

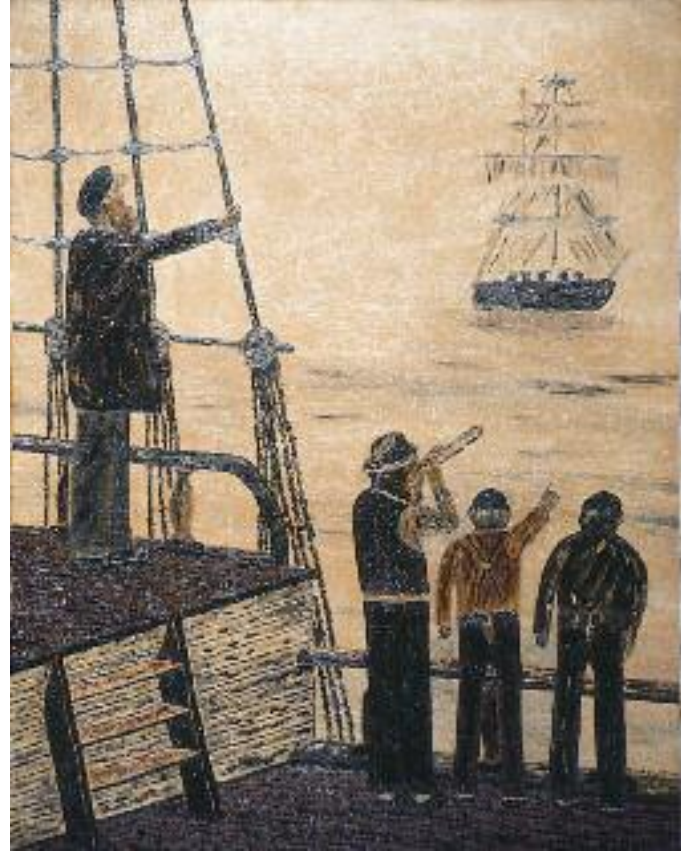
crosscurrents

SUMMER 2010
VOL 13 NO 4

The Journal of Addiction and Mental Health

TOUGH GUISE

Reaching out to men



“OUR MEN HAVE LOST THEIR PLACE”

Aboriginal men’s shelter guides
men on healing path

A ROOM OF THEIR OWN

Men’s sheds build communities
of support and purpose

FROM ABUSE TO ADVOCACY

One couple’s story of
the power to change

FATHERS ON THE SIDELINES

Depression can strike new dads –
but where can they turn?

**The “psychotic
psychologist”**
Fighting stigma
from within

**Telling
their stories**
Women find their
voice through writing

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Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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Ghost Ship, Raymond Wasilczyk, oil on canvas, 16" x 20"

Raymond is a self-taught artist who paints in oils and acrylics. His artwork has appeared in the Being Scene exhibition through Workman Arts at the Centre for Addiction and Mental Health in Toronto.





Whose health should we worry about most – men’s or women’s? Feminists have long called for more sensitive and appropriate health care for women. Yet around the world, men die sooner than women. They have higher rates of smoking, alcohol use issues and heart disease. And they are much more likely to kill themselves.

But it’s not a matter of competing interests. If a gender perspective reveals inequities for women, it can also identify areas of concern for men. Research shows that biological and socially constructed differences between women and men contribute to gender differences in the nature of health problems, health-seeking behaviour and responses of health care providers. The men’s health movement that emerged in the 1990s owes a debt to feminism, which developed this gendered way of looking at the world. So the point isn’t to determine who is more deserving of attention. The point is that both men and women suffer when health care professionals and policymakers fail to understand how gender influences health and health care.

This issue of *CrossCurrents* examines male experiences of mental health and addiction issues. It also explores unique opportunities to meet the needs of men. Our stories cover depression and masculinity, as well as depression among new fathers. And speaking of fathers, we profile a unique smoking cessation intervention that targets new dads – a departure from the traditional focus on mothers and smoking. You can also read about an Aboriginal men’s shelter, where our writer spent an inspiring day with staff and some of the men. You can also take inspiration from a story about men’s sheds, a growing movement in Australia that holds promise for promoting men’s well-being beyond that country’s borders. Another story profiles a “power couple” that went from abuse to educating and counselling others about domestic violence. Finally, turn to the Last Word column, where Ramona Alaggia, a social work professor at the University of Toronto, tackles the “gender symmetry” debate around male victimization.

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Check out *CrossCurrents* on the web. You can participate in our discussion boards and comment on blogs. Visit us at www.camhcrosscurrents.net. Get involved and send us your ideas about how we can make *CrossCurrents* better.

Mad science

I came across the Ig Nobel Prize ceremony more than a decade ago, and some of the research still makes me laugh. Every year, researchers are granted awards similar to the Nobel Prize, but with the aim of honouring research that makes you laugh, then think.

Now in their twentieth year, the awards, presented by the *Annals of Improbable Research*, have real Nobel Laureates among the judges.

From the start, experimental psychology has been well represented. In 1993, an Ig was presented to John Mack of Harvard Medical School and David Jacobs of Temple University for their conclusion that people who believe they were kidnapped by aliens from outer space probably were. In 1994, Lee Kuan Yew, former prime minister of Singapore, won for his 30-year study of the effects of punishing three million citizens of Singapore whenever they spat, chewed gum or fed pigeons. In 1995, researchers from Keio University in Japan earned an Ig for training pigeons to discriminate between the paintings of Picasso and Monet.

After that sweep, psychology briefly fell out of favour until Justin Kruger and David Dunning won in 2000 for their landmark study, “Unskilled and Unaware of It: How Difficulties in Recognizing One’s Own Incompetence Lead to Inflated Self-Assessments.”

In 2004, Daniel Simons of the University of Illinois at Urbana-Champaign and Christopher Chabris of Harvard University earned an Ig for their study of inattention blindness. In that study, participants watched a short video in which two groups of people (wearing black or white t-shirts) passed around a basketball. Participants were given tasks, such as counting the number or types of passes made by the teams. Participants watched a number of short videos. In one video, a woman walks through the scene either carrying an umbrella or wearing a gorilla suit.

After they had seen the videos, participants were asked whether they had seen anything out of the ordinary. Surprisingly, 50 per cent did not report seeing the gorilla.

This was a classic Ig, because although it is funny, it makes us stop and think. The researchers stated that this finding shows we are wrong to think that important events will draw our attention away from everyday tasks. Perception is based on attention more than we think. This point is made repeatedly by people with lived experience of mental health and addiction issues, who claim that we as clinicians often miss what is important, although we complete our everyday tasks.

Visit the Ig Nobel website at <http://improbable.com/ig/> for more research to make you laugh – and think.

Kwame McKenzie, MD, MRCPSYCH (UK)

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Telling their stories: Women find courage and voice through writing

NORA UNDERWOOD

*By setting down in words
My thoughts, idea, reflection and memories
I can make sense of things and let go,
Release*

Through a song, letter, prose or a poem like this

(from “Food for Thought,” by Annalise)

Readings are a fairly commonplace occurrence in a city like Toronto. But the crowd gathered at a downtown Toronto public library has not come together for any ordinary reading. About 60 people mill around, preparing to celebrate the launch of a new magazine and a reading by several of its contributors. The excitement in the room – coming from both the writers and the audience – is palpable.

Called *Roots to Branches*, the magazine is the product of a 10-week pilot project – a writing group for women at Sistering, an agency that supports homeless, marginalized and low-income women. The creative writing workshop, called Sister Writes, was the brainchild of Toronto author and arts educator Lauren Kirshner, who wanted to find a way to help people in her community develop the tools to tell their own stories.

“The mainstream media says very little about the lived experiences of women facing poverty and mental health issues, and this near silence creates the illusion that these experiences do not exist,” Kirshner says. *Roots to Branches* “is one small step in filling in the many silenced, unexplored and unrecorded voices in our city.”

Supported by Sistering, the Toronto Arts Council, the Toronto Public Library and the Lawrence Foundation, the pilot was deemed to be such a success that two more groups have been added. Most of the women in the pilot say they will join in the second group. “It’s like a family,” says Emily, a woman in her 50s who came to Canada from an island in the Caribbean and who was the first reader of the evening. “You learn from the people, from their experiences. Taking from that helps you to write more, and more positive.”

Sister Writes participants celebrate the launch of the magazine *Roots to Branches*.



“More positive” is a necessity for most, if not all, of the women who pass through Sistering. “The majority of women who come here have suffered some kind of trauma – sexual trauma, violence – or have been marginalized because of their sexuality, their race, a disability, their age,” explains Carol Allain, Sistering’s drop-in services manager. Some of the 2,000 or so women who come through the doors every year have mental health issues or addiction or both. “Writing is very healing for women,” says Allain. “When Lauren approached me, I thought it was something the women would really like, and I knew that Lauren would be able to work with women at different levels and make them feel comfortable.”

At a workshop two weeks before the reading, however, the core group of women – Emily, Mary, BJ, Cerima, Wanda and, later, Maggie – are anything but comfortable. Today, Kirshner is leading them through a dry run, getting them to choose stories from the newspaper and then stand up and read them to the group – slowly, audibly, with emphasis on certain words or pausing to keep the audience hanging on. The women are self-conscious and joke around with one another nervously, but once they actually start taking turns, their critiques are helpful and very supportive.

Kirshner gives out reading copies of the stories the women are to read at the magazine launch so they can practice at home in front of the mirror; none of the women are to see one another’s work, so the finished product – a professionally printed and bound 39-page colour magazine – will be a surprise. “They’re very supportive of each other and have become more and more so,” says Kirshner. “Every week I try to do something to make the group more cohesive. I want everyone to feel that their voices and their spaces are being respected.”

Kirshner, who is working on her second novel and embarking on a PhD in communications and culture at York-Ryerson University, counts some of the inspiration for *Sister Writes* as a three-month poetry workshop she led with inpatients at Toronto’s Centre for Addiction and Mental Health in 2005. She also interned a year ago at the Parkdale Street Writers group. *Sister Writes*, says Kirshner, is “a way to talk about writing and share writing with a group who would appreciate it.” Throughout the pilot, Kirshner brought in several young writers to act as mentors.

The women in the first group of *Sister Writes* represented a range of ages – the median was 44 – and backgrounds. But what they shared was a need to find their voice. “They’re almost all survivors of some kind of trauma,” says Kirshner. “I never asked them point blank, but it’s coming through in their writing. They’ve all had to struggle pretty hard to make their own place in the world.”

Kirshner also hopes that writing creatively will help the women build life skills – how to listen, how to articulate thoughts and feelings. “I want them to become confident speakers, to become advocates for themselves through writing,” she says. “I want to give them the skills to better represent themselves – to write a letter to their landlord, to write to a city councillor, to become active in the community.”

Kirshner has also witnessed the workshop’s therapeutic benefits. Each week, she suggested themes that she felt would be stimulating or provocative, such as “mothers” or “adolescence” – “all the hot buttons that would be hot, especially for them,” she says. There were digressions, of course, that were “interesting sometimes and funny.” But there were also epiphanies and tears, Kirshner says, “feelings that have been buried for a while. It was very moving.”



Creative writing gives voice to marginalized women.

For Emily, the focus of her writing so far has been on her beloved mother and her own childhood. “I get up in the night and write – pieces that can be put together,” she says, as she lets me read a beautiful story about her mother. “It gives relief.” Emily, like the other women, is soaking up the experience of *Sister Writes* like a sponge. Another participant, Mary, says she loves to learn, to enhance her life. “I’ve learned the way we can write better and how to view other writers and how to think like a writer,” she says. “It makes me feel good.”

On the evening of the reading, the writers sit near one another in the first couple of rows, well turned out, excited and nervous. Mary cuddles her grandson. After an introduction by Kirshner, Emily, who confesses to having been sick the night before, but who nevertheless looks beautiful in a pink and green blouse and head scarf, reads first. From the moment she starts until the last reader finishes, the audience is transfixed and moved by the stories the women have written about small important details of their lives, about the difficult, upsetting things they have endured, about the people they love and cherish.

The response is overwhelmingly enthusiastic. These women have clearly inspired one another, have inspired and been inspired by Kirshner – for and from whom there is obvious affection and respect. They have affected everyone who hears their stories.

Building on the success of the first group, Kirshner hopes the next group will jump to four hours a week from two, to 12 weeks from 10, with room for more women to join. She wants participants to write longer pieces and become editors of their own work. “I’m trying to break down the division between writers and people who want to express themselves,” she says. “We’re still at the beginning.” ■

If you know a woman who might be interested in joining *Sister Writes*, call Sistering at 416 926-9672, or send an e-mail to info@sistering.org

The “sometimes psychotic psychologist” fights stigma of schizophrenia

PATRICIA NICHOLSON

Dr. Fred Frese is many things – a psychologist, a retired U.S. Marine and a person with schizophrenia.

His resume is impressive: He was director of psychology at a large psychiatric hospital. Last year, the American Psychological Association awarded him its highest honour – the Presidential Citation. He is a past president of the National Mental Health Consumers Association. And he’s been giving talks about schizophrenia and mental illness for more than two decades.

“Twelve years after I was committed as insane, I’m the director of psychology at the largest psychiatric hospital in the state.”

But Frese says he couldn’t have done any of those things if he had disclosed his illness early in his career. “It would have been impossible,” he says. “Nobody hires schizophrenics.”

As a speaker, he’s both funny and inspiring, telling his own story as someone in recovery from schizophrenia, as well as the broader story of how schizophrenia and other mental illnesses are perceived. There has been some progress in chipping away at the stigma of mental illness in recent decades, says Frese, but it’s a slow process.

“When I started, no one would acknowledge having mental illness of any kind,” he tells me when we meet the day after he gave a talk in Toronto. “Now it’s OK to have depression from time to time. It’s even OK to have bipolar disorder ... more and more, that’s become something you can talk about. But schizophrenia isn’t quite there yet. Schizophrenia still scares people.”

Frese was diagnosed at age 25. While in the Marine Corps during the Vietnam War, he was assigned to guard nuclear weapons at a base in Florida. While musing on the reasons why the war was going poorly, he came to the conclusion that not only were Chinese communists brainwashing U.S. troops in Vietnam, but they had also mastered the ability to hypnotize people from a distance, and were now able to influence government leaders and high-ranking officers back at home. Realizing the base and its nuclear weapons could

be at risk, Frese reported his conclusions to the person most likely to understand the risks of brainwashing – the base psychiatrist.

“He listened and smiled, and when I got up to leave, there was a man in a white coat on either side of me. They escorted me to a little room and slammed the door,” Frese told the audience at his talk in Toronto. “Just like that, I knew that psychiatrist had been hypnotized by the enemy.”

Frese’s initial reaction to the diagnosis was disbelief, and it took him a while to accept that he had a mental illness. “I was in shock that they were calling me a crazy person,” he says. “But when they kept locking me up, eventually I began thinking, something’s wrong here.”

After his initial diagnosis, Frese was committed 10 times over the next 10 years. But during that time, he also became a psychologist – almost by accident. “I just happened to fall into the field,” he says. “I had

majored in psychology as an undergrad in college, but I wasn’t really interested in mental illness. I was put through by the U.S. navy, and they were very encouraging of students learning about leadership. They thought psychology had something to do with leadership, so I majored in psychology.”

Years later, after being released from hospital following a breakdown, Frese was living in a boarding house near Ohio State University in Akron. One of the graduate students living there told him that his degree qualified him to work as a psychologist for the state and encouraged him to apply.

“I very reluctantly took the test. I got extra points for being a veteran,” Frese says. He ended up working for the psychiatric hospital as a psychologist officially employed by the state of Ohio. He worked there for about three years and then arranged a leave of absence to go back to graduate school.

After finishing his PhD, Frese was assigned to work at the Western Reserve Psychiatric Hospital in Ohio, where he was later promoted to director of psychology, staying until he retired in 1995. “Twelve years after I was committed as insane, I’m the director of psychology at the largest psychiatric hospital in the state,” Frese says. “Quite a change for me.”

But being a “sometimes psychotic psychologist,” as Frese calls himself, had its challenges. “I was under orders from my superiors not to tell anybody about my condition,” he says. When he wasn’t doing well, the cover story was that he had flu, “because you can’t have the insane running the asylum. Or if you do, you can’t tell anyone about it,” he says.

What started Frese on the long road from secrecy to speaking tours was a policy change that required oversight boards to include a mental health consumer. Frese was that representative for the Akron area, although he wasn’t openly identified as such. “They were very discreet about it initially,” he says. But it was a couple of years after that, during a talk at Kent State University, that Frese outed himself.

"I just got up and said, 'Everybody who has actually been locked up and put away, please stand up and identify yourselves,'" he recalls. When no one stood, he said, "I guess I'm the only one standing here then." "I didn't plan to do that ahead of time; I just did it," he says. "And since then, I've gotten a lot of attention."

Once he began talking about his illness and even making appearances on local television, it was no longer a secret. "It was awkward for staff because this was new for them," he says of reactions at work. "But most of the patients loved it. One of the staff was one of 'them.'"

Frese's parents, who had never mentioned his illness at home, saw one of his television appearances. When he arrived at their home later, his father met him at the door. "I didn't know what he was going to say," recalls Frese. "But he said, 'Son, we're proud of you.'" A week later, his mother called, saying that while she was very proud of him, could he please tell people that his condition was not from her side of the family.

"That generation was one where nobody acknowledged that they had insanity in the family or in themselves," says Frese. "This has been such a taboo topic. And that's one of the things we need to change."

Decades after his first disclosure, Frese still gets some negative reactions. But other times, his openness gives him the opportunity to meet people who might otherwise think



Dr. Fred Frese speaks with humour and candour about being a "psychotic psychologist."

they were alone in the world. "I was giving a talk to 150 judges in Ohio two years ago," he says. "One of them came to me and said, 'Dr. Frese, I've been on the bench 25 years and I'm going to tell you something that nobody knows, except my wife and my psychiatrist. I have the same condition you do. And I can't tell anybody.'"

When he wasn't doing well, the cover story was that he had flu, "because you can't have the insane running the asylum."

The stigma associated with schizophrenia can indeed be a bigger threat to a career than the illness. "The shame, the disgrace is so extreme that so many of us who have been able to recover think like I used to: Don't tell anybody," says Frese. When he disclosed, he says he felt he had "political cover" from a department head who was very pro-consumer. He also felt the timing was right.

"In my calculation of how open I was going to be, I figured I was close enough to retirement if they decided to get rid of me – and that's eventually what happened," he says. The pro-consumer department head moved to another position elsewhere. "When she left, it was a matter of time. And one day, they said, 'You're gone.' But by that time I could retire, and that's what I did."

Frese recommends this approach to others who are considering disclosing a mental illness. "If you're a young person, quite frankly, it is still very threatening to your career," he says. "But once you're retired or close to retirement, that's what a lot of us are doing – revealing we have this condition, being open about it. It really helps fight the stigma."

Advocacy can be the best medicine, says Frese. It was when he first became active with the National Alliance on Mental Illness that a colleague asked him how he had been able to recover from schizophrenia to the extent that he had. "I promised to try to figure out how I did that," he says. The result was one of his best-known publications: *Twelve Aspects of Coping for Persons with Schizophrenia*.

Frese also supports simple, everyday acts that fight stigma. When he travels to give a speech, he takes advantage of opportunities to demystify mental illness for people he meets en route. "Whoever has the misfortune to sit next to me is not going to leave that flight without knowing they sat next to someone with schizophrenia." ■



Children of psychiatric clients benefit from nurse attention

Children of parents with mental illness are known to be at increased risk of mental health and behavioural disorders later in life. However, research from the University of Kuopio in Finland indicates that nurses, who have frequent contact with clients and their families, can make a significant contribution to improving outcomes for these children. The study results are based on the questionnaire responses of 222 registered mental health nurses (RNs) and 88 practical mental health nurses (MHNs) working in adult psychiatric units in Finnish university hospitals. While most of the nurses reported that they met with the children of clients a few times a year or not at all, 95 per cent of RNs and 96 per cent of practical MHNs said they regularly collected information about the children. All nurses reported that they sought to guarantee the children's safety and arrange care for them when necessary. Sixty-eight per cent of RNs and 70 per cent of MHNs took the time to explain the parent's illness to the children. However, only 46 per cent of nurses talked to the children about their fear of becoming mentally ill themselves. RNs were more likely to discuss the parent's situation with children if they were parents themselves, or if they were older, had 20 or more years of experience, were divorced or widowed, used family-centred care or had further family education. The authors conclude that family-centred care increases nurses' interaction with children and increases their ability to "implement preventive child-focused family work into practice."

Scandinavian Journal of Caring Sciences, March 2010, 24 (1): 65–74. Teija Korhonen et al., Department of Nursing Science, University of Kuopio, Kuopio, Finland.

Youth clinics aid immigrant women concerned about family honour

There has been growing concern in many countries over the number of young women from immigrant backgrounds who have been exposed to murder, violence and other acts by male relatives in the name of family honour. Now, research from Sweden's Karolinska Institute indicates that youth clinics can play a key role in addressing the problems of women who fear repercussions related to protecting family honour. Seven midwives and five counsellors from four Stockholm youth clinics participated in a series of group interviews as part of the study. The main concern expressed by youth clinic staff in assisting young women with honour-related problems was to avoid making the situation worse. Staff typically engaged in a worry analysis process that involved the creation of a refuge, risk assessment, and worry-reducing measures. The constant fear that the secret of their sexual activity would be discovered, as well as the fear of isolation and violence, was a source of stress for the women that could potentially result in depression. One difficulty they faced was that the simple act of coming to the youth clinic could be seen by their families as meaning that they had had sex, which would be a breach of honour rules. As a result, the women might be reluctant to seek help if the clinic was in a public place. The worry-reducing measures employed by youth clinic staff could include empowerment, keeping the woman's secret, mediation with the family, or secondary prevention designed to prevent the woman from getting into a worrying situation again. Empowerment generally involved providing the women with information about bodily function, sexual matters, taking sides with them and encouraging them to take control of their own bodies.

Scandinavian Journal of Caring Sciences, March 2010, 24 (1): 32–40. Venus Alizadeh et al., Center for Family and Community Medicine, Karolinska Institute, Huddinge, Sweden.

Past mental health disability episodes increase likelihood of future episodes

A new study from the Centre for Addiction and Mental Health in Toronto, Ontario, has found that workers who have had disability leave for a mental illness are at high risk for another such episode. These findings are based on data from 10,061 workers employed by a Canadian resource company. Twelve per cent of these employees had a disability episode in 2005: two per cent for a mental health disorder and 10 per cent for a physical disorder. Compared with workers who had disability episodes related to a physical disorder, those with mental health disability episodes were more likely to be women, to have disrupted marriages or to be single. Rates of recidivism were high among those with mental health disability episodes. Workers with previous mental health disability episodes were almost seven times more likely than those without a previous episode to have a subsequent mental health disability episode. In contrast, those with previous disability episodes related to physical disorders were only twice as likely as those without a previous episode to have a subsequent physical disability episode. The fact that workers who were married were less likely to have a mental health disability episode than those with disrupted marriages suggests that ensuring a supportive work environment might help to protect workers against mental health disability.

Journal of Occupational and Environmental Medicine, December 2009, v. 51 (12): 1394–1402. Carolyn S. Dewa et al., Work and Well-being Research and Evaluation Program, Centre for Addiction and Mental Health, Toronto, Ontario.



Discrimination related to sexual orientation increases risk of substance abuse

The experience of discrimination appears to increase the likelihood of substance abuse among lesbian, gay and bisexual adults, according to research from the University of Michigan in Ann Arbor. Researchers used data on more than 34,000 American adults from wave 2 of the 2004–2005 National Epidemiologic Survey on Alcohol and Related Conditions, 577 of whom identified themselves as lesbian, gay or bisexual (LGB). Overall, substance use disorders were more prevalent among LGB adults (28%) than among heterosexual adults (11%). Approximately two thirds of LGB adults experienced at least one type of discrimination in their lifetimes. In the past year, 38 per cent of LGB adults reported discrimination related to their sexual orientation; 48 per cent reported gender discrimination; 50 per cent reported racial/ethnic discrimination; and 11 per cent reported all three types of discrimination. For LGB adults who reported all three forms of discrimination, the adjusted odds of having a substance use disorder in the past year were almost four times greater than for those who reported no discrimination. Those who reported lifetime racial discrimination only or both sexual discrimination and gender discrimination also had significantly increased odds of substance use disorders compared with those who reported no discrimination. The authors conclude that health care professionals should take into account “the role multiple types of discrimination plays in the development and treatment of substance use disorders among LGB adults.”

American Journal of Public Health, January 14, 2010 online: e1-e7, doi: 10.2015/AJPH.2009.163147. Sean Esteban McCabe et al., Substance Abuse Research Center, University of Michigan, Ann Arbor, Michigan.

Pressure keeps substance-using pregnant women in treatment

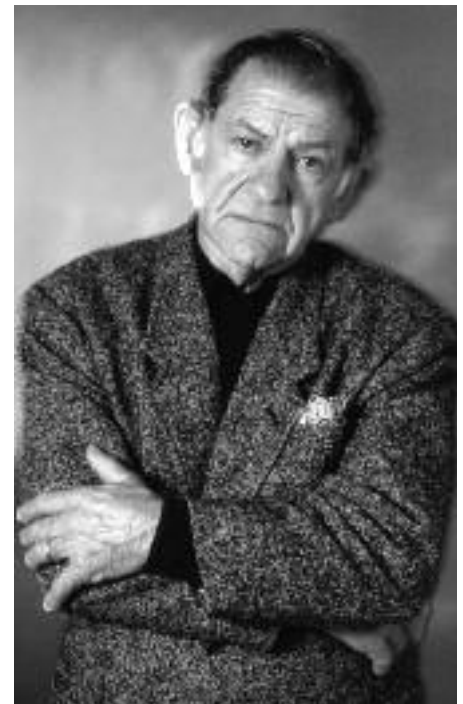
External pressure can increase the likelihood that substance-using pregnant women will remain in treatment, according to a study from Wayne State University in Detroit, Michigan. Researchers looked at data on 200 women from a National Institute on Drug Abuse clinical trials study who were receiving community-based substance abuse treatment. The women were asked whether they had been pressured to attend treatment under threat of jail terms, having their children removed from them, or losing their housing. Thirty-six participants reported being pressured to enter treatment, while 164 were not pressured. Of those who reported coercion, 44 per cent faced legal pressure; 17 per cent were pressured regarding their housing; 36 per cent reported pressure from child protection services; and three per cent were pressured by both legal and housing authorities. The researchers found that those in the coerced group attended an average of 71 days of treatment before dropping out, compared with 46 days for the non-coerced group. The coerced group also had fewer drug-positive urine tests at baseline (29% vs. 40%), during treatment (15% vs. 29%) and at three-month follow-up (18% vs. 27%) compared with the non-coerced group. Although the reduction and prevention of drug use during pregnancy is an important goal, the authors caution that “the use of external pressure could lead to avoidance of health care settings or could inhibit disclosure of substance use among those who do seek care.”

Drug and Alcohol Dependence, March 1, 2010, v. 107 (2-3): 149–153. Steven J. Ondersma et al., Department of Psychiatry and Behavioral Neurosciences, Wayne State University, Detroit, Michigan.

Early cannabis use may increase risk of psychosis

Cannabis use at an early age significantly increases the risk of psychosis among young adults, according to research from the Park Centre for Mental Health in Wacol, Australia. Researchers studied the relationship between cannabis use and mental health among 3,801 individuals born between 1981 and 1984. Participants were followed for 21 years, at the end of which they were asked about past cannabis use and were assessed for non-affective psychosis, hallucinations and delusions. Sixty-five participants were diagnosed with a non-affective psychosis, such as schizophrenia, persistent delusional disorder or acute and transient psychotic disorders, and 233 endorsed at least one hallucination item on a diagnostic interview. Those who had used cannabis for six or more years were twice as likely as those who had never used cannabis to develop a non-affective psychosis, four times as likely to have high delusion scores, and almost three times as likely to have experienced hallucinations. Within the 228 sibling pairs in the sample, siblings who had been using cannabis for longer periods were more likely to have higher delusion scores. This makes it less likely that the associations found in the study were the result of genetic or environmental influences, since the siblings could be expected to have a common genetic and environmental background.

Archives of General Psychiatry, March 1, 2010, v. 67 (5), doi: 10.1001/archgenpsychiatry.2010.6. John McGrath et al., Queensland Centre for Mental Health Research, Park Centre for Mental Health, Wacol, Australia.



Hostility may link depressive mood and mortality

Depressive mood is known to be associated with an increased risk of death. Now, new research from the European Georges Pompidou Hospital in Paris indicates that much of that association may be explained by hostility. Researchers followed 14,356 employees of the French national gas and electricity companies over an average of 15 years, beginning in 1989. Employees were asked to fill out questionnaires assessing their mood and personality. By the end of the study, 687 of the participants had died. Mortality was predicted by depressive mood, even after taking into account variables such as age, sex, education level, body mass index, alcohol consumption and smoking. However, adjusting for hostility (hostile thoughts) considerably reduced this association. On the other hand, hostility was the only personality trait that remained significantly associated with mortality after taking into account depressive mood and the full set of variables. Mortality was not predicted by type A personality, challenging previous findings that linked type A personality with ill health and mortality. The authors speculate that hostility may increase mortality by promoting depressive mood, or depressive mood could result in more hostility, which in turn might increase mortality. They recommend further research to determine whether therapeutic interventions that target hostility could improve health outcomes associated with depressive mood in both healthy and ill individuals.

Psychotherapy and Psychosomatics, 2010, v. 79 (3): 164–171. Cédric Lemogne et al., Department of C-L Psychiatry, European Georges Pompidou Hospital, Paris, France.

The strong, silent type

Is masculinity bad for men's mental health?

BY DR. JOHN OGRODNICZUK AND DR. JOHN OLIFFE

Don is a 41-year-old self-employed welder from a small rural town.

He has been happily married to Joan for 18 years and has three healthy boys. Don coaches his oldest son's hockey team and curls in the local men's league. His friends describe him as gregarious, giving and outgoing.

Thirteen months ago, Don incurred a back injury on the job that kept him off work for two months. He had to stop curling and coaching hockey. In the acute phase of his injury, Don required physical assistance from Joan, which he often commented was humiliating. Eventually, he attempted to resume welding, but recurring back pain meant he could only work intermittently.

Joan noticed that Don was increasingly irritable and angry. He began to drink six cans of beer every evening along with a few shots of whiskey to help him sleep. He slept and ate much more than usual. He was increasingly

housebound and spent a lot of time on the Internet researching self-help back cures. He refused to host guests any longer. Intimacy disappeared from his marriage.

Recognizing that Don was "not his normal self," Joan suggested that he see their family doctor. Don would snap back, "What the hell can he do? My back is wrecked for good." Don would occasionally visit the doctor for check-ups on his back, but he never disclosed other health concerns.

Don grew more despondent and isolated. One Sunday, Don's wife and sons returned from church and found a note taped to the bedroom door. In it, Don explained how he felt useless and hopeless since his injury – that he was no longer a good man, that he was no longer a good husband and father, that he was a burden. Joan found Don lying across the bed, dead from a self-inflicted gunshot wound.

THIS COMPOSITE CASE HIGHLIGHTS THE INTERSECTION BETWEEN men's mental health, masculinity and help-seeking attitudes and behaviour. It is well documented that men seek help for mental health issues less often than women do. Many factors inhibit men from seeking help for mental illness. The way they think about themselves as men may be a contributing factor. Men tend to be concerned with being competitive, powerful and successful. Traditional notions of masculinity mean that men are supposed to be tough and self-reliant; that they manage pain and take charge of situations. It's a sign of weakness to need help or depend on someone else, even for a short time or in a time of crisis.

This traditional view of how men should be – always tough and self-reliant – is also held by some women. Some men worry that if they talk about their feelings of depression, their partner may reject them. This can make it hard for men to acknowledge they have a health problem, especially a mental health problem.

We also know that men are more likely to arrive in the emergency room than in general practice, which reflects men's denial of illness, preference for self-surveillance and reliance on self-management strategies. It means that mental health issues, such as depression, often go unrecognized, sometimes until it is too late, as in Don's case.

Evidence also suggests that men have difficulty articulating their problems when talking with health care providers. And health care providers who see men at routine check-ups or during visits for physical complaints may themselves miss the signs of depression or other

mental health issues. Depression affects men and women, but what they experience and how they respond is quite often different. Men tend to focus on the physical symptoms, such as feeling tired or losing weight. They are also more likely to say they feel irritable or angry, rather than saying they feel "down." This is one reason why men often don't recognize that they are depressed – and neither do their health care providers.

Don's fate is all too common for depressed men, whose illness often goes undetected and untreated. However, such a tragic outcome can be avoided. Knowing and investigating the signs and symptoms of depression in men is a critical first step. Furthermore, being aware

SUFFERING SILENTLY: HEALTH SERVICES FAST FACTS

One of the biggest differences between men's and women's health is their respective use of health services. According to Statistics Canada's Canadian Community Health Survey on Mental Health:

- 10% of men experienced symptoms of the surveyed mental health and addiction issues, compared to 11% of women. (Other statistics show that 4 of 5 suicides are male.)
- Men are 1.5 times less likely than women to turn to psychiatric services.
- Women are twice as likely to consult a psychologist.
- Women are 2.5 times more likely to turn to a general practitioner.

of and able to connect men to various treatment options can positively impact the lives of men and their families.

In our experience, all-male group therapy may provide men with a safe environment to discover and express intense and vulnerable emotions associated with their depression, and allow them to connect through their shared experience. Groups offer men an opportunity to connect with other men and regain a sense of purpose and well-being.

Realizing the potential for helping men with depression or other mental health issues will, of course, depend on men's willingness to acknowledge that asking for help is a sign of strength, not weakness. When men do seek help, it is also important for us as mental health professionals to be aware of our own values and biases about men because these attitudes influence treatment. The growing number of men's health organizations focusing on research in men's health will play an important role in creating awareness and promoting social acceptability of mental health issues among men. ■

Dr. John Ogrodniczuk is an associate professor in the Department of Psychiatry at the University of British Columbia. **Dr. John Oliffe** is an associate professor with the university's School of Nursing.

Are you providing gender-responsive mental health or addiction services for men in your practice?

Access this story online and let us know what you are doing.
www.camhcrosscurrents.net



**WHEN THE GOING GETS TOUGH, THE TOUGH GET HELP:
RESOURCES FOR REACHING MEN**

American Men's Studies Association <http://mensstudies.org>

A forum for researchers and practitioners to exchange information and gain support for work on men and masculinities. You can also link to the 2009 conference, held in Montreal, Quebec, to see what Canadian researchers are doing in this area.

HIMM: Health, Illness, Men and Masculinities www.himm.ca

This group of Canadian researchers focuses on masculinity as a social determinant of health.

Men and Depression – National Institute of Mental Health

www.nimh.nih.gov

This section includes resources for health care professionals, including screening tools, information about treatment options and a link to NIMH's national awareness campaign, Real Men. Real Depression. On the website, search the term "men and depression."

Men Get Depression www.mengetdepression.com

This U.S. education and awareness campaign aimed to increase knowledge, reduce stigma and promote screening and treatment for depression and educate the public about depression and suicide risk in men.

Men's Health Forum www.menshealthforum.org.uk

This UK-based organization recently released a report, *Untold Problems: A Review of the Essential Issues in the Mental Health of Men and Boys*. In developing a guide on how to meet the mental health needs of men identified in the report, the forum invites people to submit suggestions. For the report and to submit ideas, choose "Issues" and then "Mental Health."

Men's Health Research Program – University of British Columbia

www.menshealthresearch.ubc.ca

This program studies men's depression and men and smoking, among other health topics.

Men's Mental Health – Mind www.mind.org.uk

The British mental health organization Mind provides information for professionals who work with men experiencing mental health issues. Also read about Mind's Get It Off Your Chest awareness campaign for men's depression and the resulting report about men's health-seeking behaviour. On the website, search the term "men's mental health."

Society for the Psychological Study of Men and Masculinity

www.apa.org/divisions/div51/

Division 51 of the American Psychological Association publishes the journal *Psychology of Men and Masculinity*. Also visit the website of the APA's 2nd National Psychotherapy with Men Conference, held this month, to see what is happening in the field.

"Our men have lost their place"

Aboriginal shelter guides men on healing path

BY AMANDA DALE

CROSSING THE THRESHOLD INTO NA-ME-RES, A 63-BED ABORIGINAL men's shelter in mid-town Toronto, Dave P., a Micmac from Nova Scotia, might have noticed the coat of arms that promises Food. Water. Shelter. Friendship.

But at that time, he was not noticing much. "What got me off crack was being here," Dave tells me, as he packs to leave the shelter for his own room at Sagatay, the organization's 22-bed residential healing and learning centre next door. "These people made me feel welcome. I was sceptical about going to a shelter," he admits. With no alcohol or other drugs to tempt him at Na-Me-Res, he still hasn't beat his addiction, "but," he says, "I have my fist around it."

And now Dave has a brand new start. Today he "graduates" to Sagatay, where traditional healing circles and specialized men's programming blend the practical and the spiritual. "I never thought

"Men have lost their place and often take it out on women. And women look at them and can't forgive."

this day would come," he says. It's all part of the long journey to healing from violence, mental health issues and addiction through an approach that identifies the roots of these problems in a long legacy of colonial policy.

"Our men have lost their place," says Vivian MacNeil, manager of program development at Na-Me-Res. She and former employee Dorian Tiller partnered to develop the Special Needs program, which supports men like Dave who have mental health and addiction battles on their hands.

"Our men have lost their traditional roles," says MacNeil of the rapid intergenerational loss of culture and belonging afflicting Aboriginal communities. "Add to this sexual and physical abuse from residential schools, survival on the streets and the spread of substance use as a way of coping ..." Her voice trails off, the results of this tragic spiral evident in the jammed hallways and program rooms all around her.

At both the shelter and Sagatay, medical and psychiatric services are melded with traditional healing models that restore aspects of Aboriginal identity and belonging, a cultural lens that restores dignity, hope and purpose.

Most men at Na-Me-Res have left reserves, where unemployment and social conditions – poor housing and inadequate educational resources – make it impossible to get ahead. "The women are leaving violence and the men are coming for employment," MacNeil explains. "But when they get here, they get lost."

The pull from reserves has revealed a significant deterioration in mental health and means that a disproportionate number of homeless people are Aboriginal – 29 per cent, according to the City of Toronto's 2009 Street Needs Assessment. But Toronto's shelter system is not geared toward their unique needs and history. Na-Me-Res is.

As a key element of colonial policy, the Canadian government sought to make Aboriginal peoples fit in by outlawing their cultures, banning their languages and family and community traditions. Entire generations of First Nations and Inuit peoples also endured direct physical and sexual abuse through residential schools and other institutions, while being robbed of the chance to parent their children. It is estimated that up to five generations of Aboriginal people have been prevented from intergenerational bonding from these policies, which fulfill in part the international legal definition of genocide.

Peter Menzies, clinic head of the Aboriginal Service at the Centre for Addiction and Mental Health in Toronto and president of the board at Na-Me-Res, has examined this intergenerational trauma. His study published in 2006 in the *Canadian Review of Social Policy* has made it clear that trauma is at the root of much persistent homelessness among the men MacNeil and her staff see every day in the Special Needs program.

For MacNeil, this program has a special place in the innovations she has been a part of here. In the past, difficult behaviour – not difficult histories – was what shelter workers were trained to see. Today, coming to terms with their own histories is part and parcel of what Aboriginal shelter workers do to connect with their compassion. It's all part of healing the community.

Now, admissions and discharges are seen as part of a cycle of healing, not as a failure to "progress" on the part of the man seeking support. Complicated forms, overly burdensome rules, impossible expectations and judgemental attitudes are banished. They are replaced with compassion, attentiveness and awareness of the social and historical context contemporary Aboriginal men are grappling with.

In his study of intergenerational trauma and homeless Aboriginal men, Menzies postulates that in First Nations and Inuit communities, trauma has often happened in four interconnected ways – through the individual, family, community and nation.

When trauma is experienced by more than one generation in a family, personal trauma becomes part of what it means to be in that family, explains Menzies. Where most families within a community

experience similar life events, the community can be left without the spiritual or other resources to address the problems together. When an entire people experience these things as a matter of public policy – in this case colonialism – trauma can be said to happen to a nation. No one really knows how long it can take to heal from such wide-scale trauma.

Back at Na-Me-Res, in the healing circle, the topic today is jealousy. It's Jason's turn with the feather, which signifies his time to speak. His story illustrates the loss that Menzies' study enumerates. "I had to get away from my family, from the reserve," says Jason. "The drinking. The fighting. The negativity. Infidelity. No one knew me. I was on my own. I was lost, you know?" The group answers in Ojibway. In unison. A call to a brother lost to re-enter the circle.

"I had to stop drinking," Jason continues. "And stop being so jealous. I learned to trust my wife. She said to me 'I'm tired of being your girlfriend! Step up to the plate.' Ahh, commitment!" He gets a low rumble of recognition from this group of men, all trying to do and be better. "I never thought I'd be with someone for 11 years!" A roar of congratulations. "I still struggle," Jason admits, head bowed in the brave humility that characterizes the healing approach.

The facilitator mentions that there are women in the circle today. Not usual in the men's healing circle. "It helps us find balance," he says. "I invited these ladies because they have an important perspective."

Aboriginal cultures have strong beliefs about respect for the feminine and masculine, and treating each other, the land and the community with esteem. These things are part of a circle of what is sacred and treasured. Not to be violated or disrupted. "Our communities are often cut off from this value," the facilitator tells me. "Men have lost their place and often take it out on women. And women look at them and can't forgive."

Another Dave – David R. – is in a different space. The healing circle is not his thing right now, but he finds the sweat lodge invaluable. He is part of the Special Needs program and gave up a life of solitary grief in the wake of his partner's death from cancer to begin anew at Na-Me-Res. After wandering the hiways of Canada in a state of blinding mental illness, David is now in a room of his own downtown. He visits the staff at Na-Me-Res regularly. They are his touchstone, and there is no doubt that continued contact with them has helped to keep him housed. David shows me the sweat lodge, an improbable and moving innovation that resembles a canvas tent on the cedar deck of Sagatay.

Above the fence line, an ordinary affluent Toronto neighbourhood stretches out, while the men here reach back through time to connect with what keeps life sacred for them. When asked about the role of the sweat in his healing, David has no trouble answering: "Imagine you are sitting by a campfire and your old grandmother



Nurse Vivian Recollet (standing) and Special Needs program co-ordinator Pamela Johnston help men like David R. (back) and Juan on their healing journeys.

comes out to talk to you, to help you and to guide you. That's what the sweat is like. The ancestors come and take care of you."

Back in the shelter, Dave P. can't contain his nervous excitement about moving: "This is going to be an opportunity to change my life," he says, as he waves goodbye. On his way to find a new life 100 metres and a full incarnation away from the methadone, jail time and lost family his journey has entailed, he too connects with his Aboriginal past, but in a more tangible way: "I want my grandfather to know where I am," he pleads. "Tell him I am fine. He is Micmac. He is the only one who continued to believe in me."

Dave clutches his green plastic bags of clean clothes fresh from the dryer, hope and fear visible in his open face. Hugs all around. The staff have a little glimmer in their eyes as another Aboriginal man with his own path and his own story finds his way to the high ground these men strive to reach every day. ■

A room of their own

Men's sheds build communities of support and purpose

BY NED MORGAN



The bike restoration project teaches practical skills and connects men with the community.

FOR MANY YEARS AND IN MANY COUNTRIES, MEN HAVE FOUND SOLACE in a backyard shed. But the recent phenomenon of community men's sheds is as native to Australia as the platypus and the koala. Australian men's sheds have evolved into a social movement, providing meeting, healing and working spaces for men, including those with mental health issues, or those struggling with social isolation.

"Backyard sheds have always been iconic for many Australian men," says Dr. Barry Golding, a senior lecturer in the University of Ballarat's School of Education. "The difference in the case of community sheds is that the activity is there to support, benefit and engage the men."

Sheds are not overtly therapeutic spaces, although in many cases, mental health agencies have a hand in organizing them. Many sheds aim to attract men who might be reluctant to work on something like their mental health – but want to work with their hands. The shed model is designed not to alienate men who would be hesitant to label themselves "depressed," let alone seek therapy. "What sheds essentially

do is acknowledge that many men have spent their working lives in communities of practice with other men," says Golding. "In retirement or withdrawal from the workforce through disability, men are often missing part of their working lives, identities and networks. Sheds informally create communities of practice where they can 'be blokes,' but where they can also be more aware of the need to look after themselves and other men."

In 2007, Golding joined a research team to run a government-sponsored survey of men's sheds for the National Centre for Vocational Education Research (NCVER). The number of sheds has been doubling every year for approximately 10 years. By March 2010, there were around 450 sheds established or establishing across Australia." That makes the Australian Men's Shed Association (AMSA), representing an estimated 30,000 men, the largest men's support organization in Australia.

The rise to prominence of men's sheds was spurred in part by a spike in awareness of men's health in Australia in the 1990s. According

to research released by Beyond Blue, a national depression initiative, the suicide rate in Australia was four times higher in men than women between 1998 and 2002. The study attributed this statistic in part to undiagnosed and untreated depression in men. In 2009, the Australian government began to develop a national men's health policy, and as part of this effort, launched a senate inquiry into suicide. The newly created AMSA made a submission to the inquiry, noting the vital role sheds can play in reducing isolation and depression. The inquiry will publish its findings this year.

The profile of men's sheds has never been higher, but shed organizers cannot rely on consistent government funding, either at a federal or state level, although the recent men's health policy initiatives and the NCVER survey's positive press may help to change this.

That's the hope of the mental health community. Fremantle Men's Community Shed, known as Fremanshed, is one of Western Australia's most prominent. According to program co-ordinator Alan Gowland, sheds are becoming more popular because "local health councils are seeing the benefit to men's health and well-being." Gowland designed the Fremanshed's Men's Health and Wellbeing pilot project with Monica Nunez, an occupational therapist at the Alma Street Centre, which provides mental health services. They developed the project to help men with mental illness, offering 10-week courses in woodworking, metalwork and other trades.

Fremanshed originally received a government grant to launch the project, but since the funds have all but dried up, they self-fund by charging a nominal fee and selling a DVD. One of the clients featured in the DVD is cherub-faced Daryl, a man who was "non-functional, unable to go outside, and couldn't handle public transport or crowds" before his involvement with the shed, says Gowland. The DVD shows Daryl at work making a toy wooden truck with ingenious detail. The truck has become an iconic image, adorning the cover of the DVD. Gowland reports that Daryl now has a part-time job and helps run a toy-making workshop at the Fremanshed. "He has tasted well-being and works hard to keep it happening," says Gowland.

In New South Wales, Australia's most populous state, a mental health outreach organization has turned to a shed to provide mentoring and positive social interaction for its clients. Rennay Miller is a co-ordinator of the non-profit New Horizons Enterprises and oversees its Recovery and Resource Services program for people with mental illness. New Horizons partnered with Hastings Men's Shed in early 2008. "It was a relaxed atmosphere, and our clients started to make friends, building social networks," says Miller. "Many of them had never had contact with positive male role models." Since many of the shed men were retired and could offer building skills, they fit naturally into a mentoring role.

As a success story, Miller offers that of Dan*, a man in his mid-30s who became depressed and moved in with his parents, holing up in his bedroom. "Once he started connecting with the men's shed, he was getting up in the morning," says Miller. "He's learning how to refurbish bicycles. Later he joined a golf club – the shed gave him the confidence to do that. He also volunteers at a wildlife park." Dan and the other men collected old bikes from landfills, and with the help of an instructor from a vocational school, learned to refurbish them. They kept a bike each and donated the others to schools.

Given such successes, it's no surprise that interest in the shed model has spread beyond Australia. Karen Martin, an occupational

therapist who now works with an ACT team in Chatham-Kent, Ontario, completed her clinical placement through the University of Western Ontario at another New South Wales shed. Originally set up as a meeting place for retired men, the Berry Men's Shed now welcomes men – and women – of any age. While health practitioners often refer clients to the shed, many members join simply for the "mateship" and to use the well-appointed wood workshop. "It's a place where you are identified as an individual with skills and craftsmanship, not a place where you are seen as an individual with mental illness," says Martin.

Martin found the atmosphere of the shed to be a study in open communication. "Some men preferred to work individually, while others completed projects collaboratively," she recalls. "When the men worked side by side, they were more willing to open up and discuss issues ranging from personal health concerns to possible family problems."

When asked whether men's sheds risk contributing to gender stereotypes, Martin responds that the Berry Shed "has a non-discriminatory policy welcoming men and women of any age. If women were not allowed to be members, it would take away from the



Men's sheds provide tools – literally – for promoting mental health.

purpose of the shed, which symbolizes a place free from stigmatization and discrimination."

"Many sheds were actually initiated by women," adds Barry Golding. "And men are often strongly encouraged by their female partners to participate. Sheds are unlike some other mainstream men's organizations (e.g., sporting clubs) in that they are inclusive, collaborative, caring, non-hierarchical and consultative."

Although the shed model has not yet been adopted in Canada, Martin believes it holds potential. During her occupational therapy studies in London, she worked at a mission that served men experiencing homelessness, mental illness or addiction. She discovered that the men who kept returning did so because they felt they had lost their support network in the community. "Community-based programs like sheds can assist men transitioning into the community," says Martin. "They ensure that men maintain a social support system, a key component to recovery." ■

*not his real name

From abuse to advocacy

BY HELEN BUTTERY

Cesaria Hernandez and Duane Minard use their personal experience to educate others about domestic violence.

GOING TO JAIL WAS THE BEST THING THAT HAPPENED TO FORMER Californian police detective Duane Minard. This sounds strange, especially coming from his wife of almost 10 years, Cesaria Hernandez. Even more remarkable is that they are still together, because it was her phone call to police that landed him in jail.

Minard had beat his wife so badly that she had a ruptured eardrum and fractured jaw, and one of her ribs was torn away from the muscle. It was the wake-up call that Minard needed to stop his abusive behaviour. "In other cases, there are no consequences, so the cycle of abuse continues," says Hernandez.

A decade later, the couple is still together, with nine children between them (five from previous relationships and four of their own, ranging in age from 2 to 24). But Minard and Hernandez have not merely managed to survive. They educate and counsel victims and perpetrators of domestic abuse through VODA (Victory Over Domestic Abuse), which Hernandez founded in 2002.

VODA has garnered attention, including Oprah's (the couple was featured on her talk show in 2003), through the couple's decision to stay together and take a hard look at domestic violence, which many still consider a private matter, instead of the criminal act it is. VODA holds perpetrators accountable for their actions, and makes no excuses for them.

Although many have questioned the couple's decision to stay together, they did so only after an eight-month separation to keep Hernandez and the children safe. "Never in good conscience can I say to women, 'I think you should stay,'" says Hernandez. "If a couple is going to reconcile, there has to be a time of separation," she says, adding, "It's essential for both parties to put themselves together."

The decision to stay together also came with serious, legally enforceable conditions. Minard signed a three-year notarized contract relinquishing all assets to Hernandez, including the house and car, if he abused her again. "This wasn't just between Cesaria and me anymore," says Minard. "It was a matter of public record." For abusers, who often hide their abuse behind closed doors and use financial control to gain power over their victims, this "letting go," was "excruciating," says Minard. "Power and control is what domestic violence is about." Minard's career with the police also reinforced the notion that it was acceptable to control other people with force.

Many couples, says Hernandez, find this legal agreement to be a powerful deterrent. "Men have this sense when it comes to signing a legal document that this is the real deal," she says. "The physical act of having it drawn up and signed solidifies its validity."



One couple's story of the power to change

The contract also gives power back to the victims and places responsibility squarely on the shoulders of the perpetrator.

The incident of abuse against Hernandez, two years into their marriage, was the one and only time Minard had attacked Hernandez, but it was not the first time he had perpetrated abuse. His two previous marriages featured a longstanding pattern of abuse that went unchecked for almost 20 years until those marriages ended. Minard assumed this was the course his current marriage would take, too, but he was wrong.

Instead of taking back Minard, who in his previous relationships blamed the woman for bringing on the abuse, Hernandez challenged him. "When I saw Cesaria for the first time after the incident (two weeks later), I thought she was going to want me back under my terms or we'd say goodbye," says Minard. Instead, she asked him a very difficult question: "Why did you do this to me?" After skirting the issue in his usual way, he finally replied, "I don't know, but I'm willing to find out."

Minard started finding out during the eight-month separation that followed that meeting. When Minard finally started to take responsibility for his actions, Hernandez saw it as his first step towards ensuring he never abused again. But it was going to take a lot of work. They read everything they could get their hands on about domestic violence. Both attended counselling, and Minard still sees a therapist. Minard took anger-management classes, and Hernandez joined a support group for abuse victims. If anyone asked if they wanted to talk about it, the answer was always a resounding "yes!"

Early on, Minard and Hernandez sought help from the medical community. "But they immediately wanted to drug us both – anti-depressants for him and anti-anxiety medication for me," Hernandez recalls. That was one approach they didn't support. "We needed to feel the pain. We really wanted to help ourselves to heal with a clean state of mind," she says.

For Minard, this meant facing his demons and owning up to his childhood and upbringing. As a Native American growing up on a reserve, some of Minard's earliest memories were of abuse. "I remember my uncles fighting on the steps to our home," he says. "It seemed to be part of everyday life, and it made violence comfortable," he says. On top of this, he has experienced racism and internalized his perceived social position. "I placed myself as a second-class citizen," he says. "I used violence to regain my status and feel powerful."

In the early days of VODA, Minard stayed in the background while Hernandez set the agenda. But he gradually began talking to women about why men abuse. It was a challenge to explain what he had done and what he was doing to ensure he never abused again. But he knew he was "on the right track." "The main reason this all works is my desire and determination to change my behaviour on every level, not just to be violence-free," he says.

Educating herself has been an empowering experience for Hernandez, who says she was naïve about domestic violence before she experienced it. What she didn't know and was surprised to find out was that almost all of her friends abandoned her. "It's as if they didn't want to feel my pain, or that somehow the violence might rub off on them," she says. Rebuilding her life was lonely and hard. She came to understand why so many women feel trapped in abusive relationships – their partners hold all the financial cards; their peers

"I thought she was going to want me back under my terms or we'd say goodbye." Instead, she asked him, "Why did you do this to me?" He replied, "I don't know, but I'm willing to find out."

shun them and they have nowhere to go. "We live in a violent society that continues to condone violence," she says. "As long as we continue to do that, abuse isn't going to end." A big part of making change is education. "In school, I was taught to use condoms, but domestic violence was never touched," she says.

Hernandez and Minard are doing what they can to make sure their children don't go through what they did. The older children had to face it, as they grew up immersed in their parents' recovery process. Hernandez stresses to her daughters the importance of education and self-reliance. "The younger ones are reaping the benefit because we're raising them differently," says Minard. His old disciplinary tactics of violent outbursts, power and control have been replaced by reason and time-outs.

People have asked Hernandez how she could ever trust Minard again. That trust had to be earned, she says. It took two years and a lot of work before she regained her confidence in her husband and their relationship.

As for Minard, "You have to take responsibility for what you are doing," he says. "Everything you say you are as a man – are you willing to take that energy and put it into your family?" he asks. "It never stops; the recovery process never ends." ■

Fathers on the sidelines

Depression can strike new dads – but where can they turn?

BY DIANA BALLON

ADRIAN* CAN STILL PICTURE A PHOTO TAKEN OF HIS WIFE AND TWIN boys within 24 hours of their birth. “I can see a person who’s completely shell-shocked,” he says, referring to his wife. “I think we both felt exactly the same way.”

Seven years later, Adrian is a successful corporate consultant in Toronto. His two boys are thriving, and his wife happily divides her time between a part-time career and caring for her children.

But Adrian can still recall how he felt in those early days like they were yesterday. It was “like someone has pushed you to the bottom of a well and there’s no way out,” he says. “We had two kids, and all they did was scream, so there was no relief physically or psychologically.”

At the time, neither Adrian nor his wife allowed themselves to think they were depressed. But she was. And so was he.

What Adrian experienced was the male version of postpartum depression, a phenomenon that has until recently been exclusively associated with the depression experienced by about one in eight new mothers in the year following childbirth.

This male depression – also referred to as paternal postnatal depression (PPND) – has garnered less attention than its female counterpart, despite research indicating that a smaller, but by no means insignificant percentage of new fathers also get depressed. According to a 2008 article in the *Journal of Child Psychology and Psychiatry*, about 10 per cent of fathers have depressive symptoms when the child is nine months, compared to 14 per cent of mothers.

This phenomenon reflects those darker times that parents are still reticent to talk about. They’re about exhaustion, and about the tumultuous feelings and upheaval that accompany the entrance of a new person into the home and the couple relationship. “‘Postpartum’ is a term premised on the act of giving birth,” says Adrian. “But what about the stuff that has nothing to do with giving birth – the spectrum of feelings that both men and women can have after the birth of a child that have nothing to do with hormones?”

While both men and women can struggle as new parents, men’s concerns are often less noticeable; they garner less attention; and fathers get less support. This is partly because PPND doesn’t have the same hormonal basis as depression in birth mothers, so psychiatrists may not see it as a diagnosable disorder, says Hiltrud Dawson, a health promotion consultant for Best Start Resource Centre in Toronto.

But others say PPND does indeed exist. Postpartum in fathers is “rarely talked about as a real phenomenon,” says David Sheftel, the provincial co-ordinator of the Father Involvement Network of British Columbia. Sheftel surmises that the slow change to acknowledge men with PPND is in part due to the fact that men don’t tend to ask for support, so funders and service providers don’t always recognize the value of providing support for fathers.

Depression in dads may also be less apparent. Unlike the depression that new mothers experience, the effects are less dramatic for

men – “more of a slow burn,” says Dr. Bill Watson, a Toronto family physician who has run parenting groups and groups for fathers. Parent educator Brian Russell, who works out of the LAMP Early Years Centre in Toronto, agrees. The depression tends not to hit fathers until close to a year after their child’s birth, he says. Fathers have had to keep it together for their partner in those early days; then “they kind of fall apart.”

There may also be a less benign reason for overlooking fathers’ needs postpartum. Even if a father seems depressed, others simply may not have much tolerance for it. As one Toronto mother says when asked if new dads get depressed, “Of course they do.... I do have sympathy for men who experience depression after the baby is born, but my sympathy is short-lived. New fathers have to talk about the difficulties of parenting, but then they should get on with the diapering and laundry.”

“It’s a real double standard,” says Sheftel. Men are being told they should express their fears and be vulnerable, but at the same time, society still expects them to be strong and to provide financially. They are expected to do their fair share of the housework, and they are supposed to be the rock, no matter how scared or vulnerable they may feel. So new fathers may feel shame about acknowledging their feelings. And for women, “it can be hard to hear those feelings,” Sheftel says.

Watson says that when he first started running parenting groups in the 1980s, men were reluctant to talk about their issues in the presence of their female partners. So he created separate groups for fathers only, with quite a different result. The men wouldn’t stop talking, he says. They had so many feelings, and were desperate to speak about them.

Unfortunately, for the few fathers who do get heard, many more will never attend a fathers’ group. Adrian says he confided in no one except his wife in those early days. He felt overwhelmed by the lack of help (both sets of parents live far away). He resented having to be the sole financial provider in a job he didn’t like. And he felt guilty that he couldn’t afford to pay for more help in the home. He also hated having to live up to his wife’s image of an idyllic childhood. And like so many new parents, he was exhausted. “I went from being a sound sleeper to always being in a state of alert, constantly jumping up in the night [whether to real cries or imaginary ones]. It was constant; there was no respite.”

For fathers, depression may show up in subtler ways than a classic depression. They may start to avoid the family, perhaps by working later, or by seeming more remote when they are with their family, says Russell. They may not pick up the baby’s cues. And if their partner is depressed – one of the main predictors for PPND – they may feel inadequate to help her or the baby. They have a lot of responsibility, and they get to a point when they feel like they’re doing everything wrong, says Russell.

An added complication to men taking more domestic responsibility is that “some women are reluctant to give up caregiving roles,” says Sheftel. A 2010 article in *Personal Relationships* describes how, despite the dramatic rise of mothers in the workplace, many before their child is one year old, employed mothers are ambivalent about their male partners being involved in housework and childcare. Those who saw their partners as “skillful caregivers” actually felt less competent themselves, reflecting “socially constructed ideals of motherhood.”

RESOURCES FOR HELPING SAD DADS

Canadian Father Involvement Initiative
www.cfii.ca/en/page/home

Father Involvement Bulletin
 Visit www.beststart.org/services/bulletins.html.
 Under “Special Bulletins,” choose February 10, 2010

Father Involvement Research Alliance
www.fira.ca

Postpartum Dads Project
<http://postpartumdadsproject.org>

PostpartumMen
www.postpartummen.com

There is also a catch-22. Feminism is encouraging women that they can do everything men can do in their careers, but there is no equivalent when it comes to acknowledging men’s capabilities in the home with their children, says Sheftel. Men are often portrayed as incompetent in the domestic world, and many end up feeling that way. The reality is that many haven’t had good role models for the nurturing father, and they’re less likely to have babysat as teenagers, so they don’t always know what to do. But this doesn’t mean they’re any less committed or that they can’t make important contributions to parenting, Sheftel says.

Another reality is that when new fathers do reach out, many feel alienated by what they find. A 2009 issue of the *Journal of Advanced Nursing* revealed how women-only online forums provide much-needed support to mothers, but that they can marginalize fathers by not involving them in child-rearing discussions.

At family service agencies, the reading material in waiting room tends to be women’s magazines, and most staff are women, says Sheftel. And organized activities, such as “Movies for Mommies,” exclude men by their title alone. Ultimately, “dad watches from the sidelines,” says Sheftel.

Public health programs do need to emphasize support for women in the prenatal and postpartum periods, as these are the times when women can be particularly isolated, says Dawson, but that doesn’t mean ignoring the needs of expectant and new fathers.

For now, this support is mainly relegated to fathers’ and men’s groups; however, the message is slowly seeping into prenatal classes and other family-based services that men also need help. Community services need to shift their focus from helping and supporting mothers, to helping parents, regardless of their gender, so they can be good parents and find happiness in their own right.

For Adrian, it’s been an upward battle. It has left “a permanent scar,” he says. “I’m no longer carefree as I used to be. Anxiety has become a permanent state.”

Was it shame, I ask, about the depression? No, not really, he says. “It was more bafflement. I didn’t know myself anymore.” ■

*not his real name

The “baby patch”

Smoking cessation interventions embrace new fathers

BY AVRIL ROBERTS

Fathers who smoke don't generate as much attention as pregnant women or mothers who smoke. Now, Dr. Joan Bottorff, director of the Institute for Healthy Living and Chronic Disease Prevention at the University of British Columbia, is leading groundbreaking research showing how new fatherhood may be an opportune time to help men stop smoking.

Why focus on new fathers for smoking reduction or cessation?

First, it would go a long way towards supporting women's tobacco reduction. Second, it would protect infants from second-hand smoke and create more smoke-free homes. Third, it would enhance men's health. Men typically don't think about stopping smoking until they have their first heart attack, but here we can intervene with men at a younger age. The men we interviewed talked about wanting to be able to run and play soccer and keep up with their kids, so they were already thinking about their own health as it relates to their role as fathers.

What have you learned about why expectant and new fathers continue to smoke?

Smoking is tied to men's identity; many men find it difficult to imagine life without cigarettes. Men also tell us that becoming a new father is stressful; there is added pressure to provide for their families. Because men say smoking helps to manage that stress, some believe they would be better partners and fathers if they continued to smoke. They worry that if they stop smoking they would become irritable, which might influence their ability to be good partners and fathers.

How does new fatherhood affect men's smoking?

Before men actually held their babies or the babies became real to them, they thought: “I can continue to smoke. It's not going to interfere with my partner or my baby. I'm going to smoke outside. I can keep it totally separate.” However, we found that as men began to connect with their infants, they

became more uncomfortable with smoking. They began to realize that the ideal of a good father is not a smoking father; so they sensed a contradiction as they began to change their identity from a man who smokes to a father who smokes. Taking on the identity of a father created tension and began to motivate some men. The more engaged men were in fathering, the more they reduced their smoking, simply because there was less time to smoke.

There were also fewer places to smoke – they can't smoke in the house any more. Some men became sensitive to the stigma attached to smoking – they got looks if they were smoking while pushing a stroller, for example. Others worried that while smoking outdoors they were missing important activities relating to the baby and said they wanted to be inside with their families.

What smoking cessation / reduction strategies do new fathers use?

Few men used smoking cessation aids. Most thought that if they decided to quit and had enough willpower, they could just do it. We need to reinforce the message that it sometimes takes many attempts to quit. Some men made detailed plans about how they would reduce their smoking by eliminating one cigarette a day for the first two weeks, then another cigarette a day for another two weeks and so on. It wasn't entirely clear when they would get to zero cigarettes. However, the fact that they were reducing is a step toward giving up smoking. One man told us that he had tried quitting smoking many times, but that once he became a father, it was easier – the baby was the “patch.” This shows how strong a motivator the baby can be.

Speaking of the patch, many of the men see it as a sign of weakness. Some said they carried the patch just in case they needed it. A few spoke of being teased in the gym when other men noticed they were wearing it. The men who did use the patch were doing it mostly on their own and having trouble determining the right amount to use. Providing support around the best way to

use the patch could go a long way to making the cessation process more comfortable and successful. We also have to figure out how to make the patch a masculine symbol of strength, not weakness.

How will you incorporate your findings into new smoking reduction/cessation interventions?

Based on consultations with men, their partners and health care professionals, we are developing three resources:

We have just launched a booklet featuring men talking with men. It integrates quotes from our interviews and focuses on fathering and the identity shift to get men thinking about their smoking. It presents possibilities for men to choose from to make their own way, instead of stepwise instructions about how to quit smoking.

To our surprise, some men wanted a group. We have designed a 10-week program that includes support for tobacco reduction and cessation; a strong fathering theme to help men become comfortable with fathering; and a healthy living component for stress reduction. We hope to provide child care to give partners a break while fathers attend the program. We anticipate a pilot launch this fall.

For spring 2011, we plan to integrate what we have learned about women and smoking into a better smoking cessation support for women during pregnancy and pair that with a piece that targets the smoking partner in the woman's life. A lot of tension and sometimes conflict occur in pregnant couples around smoking, so we have to address that separately with women and their partners.

For more information about tobacco reduction for new fathers, visit the Families Controlling and Eliminating Tobacco website at www.facet.ubc.ca ■

Young black men talk about looking for safety in a violent world

Wrong Place, Wrong Time: Trauma and Violence in the Lives of Young Black Men looks beyond the gunplay by offering a new window on urban violence. Author Dr. John A. Rich, a former medical director of the Boston Public Health Commission and director of the Center for Academic Public Health Practice, comes to the subject from the vantage point of someone who has worked on the problem at ground zero. Rich humanizes the cold statistics of Black-on-Black violence by presenting stories in the victims' own words.

Wrong Place, Wrong Time is not about homicide rates, which Rich rightly calls “the tip of the iceberg.” Left unseen, and scandalously unreported by the news media, are the non-fatal shootings, knifings and beatings that take place nightly. “For every person who gets shot and dies, another four get shot and survive,” he writes. He takes us into the world of the survivor and demonstrates that their traumas began long before shots rang out. Pervasive fear and the instinct for physical and emotional survival, not economic necessity, turned them to violence.

Rich introduces an unusual fact-finding methodology by engaging youth at the critical point of a life crisis – their life-saving trip through the emergency ward. The relationships that he develops with each youth served as the conduit to insights into their attitudes towards violence. They expose root causes of youth violence, experienced by

those living in the social conditions where it occurs. Rich's account is professional and personal, as he reports how spending hours and days with these young men transformed him. As I write this review, I must admit that I feel a kinship with Dr. Rich and his interview subjects – we are all Black, and the “teachings” articulated by the young men in their street vernacular resonate.

We hear from David, Kari, Roy, Jimmy and Mark, the purveyors of the lived experiences at the core of this book. We walk in their shoes on their chaotic and violent streets, and we learn something about the necessity of acting tough in order to get respect. The reader is exposed to what it means to feel physically, psychologically and socially unsafe, and how getting a weapon for self-defense or retaliation is a pressing decision for youth living within the “condition.” *Wrong Place, Wrong Time* presents the story of the relationships between experiences of loss, dehumanization and other victimizations as a precursor to trauma. One is challenged to appreciate the cultures of trauma in which both victims and perpetrators are trapped. This reality is not restricted to the United States, as similar patterns exist in Canada.

Rich was stung by the ignorance and insensitivity of his colleagues who assumed that when a young Black man was rolled into the emergency room with a gunshot wound, “He didn't just get shot; he got himself shot.”

This book implores the reader to refrain from such judgments. No apologist for violence, Rich asks that we not so much judge the actions of Kari and company, “good or bad, sensible or senseless as... hear from them and understand how and why they arrive in these perilous places.” The stories seem to affirm that Black youth are committing homicide and suicide simultaneously, as articulated by Dr. Kenneth Hardy in his 2006 book *Teens Who Hurt: Clinical Interventions to Break the Cycle of Adolescent Violence*.

We must understand that these violent young men seem to be looking for safety in a violent world, using violence. Rich suggest it is simply not acceptable to begin the analysis by examining the outcomes for victims and perpetrators; we must challenge the environments that seem to blindly sustain the cycle of victimization in order to prevent it. *Wrong Place, Wrong Time* makes a compelling case for addressing youth violence from a public health framework, and I intend to make it required reading for my staff. ■

Wrong Place, Wrong Time: Trauma and Violence in the Lives of Young Black Men. John A. Rich. Johns Hopkins UP, Baltimore, Maryland, 232 pp. 2009. \$24.95 hardcover.

Lew Golding is manager of the Substance Abuse Program for African Canadian and Caribbean Youth at the Centre for Addiction and Mental Health in Toronto.

Ask the ethicist

Do you think Dr. Gregory House of the popular TV show *House, MD*, is the epitome of ethical medical practice? Can he teach clinicians useful lessons in health care ethics?

Read what Barbara Russell, bioethicist at the Centre for Addiction and Mental Health in Toronto, thinks about this topic, and more, in her Ask the Ethicist blog. It's a new, regular online feature of *CrossCurrents*, where you can add comments and submit ethics questions to be considered for future columns.

blog

Read the Ask the ethicist blog at
www.camhcrosscurrents.net/blogs/ethicist/

Reaching beyond gendered responses to address male victimization

RAMONA ALAGGIA

Abuse and violence have long been constructed along gender lines, with the dominant framework emphasizing male perpetrators and female victims. Although most sexual crimes are committed by men, this should not discount the reality that males, especially in childhood, are as vulnerable to sexual victimization as females. Reported rates of child sexual abuse have long been regarded as the “tip of the iceberg,” with Canadian rates of female victimization estimated at about one in four for girls before age 18 and about one in six for boys. However, recent studies suggest that prevalence rates of sexual abuse of boys have been significantly underestimated and may be closer to those of girls. Disclosure for all children is difficult, but it might be more complicated for boys because of societal attitudes that boys are expected not to be in positions of weakness and because boys are most often sexually abused by men. Research shows that disclosing same-sex abuse is threatening for most males.

From a feminist perspective, women and children historically have been vulnerable to sexual exploitation and violence because of their disempowered position in society and their relational and economic dependence on men. Males in childhood are treated in the same devalued position as women and female children. While trends are slowly shifting in gender relations, we still see generations of men exhibiting serious effects of childhood victimization that include depression, aggression, low self-esteem, addiction, anxiety and sexual dysfunction that persist into adulthood. Unfortunately, these problems manifest in ways that often result in men ending up in the criminal justice system, often for violent crimes.

Male victimization in cases of childhood sexual abuse raises important questions of gender symmetry, as there might possibly be as many boy victims as girl victims. However, significant gender

differences still clearly exist when examining perpetrators, since studies consistently show that there are many more male than female perpetrators of child sexual abuse.

Domestic violence is another area of controversy where male victimization is being debated in terms of gender symmetry. Gender symmetry centres on notions that males and females are equally victims of childhood sexual abuse and intimate partner violence, and that there are as many female as male perpetrators of all forms of abuse. While clinical research indicates that women are most often the victims of intimate partner violence, population studies now claim that men are just as often victims, especially in younger couples. These results are somewhat skewed, as they are derived from sociological studies that rely on college and university samples in which developmental and alcohol factors may account for mutual couple violence. When shelter and child welfare clients are investigated, the overwhelming numbers of victims are women. The consequences of violence are also more profound and enduring for female victims on emotional and financial dimensions, and especially in regards to safety. Homicide victims of intimate partner violence in North America are predominantly women and children. Canadian census data also indicate that women are significantly more likely than men to suffer serious injuries with life-long repercussions as a result of domestic assaults. Abused women who are forced to flee relationships are more frequently left in financial ruin and alienated from their cultural communities and extended families. The consequences of domestic violence are more serious and far-reaching for women in all areas of functioning.

Gender symmetry and its relationship to intimate partner violence is a murkier issue. Many researchers and clinicians are sceptical of how women's use of violence is measured because self-defence by women

and the use of violence in retaliation for long-term abuses are counted. Critics argue that these acts are qualitatively different and should not be lumped in the same category of men's violence perpetrated for control and subordination. It is further asserted that if shelters for men did exist, they would be grossly underused because significantly fewer men are abused and fear for their lives, and men have more access to financial resources to leave relationships in ways other than turning to shelters.

Male victimization has entered the arena of identity politics to claim their status as a marginalized group who are not readily identified or accepted as victims of sexual and relational violence. With this emergence come agendas for the creation of and access to resources. Men's advocacy groups claim that if services such as shelters existed for abused men, they would be filled. Men who were sexually abused as boys assert that when men disclose, there are almost no survivor services for therapy to recover from their victimization. Male survivor groups have formed in the United States and have been successful in creating service networks and raising awareness of the prevalence of male child sexual abuse; for example, they have exposed the extent of sexual abuse by clergy, which has forced the Roman Catholic Church to start to acknowledge these historic violations and to take action to prevent further abuses.

In the final analysis, what should not be lost to these debates is that regardless of gender, violence has serious effects. No one should be assumed to be free from risk. These issues should be explored with anyone seeking psychosocial counselling and need to be addressed through compassionate dialogue and effective treatments.

Ramona Alaggia holds the Chair in Children's Mental Health at the Factor-Inwentash Faculty of Social Work at the University of Toronto.

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CANADA

National Summer Institute on Addictions

July 12–15, Stanhope, Prince Edward Island
 Contact: NSI 2010, c/o Canadian Centre on Substance Abuse, 75 Albert St., Ste. 500, Ottawa, ON K1P 5E7
 e-mail nsi@ccsa.ca
 www.ccsa.ca/Eng/NewsAndEvents/CCSA_Events/

3rd Biennial Conference on Brain Development and Learning

July 16–20, Vancouver, British Columbia
 Contact: UBC Interprofessional Continuing Education, Room 105, 2194 Health Sciences Mall, Vancouver, BC V6T 1Z3
 tel 604 827-3112
 e-mail devcogneuro@gmail.com
 www.interprofessional.ubc.ca/bdl.html

International Network on Personal Meaning 6th Biennial Conference: "Creating a Psychologically Healthy Workplace"

August 5–8, Vancouver, British Columbia
 Contact: INPM, 13 Ballyconnor Court, Toronto, ON M2M 4C5
 e-mail info@meaning.ca
 www.meaning.ca

Psychosocial Rehabilitation Canada Conference

September 20–23, Ottawa, Ontario
 Contact: PSR/RPS Canada, P.O. Box 13060, 140 Holland St. W., Bradford, ON L3Z 2Y5
 toll-free tel 866 655-8548
 fax 705 456-9786
 e-mail support@psrrpscanada.ca
 www.psrrpscanada.ca

Canadian Psychiatric Association 60th Annual Conference

September 23–26, Toronto, Ontario
 Contact: CPA, 141 Laurier Ave. W., Ste. 701, Ottawa, ON K1P 5J3
 tel 613 234-2815
 fax 613 234-9857
 e-mail conference@cpa-apc.org
 www.cpa-apc.org/browse/documents/92

Canadian Coalition for Seniors' Mental Health 4th National Conference

September 27–28, Halifax, Nova Scotia
 Contact: CCSMH, c/o Baycrest, 3560 Bathurst St., Rm. 311, West Wing, Old Hospital, Toronto, ON M6A 2E1
 tel 416 785-2500, ext. 6331
 e-mail kwilson@baycrest.org
 www.ccsmhvents.ca/2010conference

Health and Wellbeing in Children, Youth and Adults with Developmental Disabilities Conference

September 29–October 1, Vancouver, British Columbia
 Contact: UBC Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3
 tel 604 822-7524
 e-mail ipad@interchange.ubc.ca
 www.interprofessional.ubc.ca/Developmental_Disabilities.html

5th International CECD Conference: Creative Expression, Communication and Dementia

October 1–2, Penticton, British Columbia
 Contact: Society for the Arts in Dementia Care, 125 West 2nd St., Ste. 100, North Vancouver, BC V7M 1C5
 tel 604 986-6408
 e-mail Info@CECD-Society.org
 www.cecd-society.org/

Canadian Society of Addiction Medicine Annual Conference

October 19–23, Charlottetown, Prince Edward Island
 Contact: CSAM, 47 Tuscany Ridge Terrace N.W., Calgary, AB T3L 3A5
 tel 403 813-7217
 fax 403 944-2056
 e-mail admin@csam.org
 www.csam.org

Thriving in 2010 and Beyond

October 22–24, London, Ontario
 Contact: Thriving in 2010 and Beyond, c/o Canadian Mental Health Association, London-Middlesex Branch, 648 Huron St., London, ON N5Y 4J8
 tel 519 434-9191
 e-mail info@thrivingin2010.ca
 www.thrivingin2010.ca

UNITED STATES

State Associations of Addiction Services National Conference

July 11–14, Cincinnati, Ohio
 Contact: 236 Massachusetts Ave. N.E., Ste. 505, Washington, DC 20002
 tel 202 546-4600
 fax 202 544-5712
 e-mail registration@sitesolutionsworldwide.com
 www.saasnet.org/drupal-6.6/node/101

4th National SAMHSA Conference on Women, Addiction and Recovery

July 26–28, Chicago, Illinois
 e-mail SAMHSAWomensConference@ahpnet.com
 www.samhsawomensconference.org/

68th Annual Conference of the International Council of Psychologists

August 3–7, Chicago, Illinois
 e-mail SMachizawa@thechicagoschool.edu
 www.icpweb.org

American Psychological Association 118th Annual Convention

August 12–15, San Diego, California
 Contact: APA, 750 First St., N.E., Washington, DC 20002-4242
 tel 202 336-5500
 fax 202 336-5693
 e-mail convention@apa.org
 www.apa.org/convention/

18th ISPCAN International Congress on Child Abuse and Neglect

September 26–29, Honolulu, Hawaii
 Contact: International Society for Prevention of Child Abuse and Neglect, 13123 E. 16th Ave., B390, Aurora, Colorado 80045-7106
 tel 303 864-5220
 fax 303 864-5222
 e-mail congress2010@ispcan.org
 www.ispcan.org/congress2010

American Psychiatric Association 62nd Institute on Psychiatric Services

October 14–17, Boston, Massachusetts
 Contact: APA, 1000 Wilson Blvd., Ste. 1825, Arlington, VA 22209-3901
 tel 703 907-7300
 e-mail: apa@psych.org
 www.psych.org/ips

Association for the Treatment of Sexual Abusers 29th Annual Research and Treatment Conference

October 20–23, Phoenix, Arizona
 Contact: ATSA, 4900 SW Griffith Dr., Ste. 274, Beaverton, OR 97005
 tel 503 643-1023
 fax 503 643-5084
 e-mail atsa@atsa.com
 www.atsa.com/conf.html

American Association for the Treatment of Opioid Dependence National Conference

October 23–27 Chicago, Illinois
 Contact: 225 Varick St., 4th fl., New York, NY 10014
 tel 212 566-5555
 fax 212 36604647
 e-mail info@aatod.org
 www.AATOD.org

American Academy of Child & Adolescent Psychiatry 57th Annual Meeting

October 26–31, New York, New York
 Contact: AACAP, 3615 Wisconsin Ave., N.W., Washington, DC 20016-3007
 tel 202 966-7300
 fax 202 966-2891
 e-mail ntejada@aacap.org
 www.aacap.org/cs/AnnualMeeting/2010

International Nurses Society on Addictions National Educational Conference

October 27–30, Old Greenwich, Connecticut
 Contact: International Nurses Society on Addictions, P.O. Box 14846, Lenexa, KS 66285-4846
 e-mail intnsa@intnsa.org
 www.intnsa.org/events.php

National Federation of Families for Children's Mental Health 22nd Annual Conference

November 5–7, Atlanta, Georgia
 Contact: National Federation of Families for Children's Mental Health, 9605 Medical Center Dr., Ste. 280, Rockville, MD 20850
 tel 240/403-1901
 fax 240 403-1909
 e-mail ffcmh@ffcmh.org

6th World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders

November 17–19, Washington, DC
 tel 617 618-2262
 e-mail aoneill@edc.org
 http://wmhconf2010.hhd.org/

Association for Behavioral and Cognitive Therapies 44th Annual Convention

November 18–21, San Francisco, California
 tel 212 647-1890
 e-mail convention@abct.org
 www.abct.org

ABROAD

16th International Network for Psychiatric Nursing Research Conference

September 22–23, Oxford, United Kingdom
 Contact: Kathryn Clark, Royal College of Nursing, 20 Cavendish Square, London, UK W1G 0RN
 e-mail kathryn.clark@rcn.org.uk
 www.rcn.org.uk/research2010

International Society of Addiction Medicine Annual Meeting

October 4–7, Milan, Italy
 e-mail dntb@unimib.it
 www.isam2010.medicina.unimib.it

4th International Conference of Schizophrenia

October 22–24, Chennai, India
 Contact: Dr. Thara / Dr. R. Padmavati, Schizophrenia Research Foundation, #R/7A North Main Rd., Anna Nagar (West Extn.), Chennai 600 101, India
 e-mail info@icons-scarf.org
 www.icons-scarf.org

2nd International Conference on Violence in the Health Sector

October 27–29, Amsterdam, The Netherlands
 Contact: Oud Consultancy, Hakfort 621, 1102 LA Amsterdam, The Netherlands
 e-mail conference.management@freeler.nl
 www.oudconsultancy.nl

53rd International ICAA Conference on Dependencies

November 7–12, Cancun, Mexico
 e-mail icaa2010@icaa.ch
 www.icaa.ch/mexico2010.html

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