with my symptoms" by investigating all the possible alternatives and contexts. The latter may be true sometimes, but it may just as easily be an excuse or a wrong self-assumption. **i**

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From the Research Literature

Sexual abuse histories are highly correlated with addiction among men,[2-4] and more specifically, among youth of both genders.[5] Furthermore, those men and youth who develop substance abuse problems and have a history of sexual abuse exhibit more extreme alcohol and drug use than the female counterparts.[5]

Despite differences in the reporting of sexual abuse and addiction problems according to gender, the effect of abuse on treatment outcomes for both genders is similar.[6] Outcome research highlights that if men receive addiction treatment that addresses their sexual abuse history, they too can benefit from treatment provision.[6] Historically, however, men are more apt not to report histories of sexual abuse than their female counterparts and thus are overlooked in terms of treatment interventions that would address sexual abuse and addiction problems.[7]

Narrative From the Field

When I was managing an addiction treatment program, I suspected that many of the men we were serving did not disclose that they were struggling with sexual abuse histories and using substances as a coping method. This suspicion was based on conversations with certain male clients, and reading the limited amount of pertinent research available.

After consulting with staff and clients, as well as the Ministry of Health who funded our program, our agency decided to alter the way we explored trauma histories in assessments of the people we served. While the Ministry of Health standardized assessment included sections on trauma history and on transgender identity as distinct from the binary male and female, the questions were often asked without relevance to the individual's stated gender. Furthermore, there were no consistent guidelines on how to incorporate normalization and validation, as well as gender sensitivity, into the assessment process.

Given that research indicated men were less likely to disclose abuse, or to make the link between sexual abuse and addiction, a simple gender-sensitive assessment approach was developed. Counsellors were encouraged—in their own style and words—to specifically, but briefly, outline in the trauma section the following points, using the appropriate client-identified, gender-specific term:

1. Men/women/transgender people often do not report sexual abuse histories due to shame and social stigma.
2. Many men/women/transgender people who struggle with addiction often struggle with histories of sexual abuse.
3. We as an agency often work with men/women/transgender people who struggle with these issues.

Over the course of one year, in 2000, individual assessment data, case notes and progress reports were analyzed to see if there was a marked difference in disclosures after the new assessment guidelines had been instituted. We found that sexual abuse disclosures increased by 35% among men, 5% among women and remained the same for transgender people.

The effect on the disclosure rate in men was dramatic. I suspect that, although disclosure was difficult for women and transgender people in our program, those groups are generally more likely to disclose; however, research with these populations also needs to be conducted.

Disclosures did not primarily occur during the assessment phase of treatment, but later, after the counselling relationship had been established. Follow-up with individual clients indicated that many of them felt more comfortable in disclosing their history because the issue had been "named" for them as men.

More Recognition and Research Needed

More research needs to be conducted into the relationship between sexual abuse and addiction among men. Research also needs to be developed to include the identities of transgender people. Studies which assist in the development of practice guidelines concerning this issue are sorely needed.

While I have highlighted only one practice strategy based on my personal experience, I suspect there is a wealth of practice information and expertise that should be made accessible to addiction professionals and evaluated through rigorous measures. If we as professionals and researchers give voice and recognition to this issue, perhaps more men who struggle with both sexual abuse and addiction will access services and seek to address their problems. Furthermore, by raising awareness of sexual abuse, addiction and the needs of men, perhaps the larger societal issues that result in abuse and addiction can begin to be confronted.

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Understanding Suicide Risk Among Young Men

Jennifer White

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Whenever I am asked to give an educational presentation about suicide, there is typically a well-defined moment when the learners in the audience get very focused and quiet and become particularly engaged with the material. It is when I show the graph that compares rates of suicide among young males with the rates among young females (see Figure 1). With one glance at this slide—which shows that young males are killing themselves three to four times as often as females—participants immediately understand that suicide among young males is a very serious concern.

To put some of these numbers into perspective, consider the following. There were a total of 430 suicides among males ages 15 to 24 in Canada in the year 2000, a rate of 20.2 per 100,000.[1] Among females of the same age there were a total of 112 suicides or 5.5 per 100,000. Consistent with the pattern observed in other developed nations, Canada witnessed a dramatic rise in youth suicide rates between the 1950s and the 1980s, with much of this increase accounted for by suicides in young men.[2]

Closer to home, there were 20 suicides (13.9 per 100,000) among males ages 15 to 19 in British Columbia in the year 2003 compared with five suicides (3.7 per 100,000) among females of the same age.[3] The vast majority of male suicides in this age group were by hanging or firearm, which may partially explain their elevated rates since these methods are almost always lethal. Finally, 75% of all suicides in the province of BC are among males. As the participants in my educational presentations inevitably ask: What is going on here?

Risk Factors for Youth Suicide

Suicide is complex and most researchers and mental health practitioners agree that, in order to understand suicide, we need to recognize that there are multiple sources of risk occurring at many different levels. The following are some of the most well-established risk factors for youth suicide:[4]

- mood disorders, substance use disorders and co-occurring disorders
- previous history of suicidal behaviour
- family history of suicide
- physical abuse
- current life stressors
- exposure to sensationalized media reports of others' suicidal behaviour
- having access to the lethal means for suicide (e.g., firearms, medication)

An understanding of suicide among Aboriginal youth must also recognize the damaging consequences of historical and political practices such as colonization, government-sponsored policies of assimilation and residential schooling.[5]

In addition to recognizing these common risk factors for youth suicide, how might we come to understand young males' particular vulnerability to suicide?

Suicide Among Youth In BC Aged 15-19:

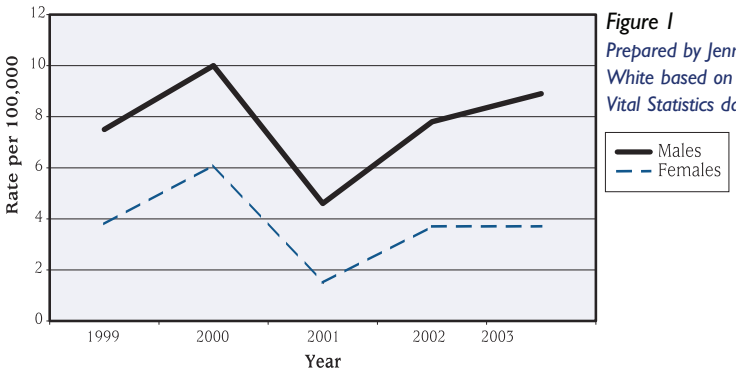

Figure 1
Prepared by Jennifer White based on BC Vital Statistics data

Understanding Male Vulnerability to Suicide

A recent cross-country comparison of several industrialized nations examined the relationship between rates of youth suicide and specific social and cultural variables. These variables included quality of life, social attachment, and measures of individualism (e.g., personal freedom and control).[2]

Rates of suicide among males in these countries were strongly linked to levels of individualism. The authors suggest that this could be one possible factor accounting for the dramatic rise in male suicide rates in the past 50 years. These authors go on to suggest that common markers of "progress" in industrialized nations (e.g., materialism, mobility, individualism) are not always balanced with a corresponding commitment to social obligation and tradition. This may be particularly so for "newer" industrialized countries like Australia, New Zealand, United States, and Canada, all of which have witnessed a tripling of their youth suicide rates since the 1950s.

It is not clear from this study why the "costs" of individualism might be greater for young males than females in terms of increased risks for suicide. The authors, however, suggest that the failure of these Western societies to provide appropriate sources of social identity and attach-

ment, while at the same time promoting unrealistic expectations of personal freedom and autonomy, might be contributing factors. It is possible that this combination of expectations and social circumstances may be more of a hazard for males than females.

Another study examined the issue of help-seeking among young males. This is of particular relevance in understanding suicide risk among males since we know that males tend to access formal mental health services less often than females.[6] Based on a series of in-depth interviews with white, middle-class, American male high school students, researchers identified a series of key themes that may help shed some light on why young men are reluctant to seek help during times of emotional distress.[6]

A core issue for these young men was "the pressure to fit in," which often precluded them from asking for help for fear they would be perceived as weak. This was coupled with a desire to maintain a strong masculine image of success and independence.

Suggestions for making services more available and attractive to males included high-level societal change, normalizing males' efforts to seek and receive help, and helping males find opportunities to experience a sense of purpose and empowerment.

Conclusion

While we must continue to recognize and respond to individual-level risk factors for youth suicide (e.g., recognize and treat depression), studies suggest that we must also understand the role of broader social influences in the emergence of suicidal behaviour among males. Both studies suggest there may be an important role for mental health promotion programs that actively cultivate realistic expectations for the future, promote self-awareness and a strong cultural identity, foster healthy social attachments, and enhance help-seeking among young males. In other words, if we want to develop effective youth suicide prevention programs then we must intervene with young people and their social contexts. **i**

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A 'Big, Strong Man'

Workplace depression can strike anyone, but men find it more difficult to ask for help

Spencer McDonald

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Life is good. I run my own company, give talks on workplace depression to business leaders, and appear on radio and TV.

But it wasn't always that way. I've been 'down.' But there was a time when supportive friends and family suggested I might be depressed.

I rejected that possibility outright—after all, I am a six-foot, 285-pound, big, strong man! I'm a senior manager with a staff of eight people. I'm an important fellow—I don't have time to be depressed. I ride motorcycles and drive semi-trailer trucks. I teach sailing. I operate power tools, for heaven's sake! Big, strong men don't get depressed.

I just needed to get motivated. You know, if I could get myself going, I would keep up the momentum and get back on track. Sure, no problem!

But every day, by noon, I would be on the couch or back in bed. I was defeated by the simplest things, like unloading the dishwasher, which had been waiting for… well…a long time. I just couldn't face it. I rarely went out, ate potato chips and dip for dinner, gained 60 pounds, withdrew from friends and pretty much memorized the TV guide.

I was not depressed!

Or, was I?

The day I finally admitted that perhaps I could use some help, I found myself, at 2 o'clock in the afternoon, in bed, with the drapes drawn, shoes on and fully dressed, curled up in a fetal ball with the covers over my head, crying like a three-year-old. Not depressed though; not me! But everything seemed so black and hopeless that I finally crawled out of bed, asking myself, "What harm could there be in finding out a bit about depression?"

I came across a screening test on the Internet and—oops! The results were off the scale. Well, that was depressing.

I thought I was a freak. Men don't get depressed, especially not big, strong men like me.

I realize now that I am not a freak. At any given time there are 1.4 million clinically depressed employees and executives in Canada. In fact, since the early 1990s—the decade of downsizing and restructuring—the hours worked by Canadians have increased at six times the rate of growth in labour productivity. Studies show that in the same decade, depression was growing and affecting younger people. And Harvard University has projected that by the year 2020, depression will become the greatest cause of work days lost through disability and premature death in the world's developed countries.[1] I wasn't alone.

With an education in psychology and counselling, I got pretty interested in depression treatment and the effects on workers and the workplace. I spent hours researching and reading everything I could find.

I learned that early detection and treatment is the key. The symptoms of depression often appear more clearly at work, where employers can help by developing strategies that will save lives and money.

Mental health disorders are driving business costs up through lost productivity, disability and absenteeism. Depression is the most expensive of all. Each depressed employee costs a business around $10,000 a year. With up to 10% of the workforce affected, the costs add up quickly, making it just good business to confront the problem head on.

Employers can tackle worker depression in several ways, and the savings will outstrip the cost of these initiatives many times over:

- Employee education, awareness and screening
- Creating a mentally healthy workplace by reducing stress, uncertainty and conflict
- Encouraging and supporting effective treatment programs
- Reviewing corporate medical programs and employee health benefits
- Improving employee assistance programs (EAPs)

Today, I'm still big and still strong, but I'm wiser and happier. I'm off the couch. Every time I give a talk about depression in the workplace someone stays after to share his or her story and inspires me to keep educating and working to remove the stigma of this illness.

The smartest thing I ever did was to admit that I was in trouble and to reach out. If a big, strong man like me can ask for help, so can you. i

footnote

1 Wilson, M., Joffe, R.T. & Wilkerson, B. (2000, July). *The unheralded business crisis in Canada: Depression at work.* Paper presented at the Business and Economic Roundtable on Mental Health, Toronto, ON.

Men are Dying
And 'dying' for mental health research!

James Hodgins

James is Board Secretary for the Toronto Men's Health Network, and is a social marketing consultant and family mediator

A Family Tragedy

The recent news that two parents and a child had been murdered sent shock waves throughout Toronto. A tragedy at any time, this seemed particularly horrific. Only weeks before Christmas, and two young children left without either parent.

Why had it happened? Neighbours described them as a perfect couple. He loved her so much. She was always smiling. There was no warning.

Within hours, media reports advised that one parent had likely killed the other, and then killed their child, then committed suicide. Stories swirled about a possible family dispute, laying rapid foundation to speculation the father had become enraged and had 'lost it.'

Forensics, however, soon made it clear that the mother did the killing. Shocked police reported that we may never know why. But others had already jumped in to fill in the missing pieces.

The 'Mother'

Within 48 hours of the event, countless experts were lining up, saying the mom was a victim, even though she was a murderer. Mental health and social service professionals covered the airwaves. They described types of postpartum depression, saying that up to 70% of mothers experience depression following birth, and outlining support available to assist mothers experiencing this horrible depression. Advocates even accused the government of indirect responsibility because of insufficient support for women following birth.[1]

The tragedy had apparently been solved: everyone was a victim. Depression is serious and we definitely want to do what we can to help those with it, especially to avoid tragedies. Health professionals called for more research and support for mothers. But no one mentioned protection and services for fathers and children at risk from violent postpartum outbursts.

The 'Father'

What if the genders in the tragedy had been reversed? What if the dad had killed his wife, murdered their child, and then committed suicide? What response then?

What if Dad had been a victim of circumstances such as family separation, which can induce a severe state of depression in fathers—one that could cause a dad to not only contemplate suicide, but to want to harm close family members? To avoid future tragedies, would health professionals call for more mental health research and social services for fathers experiencing extreme stress?

Based on recent history, advocates would likely brand Dad a cowardly perpetrator of family violence. Far from being a possible victim of severe depression or a mental disorder, dad would be charged as a male seeking control over his wife and family. Rather than identifying a separated father as a member of an at-risk group needing support, advocates would urge more protection for women and children against angry men and fathers.

Men Much More Likely to Commit Suicide

To help ensure safety for every citizen, the mental health community can contribute to a better understanding of all types of family murder and suicide. Why are 3,000 Canadian men committing suicide annually? This is four times the rate for women.[2] What is the impact of family separation on the mental health of fathers?

Dr. David Crawford and Professor John Macdonald of the University of Western Sydney reported that the pain of separation and divorce is having an alarming effect on the health of Australian males. They conclude relationship breakdown and divorce are leaving many men, especially fathers, emotionally broken and unable to cope, contributing to high rates of suicide and harm of others.[3]

Divorced men at higher risk

Dr. Paul Links, professor of psychiatry and chair of suicide studies at the University of Toronto, reports that difficult divorces or loss of children fit the profile of loss leading to suicide. Divorced men kill themselves twice as often as single or married men,[5] and since men in general commit suicide four times as frequently as women,[2] divorced

what you should know about male suicide

- There are 3,000 male suicides in Canada annually[7]
- Men are four times more likely to commit suicide than women[2]
- Male youth are three times more likely to commit suicide than girls[8]
- Divorced men are two times more likely to commit suicide as single or married men[5]
- Relationship breakdown causes significant emotional breakdown[3]
- Male suicide cost to Canadian society is $2.5 billion annually[6]
- Little is known about male suicide
- More mental health research is desperately needed

men commit suicide eight times more often than women in the general population. Yet, little is known about male suicidal behaviour in Canada.

Suicide exacts a terrible toll on society, emotionally and financially, but very little research is available. The mean total cost estimate per suicide death in 1996 was $849,878.[6] Based on the approximately 3,000 male suicides across Canada in 1998,[7] the total cost in 1998 for male suicides across Canada would have been approximately $2.5 billion.

It has been 10 years since the Task Force on Suicide in Canada reported a pressing need for more information on suicidal behaviours. With nearly 3,000 men and fathers dying annually through suicide, the urgency seems obvious.[7]

To develop innovative and effective approaches to suicide prevention, more knowledge of the causes and factors that increase risk is required. It's time for Canada's mental health community to bring its expertise and professionalism to the table and launch a series of fresh studies on the psychological stresses and emotional pressures fathers and men are experiencing.

Dead fathers need to be listened to—so we can help every child and family member. **i**

footnotes

1 Carey, E. (2004, December 3). Mother is prime suspect: Psychosis is not just 'baby blues.' *Toronto Star*, p. C4.

2 Langlois, S. & Morrison, M. (2002). Suicide deaths and attempts. *Canadian Social Trends, 66*, 20-25. A publication of Statistics Canada.

3 Crawford, D. & Macdonald, J. (2002, October). *Fathers and the Experience of Family Separation*. Paper presented at the First National Conference on Mental Health of Persons Affected by Family Separation, Liverpool, UK. Retrieved February 1, 2005 from menshealth.uws.edu.au/documents/Fathers%20sep%20ment%20hlth.htm

4 Grewal, S. (2002, February 15). Men, divorce and suicide. *Toronto Star*, p. F1.

5 Kposowa, A. (2000). Marital status and suicide in the National Longitudinal Mortality Study. *Journal of Epidemiology and Community Health, 54*, 254-261.

6 Clayton, D. & Barceló, A. (2000). The cost of suicide mortality in New Brunswick, 1996. *Chronic Diseases in Canada, 20*(3). Retrieved February 1, 2005 from the Public Health Agency of Canada website at www.phac-aspc.gc.ca/publicat/cdic-mcc/20-2/e_e.html

7 Health Canada. (1994). *Suicide in Canada: Update of the report of the task force on suicide in Canada*. Retrieved February 1, 2005 from the Public Health Agency of Canada website at www.phac-aspc.gc.ca/mh-sm/mentalhealth/pdfs/suicid_e.pdf

8 Statistics Canada Health Statistics Division. (2001). *Mortality, summary list of causes*. Ottawa ON: Statistics Canada. A shelf table of 1998 statistics, catalogue no. 84F0209XPB.

RESPECT

A rap song for teens

This excerpt from the rap song RESPECT was written by Noah Davis under the moniker Mosaik. The entire song is performed by the Rubix Project, a collaboration of hip hop lyricists Achilleas and Mosaik, and producer/writer/musician Josh Zotzman. See "stuff we've done" at yesmeansyes.com

Noah Davis

Noah is an actor, writer, rapper, feminist, agent of social change, and youth program developer and facilitator. He has worked in Victoria with the Women's Sexual Assault Centre's Project Respect team and is currently in Vancouver working with SafeTeen

It's all about respect.
We get our mindsets correct.
Pull together
and form a gender balance.
United, no doubt we can end the violence.
Divided, we will be destroyed by the silence.
It's not about him or her, they or them, you or me;
it's about us together in unity,
becoming agents
of social changes
to build immunity
to the ignorance which becomes contagious.
Attack sexual assault through prevention
our best weapon:
communication.
Open discussion to understand what we facin.'
Intimacy is a mutual decision.
You have the right to say no,
and the responsibility to listen.
Rape is a social condition
created by labels and gender stereotypes.
Set your own values, be aware of your rights.
You have the right to be sexual
but it must be consensual.
And that union must be based on trust.
To force yourself upon another
has nothing to do with lust;
it's struggle for power and control.
But if you feel the need to have power over someone else
you're trying to compensate for a lack of power in yourself.
To be able to respect those around you
respect within is what it comes down to.

Chorus RESPECT
my life, my rights, my choice
RESPECT
my love, my body, my voice

> "To facilitate the empowerment of youth… to throw the pebble that starts the avalanche, is an indescribable joy."
> — Noah Davis

Male, Chinese and Immigrant

Mental health shame runs deep

Andrew Lee, MA

Andrew is a psychotherapist with Change Now Psychotherapy and Counselling Services in Richmond, BC. He has a master's degree in counselling psychology from the Adler School of Professional Psychology. Andrew can be reached at 604-275-1316

David's story

David is an immigrant in his 30s. He moved from Nanking in China to Vancouver with his wife and his three-year-old daughter two years ago. He arrived here with a dream that his family would enjoy a better lifestyle. He also believed he could find a decent job and create a promising career. He was convinced that he made a good decision and his effort was going to pay off. Immigrating to Canada was the future for him and his family.

David's dream, however, did not become a reality. First of all, he experienced hardship in job hunting: his graduate degree and previous working experience in the computer engineering field in China was not recognized by Canadian companies. Because he possessed professional competency, David felt this was unfair, and he was very upset with being denied opportunities.

After a long and futile search, David could only find a job as a seafood clerk in a Chinese supermarket. He regarded this job as far less satisfactory than the job he had as a mid-level manager in Nanking. In his opinion, a decent job would be a managerial job in an office. He felt frustrated and discouraged.

David's income was low and the financial situation of the family was not solid. Money issues triggered many conflicts between David and his wife. Although he did have some savings from his previous job and from investments, the couple could not see a better future. David's wife told him that he was "useless" because he could not bring home "sufficient" money.

David's self-esteem had dropped, and with the constant family conflict, his emotions took a downward spiral. He was disappointed with himself and felt guilty about making his family members' lives miserable. He withdrew from his family and his colleagues.

Eventually David lost interest in his hobbies (fishing and bowling), and he developed neck tension, headaches and sleep inconsistency. His appetite became low, and he ate and drank very little; his weight dwindled. David's friends began to suspect that he may have developed depression. Even though his condition impaired how he functioned in his life, David refused all psychological or medical help suggested by his friends.

Although he knew that he should open himself up a bit and talk to someone about his problems, David felt too ashamed to do so—expressing problems to others is a strong taboo in the Chinese culture.

David is not alone

David's story is a made-up but highly plausible scenario. A male, Chinese, new immigrant develops a mental disorder largely due to maladjustment to the life in Canada—although we believe physiological factors also play a causative role. It is fair to say that an individual develops his or her "expression of psychopathology" according to social and environmental impacts, as well as genetic factors together with individual lifestyle and unique psychological dynamics.

Mental health issues, however, have become a major concern in the immigrant Chinese community over the past few years. Because immigrants face tremendous cultural, social, financial and psychological challenges, the transition period to life in a new country is a vulnerable time.

Depression is not the only mental health problem occurring in male immigrants: anxiety, panic attacks, obsessive-compulsive symptoms, schizophrenia, bipolarity and chronic anger can be seen in this group as well. While there may be more Chinese females suffering depression than Chinese males, Chinese males may be more likely to express the same distress through anger. Chinese males, though, are less likely to reach out to community resources than are Chinese females, and they often quit psychological treatment prematurely.

Although there are numerous mental health issues in the Chinese community, there are some common patterns. For example, due to cultural factors, strong feelings of shame, guilt and denial are deeply rooted in Chinese males who have mental disorders. Receiving professional help is frequently regarded as a taboo, and those with mental illness are given outdated labels, such as being "crazy" or "insane."

It is important to explore how to actively enhance and encourage Chinese men like David to adapt to updated North American mental health concepts, which recognize that it is not abnormal to experience mental problems. This would help improve prevention and therapeutic efficiency in both medical and psychological domains.

A Mirror Image?

Men and mental illness in Canadian and Chinese cultures

Cynthia Row
Interviewers: Pat Merrett *and* Vicki Rogers

Cynthia is Editorial Assistant for Visions

Pat is Newsletter Editor for the Mood Disorders Association of BC (MDABC)

Vicki is Education Director with MDABC

two men of Chinese heritage were recently interviewed by Pat Merrett and Vicki Rogers of the Mood Disorders Association of BC. Mark and Winston (not their real names) were asked about their experience of being males with mental illness within the Chinese culture.

I expected these interviews to support the commonly held belief that attitudes about men and mental illness are more progressive in North American culture than in Asian cultures. But, as is often the case, casting a critical eye on another culture reveals much about one's own. In fact, these interviews betrayed the conceit that traditional stereotypical expectations of men to be emotionally strong and unflappable have changed in our culture—that we now accept mental illness as part of the male experience without prejudice—while attitudes about men with mental illness in Chinese culture lags far behind.

The reality is more likely that acceptance and support of men with mental illness has progressed in Asian cultures, and that Asian attitudes towards mental illness in men have caught up to our own. But the understanding and acceptance of male mental illness in Canadian culture remains largely intellectual and academic, while the reality is that men still expect themselves, and other men, to be emotionally strong no matter what, and they are fearful of disclosure. Expectations of men and men's expectations of themselves in both cultures are unrealistic—and harmful (reflected by high suicide rates among men). Special attention must be paid to these realities, as evidenced by the articles in this edition of *Visions*.

Winston pointed out that, in Chinese culture, all illness is stigmatized; mental illness is not singled out as especially shameful. "It is not really just mental illness," he says. "We had a party and there was a little girl who was crippled, in a wheelchair, and my mother pulled me aside and said, 'Are you bringing that person into the house? Are you sure that she's accepted here?' And this person [in the wheelchair] was a well-known person in the community. If that is the way she's accepted, can you imagine what it is like for others?"

The reaction of Mark's family and friends to his depression is a familiar one to anyone experiencing depression: "Why can't you just be happy? If you just cheer up, everything will be better."

Mark also highlighted another frustration for men seeking help for mental illness. "I had to do my own research to find out what was wrong. Doctors didn't help at the beginning," he says. While it is appropriate for physicians to rule out physical causes of mental distress, there is much anecdotal evidence suggesting that physicians are quicker to consider a diagnosis of mental illness in women than in men, with the result that treatment for men can be delayed.

When asked if there was a difference between the reactions within Canadian and Asian cultures to men with mental illness, Mark responded, "Maybe I'm biased, but I don't see any difference between the Asian or Canadian population. We suffer from the same problem. It is not just Asian groups, but people in general don't want to seek help. Why? Denial."

The April 1, 2004, suicide death of a Hong Kong superstar, actor and singer, Leslie Cheung Kwok-Wing, is a wake-up call for the Chinese population, says Mark. "People realize that depression can be a fatal illness. No more 'just cheer up—it won't kill you.'" A society's understanding of mental illness is always advanced when the illness affects a person of prominence, but it is a lamentable fact that it takes such an event—whether in Asia or in Canada—to draw attention to an illness that affects so many.

Being among non-Asian Canadians doesn't seem to make Winston any more comfortable about disclosing his illness. "In society it is difficult to be Asian," he says. "At work, with six executives, I'm the only Chinese. I don't say anything about it, especially at work. Only my family is aware."

Awareness, acceptance and the treatment of mental illness in men has come a considerable distance in both Canadian and Chinese cultures, but they both have a long, long way to go. i

Nurture over Nature

Relearning that sharing feelings is healthy

Rodney Baker, MA, CPRP

Rodney is a Certified Psychiatric Rehabilitation Practitioner, Executive Director of the Simon Fraser branch of the Canadian Mental Health Association, and a counsellor in private practice. He may be contacted at keycounselling@yahoo.ca

Guys are supposed to know stuff! When I kissed my very first date goodnight, I got a nasty shock. She made an "ugh" sound in the way that only young girls can, wiped her lips and said, "Who taught you how to kiss?" And this after I paid for her to see an Elvis movie and bought her peanuts! But I was learning what it takes to be a man.

When I fell down and scraped my knee, I learned not to cry and to "be a tough soldier for Mummy." When my twin sisters, who were 10 years my junior, fell and skinned their knees, they were encouraged to cry. "Oh! Poor darling! Come to Mummy." If my dad told me off and I started to cry, he would say in a rather disdainful way, "Oh, the taps are turning on."

When I was 16 and got slapped on the face at school in front of the whole class, my eyes brimmed, but no tears ran down my face—victory!

When I was 18, my father died. My mother and 10-year-old sisters cried, but by that time I had learned not to cry. I helped make the funeral arrangements and brought the urn to the church afterwards.

We all learn how to behave from the culture around us. There were different, gender-specific ways of handling a crisis: I was trained to ignore it; my sisters were trained to embrace it.

At about age 45, I started getting into difficulty in my marriage. My wife and I visited a marriage counsellor, and my wife told her all about our problems. The counsellor then looked me in the eye, meaningfully, and said, "How do your feel about all this?" I had no idea what to say. One feeling I could identify, however, was uneasiness. Complain about my wife's behaviour to a stranger? I had always tried to protect her!

About this same time, I went to a men's weekend. It was described as an "initiation into manhood." For the first time, I heard other men being honest about their problems. I took part in a grieving circle, with 200 men sharing the pain of their losses. After the men's weekend, it took a year of once-a-week meetings until I felt safe enough to share some of what I felt.

I learned the value of identifying and sharing my own emotions. This was so amazing that I decided to learn more about healing, relationships, and psychology in general.

I sold my boat building business, trained as a counsellor and began the second half of my life as a psychotherapist working in the mental health field.

I did a lot of couples counselling and helped a lot of men begin to identify their feelings. Until feelings are identified, they can't be expressed, and partners will not know who their men really are. While the men found it hard to share how they felt, some wives found it difficult to embrace the new "job" of giving consideration to their husband's feelings.

Emotions are survival signals, provided by evolution to warn us when something is wrong. This is why it is important not to ignore them. Ignoring physical pain would be considered stupid: if we burn our hand on a stove, the pain warns us not to touch a hot stove again.

We treat emotional pain warnings quite differently and do things that 'burn' us over and over again—often from societal expectations that that we "should" be doing them. This is the stuff that nervous breakdowns, depression and anxiety are made of. If we are feeling depressed or anxious, it is a warning that we need to change our behaviours, not to just take pills that numb our feelings so we can keep doing negative behaviours longer. Pills can certainly help in the case of anxiety or depression, but medication should always be accompanied by psychotherapy. It is imperative to change the behaviours that are causing or maintaining the problems.

Recently I gave a presentation on men's health to a Canadian Union of Postal Workers group. I first asked, "So, guys, how are we doing around men's health issues? Who thinks we are doing okay?" About 75% put up their hands. "Who thinks men are not doing okay?" Only a few people put up their hands.

I then put an overhead up with Stats Canada research findings[1] showing how men were doing compared to women, and the faces in the room changed. Men are:

- 40% more likely to die from diabetes
- 55% more likely to die from cancer
- 64% more likely to die from pneumonia or flu
- 78% more likely to die from heart disease
- 80% more likely to die from disorders of the kidney
- 84% more likely to die from arterial diseases
- 92% more likely to die from mental disorders
- twice as likely to die from lung disease
- twice as likely to die from unintentional injuries
- four to six times more likely to die from suicide

Since men and women are made from the same basic materials, it appears that nurture rather than nature is responsible for these statistics.

I then asked what was different about being a man, and what kind of gender-specific messages

they had received growing up. There was a spontaneous outpouring of responses, which I wrote on a flip chart: "Suck it up," "Be a man," "Don't whine," "Just get on with it," "Real men don't cry," etc., etc. While these messages about how to behave may have been useful in simple pre-industrial times, statistics reflect that they appear to be killing us in the more complex society of today. Neglecting warning signals may work to win individual skirmishes, but as 'soldiers,' we are losing the battle to maintain our health.

Perhaps the saddest and most telling statistic related to men's mental health is the horrific rate at which men commit suicide. Most suicides result from emotional pain becoming unbearable. If you are programmed not to complain, and you are supposed to know how to cope, there can be no relief from sharing pain, because there is no sharing.

Where do men go for help? Good question! If you look in the Red Book,[2] there are literally dozens of organizations to help women and only two to help men.

That men are not receiving help may simply be a result of not asking for help. Luckily, a new generation of men may be on the way. Recently, I've had a few young adult males, 19 years of age, come to my counselling practice for help. This is a first—only 10% of my clients are men, and most tend to be in their 30s and 40s—and is a promising sign.

Let's encourage men to talk about their problems, for it may be a big factor in helping our sons, fathers, uncles and brothers to survive. **i**

footnotes

1 Statistics Canada. (1997). *Selected leading causes of death, by sex*. Retrieved July 2004 from www.statcan.ca/english/Pgdb/health36.htm.

2 Information Services Vancouver. (2003). *The Red Book: Directory of services for the Lower Mainland*. Vancouver, BC: Author.

My Journey

From blowing up rock to taming bipolar disorder

Stewart Ludtke

Stewart is a mental health consumer and lay support group co-facilitator with the Mood Disorders Association in Victoria, BC

Dynamite attracts a strange breed of people. One day in 1974, when I was 19 years old, I saw a guy drilling a hole in solid rock. I thought it was so cool, I asked him if I could try it. At the time I didn't know I'd taken my first step on a path to alcohol and other addictions. And I didn't know I was bipolar. But six months later, I had earned my first blasting certificate, and I did my first solo blasting in the winter of 1975.

Like I said, I was surrounded by a strange breed of people, and I fit right in. Many blasters, me included, have a tendency toward pyromania; they're all mesmerized by bonfires and get kicks from blowing up old cars and launching stumps. Most of the guys were bikers from around Victoria, but everybody drank and everybody partied.

Try as I might in high school, I hadn't been much of a drinker prior to 1974, though I smoked cigarettes some. Two weeks past my 19th birthday, however, the foreman and crew whisked me off into their bar scene. I'm 49 now, and looking back I can see that this was one more new world I had entered and adapted to—one I had chosen for myself.

Steady employment meant steady paycheques, and in my early 20s, the money was rolling in. I was single, owned my own home and drank every day. I began to practically live in one particular bar.

Blasting work entails long hours and is physically difficult in the extreme. I'd be up at 5 a.m. to set up at the job site by 8 a.m., work till 4 p.m. and head back to the yard. After fuelling up the truck and compressor, talking with the boss about the job, and listening to him moan about how much money he was losing, I'd drive to the bar and drink until closing, then take friends and a case of off-sales home. And get up at 5 a.m.!

I know now that I went through several manic and depressive swings between 1974 and 1987. My birthday is in June, on the first day of summer. As May approached, I could sense my energy level increasing. Some sleepless nights I would be consumed by an idea or "get rich" plan. All through summer and fall I had a contagious enthusiasm for ideas, could influence just about anyone, and had a lot of fun—most of it pretty harmless. But by January, I'd end up hungover and broke, or worse, in debt. I'd begin to isolate myself, not wanting people who knew me as a vibrant, fun guy to see me when my

personality seemed to be melting away. I'd lose my ability to remember simple things, and a few beers would knock me over. My attitude at work was deplorable, and if my boss of 10 years wasn't such a great guy, I'd have been fired several times over.

By 1980, when I was 25, I was smoking a pack and a half of cigarettes a day, had tried most drugs and was a full-time alcoholic. I couldn't just sit and have a few beers—I always drank as many as possible. And I was turning into a mean drunk with no self-control. Drugs give a temporary high but you always pay a price for what you get. Cigarettes are just about the worst waste of time and money, and the health risks are staggering. And alcohol just plain got in the way.

I managed to quit smoking in 1980 with the help of a dear friend who runs a quit-smoking centre. She talked to me at my bar for about two weeks, saying that most of the hundreds of chemicals in cigarettes leave your body in just a few days, so the rest of kicking smoking involves breaking mental habits. She said that when I was ready, I'd stop. I've now been an ex-smoker for 24 years.

My son Jarrod was born in 1984. I'd known his mother for several years and a relationship with her just wasn't possible, but I did want to help. To come up with extra money for support, I stopped drinking, from November 11, 1984, to May 11, 1985, exactly. Then I started pounding the beers again. It was my manic time and I was missing the action of the bar. When you drop out of alcohol circles, your friends and acquaintances don't follow, so it gets lonely. I wasn't a '12-Stepper,' so my willpower just ran out.

In 1986, two years after Jarrod was born, I met my wife Katy. She's been the backbone of my support system ever since. She was there for me in 1987 when my best friend died in a freak accident. She was there when I quit my job and went to school.

But alcohol was getting in the way: after just one beer I couldn't study, my grades suffered—and I was in danger of losing my wife. So, in 1990 I took my last drink. I was working as a carpenter's apprentice at the time. Drinking on grand scales seemed to have gone out of style, so I didn't notice much difference. Besides I was very busy with Katy's and my new land—two-and-a-half acres of rock that I blasted for driveway, house and more.

Now I only had pot to self-medicate my moods. I never really liked pot—I got too paranoid and forgetful—but it was the pot that brought me to the discovery that I'm bipolar.

The rollercoaster ride wasn't over, either. In 1995, I lost a seven-month court battle, and wasn't able to see my son Jarrod any more. He was 10 years old and I cared for him deeply. Then, during the summer of 2000, my manic motor started up and pot seemed to be inspiring me. First it was one whole joint, and by the end of September, I was smoking 12 joints a day. Even being manic I knew I shouldn't be doing this, so I went to see my doctor, who pronounced me full-blown manic-depressive.

I quit smoking pot in December 2000 after six months of taking antipsychotic medication. Today I take Epival every day for mood stabilization and Effexor for depression. It was rough at first, but a key part of my recovery has been a great support group through the Mood Disorders Association of BC in Victoria.

At first I didn't want to go to the support group, but my wife dragged me. I had never been to a psychiatrist and thought they would hook up the 'jumper cables' and give me 20,000 volts. The group, however, was able to calm me down and let me know that there was nothing to fear. I've been to every meeting since, and co-facilitate most nights. To be among people who experience the disability first-hand is priceless. Until you know you're sick, you really believe all the terrible thoughts you have about yourself and tend to isolate, which is the beginning of the end for a lot of people.

I couldn't have managed any of my crises without support from friends and family. The most important thing, and perhaps the hardest thing, is to ask for help when you need it. If you're choosing self-medication before family, friends or what you know in your heart are the right things to do, you have a problem. I discovered I was bipolar four years ago, at age 45. Now I work, I laugh and I live a good life.

I still have a current BC Blasters certificate, and a few years back I blasted the site for the new cancer clinic at Royal Jubilee Hospital. In 1989 I began a carpentry apprenticeship and today I'm a certified journeyman carpenter, as well as a certified computer graphics technician. Katy and I laugh and love like kids.

Two years ago on Father's Day, Jarrod called me up and we went for a drive. We've seen a lot of each other since. We've worked together, gone to the US twice, and have just plain hung out. He turned 20 on December 10, 2004. I got him a full set of rugged rain gear and we trudged out to the Sooke Potholes during an epic downpour. The waterfalls made the ground rumble, and we had a gas. He knows I'm bipolar and it doesn't matter. i

related experiences

If you'd like to read other men's stories about mental illness and problem substance use, go to www.heretohelp.bc.ca/experiences

note

According to the 1996 Canadian Census, in the category for crane operator, drillers and blasters, there were 130 women to 15,570 men. Stats Canada. (1997). *Labour force 15 years and over by detailed occupation*. Retrieved January 20, 2005, from www.statcan.ca/english/census96/mar17/occupa/table1/t1p00h.htm

About a Man Who Suffered Needlessly

Frank G. Sterle, Jr.

Frank edits two community newsletters: Community Connection, published by the South Surrey branch of Canadian Mental Health Association; and Whale Tales, put out by Whale House, a clubhouse operated by OPTIONS: Services to Communities. Frank lives in White Rock, BC

Although I have no means to be sure,I believe that Dad's mental illness was probably within him, or at least dormant, for many years; at least for as far back as I can recall. I was the most affected among us kids—I had a brother and two sisters—for I spent the most time with Dad, usually for long periods on fishing trips. He was a gill-net fisherman; I was the youngest boy.

"Hey, Dad, there's a sea lion in the net!" I exclaimed to my father, one day out on the boat. I was only a preteen boy, but I could tell a sea lion's head when I spotted it. "Should I pull out the shot gun?" Fishermen often carried guns to scare or stop seals and sea lions from destroying their nets and catch.

"No," he replied, passively watching the sea lion's head bob up and down as it tore salmon from the net, causing hours of damage to the net, not to mention the loss of salmon revenue. At just age 12, I knew this was a serious loss. But even with the only two boats in sight sitting way off in the distance, and neither directly behind the sea lion's head, my dad wouldn't touch the gun.

Dad didn't like guns, and I think I know why. When, as a 19-year-old, he escaped from the strictly Communist former Yugoslavia following WWII, he had to shoot at a border guard, who was more than willing to shoot him. Five years before my dad died (in 2002 at age 72), he travelled back to Slovenia, where he found out that he had only wounded the guard, as he said he'd tried to do. It was a great relief to my dad to learn this after almost 50 years.

After escaping to Trieste, Italy, Dad made his way to BC and took up jobs in mining and forestry. It was all a trying time for Dad, from what he told me—leaving his loved ones back in the "Old Place," as he'd refer to his village and place of birth.

He was a very honest man—one who would sooner give away $100 that belonged to him than take $50 that was not his. Indeed, it was quite ironic that a man, who was being abused by fellow Canadians, remained so honest. It was bad enough that Dad had to move halfway across the world and reside with strangers, but he also had to endure bigotry from fluently English-speaking fellow employees—Canadians who didn't care much for Dad's accent and broken English. They called him a "f——g DP" (i.e., displaced person). One police detective, who my dad was making inquiries to about a legal matter, told my father that people of Dad's ethnicity were "all the same bad sort."

I believe all of this contributed to the culture shock endured by Dad, which made him into a cynic who eventually succumbed to mental illness. Dad worried excessively; for example, he was afraid to invest in this or that, even when there was little chance of financial loss. And he was very negative towards many other people—mostly not in front of them, but in front of us kids. He disparaged people the same way people were mean-spirited toward him.

There were indications he may have had some obsessive-compulsive disorder: for a number of years, each time Dad returned from fishing he would inevitably make numerous trips back to his locked, docked boat to make sure it was securely padlocked.

Additionally, Dad had a hearing loss from exposure to a large diesel engine during years of fishing-boat travel, which exacerbated his often obnoxious attitude. He got himself a hearing aid that worked great; however, he refused to wear it. Dad never explained why, and we assumed that he was afraid of sudden loud sounds blasting his hearing-aided ears, or that he was too embarrassed to wear it, or both.

As dad aged, his cynicism and very worry-prone nature grew worse. He'd get agitated at almost anything. He complained a lot that we were not speaking correctly or loud enough, when it was his own hearing damage to blame.

My dad was also extremely cautious about taking medications, So we, in effect, had to deal with Dad, as his 'psychiatrists' of sorts, observing and occasionally throwing a dose of reality to the 'patient' who was usually reluctant to accept it.

We all still, at least to some extent, love Dad, but everybody in the family chose to spend as much time away from Dad as possible. We were all very negatively affected by Dad's refusal to admit to his illness. His pride was at stake. This was, indeed, a sad reality, which could likely have been avoided if Dad had swallowed some of that pride.

Too Proud to Ask for Help

And not knowing when to ask

Ian Chovil

Ian is employed by the Homewood Health Centre, a mental health and addiction treatment facility in Guelph, Ontario. He is a consumer consultant for the Community Outreach and Support Program and a peer specialist for the rural Assertive Community Treatment Team. Awards include the Clarke Institute of Psychiatry Courage to Come Back Award (1998) and the Guelph Mayor's Award of Excellence (2001)

I had an insidious onset of schizophrenia that progressed for nine years. It was so gradual that I lost all my human relationships without anyone realizing I was becoming ill. I've been told that schizophrenia often follows this pattern: first you have trouble with your attention span, then you lose your social skills (I was socially inept in early high school), then you lose academic ability, and then you develop psychosis.

I knew something was wrong, and I read a lot of stuff like Gestalt psychology (focusing on the immediate present and expressing feelings) and Rolfing (body work that manipulates the myofascial or connective tissue system). But having no knowledge of schizophrenia, I wasn't moved to make an appointment with my family doctor. I suffered quietly without ever seeking help.

People need to know when to seek help. I have since learned that the three main characteristics of serious mental illness are the severity of symptoms, the duration of symptoms and the disability caused by symptoms. I've also learned that all untreated schizophrenia leads to psychosis, and all untreated psychosis eventually leads to hospitalization, homelessness and/or incarceration. I spent time in all three places over the course of a ten-year untreated psychosis.

In 1979, I was kicked out of graduate school in Halifax for incomplete course work, and within a year I was homeless in Calgary, believing I had caused the Mount St. Helens volcano eruption. I was homeless for six months. I had lost my ability to survive in the competitive world of employment and was completely alone, without any supportive relationships. And I was too proud to run back to my parents with my tail between my legs. If you're male, once you leave home it's hard to go back.

As winter came on I was driven to Victoria, where I was able to pay rent for a basement room, and where I studied Tibetan Buddhism.

Victoria is a beautiful place, but I felt I was being punished for bad karma, and I barely survived. My mind was constantly invaded by thoughts of a particular Tibetan lama. Within five years I was convinced there was a secret war going on between two groups of people: the Tibetan 'anti-sexuals' (the celibate monks) and the Tantrics, who were very sexual. Whoever won the secret war, I thought, would determine the fate of humanity. If the anti-sexuals won, humanity would destroy itself in a nuclear holocaust that would break up the continental plates, evaporating the oceans and destroying all life on the planet. In 1985, I ran away from the anti-sexuals. I headed back to Ontario and, several weeks later, a plane blew up over Lockerbie, Scotland. I got very scared; the anti-sexuals were obviously trying to kill me.

In psychosis, unrelated events can become very significant and often very frightening as your mind jumps to wild conclusions about powerful outside forces. For the next five years I interpreted song lyrics as secret messages, and the messages let me down time and time again. My imaginary wife promised that three blonde beach bunnies would drive up in a jeep and take me to a cabin in northern California. For several years I just knew that a stretch limo would pull up with two identical teenage girls, who knew who I was. When the aliens promised to transfer my mind to the body of a wealthy man on the French Riviera, but instead I woke up on the living room floor of my cockroach-infested rooming house, I became furious, and started breaking windows. The police arrived very quickly, and I was subdued and hauled off to a holding cell and then put in jail.

The police intervention marks a watershed in my life. As a condition of my probation, I was sentenced to see a psychiatrist for three years. This eventually led to hospitalization for alcoholism in 1990, and treatment for schizophrenia.

The first few years of treatment were really tough. I was so alone, so poor and so celibate. I made a few friends at a day program, but I really missed the opportunity to socialize with women my age. And I felt ashamed of my poverty.

I kept expecting my psychiatrist to perform miracles and make all my problems go away. One day, however, I realized that if anyone was going to solve my problems, it would have to be me. The medication would enable me to solve my problems myself.

Each year on medication for schizophrenia has been better than the previous year. I'm now working 30 hours a week and enjoying life a lot. I just wish I had asked for help when I was 17, so that I could have enjoyed more of the years I've already spent.

websites for youth

www.cmha.ca/highschool
www.cmha.ca/english/intrvent
www.cmha.ca/mylife
www.ssoaware.com
www.camh.net/education/tami_introduction.html
www.orygen.org.au
www.eppic.org.au/resources
www.psychosissucks.ca/epi
www.facetheissue.com
www.getontop.org
www.reachout.com.au
www.zoot2.com
www.mindyourmind.ca
www.chovil.com

My Double Life

Ian Ross

After 20 years of living on the edge in London, England, Ian recently moved back to his native land. He is currently finding his feet in Victoria, BC

Rock 'n' roll rebel

I did well at school and in sports until rock 'n' roll took over my life in 1974. I was 14 and it was the great escape into a glamorous and magical world. I got into drugs, drinking and partying. I could at least talk to girls when I was drunk. To them I looked pretty confident and outgoing.

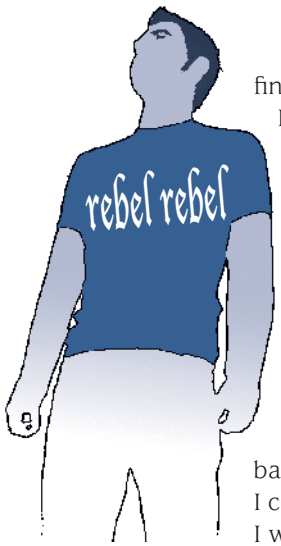
Some guys were even envious of me. I was the leader of a gigging rock band and looked the part—and I went out with beautiful girls. I could outdrink most people and was always the last person to stop partying. Sure, I got into fights and had some car accidents, chalked up a criminal record and so on, but hey, I knew how to have a good time!

Behind the mask, however, the reality was quite different.

Ultra-shy and a late bloomer

I was a very shy child, afraid of meeting new people and unable to even speak to many adults. I spent the first week of nursery school hiding under a coffee table in the lady's living room while the other kids played in the basement.

I wet my bed almost every night. I developed asthma and an allergy to dogs. In those days, many people didn't take such things seriously, and I had no inhaler to get me out of trouble.



My depression, as far as I can remember, started at age seven when my parents split up. That hurt me deeply. After, when my mother went out with men, I would stay up crying and unable to breathe. I took out my anger on my little brother, beating and bullying him.

In my teens, I was still wetting the bed. This was really embarrassing when I stayed over at other people's places. I'd cover up the evidence as best I could.

I took a lot of time off school, often with the flu, which led to anxiety about returning. I'd put it off, staying in bed.

At 17, I still hadn't gone through puberty. All the other guys at school were bigger and hairier than me. I tried to hide my nakedness in the gym changing rooms. I made my voice as deep as I could. When the hell was I going to become a man?

During the next year, I finally matured physically. But there was still something missing.

Sexual inferior

I wasn't able to ejaculate. No matter how much I tried, with or without a partner, after becoming erect, nothing more would happen. I felt too embarrassed to tell anyone, so I continued to pretend that I was 'alright Jack.'

I only made out with girls when I was really drunk and had enough nerve. I could also use the alcohol as an excuse for not being able to perform properly in bed. When the girls got too close, I would break off from them so they wouldn't find out about my embarrassing condition.

I wished I could be someone else. I just wanted to be able to have sex like a normal person. And I was too afraid to tell anyone my big secret, which was eating me up inside. I was afraid of ridicule and being seen as 'less.' I swore that if my problem was ever cured, I would be the happiest man alive.

At 21 I finally worked up the courage to tell a doctor. I had an operation, and was told afterwards that they didn't find anything wrong. As you can imagine, I wasn't glad to hear that at all. I had been hoping they would find something they could fix, so I'd be better. But nothing had changed. It felt like the doctor had dealt me a life sentence.

A little release!

Then, when I was 22, I fell in love. After seeing Elena* awhile, things came to a point where I felt I had to let her in on my secret. I was scared out of my wits that she would leave me—and was most surprised when she didn't. It was an incredible relief to have someone I could share my secret with.

Elena and I started having sex on a regular basis. She knew her body really well and loved sex. My problem was a plus from her point of view: I could go on forever, given that I couldn't climax.

One day, after we'd been together for over a year, something happened. We were in bed working up a real sweat. I was at the edge of my strength and holding my breath, when I felt a little release. I looked down into her wide-open eyes.

"What was that?" I asked.

"You just came," she answered.

We crumpled up with laughter. So there it was. At 23 years old, I finally managed to 'come' inside a woman.

With practice, I learned how to make love. I was 'fixed'!

** Elena is a pseudonym*

The breakthrough with Elena was major: the sexual problem had been psychological and related to my fear of intimacy dating from early childhood. I don't remember receiving any close affection as a child. According to my mother, I pushed her away—perhaps because I could sense her awkwardness; I was her first child and she wasn't a confident mother.

I had sworn that if my problem was cured, I would be the happiest man alive. But my relationship with Elena didn't last, and I started finding other things to get depressed about.

Still a rough ride

I carried on with the crazy lifestyle. I still played in bands—rock through punk, new wave, goth and grunge—though I found it hard to keep a group together. I moved to London (UK), hoping for success in a bigger pond.

My public persona was strong, successful, confident, virile and free. To others I appeared gregarious and even outgoing—especially when drinking.

I never felt comfortable in my own skin, however, and was envious of others who seemed so relaxed. The problem got worse as time went on. I was angry and depressed about the state of the world—wars, environment, materialism and so on—and felt overwhelmed, particularly when things were not going well in my personal life. I was emotionally detached and unable to communicate my real needs or show weakness and ask for help. I yearned for touch when I was drunk, and so would be on the chase constantly.

Deep down I needed help. I was still the hurt, lonely child scared of human contact, but desperately in need of affection and acceptance. There was a constant turbulence in my gut. I would forget to breathe. I had nightmares; would stay in bed, unable to face anyone, sweating and shaking for days at a time—from fear, and also from alcohol withdrawal. Hiding. Heaviness and thoughts of suicide.

At 30, I finally admitted that I had a problem.

Therapy: scary but necessary

After trying antidepressants without any joy, I asked my doctor what I could do. With his recommendation, I was able to get a place with a psychotherapy group at a local hospital. I got something from these once-a-week sessions, but it was only later on, in an all-male therapeutic community, that I gradually opened up and started sharing deeper, more personal stuff and then getting in touch with my emotions.

Amongst other men it was particularly difficult to show weakness or vulnerability. The therapy was terrifying, and I had nightmares during that time. But the more I went to those scary places, the more I gained. The scarier the place, the more important it is to go there. I eventually began to lose that constant churning in my gut and started to come to terms with myself.

Finding peace

If I don't share problems, or at least work them out, I know they will fester beneath the surface and come back and bite me (and/or somebody else) at a later date. The first and most difficult step was to admit that I needed help.

I am still somewhat emotionally detached, and I have to keep working on that. I still get stressed and have bad days, but I don't drink to excess any more. I'm more at ease and feel a lightness. And now, what I present outwardly has much more to do with what's going on inside. If I'm happy on the surface, you can be sure I'm happy the whole way through.

The Tragedy of Self-Medicating

Personal and workplace loss

Rafe Mair

Rafe was a lawyer and provincial cabinet minister before turning to broadcasting and writing on public affairs. He has written several books and innumerable columns in addition to his morning hotline show on CKBD 600 AM radio in Vancouver. For more on Rafe's opinions, hobbies and books see www.rafeonline.com

One in five people will have mental health problems in their lifetime. Many now say it's closer to one in four.

What the statistics don't tell us, however, is how many people who are depressed actually get help. I have a hunch that the percentage is small, and of those who do get help, many will not get much relief.

For people who have depression, there is the dimension of stigma, which makes it extremely difficult to seek help. Men are more affected by stigma, because they believe that more is expected of them. They've been taught not to cry. Stiff upper lip and all that. I was diagnosed with anxiety and depression 15

Rafe Mair interviews Susan Rook, a Bottom Line Conference 2005 speaker

years ago and was fortunate enough to have a doctor who knew something about the subject. That's rare enough today, but it was damned near unheard of back then.

So how does the undiagnosed depressed person cope?

We get into the area of speculation here, but I suspect that a great many people 'self-medicate.' That's a normal response; most of us do that with other ailments.

In 1966, at 59 years of age, my father died of cirrhosis of the liver caused by drinking a bottle of Seagrams 83 Canadian whisky every day of his later adult life. Looking back, it's clear to me that this was self-medication. He was depressed. There was no one who would help then. If your problems were serious enough, you had a 'nervous breakdown' and went, most likely, to an institution.

Most evidence we have of the association between depression and self-medicating is anecdotal and not scientifically proved. Not all people abuse substances because of depression or allied maladies. Unless credible studies investigate the causes of addiction, we may, indeed, never know the actual extent.

Back in 2001, I started to look around me and to think about life experiences in the workplace. I began to wonder about many of the failed careers—and workplace accidents, for that matter. Many appeared, on the surface, to have been alcohol or drug related. And I wondered if they might have had a deeper meaning. Why did so many males of my acquaintance slip from showing great promise to losing their jobs?

In 2002 I began to do a bit of research. 'Research' may be too lofty a term, but I did start to ask questions of doctors, nurses, social workers and employers. I was convinced I was onto something: I was certain there was a relationship between substance abuse and depression. If I was right—and many others much more learned than I were thinking along the same lines—what a tragedy! It was a personal tragedy for each individual, but it was also a tragedy for friends and family.

But frankly, there was another factor. Employers were losing money on big investments. I started to read about safety on the job and talked to a number of union officials. Substance abuse was a major cause of industrial accidents. Labour had a stake in this too.

In 2002, I also became involved with the first-ever Bottom Line Conference, spearheaded by the Canadian Mental Health Association. Representatives of unions, employers, mental health professionals and the government were brought together in the same room to discuss these issues. The conference was a resounding success and continues to be held annually.

It was tough sledding at first, though. New concepts often have a problem overcoming inertia. And there were some pretty prickly relations here. The provincial Premier was a politician, and so, in every sense, were the labour leaders. We all came into the room with some pretty deeply rooted prejudices. At times, some of the participants were at each others' throats.

But it did come together. The common, uniting element was tragedy—tragedy that all had seen; tragedy that could be avoided.

We've come a ways, but there is still a long way to go. It's tough as hell for a depressed person to admit it—especially for a man who has been taught to face problems with a stiff upper lip to admit to his boss or co-worker that he has a drinking problem (the drug of choice is irrelevant). But a start has been made, and that's important. Trust is being built. I think I can say that jobs and marriages are being saved. Indeed, people's lives are being saved.

What can the ordinary person do to help someone in trouble? Understand. Don't be, or appear to be, judgmental. If your relationship is close enough, try to get the person to see a helping professional.

There is now awareness that there's a very direct line between substance abuse and depression. That awareness is a sign that, as a society, we're less afraid of the subject and more willing to understand and be compassionate. But, as I said, we've got a long way to go. Often the help needed is hard to come by. But we have at least made a beginning. i

Female-to-Male Youth

Gail A. Knudson, MD, MPE, FRCPC

Gail is a psychiatric consultant at the BC Centre for Sexual Medicine and Clinical Instructor in the UBC Department of Sexual Medicine

Adolescence is a time of excitement, growth and change. An important developmental task in adolescence is separation from parents and creation of attachments to peers and partners. It is also a time for risk-taking activities. Youth who are gender variant and whose sexual orientation is not heterosexual are at greater risk.

This paper will introduce the concept of gender identity disorder (GID) as applied to natal females and will also explore the potential mental health risks for this population, as well as offer treatment strategies and resources available in BC.

Definition of terms

To begin, it is important to include a definition of terms. Bockting and Coleman[1] have defined the following terms: *gender identity* refers to one's basic conviction of being a man, a woman or another gender, such as *transgender; natal* or *biological sex* refers to one's sex as it appears at birth; *sex role* refers to characteristics culturally defined as masculine or feminine and commonly known as *sex-role stereotypes;* and *sexual orientation* is defined by sexual attraction to others.

The term *transgendered* is usually applied to individuals whose appearance and behaviours do not conform to the gender roles as ascribed by society for people of a particular sex and includes cross-dressers, transsexuals, drag queens/kings, and male and female impersonators. Transgendered is an umbrella term that encompasses people who are gender variant.

The term *transsexual,* while fitting under the transgender umbrella, is at the more extreme end of gender variance. A transsexual is a person whose gender identity is opposite to his or her biological sex.[2] A natal female who identifies as male is termed an FtM (female to male). There is no explicit term to identify a transsexual who is on hormones and/or has had surgery to facilitate a sex change.

The *DSM-IV,*[3] introduced in 1994, replaced the term transsexualism with *gender identity disorder* (GID). Individuals with GID have a strong and persistent cross-gender identification and a persistent discomfort with their sex, or a sense of inappropriateness in the gender role of that sex, causing clinical distress in social, occupational or other areas of functioning in childhood, adolescence or adulthood.[3]

FtM: from childhood to adulthood

Few studies have looked at the developmental trajectories of children and youth with gender identity disorder. Even fewer have studied girls. These studies suggest that only a few of children who were followed across time are diagnosed with GID into adolescence and young adulthood.[4] Most become attracted to those of the same sex.

Those presenting to gender clinics in their adolescent years, however, have a higher probability of the GID diagnosis remaining.[4]

Although many researchers believe that gender identity is formed between ages three and five, it appears that another crucial period for shaping gender identity exists in early adolescence. Zucker postulates that gender identity may be somewhat malleable in childhood and gradually consolidates as the person reaches adolescence.[4]

Whether the cause of GID is biological, psychological or both is still unknown. In any case, efforts should be focused on assessing for risk factors and offering intervention and support. The goal is to strike a balance between expression of their male identity and the safety of the individual.

Risk factors

FtM youth are at greater risk for mental health issues than are non gender-variant youth.[5] They may become segregated of their own accord or, more likely, because of stigma. They may be teased, ridiculed, harassed or abused. This may lead to feelings of rejection, shame, loneliness, depression and suicidal ideation. The teen may then withdraw and isolate or act out and become self-destructive with high-risk behaviours.[5] Depression is more frequent amongst the gender dysphoric adolescent girls than boys, while harassment/persecution is significantly more common in gender dysphoric adolescent boys than girls.[5] In either case, there is an increased risk for substance abuse, self-harm and suicide.[5]

Intervention and support

There have been no controlled studies thus far on intervention with children or adolescents.[4] Most clinicians follow the HBIGDA Standards of Care,[6] an evolving set of guidelines representing an international consensus on best practices relating to gender transition.The main point to remember with children is that the vast majority outgrow their feelings of gender dysphoria and most likely will be attracted to the same sex.[4]

In terms of intervention, a team approach is warranted. FtM youth must have support for their transgendered experience from family, school, peers and mental health professionals. Parental support is crucial to positive outcome. Adjustment in school is very important and teachers should model respect of diversity.

Many urban schools now have Gay–Straight Alliances that, together with school administration, help prevent hostile environments. Peer support groups such as the Lesbian and Gay Youth Society of BC's Youthquest and those offered through the BC FTM Network are important to decrease social isolation. Mental health professionals, as well as primary care physicians, have a vital role in monitoring risk factors and offering treatment. Reversible hormone therapy should only be considered after consultation with the members of the care team and parents.[6] i

footnotes

1 Bockting, W.O. & Coleman, E. (1992). A comprehensive approach to the treatment of gender dysphoria. *Journal of Psychology and Human Sexuality, 5*(4), 131-155.

2 Cole, C.M., O'Boyle, M., Emory, L.E. et al. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*(1),13-26.

3 American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (4th ed.). Washington, DC: APA.

4 Zucker, K.J. (in press). Gender identity disorder in children and adolescents. *Annual Review of Clinical Psychology*.

5 Di Ceglie, D., Freedman, D., McPherson, S. et al. (2002). Children and adolescents referred to a specialist gender identity development service: Clinical features and demographic characteristics. *International Journal of Transgenderism, 6*(1). Retrieved February 10, 2005, from www.symposion.com/ijt/ijtvo06no01_01.htm

6 Harry Benjamin International Gender Dysphoria Association. (2001). *Standards of Care for Gender Identity Disorders* (6th version). Retrieved February 9, 2005, from www.hbigda.org/soc.cfm

related resource

(2004/05). Over the rainbow: Issues in sexual orientation and gender. *CrossCurrents: Journal of Addiction and Mental Health, 8*(2). Centre for Addiction and Mental Health, Ontario. Articles look at youth suicide and discrimination, homophobia, gender reassignment surgery, substance use and the gay club scene, and services for the LGBT community.

resources available in BC

BC FTM Network at ***bcftmnetwork@off-gridsolutions.ca,*** or call 604-255-2313.

For youth seeking FtM-specific peer support

- Trans Alliance Society of BC at ***www.transalliancesociety.org***
- Transgender Health Program (THP) of Vancouver Coastal Health Authority provides the following:
  - Information on service providers at ***www.vch.ca/transhealth/resources/directory***
  - Youth-specific electronic services at ***www.vch.ca/transhealth/resources/links/peer.html#peeryouth***
  - FtM-specific health information at ***www.vch.ca/transhealth/resources/links/healthinformation.html#healthftm***

  Contact the THP at ***transhealth@vch.ca,*** or call toll-free in BC at 1-866-999-1514

damian's story: strength in gentleness

Chronic depression caught up with me when I was about eleven. I never sought help. I just coped with it until my early forties. During puberty my sense of gender was not clearly masculine—I just thought it was my fault I was failing as a girl... Being female was something I thought you had to learn and I just hadn't learned it yet. So I started to deliberately watch how women behaved. ... From that time until I started to transition I carried a conversation in my head: "I'm being seen as a girl/woman—What is the most appropriate female response I can give in these circumstances?" I didn't even know that filter was there until it stopped. ...

I had been woman-attracted since my early adolescence but I buried that. I didn't do anything about it until I was about forty. But I didn't know what to do. I had never connected with the lesbian community. ... Instead, I joined the Anglican gay group Integrity. They were all men and they kept wondering why I stayed. But I liked being with them.

Some of my depression started to lift in these years. Well! A person can only live so long working full time, so busy they never eat properly, get only 3–4 hours sleep a night, using energy to live with a chronic illness [arthritic disorder], before something gives way. I'd done this for year and years. In 1995, my health collapsed and I was forced to drop everything except work. Suddenly the carefully constructed world of external definers disappeared out of my life. I was left too weak to run away anymore....

I had been constructing myself externally from the outside-in for so long that it took a lot of courage to accept this was coming from the inside and I could trust it. First I asked "Am I a man or a woman?" Then when I had to accept that I was a man, I faced the worst part of the transition. I felt that I had totally failed...But I couldn't stop, because it felt more and more right, comfortable, real, me. Then I asked, "But if this is me, then who am I as a man?" Finally I realized I had absorbed role models as a kid and that energy was already part of me. The men I felt close to were kindly, gentle, generous people. That spoke to the core of who I am. ... When I was able to accept that there is strength in gentleness, then I was ready to do the external transition...

When I started the transition I started questioning the rigidity of the binary—the concept that there are only two genders and we fit into either one or the other. I used to talk a lot about "queering the binary" and suggested we are all in the middle, that everybody has a bit of both genders (and a bit of both sexual orientations). I think that's a necessary dialogue, but right now I'm happy with the binary for myself. "Transsexual" implies a rigidity, moving from one side of the binary to the other. For that person the middle ground is not comfortable. And that's me. I don't really want to keep coming out as a "trans." I just want to live as a man now.

The gains have been overwhelming. I work with the public and have had dozens of encouraging comments from them and from co-workers. Most friends and acquaintances have been so affirming. My partner, whom I met in 1996, has been a daily companion and champion. And finally, I feel good about myself, comfortable about myself. No need to pretend anymore. Depression's gone. My life is much more balanced. I feel ordinary, content. Now I'm simply one more little guy in the world doing his bit to make the world a better place.

Excerpted with permission from Cross, K. (2001). The Trans Biography Project: Stories from the Lives of Eleven Trans People in BC. *Vancouver: Women/Trans Dialogue Planning Committee and Trans Alliance Society. Available at www.transalliancesociety.org/education/*

Damian is a 53-year-old transsexual man. He began his transition in 1995 and is now legally male.

Extreme Kindness and Mental Health

Brad Stokes-Bennett

Brad is a member of the Victoria-based Extreme Kindness Crew. Along with Erik Hanson, Val Litwin and Chris Bratseth, he has co-authored Cool to Be Kind: Random Acts and How to Commit Them
www.extremekindness.com

The Extreme Kindness Crew is in the business of making people feel good. It is a group of four young men based in Victoria who, after September 11, 2001, decided to empower themselves and the people around them with simple acts of kindness.

As a member of the Extreme Kindness Crew, I have discovered the power that "extreme kindness" has in contributing to the welfare of a person's mental state.

As a young man, my personal peace of mind was often directly related to my physical and recreational activity. By challenging myself with surfing, climbing mountains, snowboarding, sailing or even just running long distances, I tapped into a powerful force, which I now call the "extreme." The extreme can also be found in many other ways: reading a book, watching a movie, dancing or writing a poem. When studying English literature at the University of Victoria, I found reading and writing certain types of poetry an incredible way to connect to the extreme. I learned more and more that the extreme can always be found in the same places you find your passions.

By pairing the two energies of extreme and kindness, we in the Kindness Crew have been able to sustain our mental health and well-being while taking on the huge challenge of connecting the world through kindness. We make sure we are always being true to our passions in life, and at the same time, we are making our planet a better place to live.

Kindness is a universal language that can be used to connect our world—an invisible thread tying each living person together. It is defined in every language and culture, and the core definition usually includes generosity, helping and giving to others. It is a simple and powerful social tool that bridges the gaps between all the cultural and legal borders of the world's nations.

Kindness and the opportunity to perform random acts of kindness can be found everywhere—you just need the right perspective to see them.

We have come to realize that giving back to the community has the potential to be both fun and exciting. Being a kind person does not mean you have to sacrifice anything, but instead can result in incredible adventures and great stories. There can be no better way to interact with your world and the people you meet in it.

By committing to extreme kindness you give yourself the power to improve your life and the lives of everyone you meet. You allow positive energy to enter your thoughts on a constant basis, creating a healthy mental state. And you come to realize that you have personal control over how you are feeling day to day. If someone treats you badly or bad luck falls at your doorstep, all you have to do to improve your situation is to perform an act of kindness.

I definitely believe that our group can impact the lives of young men in particular. The Extreme Kindness Crew members serve as positive role models and set healthy examples for other young men to follow. We are living proof that kindness can be fun, healthy and empowering for young men. Being kind is an important part of being a balanced, strong and powerful young male. You don't have to be mean to show your toughness and masculinity. The extreme in all of us is best utilized in the positive sphere of our thoughts and actions. i

Postpartum Depression
In men?

Laurynas Navidauskas

Laurynas is an undergraduate film and political science co-op student from Simon Fraser University. He currently works in the Public Education Department of Canadian Mental Health Association, BC Division

Picture a scenario: you and your partner start sharing your life, and before you know it, there are three of you—her, you and a little screaming bundle of joy. You should be happy, the happiest dad in the world—after all, the little human creature is your flesh and blood, your successor—but instead, you feel empty inside. Why?

Postpartum depression, a term usually heard in a context of a new mother, does apply to males as well. Although this kind of depression in fathers is a debated issue—with many professionals arguing that 'proper' postpartum depression has a hormonal factor that doesn't apply to males—even the opponents of the term concede that many new fathers experience the 'baby

blues' during the first months after the birth of a child. While these changes are not triggered by the physiological processes in the father's body, they can nevertheless have consequences as serious as a mother's postpartum depression.

Depending on the definition of depression used, various studies and surveys show depressive symptoms in new fathers ranging from 2%[1] to 9%,[2] to a whopping 49%.[3] A significantly higher level of symptoms is observed in big, urban areas, or in the cases of being a stepfather or a single mother's partner.[4] The signs of postpartum depression are:

- feelings of overwhelming responsibility and fear of failure
- loss of sleep and appetite
- withdrawal, disregard to personal hygiene
- feelings of sadness and emptiness
- inability to concentrate, irritability, restlessness
- loss of sex drive
- physical aches and pains[5]

There are many factors contributing to a new father's mood impairment. Some of them are associated with the new responsibilities fathers face, such as having to provide income for the partner and the baby,[6] and the anxieties about the social role of a father.[7] Other strong sources of paternal worries: the health and well-being of the mother and the child, the changes in relationships between a husband and a wife, and, upon the arrival of the next generation, the realization of one's own mortality.[6] This stress is often further complicated by social stereotypes of a male, who is supposed to 'be strong'; the new father is unlikely to share his concerns with others.

Although most fathers will experience some kind of anxiety during the first year after the birth of a child, the severity of the symptoms can be significantly decreased through maintaining a healthy lifestyle. Distress can be alleviated through social support and through interaction with the baby. Psychologists suggest that mothers encourage fathers to talk to the baby before the birth, let them touch Mom's belly to feel the baby kick, and allow fathers to spend time alone with the baby as much as possible after the pregnancy.[6]

Fathers should be encouraged to continue their previous hobbies, exercise and maintain a healthy diet. Foods rich in tryptophan, such as turkey, milk and bananas, as well as foods with omega-3 fatty acids, such as lake trout and salmon, will increase the levels of the 'feel-good hormone' serotonin. Similarly, it is believed that a high-fibre diet decreases stress levels and leads to a more positive attitude.[5]

Furthermore, a new father's increased social interaction, such as sharing experiences with other fathers, might prove to be very useful, while others suggest that sharing the feelings with the mother is always the best solution.[7] It is important, however, to also be mindful of the mother's mental health—as research shows, the partners of fathers with a postpartum depression are two or three times more likely to also suffer from a postpartum mood disorder, compared to the partners of fathers who are not distressed.[1]

Unfortunately, these preventative measures are not always successful. If symptoms persist, the new father should consult his family doctor or mental health professional. In some cases, antidepressant medications, counselling and psychotherapy may be necessary. To some, these measures may seem far-fetched, but they are a very small price to pay for bringing joy and understanding into new-family life. i

footnotes

1 Matthey, S., Barnett, B., Howie, P. et al. (2003). Diagnosing postpartum depression in mothers and fathers: Whatever happened to anxiety? *Journal of Affective Disorders, 74*(2), 139-147.

2 Ballard, C.G., Davis, R., Cullen, P.C. et al. (1994). Prevalence of postnatal psychiatric morbidity in mothers and fathers. *British Journal of Psychiatry, 164*(6), 782-788.

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4 Miller, K. (1998). Depression in men before and after the birth of a child. *American Family Physician, 58*(7), 1670.

5 Ewing, S. (2004). *When men get the baby blues*. Retrieved February 9, 2005, from www.handbag.com/family/health/maledepression

6 Shapiro, J.L. *Seven fears expectant fathers face*. Retrieved February 9, 2005, from www.babycenter.com/refcap/pregnancy/expectingdads/8247.html

7 Kleiman, K. *Ask the experts: Can men get the postpartum blues?* Retrieved February 9, 2005, from www.babycenter.com/expert/dadsbaby/3870.html

related resources

www.fathermag.com
www.fathers.com
www.dadscan.org

Men Have Eating Disorders Too

A retreat approach

Gary Holdgrafer

Gary is a residential facilitator at BridgePoint Center for Eating Disorders in Milden, Saskatchewan. For more about Gary, visit www.exploringcreativity.com

I looked around the circle of men the first evening of a weekend retreat. I wondered about the personal challenges each man was coping with by eating too much, too little or by bingeing and purging.

These men all had unhealthy relationships with food, and had been labelled as having eating disorders. However, I saw them as people who had troubled spirits in their various-sized bodies. This article is not about eating disorders in men, but about men who have eating disorders.

Men's retreats are offered at BridgePoint Centre for Eating Disorders, a residential program in Milden, Saskatchewan. I facilitate those retreats.

Asking for help

The men had gathered courage to attend. Their presence was a plea for help with a personal situation they could not solve. Each had taken the risk of placing himself in the vulnerability of an unfamiliar experience. It was a sign they were ready for more healthy lives.

The men had expectations of how the retreat would unfold. They looked to me for answers. I believed each man would discover for himself what worked best. I modelled that process. I admitted my nervousness about starting a retreat and recognized that they felt the same way.

A man talking about his feelings is not typical. It was not in their picture. I wanted to separate myself as a person from the leader role and their expectations of it. My message was: "Talking personally with other men is okay here."

Safety was important. These men might fear criticism for acting differently from the conventional ideas of manhood. Confidentiality was emphasized to ensure safety. The rule was: What happens here stays here. Trust developed as they got to know each other.

Building community

Speaking to strangers, personally or not, is frightening. Each man introduced himself briefly and included an amusing personal experience. Laughing created feelings of safety, which produced more laughter as the men relaxed.

They organized into pairs and discussed questions on personal issues such as where they were stuck or what was going well. This was an opportunity to relate to other men in a personal way as they shared experiences. They talked more in these pairings than in the group.

The men came together as a whole group to end the evening. They each 'checked out' with a sentence describing how they felt. This brief, personal sharing by each man in the presence of the others provided me with a status report.

I wanted them to bond into a supportive community of men working together. Bonding results in mutual acceptance and willingness to listen to and learn from each other. Each man acted as a witness to the personal sharing of every other man.

Rather than living in the silence of withdrawal, being seen and heard by other men who were compassionate witnesses was important to their personal growth. In the residential setting, the men continued to bond after the session ended.

Getting down to work

Personal stories were shared in the group the following day. This was an important experience of being witnessed. I had spoken first, about the significant events in my life and how they influenced my default responses to life situations.

Default responses are automatic. Little thought is given to other choices that might be healthier. Primary defaults among these men, in response to personal pain, were unhealthy eating and withdrawal. Their ways of coping, reinforced by self-limiting beliefs like low self-worth, had become habitual as the only choice.

Self-worth was an issue. They expressed difficulty in hearing positive comments about themselves from others. They were anxious when asked to write, and then read aloud, a list of positive comments about themselves.

The men participated in a variety of activities. They were playful. They were serious. They experienced self- care in soothing meditations.

Each man shared what he had noticed about himself in the activities. I encouraged personal awareness of their default responses. Asking them "How is that like your life?" emphasized the similarities that exist between responses in a retreat and in life.

My approach was responsive. I listened and offered feedback. Timing is important. Suggestions are useless if the listener is not ready to hear them—particularly new choices to defaults, as defaults are not surrendered easily. To stay personal with the men, I used my life experiences as the basis for my feedback.

Ending is the beginning

The retreat ended with each man stating what he had learned and a manageable change he would make. They left in greater spirits, having stretched themselves, never to be exactly the same as when they arrived. Each had taken an important step on the journey that is less about food and more about life.

Men's Empowerment for Learning and Living

Leanne McKenna

Leanne is Business Manager and Acting Program Director, Funded Programs, for Jackson-Murray Consultants Inc.

In 1999, the Provincial Men's Committee (now defunct) was formed in British Columbia to address concerns related to men-specific alcohol and drug treatment issues. Their mandate was the achievement of high-quality, accessible and gender-specific treatment and prevention services for men experiencing, or at risk of, substance misuse. The committee was comprised of 11 members who, through collective wisdom and personal and professional experience, contributed to the development of addictions treatment for men in BC.

One of the premises underlying the development of a men's gender-specific program was that there was a growing consciousness, and awareness at the biopsychosociospiritual level, of changes in concepts of manhood. The committee was concerned with the relevance of these changes to the treatment of addictions at all stages of the lifespan.

Through the development process, it also became apparent that the profile of male clients in addiction services had changed; i.e., there was more injection and poly-drug misuse, and a lower age for the predominant treatment group.

Recovery from addiction requires both a range of external changes in an individual's behaviour and a range of changes in each individual's internal world of feelings, feelings about feelings, perceptions, expectations, and yearnings—in their deepest sense of self.

What a man shows in the external world may not be a true reflection of his internal world; the expression may be coloured by external messages about how an individual or a group of individuals think the world wants men to be. Messages received from family, friends, teachers, and media influence how men behave, including their relationship to alcohol and other drugs. The messages are different for men than for women.

Armed with this knowledge, the committee endeavoured to capture the success of other gender-specific programs, such as the WELL (Women's Empowerment for Learning and Living) Program, by developing the MELL (Men's Empowerment for Learning and Living) Program.

The MELL Program

The MELL Program was specifically designed to approach addiction and recovery from the perspective and experience of being a man. Program objectives are to provide effective, innovative and flexible treatment programming that would allow men to participate in intensive addictions treatment within their own communities while maintaining their family and social responsibilities. MELL offers the opportunity for men to participate with other men in examining and experiencing their addiction and recovery in the context of being a man. It is co-facilitated by men to help group members learn to trust and speak freely with other men.

MELL is a highly structured, intensive psychotherapeutic program delivered in 25 sessions. If needed, three of these sessions allow participants and facilitators to focus on particular modules or issues that may become relevant to a given group.

The MELL Program is for adult males 19 and over. The intensity of topics and material covered in a group setting requires clients to be in second stage recovery (approximately two months of abstinence) rather than early recovery. Abstinence is required for the duration of the program, for the benefit and safety of all group members, and because the nature of the material and depth of the experiences may trigger covert issues. If clients are prescribed medication or are under a doctor's care for methadone maintenance, the acceptance criteria would also include client stabilization and the ability to participate in the group process.

In the spring of 2001, Jackson-Murray Consultants, a Surrey-based addiction counselling and treatment agency, was one of five BC based organizations awarded the opportunity to deliver the pilot program. Each of the trials was independently evaluated to ensure program content and appropriateness, keeping within the original mandate of the Provincial Men's Committee.

Since then, Jackson-Murray has continued to deliver the MELL Program. It is currently offered four times a year, on a mobile basis, throughout the Fraser Health region. Offered as either a day or an evening/weekend program, the delivery times and dates are based entirely on client need.

The success of MELL is contingent on the progress made by each individual group member. Staff are thrilled with the positive feedback that continues to come in from participants.

The MELL Program is funded by the provincial Mental Health and Addiction Branch, through the Fraser Health Authority. For more information on MELL, contact the nearest Fraser Health mental health outpatient clinic (see www.fraserhealth.ca/about/facilities/facilites-list.asp), or Jackson-Murray Consultants at 604-589-7080 or toll-free at 1-800-668-3205

Wellness Gathering

Contributing to the mental health of First Nation men

Brian Muth

Brian is an Aboriginal mental health liaison worker employed by Stó:lo Nation Health Services in Chilliwack, which serves First Nations, Metis and Inuit individuals within the Fraser Health Authority. Brian has a BA in counselling and a Community Mental Health Certificate from Douglas College. He is the father of three children who are members of the Tzeachten First Nation.

The following article is based on personal experience and the results of interviews with First Nation men. These individuals comprise staff with Stó:lo Nation, as well as consumers of mental health services offered through Stó:lo Nation Health Services and other community mental health centres. Specific clients are not referred to by their actual names to protect anonymity and the privacy of their families and communities.

"The Men's Wellness Gathering saved my life," commented Bill, a First Nation band member. He was referring to a gathering of 40 Aboriginal men from various communities throughout BC. This was the eighth year of such a gathering. Sponsored by Stó:lo Nation Health, it is held annually in the fall at various locations throughout the Fraser Valley.

To many, this gathering, which specifically addresses the mental health and wellness needs of Aboriginal men, has become one of the most significant programs offered by the Stó:lo Nation.

The planning committee, chaired by health director Brian Williams, includes men from Stó:lo Nation Health, Community Development, Xyolhemeylh Child and Family Services and the Indian Residential School Survivors Society. The various gathering topics throughout the years have included addictions, residential school issues, mental health, family and relationships. Activities include guest speakers, healing circles, sweat lodges, drum making, carving, canoeing, slahal games, drumming and singing, storytelling and nature walks. This year's gathering, held at a conference centre called Sts'ailes Lhawathet Lalem (Chehalis Healing House) on Chehalis First Nation land, focused on the impact of the residential school experience on the individual and family.

On the third day of this most recent gathering, depression and anxiety screening was offered to the participants and staff. This screening was administered by me and two of Stó:lo Nation's addiction prevention counsellors, Lawrence Roberts and Pat Walsh. This was under the auspices of the annual, provincial Beyond the Blues: Depression Anxiety Screening and Education Day project of the BC Partners for Mental Health and Addictions Information (for more information, see www.heretohelp.bc.ca/events.)

At first we weren't sure how the screening would be received, but the response was overwhelming. The context of the gathering had created a sense of safety; it was a good place to focus on emotional well-being. Staff, clinicians and participants all lived, shared meals and participated in activities together, which strengthened relationships and resulted in a high level of trust. Individual screening interviews went longer than expected as the men opened up and talked about their lives in ways they hadn't done before.

When discussing the screening in a later interview, Lawrence (counsellor and Tzeachten First Nation member) mentioned, "Men felt safe, and the atmosphere of openness created an interest to learn more about themselves. The screening and interview provided a good mirror or reflection and gave extra one-on-one attention. This individual sharing, in turn, helped them gain confidence to share in the larger circles and gave a sense of hope knowing that help and support is available."

Lawrence went on to comment that the assessments seem to be designed for a primarily non-First Nation target group, so it may be more difficult to get an accurate assessment. Some First Nation individuals may score high on the depression/anxiety scale, but are nevertheless functioning well because they have supports. These supports are primarily cultural and spiritual in nature and involve traditional methods of processing unresolved issues. They include healing/talking circles, prayer, sweat lodges, ceremonies, gatherings, and work with spiritual healers.

In addition to traditional methods, other therapies also provide ongoing support. Bill, who admitted to feeling depressed and suicidal prior to the gathering, completed the screening and interview. He shared this experience: "After, Lawrence came to my house and offered more counselling by a therapist. I was feeling better after the gathering, but didn't want a relapse so I agreed. Seeing Terry since October has really helped me get emotionally stronger…helped me and my family."

When Aboriginal men discuss addiction, substance misuse and mental health issues, the conversation always moves to the sources of these problems: identity issues, lack of purpose, little sense of belonging and difficulty communicating emotions.

Lawrence noted that many problems facing Aboriginal men are results of the residential school experience, both directly and generationally. Many men struggle with feelings of isolation; they feel that they just don't "fit" anywhere. They experience difficulty dealing with emotions, communicating, and nurturing healthy relationships. They have difficulty admitting problems in general and don't want to appear weak.

Bill agreed that a challenge facing Aboriginal men is "talking about it…for years we never talked about

it—emotional issues. One main reason men use and abuse, and experience depression and suicidal thoughts, is the inability to deal with past issues. These are issues related to family and effects the residential school had on parents."

Leslie Williams, the post-secondary education coordinator with Stó:lo Nation, is from Skwah First Nation in Chilliwack. He agreed that much of the addiction and other mental health issues are related to historical family issues and problems in present relationships. "They don't know who they are and where they come from. Many who were separated from parents, family, culture, language and community and placed in residential schools or non-Native foster homes don't know their identity, roles, gifts, spiritual and cultural values; don't know where they belong and have little knowledge about how to find out. Fear holds many men back."

Gatherings such as the Men's Wellness create a good place for men to begin their healing journey. Such places are important for Aboriginal men because they provide an opportunity for the men to face their fears in a safe atmosphere. They can look at the deeper issues that may have contributed to addictions and other mental health problems.

Sharing circle: Herb Joe, Traditional Counsellor for Sto:lo Nation's Xyolhemeylh Child and Family Services Dept. (standing) and Darren Charlie, Group Facilitator

John, who has attended for four years straight, explained, "Listening and sharing are the keys. For many men, it is the first time they have been able to share or talk about the 'real' life story beyond just surface stuff—jobs, money, hunting, fishing, cars, trucks and other things. Part of healing is talking about it, grieving it and letting it go…don't carry it. The ultimate thing is to go back and feel it in a safe environment, with others who talk about and share the same…gives the ability to deal with it in a good way."

Lawrence, who has been on the planning committee for the last five years, agreed with John and added, "The Gathering helps men get in touch with themselves and increases pride and sense of value through discovery of self, identity and culture. It seems to always go back to self-esteem and self-respect. This builds up courage to face the difficult issues in life. I've seen this increase in courage for those who keep coming back. The being together as a group creates a family atmosphere as we grow and bond together. Spending time together doing different activities creates this bond and trust—drumming, singing, drum making, carving, canoeing, healing circles, nature walks, sweats, speaking with elders, meals together, workshop and keynote speakers, storytelling and laughter."

Leslie presently works with young men who come for education support. "Many have no idea who their family is or who they are connected to, and although they may be able to achieve academically, an inner emptiness remains," stated Les. He went on to discuss the work that is accomplished at the gatherings: "New connections and 'family' are made at these gatherings. Men leave stronger, with a sense of mutual responsibility. They become part of each other. The circle is like family and the sense of common experience gives strength and hope."

Strength and hope is the common message I hear from Aboriginal men who attend men's healing gatherings. This is summarized by the Men's Wellness Gathering logo—the Wellness Salmon, drawn in 2000 by Craig Ned, a Stó:lo artist and carver from Sumas First Nation.

The salmon represents a continuous striving and succeeding against all difficulties. The three faces represent the faces of Aboriginal men 'getting better.' The first one is sad and depressed, the second one is feeling better, and the last one represents a happy man. The inspiration for the last face comes from the 'winning' symbol used in the First Nation game of slahal.

Within Aboriginal communities, healing involves balance: physically, mentally, emotionally and spiritually. Basic to this healing are elements of safety, responsibility, respect and cooperation. The Men's Wellness Gathering and other healing gatherings for men provide many of these elements and an opportunity to address deep issues of identity, purpose and belonging. i

Gayway
Supporting gay men

Gayway volunteers at Vancouver Pride Parade, August 2004

Phillip Banks

Phillip is Director of HIV Prevention at AIDS Vancouver and coordinates Gayway, AIDS Vancouver's gay men's health program. He has worked in community development and health promotion for over a decade

For more information visit Gayway at 913 Davie Street in Vancouver, from 10:00 a.m. to 4:30 p.m. Monday to Friday; or check out www.gayway.ca

The days of HIV disease being treated as the only health issue of importance for gay men are over. For a number of years now AIDS, Vancouver has been looking at health and gay men through a broader lens: one that encompasses more than just physical illness and disease and that acknowledges more complete and complex individuals and communities.

In the mid '90s, AIDS Vancouver's HIV prevention program, Man to Man, shifted from focusing on how individuals' behaviours put them at risk for HIV, to also looking at gay men as a group. This shift helped us understand that, as a group, gay men may have common issues that could be addressed by focusing on factors making them vulnerable to HIV disease. Things like homophobia and social status need to be addressed just as much as an individual's specific behaviours (e.g., whether or not he uses condoms) when doing HIV prevention. So do issues like drug use and mental health. We shifted our name to Gay Men's Health Programs.

In early 2003, Gay Men's Health Programs moved into a storefront office space on Davie Street and changed its name once again, this time to Gayway.

Gayway is a health promotion program for gay men, which provides opportunities for the men to share their experiences, skills and resources with other men in order to build healthier communities. The program offers training and support for gay men to enhance or learn skills they can share with the community in the form of workshops and discussion groups. The groups cover a whole range of activities and issues. Some of the groups offered early in 2005 included financial management, goal setting and time management, a writer's workshop, a book group, a knitting group and a support group for men with sexual addictions.

Gayway also develops educational materials such as pamphlets and brochures that paint the big picture of what health means and provide information to help gay men better understand and address various issues. We also produce a small magazine called Gayze. Four times a year, a group of volunteers put together personal stories, health information and fun facts and images and distribute it throughout Vancouver.

A peer counselling and support program called Coffee Talk is provided via trained volunteers. We offer it face-to-face and over the Internet through local chat rooms. Peer counsellors listen to men talk about whatever they feel like talking about, and information and referrals to other services in the community are provided.

In the last year we've developed two health promotion campaigns. The first one was sent out across the country. It looked at the things gay men are already doing in big and small ways to create community and positively impact their health. The other was an HIV prevention campaign focused here in Vancouver that looked at how assumptions some gay men make about the HIV status of their partners can lead to choices that put them or their partners at risk for HIV infection.

But there is still much work to do. Mental health issues in the gay male population are often talked about, but rarely addressed at the community level. The prevalence of depression and anxiety within the gay male population is said to be higher than in the general public. Some explanations suggest homophobia and heterosexism are factors. Things like social and religious discrimination and a lack of family and institutional support are some of the psychosocial causes of depression and anxiety among gay men.

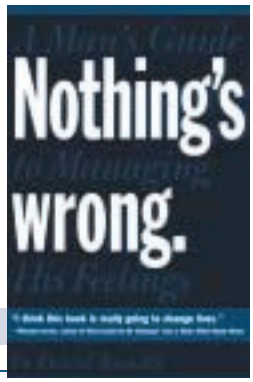
HIV disease can also contribute to depressive illness. Some people see depression in people living with HIV as a reaction to being diagnosed with the infection. Depression can be related to HIV, specific HIV-related disorders, or medication side effects. Gayway encourages men living with HIV to speak openly with their health care practitioners about any symptoms they experience that could lead to an accurate diagnosis and appropriate treatment of mental health conditions.

Gay men, like everyone else, experience a range of mental health issues. We require mental health services that acknowledge and validate our complete identities and deliver services in environments free of homophobia and discrimination.

Similarly, the gay community needs to work harder to recognize and include gay men with mental health issues as important members of the community. Working together we can continue to create communities that will support all of us in living healthier, more vibrant lives.

Nothing's Wrong

A man's guide to managing his feelings



By David Kundtz. Boston, MA: Conari Press, 2004. 155 pp. Review by Aaron White

During the first session of a community college course on masculinity that I was teaching, I asked the men why they had come, and I will never forget what one middle-aged man said. "My wife pushed me to come. She's always bugging me, asking me to tell her what I am feeling. And I'd love to. I just don't have a clue." The man was serious. Although a very competent man in most areas of his life, he did not know how to even begin to share his feelings with the person he was closest to in this world.

Many women can relate to this man's wife, and many no doubt share her frustration over trying to deal with men and their emotions. Men can appear stubborn and mulish, but the reality is that most men simply have not been taught how to identify, label and appropriately express their emotions. For many of us men, it is almost as if, when we look inside ourselves, we see a terrifying, black void. As a result, it is no wonder we would rather do just about anything to avoid dealing with our feelings. This emotional restriction causes tension between men and women, puts limits on the depth of our relationships, and sets men up to have considerable difficulty dealing with mental health issues. After all, it's pretty hard to manage feelings of anxiety or depression if you have zero practice in talking about what is going on inside your head and body.

To remedy this situation, David Kundtz has written *Nothing's Wrong: A Man's Guide to Managing His Feelings.* This is a book written for men by a man who appreciates and understands men. The author, a therapist who has worked for many years with men, explains that the book is "specifically designed for guys who never got a map for navigating the highways and byways of the emotional realm."

As the title, *Nothing's Wrong*, suggests, the author does not believe that men are inherently flawed beings who need to be taught what to feel. On the contrary, men are okay; they just need to be encouraged to understand and express their feelings in a way that is natural for them. Frequently, he says, this means paying attention to what a man is feeling in his gut, the place where many men seem to carry their emotions. Having stated that there is nothing wrong with men, the double meaning of the title also alludes to the large degree of defensiveness that is generated in so many of us men when the topic of feelings comes up, especially when women are the ones bringing up the issue.

Nothing's Wrong offers excellent descriptions of the ways that some men dissociate from their emotions. It also provides an interesting description of the dominant ways that men tend to deal with their feelings. For example, many men are more comfortable expressing a feeling through action (such as engaging in an activity with a friend) rather than by talking about the feeling. And often men are more comfortable if they can discuss things logically. But while the author is careful to not criticize men for their preferred methods of dealing with emotions, he explains extensively why it is in men's interests to learn other ways of attending to their own feelings and the feelings of others.

To assist the male reader, the book offers a simple three-step process for how a man can learn to notice a feeling, name the feeling and express the feeling. He offers useful suggestions for how a man can work his way through each step in the process.

Because the author's appreciation of men comes across strongly, the book will be user-friendly for the average man. As such, it would make an appropriate present to give to an adult or adolescent male in your life. It would also be useful for counsellors to assign to men as homework reading.

Nothing's Wrong fails in one aspect: it skirts around the issue of men's anger, the one emotion that most men have plenty of familiarity with. My clinical experience is that many males (especially adolescents) tend to be able to identify anger quite easily, most likely because they perceive anger to be the only emotion that society allows a man to feel. As a result, I see many men bypassing the less 'manly' emotions of fear or sadness and flashing quickly to rage instead.

In working with men, I have repeatedly found that almost all men can be successfully taught to identify the other feelings that usually accompany or precede the anger. With effort and guidance, men can learn to slow down and think about all of the other feelings they are experiencing besides anger. It would have been helpful if the author had included a section helping men to do this on their own. Despite this oversight, *Nothing's Wrong* remains a welcome addition to the self-help guides out there, especially as most of those guides are written for women.

Aaron is Guest Editor for this issue of Visions. *See his editorial and bio on page 4*

General Mental Health

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- Men's Health Information and Resource Centre, Australia. Several helpful resources including *Men, Mental Health and Cultural Diversity, Separated Fathers and Mental Health,* and *The Relationship between Elderly Men, Aged Care and Depression.* Go to menshealth.uws.edu.au and click on 'On-line Articles.'
- Stewart, G. (2002). Men's mental health [fact sheets]. MIND: UK National Association for Mental Health. See www.mind.org.uk/Information/Factsheets/Men
- Psychology of Men and Masculinity. Relatively new academic journal. See www.apa.org/journals/men or call 1-800-374-2721 to subscribe.
- Brooks, G.R. & Good, G.E. (Eds). (2005). The New Handbook of Psychotherapy and Counseling with Men: A Comprehensive Guide to Settings, Problems, and Treatment Approaches. Revised and Abridged from the Previous Edition. John Wiley & Sons Canada.
- Kennedy, H. (2001). Do men need special services? *Advances in Psychiatric Treatment, 7*(2), 93-99. Fulltext online at apt.rcpsych.org

this list is not comprehensive and does not imply endorsement of resources

don't forget all the resources listed at the end of Visions articles as well

Addictions

- Zelvin, E. & Straussner, S. (Eds). (1997). Gender and Addictions: Men and Women in Treatment. Jason Aronson.
- Alberta Alcohol and Drug Abuse Commission. (1998). Anger and Addictions. *Developments, 18*(2). Online at corp.aadac.com/services/developments_newsletter
- Singer, J.A. (1997). Message in a Bottle: Stories of Men and Addiction. Free Press.

Mood Disorders

- Cochran, S.V. & Rabinowitz, F.E. (2000). Men and Depression: Clinical & Empirical Perspectives. Academic Press.
- Mayo Clinic. (2004). Male depression: Don't ignore the symptoms. Go to www.mayoclinic.com and click on 'Men's Health' under 'Healthy Living Centers.'
- Lynch, J. & Kilmartin, C.T. (1999). The Pain Behind the Mask: The Origins, Consequences, and Remedies of Masculine Depression. Haworth Press.
- Real, T. (2005). I don't want to talk about it: Overcoming the secret legacy of male depression. Augsburg Fortress.
- Men Helping Men with Mood Disorders. maledepression.com

Body Image and Eating Disorders

- Andersen, A., Cohn, L. & Holbrook, T. (2000). Making Weight: Healing Men's Conflicts with Food, Weight, Shape and Appearance. Gurze Books.
- Pope Jr., H.G., Phillips, K.A & Olivardia, R. (2000). The Adonis Complex: The Secret Crisis of Male Body Obsession. Free Press.
- Phillips, K.A. (1997). The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder. Oxford UP.
- Luciano, L. (2002). Looking Good: Male Body Image in Modern America. Hill & Wang
- Krasnow, M. (1996). My Life as a Male Anorexic. Haworth Press.

Boys

- Douglas, S. (2004). Dude, What's Your Mood? A game by a Canadian clinical counsellor that could be useful for talking with boys about their feelings. See www.familycounselling.net/DudeWhatsYourMood.html
- Horne, A.M. & Kiselica, M.S. (Eds). (2000). Handbook of Counseling Boys and Adolescent Males: A Practitioner's Guide. Sage Publications.
- Kipnis, A. (1999). Angry Young Men: How Parents, Teachers, and Counselors Can Help 'Bad Boys' Become Good Men. Jossey-Bass.

Abuse

- Lew, M. (2004). Victims No Longer: The Classic Guide for Men Recovering from Sexual Child Abuse. Perennial Currents.

National Clearinghouse on Family Violence, Public Health Agency of Canada. (1991-2004). Intimate Partner Abuse Against Men. A great collection of discussion papers and services directories for abused men and boys. See www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/maleabus_e.html

Dorais, M. (2002). Don't Tell: The Sexual Abuse of Boys. McGill-Queens University Press.

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