Mind the (gender) gap
...in Canada’s new mental health framework

Making the links
Violence, trauma and mental health

Girls take action on mental health
Gender and the mental health of young Canadians

Understanding stigma through a gender lens
**Editor's Note:**

This issue of *Network* focuses on why and how gender matters in mental health in Canada—a high priority in our work at the Canadian Women's Health Network and the Centres of Excellence for Women's Health. With the Mental Health Commission of Canada currently shining the spotlight on mental health issues across the country, we have the opportunity to further promote and advance sex- and gender-based analysis of mental health care in this country. In January 2009 the Commission released its first draft framework of a Canadian mental health strategy for public discussion: *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy in Canada.* Unfortunately, the Commission’s newly released strategy does not yet include a sex- and gender-based analysis.

*CWHN* and the Centres of Excellence continue to work as part of the Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions (established in 2006) to promote the need for a sex- and gender-based analysis, especially as the Commission begins to implement its recommendations. The Working Group’s background research report, *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview* (updated in 2008) presents compelling evidence that gender and mental health are inseparable.

The articles in this issue of *Network* reiterate some of the key points of the Working Group’s report and demonstrate how important it is to include a sex- and gender-based analysis in mental health to create programs and develop models of care that effectively address the needs of all Canadians.

Carolyn Shimmin, Information Centre Coordinator at CWHN, has worked closely with the Ad Hoc Working Group. Her article “Mind the (gender) gap” discusses the Commission’s new health strategy and why sex and gender must be considered. Another article by Shimmin addresses the topic of stigma associated with mental health and provides an analysis of anti-stigma campaigns—one of the priority areas of the Commission’s strategy.

The work of the Centres of Excellence for Women’s Health is profiled in an article on the complex links among violence, trauma and mental health, and in another article examining the mental health of health care workers. An excerpt from a new report, *The Need for a Gender-Sensitive Approach to the Mental Health of Young Canadians,* presents the work of the Girls Action Foundation. And the DisAbled Women’s Network Canada presents the results of a recent survey on accessibility at women’s shelters in Canada, poignantly illustrated by one woman’s story in Prince Edward Island that reveals a face behind the statistics.

One of the aims of this issue of the magazine is to profile existing and effective models of mental health care that incorporate gender-based analysis. This includes the work of the Brief Psychotherapy Centre for Women in Toronto, and the...
work on “trauma-informed” models of care by the British Columbia Centre of Excellence for Women’s Health, as well as a first person account of Vancouver’s Art Studios.

We also included several testimonials from women about their personal experiences related to mental health and healing through art, spirituality and by taking action for change. The article “Are there alternatives to drugs?” answers its own question with a resounding “yes” and presents an abbreviated step-by-step guide to good physical and mental health for all (good tips for all of you activists and researchers out there working on health but neglecting your own). Finally, the expanded resource review section provides information about a variety of websites and publications focused on women’s mental health for further research and information.

The theme of gender and mental health is obviously vast and, while this is by no means a comprehensive overview, we have tried to include a diversity of issues and voices. Thanks to Carolyn Shimmin for assisting with the coordination of this issue, as well as for her contribution of articles and reviews.

This is my final issue as Editor of Network magazine. In September I will be returning to university and someone new will take my place. It was wonderful to work with the women at the Canadian Women’s Health Network and the Centres of Excellence for Women’s Health over the past year and a half, and to have the opportunity to work on a variety of women’s health issues—topics that will remain central to my studies and work in the future. With a new Director of Communications coming on board, Network magazine will be changing its face and format in the fall. So stay tuned for the next installment of information and research on women’s health in Canada.

Peace and good health to you all.

Sincerely,
Ellen Reynolds
Director of Communications
Entitled, *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy in Canada*, the Commission held stakeholders’ conferences across the country as well as an electronic consultation on their website to get public feedback on the document. Divided into eight goals, the framework includes some good recommendations, such as a recovery-oriented mental health system in which people are able to make meaningful choices of services and supports (with a funding mechanism that allows individuals to make such choices). Though the framework appears to be a step in the right direction, one thing is glaringly apparent—as with all documents published by the Commission to date, it does not include a sex- and gender-based analysis.

Health research continues to document that sex and gender matter—in research synthesis, policy and programs. In fact, research shows that a sex- and gender-based analysis leads to better science. Governments and research funding bodies have recognized this in their policies and practices. For example, in 2000, the federal government approved the Agenda for Gender Equality, an initiative which included new policies and programs and the accelerated implementation of commitments to include gender-based analysis. Health Canada’s commitment is expressed in the Women’s Health Strategy (1999) and Gender-Based Analysis Policy (2000). The Canadian Institutes of Health Research requires the application of a sex- and gender-based analysis on the basis that it is “good science,” ethical and essential to equity.

Most importantly, research shows that not paying attention to gender differences, or “gender neutrality,” leads to error, which in turn leads to missed opportunities, misuse of resources and poor outcomes. So why, in the creation of a national mental health strategy would the Mental Health Commission of Canada’s new mental health framework
Despite the wealth of literature emphasizing the importance of examining mental health issues from a gender-based perspective, a GBA has not been reflected in recent reports on mental health in Canada. None of the large-scale Canadian reports such as the Romanow Commission’s Final Report on the Future of Health Care in Canada, 2002, the Standing Senate Committee on Social Affairs, Science and Technology’s Out of the Shadows at Last: Transforming Mental Health Mental Illness and Addiction Services in Canada, 2005, and the MHCC’s A Time for Action: Tackling Stigma and Discrimination, 2008, have involved a GBA of mental health in Canada.

Just as sex and gender matter in understanding health in general, they matter in understanding and seeking the best approaches to mental health and addiction. For example, there are sex- and gender-specific differences in the types and prevalence of certain mental health conditions. Postpartum depression is sex-specific and there is a higher prevalence of internalizing disorders such as major depression in women and externalizing disorders such as alcohol and drug addictions in men. There are also many mental health conditions which appear to be gender-neutral but are not. The onset of schizophrenia differs between men and women, with men typically developing schizophrenia much earlier than women. With the severity of schizophrenia being associated with age of illness onset, men often have more severe forms of the illness.

It has also been shown that women and men seek different types of care, with men overall less likely than women to seek help whether from professionals or from lay persons. There are also sex-specific differences in the metabolism and effects of psychotropic drugs. Research has shown that there are vital differences between males and females in the metabolism and effects of psychotropic drugs used to treat schizophrenia, depression and anxiety, which may affect clinical outcomes and costs. Research also indicates that women in North America are prescribed twice as many psychotropic (mood altering) drugs compared with men.

Gender roles in society can also have an enormous impact on mental health. The World Health Organization has found that men are far more likely than women to disclose problems with alcohol use to their health care providers. Women have more difficulty coming forward with alcohol and drug addictions because of women’s perceived “place” in society as “people who bear and rear children” as well as the negative stereotype that women users are sexually promiscuous because of their drug use. This association is not seen in men. But men have more difficulty coming forward with a mental health problem as the characteristics of traditional masculinity including “don’t cry,” “be tough,” “go it alone,” and “don’t show any emotion,” can cause men to perceive mental health problems as weakness and thus not seek out the necessary help (which explains the high rate of suicide in men and alcohol and drug addiction).

Yet, in the Commission’s 58-page framework for a national mental health strategy, gender is mentioned only once. When discussing the need for supports for family caregivers, it fails to mention that 80% of all caregivers in Canada are women, and that recent research has shown that men and women differ in both their caregiving experience (women giving more hours of unpaid care than men, traveling farther and more frequently to provide unpaid caregiving than men, performing more demanding forms of caregiving than men, and more often having responsibility for more than one care recipient than men) and their caregiving needs (research has shown that men are more likely than women to feel they have other options available to them when deciding to become a primary caregiver, and women are more likely to experience difficulties, both physical and psychological, as a result of providing care to someone diagnosed with a mental illness in particular).

When discussing stigma and discrimination against those living with mental illness the Commission’s framework does not mention that women and men both experience stigma differently and differ in their attitudes towards mental illness (to read more about stigma, go to page 14).

There also seems to be a misunderstanding of what gender means in the Commission’s framework—a lack of recognition that all people and populations are always gendered and that the contexts of men’s and women’s lives matter. Gender is presented as another “cultural difference” in the framework, comparing it to the difference between urban and rural settings, or different types of work. It is not acknowledged how sex and gender intersect through race, ethnicity, class, age, location, ability, sexual orientation, etc.

The effects of a lack of a sex- and gender-based analysis of poverty and homelessness can already be demonstrated in the MHCC’s homelessness project. In Winnipeg, one of the major cities participating in the project, those working and living in homeless shelters are well aware that there are more men on the streets because women are more likely to remain in violent relationships to have shelter for themselves and their children. Without a gender-based analysis, the project will never examine these different reasons why men and women are or are not on the streets.

Although the Commissioners mention that joint action
Violence and trauma, including childhood abuse, sexual abuse, and intimate partner violence, are common in Canada. It is conservatively estimated that half of all Canadian women and one-third of Canadian men have survived at least one incidence of sexual or physical violence. Although both boys and girls are affected by family violence, four out of five victims of family-related sexual assaults (79%) are girls.

Heather Pollett writes in *The Connection Between Violence, Trauma and Mental Illness in Women* that the relationship between trauma and mental health is a complex one; not all people who experience abuse, either in childhood or adulthood, inevitably develop a mental illness, and not everyone who has been diagnosed with a mental illness has experienced abuse. Yet research has established a strong association between trauma, violence and mental health. Those reporting a history of childhood physical abuse have significantly higher rates of anxiety disorders, alcohol dependence and antisocial behaviour, and are more likely to have one or more disorders than were those without such a history.

Childhood history of abuse

Research by H. MacMillan et al. (2001) found that women with a history of physical abuse have “significantly higher lifetime rates of major depression and illicit drug abuse/dependence than did women with no history.” This association was not found in men. For men the prevalence of disorders tended to be higher among those who report exposure to sexual abuse, but only with associations to alcohol dependence. Therefore, the relationship between a childhood history of physical abuse and lifetime psychopathology (mental illness or disorder) varies significantly by gender. A similar relationship has been seen between a childhood history of sexual abuse and lifetime psychopathology.

Epidemiological studies have also shown that the risk of developing Post Traumatic Stress Disorder (PTSD) among those exposed to violence is approximately twofold higher in women and that women often experience a characteristic cluster of symptoms that has been named “complex PTSD.” Vulnerability factors may include: women’s greater likelihood of exposure to assultive violence, societal influences, gendered meanings ascribed to traumatic experiences, and hormonal influences.
Reasons for disclosure

The reasons men and women do not disclose personal trauma such as experiences of childhood sexual violence may differ as well; studies have shown that males report difficulty disclosing because they fear being viewed as homosexual and as victims, while women's difficulties centre on feeling conflicted about responsibility, and they more strongly anticipate being blamed or not believed.

Effects of violence and treatment

For women, problems most commonly associated with the experience of violence include: depression, anxiety, post-traumatic stress disorder, personality disorders, dissociative identity disorder, psychosis, and eating disorders. For men, childhood maltreatment has been associated with problem alcohol use. Women make three to four times more suicide attempts than men (though men succeed more often than women). The Ontario Canadian Mental Health Association has found that there is a significant correlation between a history of sexual abuse and the lifetime number of suicide attempts, and this correlation is twice as strong for women as for men.

Pollett writes that individuals who have experienced violence, like others dealing with mental health problems, face mental health treatments that are primarily based on the biomedical model (focused on biological and genetic factors of mental health instead of social determinants such as poverty, housing, stigma and past experiences of violence). Women who require mental health services often receive inappropriate diagnoses and treatment or are denied services because their behaviour is misunderstood or stigmatized.

She also writes that borderline personality disorder (BPD), for example, is diagnosed in women at three times the rate of men. Women with this diagnosis may be more often in crisis situations and access health resources more frequently than men because BPD is considered difficult to treat. It has been shown that if the symptoms of BPD are not recognized as trauma-related and treated as such, these women may be at increased risk for violence or even suicide. Misdiagnosis and inappropriate mental health treatment can also reinforce self-destructive behaviours such as drug and alcohol use.

Violent criminal behaviour

Men and women who do not receive appropriate care for trauma, mental health and addictions problems may end up falling through the cracks and end up within the correctional system. A study found that the pathways between childhood abuse and neglect and violent criminal behaviour are different for men and women; for men childhood maltreatment has both a direct effect on aggressive behaviour and an indirect one, through alcohol, while for women, only the indirect path was found.

In Canada, 82% of federally sentenced women have reported past sexual and/or physical abuse, and the rate increases to 90% for Aboriginal women. The Elizabeth Fry Society reports that more federally sentenced women than men have received a diagnosis of mental illness and their issues tend to be different. For instance, women in federal correctional institutions have a higher rate of self-mutilation and attempted suicide than their male counterparts.

Substance use

Substance use and mental health problems frequently co-occur among people who are survivors of violence, trauma and abuse, often in complex, indirect, mutually reinforcing ways. Many women identify substance use as a way to cope with gender-based abuse and trauma. Nancy Poole writes in *Gender does matter: Coalescing on women and substance use that alcohol problems have been found to be up to 15 times higher among women survivors of partner violence than in the general population. Yet service providers and policy-makers have not always acted on these connections; services with a primary mandate for domestic violence and sexual assault have often not served women with substance use problems, adding to women's vulnerability. Addiction services also must integrate work on trauma, provide information on the connections with addiction recovery and offer individual and group programming.

Effective models of care

The lack of gender-specific responses to the linked issues of violence, trauma, substance use, and mental health problems has resulted in significant costs for service systems: women and men with trauma histories are likely to repeatedly use emergency rooms, mental health inpatient units, and/or end up in the criminal justice system as they cope with symptoms in a context of unresponsive health and social policies and programs. A study found that women who reported a history of childhood sexual trauma were more likely to visit emergency rooms and had annual total health care costs which were significantly higher than women without such a history (these costs were still observed after excluding the costs of mental health care). It has also been shown that adult women victims of sexual trauma use higher levels of health care (more physician visits and higher outpatient costs) when compared to women who have experienced other forms of violence.

The application of a gender-based analysis has assisted health systems and communities in developing evidence-based models that provide effective, integrated, gender-specific care to women and men for violence, trauma, substance use, and mental health
The experience of trauma and violence is often central in the lives of women with substance use problems and mental health concerns. However, health and social service systems have not historically taken this reality into account. Yet, increasingly, mental health and addictions service providers are finding ways to work with representatives of the anti-violence field to offer programming that integrates support on all three issues (trauma, mental ill health and problematic substance use). “Seeking Safety” is one model of such integrated programming, developed by Dr. Lisa M. Najavits at Harvard Medical School, and is now applied in a range of settings in British Columbia.

Seeking Safety is group programming which integrates support on trauma-related, addictions and mental health issues, with a focus on establishing safety, restoring ideals and making connections to community-based services.

In November 2008, women’s and children’s health experts working with the Vancouver Island Health Authority (VIHA) and the British Columbia Centre of Excellence for Women’s Health (BCCEWH) planned a workshop on Trauma-Informed Addictions and Mental Health Practice, designed to bring together service providers interested in applying “trauma-informed” and trauma-specific approaches in their work with clients with substance use, mental health and related health and social concerns. Trauma-specific interventions focus directly on treating the effects of trauma and violence, whereas “trauma-informed” approaches take into account our knowledge of the extent and impact of trauma, and use that knowledge to ensure that the needs of women with histories of violence and trauma are better served in the provision of services and care.

At the workshop advocates and practitioners focused on approaches to delivering integrated trauma-specific programming based on the Seeking Safety model in settings such as the Victoria Women’s Sexual Assault Centre, the Victoria Native Friendship Centre, Haven Transition House and the John Howard Society. Presenters discussed trauma-informed care on the micro level of brief counselling (see article on page 27), as well as the macro level of system-wide integration. Dr. Lori Haskell, a clinical psychologist in Toronto, delivered an inspiring keynote address that described the multidimensional effects of violence and abuse on women’s lives and key implications for provision of integrated violence and addictions treatment. For example, when service providers view “symptoms” of trauma (such as self harm) as “adaptations” to intolerable circumstances, they are able to emphasize this resiliency, and help survivors recognize their strengths and inner resources, over weakness and failure.

A network of health system planners, service providers and women’s health advocates will take forth the issues identified in the workshop to the addictions and mental health planners associated with BC Health Authorities, and will promote further training on these issues for service providers.

Nancy Poole is a Research Associate at the British Columbia Centre of Excellence for Women’s Health.

For more information, visit:
Seeking Safety website: www.seekingsafety.org
BC Centre of Excellence for Women’s Health website: www.bccewh.bc.ca

For more information, see the report Women, Mental Health and Mental Illness and Addiction in Canada: An Overview on the Canadian Women’s Health Network website: www.cwhn.ca

Nancy Poole is a Research Associate at the British Columbia Centre of Excellence for Women’s Health.
NOW AVAILABLE

**A Practical Guide to Photovoice:**
*Sharing Pictures, Telling Stories and Changing Communities*

From the Prairie Women’s Health Centre of Excellence (PWHCE)

Photovoice is a participatory research and social change technique first developed by Carolyn Wang to bring forward the knowledge of marginalized community members. Community participants take photos and write text to accompany their images, revealing real life experiences. The participants are part of the team of researchers. In addition, the intended audiences, community representatives and policy-makers, are invited to be part of the planning process. The photos and text can be displayed in art galleries, libraries, schools or shopping malls, reproduced in calendars or in presentations.

After completing several Photovoice projects, PWHCE has now produced a guide to share with others interested in community-based work.

*A Practical Guide to Photovoice: Sharing Pictures, Telling Stories and Changing Communities* was written by Beverly Palibroda, with assistance from Brigette Krieg, Lisa Murdock and Joanne Havelock (March 2009).

“Seeing the Photovoice display is a moving experience for viewers, providing inspiration for reflection and action.”

Mid-month Blues:
A fake portrait hangs where the real bananas originally would.
During the mid-month blues in between my assistance cheque (2007).
By KS of PhotoVoice Regina. All rights reserved.

Copies of *A Practical Guide to Photovoice: Sharing Pictures, Telling Stories and Changing Communities* may be purchased for $12 from:

Prairie Women’s Health Centre of Excellence
56 The Promenade
Winnipeg, Manitoba R3B 3H9
Tel: (204) 982-6630
Fax: (204) 982-6637

Or you can download a copy from the PWHCE website:
www.pwhce.ca
Mental health and mental illness are leading health issues faced by Canadian youth. Yet, the child and youth mental health system is fragmented and under-funded, leading to the dubious distinction of “the orphan of the orphan” of the Canadian health care system. Efforts to address these shortcomings need to go beyond enhancing early intervention and treatment to also focus upstream to understand and address the factors that affect young people’s mental health.

The Need for a Gender Sensitive Approach to the Mental Health of Young Canadians is intended to help inform and increase the effectiveness of policies, programs and services to promote mental health and prevent mental illness among young people. The report seeks to illustrate the need to take gender and other intersecting forms of diversity into account to truly meet the needs of Canada’s young people by examining how mental health outcomes are affected by social and economic characteristics. Recommendations, promising practices, and gaps in the evidence base are also identified.

The report presents current evidence on mental health outcomes among young Canadians aged 10 to 24 as well as some of the pathways that contribute to inequities in these outcomes. Evidence was collected from peer-reviewed and grey literature examining mental health and mental illness among young people, published between 2000 and 2008. In some cases, evidence from prior to 2000 was included and research on young people from the United States was used where sufficient Canadian evidence was not available.
DOES GENDER MATTER IN YOUTH MENTAL HEALTH?

A Snapshot: Gender differences in mental health and mental illness among Canadian young people

Data collected through national and provincial surveys provide a snapshot of mental health among Canadian young people.

Mental Health

■ Young women are more likely to report feeling constantly stressed than young men (44.0% vs. 28.7%).
■ Aboriginal girls are more likely to feel seriously distressed than the general population of girls in BC (14% vs. 10%); among Aboriginal youth, more females experience severe distress compared to males (14% vs. 5%).
■ As girls grow older, they experience a steady decline in their confidence that is not seen in their male counterparts. In 2002, 4.7% of Grade 6 girls reported not feeling confident compared to 17.5% of Grade 10 girls.

Mental Illness

■ Higher rates of depression are consistently documented among adolescent girls and women than their male counterparts. The female-to-male incidence of depression averages 2 to 1.
■ Young women are more likely to report having thought about (18.6% vs. 12.1%) and attempted (5.9% vs. 2.2%) suicide than their male counterparts. Girls 10 to 14 years are 5 times as likely to be hospitalized as their male counterparts. The mortality rate due to suicide for young men, however, is 2.8 times higher than young women.
■ Young men are half as likely to be hospitalized for problems related to mental health or substance abuse than young women (1.9% vs. 4.1%).
■ Young women aged 15 to 24 are more likely to report an unmet service need related to their mental health or substance use than young men (27.6% vs. 17.5%).

It is clear that differences exist between male and female youth on many indicators of mental health and mental illness. Generally, the data reveal that girls and young women are more likely to ‘act-in’ or internalize mental health issues and mental illnesses, while boys and young men are more likely to ‘act-out’ or externalize mental health issues.

Gender also intersects with other key factors. While most surveys do not provide data disaggregated by ethno-racial groups or newcomer status, available data suggest that there are differences in mental health and mental illness outcomes based on these factors. Findings from BC, for example, indicate that Aboriginal youth experience poorer mental health and mental illness compared to their non-Aboriginal counterparts. American studies suggest that this may also be true of other racialized young people: depression, for example, is more common in both male and female racialized youth than their white counterparts.

Lifetime Prevalence of Selected Mental Illnesses among Youth 15 to 24 (2002 Canadian Community Health Survey)

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>13.9%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>14.7%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>1.5%</td>
<td>N/a</td>
</tr>
<tr>
<td>Proportion of population meeting criteria for alcohol or illicit drug use during lifetime</td>
<td>5.5%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

Prevalence of Selected Externalized Indicators of Mental Health among Ontario Students

(2005 Ontario Student Drug Use and Health Survey)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delinquent behaviour</td>
<td>10%</td>
<td>16%</td>
</tr>
<tr>
<td>Violent behaviour</td>
<td>7%</td>
<td>16%</td>
</tr>
<tr>
<td>Bullying</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Gambling problem</td>
<td>2%</td>
<td>7%</td>
</tr>
</tbody>
</table>

‘Racialization’ is defined as the complex processes through which ethno-racial groups are seen as different and treated unequally, resulting in social, economic, and political inequities; “racialized” refers to groups subjected to these processes (Access Alliance, 2007).
The evidence raises important questions, including why are there differences in these indicators between groups of young people, what do these differences indicate, and are the causes behind these differences problematic. Answers to such questions were sought through available qualitative research studies and inequality theory.

Why do mental health differences exist between different groups of boys and girls?

Understanding how the intersections of gender, poverty, racialization, Aboriginal status and other factors affect youth mental health. There is great diversity among Canadian children and youth, including differences due to gender, ethno-racial background, Aboriginal status, poverty, ability, newcomer status, and sexual orientation. These characteristics are valued and responded to differently by Canadian society, contributing to inequalities in young people's exposure to risk and protective factors, health outcomes, and their access to health services.

Gender socialization has a particularly important impact in a young person's life and their mental health. Every day, young people encounter messages about the roles, attributes, identities, and expectations considered appropriate for people of their sex, through media images; treatment by educational, health, immigration and other institutions and systems; interactions with parents, teachers, and other adults; and peer relationships. This creates pressures that can lead to negative impacts on the mental health of girls and, as is increasingly recognized in the research, the mental health of boys. The evidence also suggests that male and female youths are taught to cope with life's challenges in different ways, often resulting in the internalization of problems among girls and the externalization of problems among boys.

Gender intersects with other socio-economic factors influencing mental health, such as ethno-racial background, Aboriginal status, poverty, (dis)ability, newcomer status, and sexual orientation. Aboriginal youth, for example, face many social, political, and economic inequities related to a history of cultural oppression, including poverty, racism, inter-generational effects of residential schools, and lack of access to health, social, and educational programs.

These conditions heighten the likelihood that Aboriginal young people will encounter a wide range of risk factors that affect their mental health. As a result of the concentration of poverty and income insecurity in racialized communities, racialized youth are more likely to grow up in environments with more risk factors and fewer protective factors. Social biases that privilege whiteness and white culture also affect the mental health of young people from racialized communities. While all young people struggle to develop a sense of self, racialized youth “face added challenges, such as being labelled ‘other,’ ‘dissimilar,’ and ‘foreign’.”

In addition to often experiencing racialization, newcomer youth face additional stresses related to settlement and cultural adaptation processes. Refugee youth may also be coping with trauma related to having lived in war-torn countries and entering a formal school system for the first time or after a long break.

Conclusions and recommendations

Available research suggests that there are marked differences in mental health outcomes between female and male youth, and that these differences are related to inequalities and inequities in the lives of young Canadians, as a result of gender and several intersecting social and economic attributes. There is a need for a gender- and diversity-sensitive approach to designing policies, programs and services to promote mental health and prevent mental illness among young people. The following recommendations emerged from the review of available evidence.

1. Develop and coordinate policy frameworks to promote mental health and prevent mental illness among children and young people

According to the World Health Organization (2005), policy and legislation are important for children and young people's mental health. Such a framework should take a public health approach. This would involve broadening the current emphasis on treatment to focus more heavily upstream on the promotion and prevention by supporting healthy development among all young people and targeting of resources and services towards vulnerable young people.

2. Base the policies, programs, and services of the youth mental health systems on an analysis of gender and other forms of diversity

The effectiveness of the mental health system and policy frameworks is contingent on their ability to be responsive to gender differences and other forms of diversity and inequalities within Canada's child and youth population. A thorough gender-based analysis (GBA) involves identifying and understanding differences in health outcomes, pathways, and access to services related to gender and the intersecting factors of socioeconomic status, ethno-racial background, Aboriginal status and other inequalities.
3. Enhance the evidence base to increase understanding of the influence of gender and other forms of diversity on young people’s mental health
The availability and quality of evidence impacts the effectiveness and efficiency of efforts to promote mental health and prevent mental illness among children and youth. There is a need to enhance the Canadian evidence base on health outcomes, health inequities among groups of youth and the pathways that contribute to these differences, and the effectiveness of mental health policy frameworks, programs, and services.

4. Invest in gender-specific, diversity-sensitive programs that promote youth mental health and empowerment at the community level
More and better programs are required to promote young people’s mental health. The evidence from both the health promotion and youth development fields suggest that the young people’s active and meaningful engagement in their community has positive impacts on their health and development. Community participation and taking action on issues that impact their lives contributes to young people’s empowerment, which is critical for mental health.

To address challenges to girls’ health and development, some youth-serving organizations have developed all-girl programs that enhance empowerment through community action. These programs typically include activities that build the capacity of female youth by enhancing their knowledge, critical-thinking, and skills; safer spaces in which girls can acknowledge their experiences and find out they are not alone; interaction with supportive role models; and learning and empowerment through community action. There is potential that such program elements could be transferred to programs seeking to enhance the mental health of other groups of young people, such as newcomer youth and male youth.

It is recommended that multi-year pilot projects be supported that use an approach informed by gender and diversity analysis to empower young people and increase their resilience. Adequate resources are required for testing, evaluation and knowledge transfer to ensure that successful programs can be initiated in other communities across Canada.

5. Create supportive environments
Interventions are also required at the community-level to create environments that support young people’s development and mental health, such as ensuring availability and access to health promoting social and material resources. Universal and targeted programs are required to bolster protective factors and reduce risk factors in key social environments—namely the family, school, and community. This includes reducing poverty and violence, enhancing student readiness and engagement, and providing a wide range of accessible extracurricular activities and non-formal learning opportunities.

This article was adapted from the Executive Summary of The Need for a Gender-Sensitive Approach to the Mental Health of Young Canadians published by Girls Action Foundation in June 2008.

Juniper Glass is a Montreal writer, mother, and the Development Director of Girls Action Foundation. Lia De Pauw, MHSc, consults on youth health promotion in Canada and globally. She works with young people to understand and take action on the broad social, economic, political, and historic factors that influence their lives and health.

For a copy of the full report, including references, visit: Girls Action Foundation website: www.powercampnational.ca/en
The stigma experienced by those living with mental illness and addictions in Canada has drawn more attention in recent years. A report published by the Canadian Medical Association in 2008 demonstrates the pervasiveness of such stigma—only half of Canadians would tell a friend that a family member has a mental illness, and 46% of Canadians think the term “mental illness” is used as an excuse for bad behaviour.

One of the Mental Health Commission of Canada’s (MHCC) key initiatives is the implementation of a national anti-stigma campaign. The Commission suggests such a campaign will encourage individuals experiencing mental health difficulties to seek help, and will help eliminate stigma against them.

Although stigma is a familiar concept in the field of mental health, it is still rather complex and is often over-simplified. The term is used as a catch-all for an array of negative beliefs, attitudes and actions related to mental health. What is often left out of the discussion is that stigma exists within a social power structure that facilitates it. As Bruce Link and Jo Phelan write in Conceptualizing Stigma, stigmatization is contingent on “access to social, economic, and political power that allows…the full execution of disapproval, rejection, exclusion, and discrimination.” Researchers

“I rarely disclose to people about my depression,” says a 30-year-old woman who wishes to remain anonymous.

“I’m afraid I might be judged by others—employers, friends, partners, family. On top of having to deal with the depression, I feel like I have to deal with how others perceive me as well—it makes for a lot of work, and recovery doesn’t come easy.”

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Understanding stigma through a gender lens

BY CAROLYN SHIMMIN
have found that, in addition to labelling and stereotyping, active discrimination and the misuse of power are the most damaging aspects of stigma.

The key to an effective strategy against stigma must be an evidence-based understanding of its complexity, including recognition that women and men experience and apply stigma differently. A campaign or any anti-stigma programming that does not take gender into account risks failure, and may waste the often considerable resources invested. To date, the MHCC national anti-stigma campaign contains no sex- and gender-based analysis.

**Women, men and stigma**

Women living with mental health problems and/or addictions experience the associated stigma differently than men. The example of substance use or mental illness among pregnant women and mothers offers an illustration. Public discourses and policies surrounding pregnant women who use licit and illicit drugs are judgmental, blaming, and unsympathetic. Analysis done by the British Columbia Centre of Excellence for Women's Health of media discourses and policy responses to these women revealed highly negative attitudes that reflect the perception that the women deliberately create their difficult predicaments. Little responsibility was assigned to the system. Yet, in the same study, researchers found that women with mental illness who were pregnant or mothering were portrayed as not responsible for their situation because their behaviour was regarded as out of their control, and the system was failing them.

These differences in assigning responsibility are linked to the nature of stigma attached to pregnant women's behaviours. Though there has been some shift in Canadian public policy to embrace harm reduction approaches to substance use and addictions, the unique needs of pregnant women and mothers with addictions are frequently neglected. Similarly, public attitudes and child welfare policies may negatively affect women with mental illness who are pregnant or mothering (portraying these women as unstable mothers whose children should be taken away). These conditions may determine whether or not a woman will report substance use patterns or mental health issues during pregnancy and while mothering.

This sort of stigma is directly associated with gender roles. Researchers have argued that the stigma for women who use any licit or illicit drugs is more severe than for men because of women’s “place” in society, as those who bear and rear children and who are seen to uphold the moral and spiritual values of society. There is also the negative stereotype that women users are sexually promiscuous because of their drug or alcohol use. This association is not seen in men. The World Health Organization has found that men are far more likely than women to disclose problems with alcohol use to their health care provider.

To communicate effectively to and about women who experience substance use problems or mental illness, it is necessary to understand and reflect the social context in which such experiences emerge. It is also important to understand that stigma experienced by those living with addictions varies by gender and therefore, requires different approaches and treatment options.

A sex- and gender-based analysis also helps us understand the high rate of suicide among men. Growing up, boys encounter what William Pollack termed the “Boy Code”—a set of expectations about how boys and men should think, feel and act: “be tough,” “don’t cry,” “go it alone,” and “don’t show any emotion except for anger.” These characteristics of traditional masculinity and the stigma attached to any male who does not abide by these characteristics can cause men to perceive mental health problems as weakness and thus not seek the necessary help.

Overall, the World Health Organization has concluded that, “Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men, appear to reinforce social stigma and constrain help seeking along stereotypical lines. They are a barrier to the accurate identification and treatment of psychological disorder.”

**Women’s and men’s attitudes**

A 2007 study by Wang, Fick, Adair and Lai entitled Gender specific correlates of stigma toward depression in a Canadian general population sample, also found that factors associated with stigma appear to vary by gender, and therefore gender differences must be considered in initiatives aimed at reducing stigma.

Research examining Canadians’ attitudes towards depression, for example, found that men held more stigmatizing attitudes towards mental illness than women. Women working as health professionals, who had family or close friends living with depression, who believed taking medication may be the best help for depression, and who believed that traumatic events are a causal factor for depression, held fewer stigmatizing attitudes. These associations were not found in men; in fact, men who identified as health professionals, and who had family or close friends living with depression, strongly associated weakness of character as the causal factor for depression.

This finding is particularly relevant to the Mental Health
Commission of Canada’s plan to target health care providers in its anti-stigma campaign. It tells us that, to be effective, messaging targeted to health professionals needs to take into consideration these demonstrated gender differences in attitudes.

Youth is another priority group identified in the Commission’s anti-stigma plan. Research has shown that gender differences in negative mental health attitudes and willingness to use mental health services are already present early in adolescence. In a study examining the willingness of teens to use mental health services it was found that more girls than boys turned to a friend for help for an emotional concern, whereas more boys than girls turned to a family member first. So, here again, messaging to youth must take into account that girls’ and boys’ attitudes about mental health are different in important ways.

Stigma does not take place in a vacuum. A 2003 study by Corrigan, Thompson, Lambert, Sangster, Noel and Campbell entitled *Perceptions of discrimination among persons with serious mental illness*, found that more than half of the study group (949 participants out of 1,824), which involved people with serious mental illness, reported some experience with discrimination. The most common targets of this discrimination were mental disability, race, sexual orientation, and physical disability. Discrimination frequently occurred in employment, housing, and interactions with law enforcement. The study concluded that anti-stigma programs need to target not only discrimination related to mental illness but also that associated with other group characteristics such as race, gender, sexual orientation, and physical disability.

**Combating stigma**

“There are four approaches used to combat stigma against those living with mental illness,” says Janet Currie, a health researcher who has done extensive research on anti-stigma campaigns. 

“The first is protest, where mental health consumers watch media, etc., identifying stigmatizing words, phrases and attitudes and bringing this to the attention of the public. The second is to organize contact with people living with mental health problems. The third is anti-stigma campaigns, which receive the most money. The fourth approach is a human rights-based method that looks at landlords, employers, prisons, etc. and is court-based—outlawing such discrimination.”

Currie says that large sums of money are put into anti-stigma campaigns which, though facilitated by government, are largely funded by pharmaceutical companies. “The underlying message is don’t be afraid to report your mental illness. This, in turn, leads to an increase in labelling which potentially can cause an increase in stigma, as stigma is contingent on labelling.” But, Currie says, the ads do not talk about the punishment that goes along with being labelled—that once a diagnosis is put in your medical record it can affect your health insurance premiums and can be used in court cases, especially separation and custody cases. “It’s a hidden discrimination. And diagnosis of anxiety and depression are quite common with women,” she says.

In Michael Smith’s book *Stigma*, he writes that anti-stigma campaigns tend to use three different approaches: normalization, media and social attitudes, and rights-based protest. The MHCC anti-stigma campaign to date resembles the normalization approach, which seems to be the most frequently used, with examples in England (“Beyond Blue”), Australia (“Changing Minds”) and New Zealand (“Like Minds, Like Mine”). This approach emphasizes how common mental health problems are, and asserts that people living with mental illness are “just like us,” except that they have a genetic or medical difference. This approach is based on achieving acceptance rather than equality, and it has been argued that even people who may not be “just like us,” who may, for instance, have cognitive impairment as a result of schizophrenia, deserve to be included like everyone else.

If mental health organizations and anti-stigma campaigns were to look at the experiences of those living with severe chronic mental illnesses, such as schizophrenia, says Currie, that there would be a call for healthy and safe public housing. Instead, the call is for large sums of money to be invested in advertisements “telling people to be kinder to those living with mental health problems,” but not actually creating social and economic change for those living with the illness.

One significant finding about normalization approaches is that there is a gender difference in the effectiveness of anti-stigma campaigns. Research has shown that women with family members or friends with depression had lower stigma scores than women who did not, but this was not observed in men. In fact, the research shows statistical correlations in men between the belief that weakness of character is a causal factor for depression...
and having family and close friends with depression. Therefore, personal contact with individuals with depression is shown to have a positive effect on stigma in women, but to have no effect in men. This is relevant to the MHCC’s anti-stigma campaign, which is repeated and direct peer-based contact with people who have experienced mental illness in the hopes of reducing negative stereotypes. If, as research suggests, this approach will only work with women, it provides a clear example of how initiatives to reduce stigma that ignore gender differences risk failing at least half of this population.

Smith writes that a rights-based approach is based on the idea that those stigmatized because of mental illness represent a group of people who are wrongfully shamed, humiliated and marginalized. We see this type of stigma applied to other minorities as well. The rights-based approach seeks to counter discrimination by monitoring and enforcing equal access to health care, housing, employment and justice. This in turn leads to practical improvements for those living with mental illness not only in daily life, but also in self-confidence and social inclusion. While this approach requires major social and economic changes, and is thus the most challenging, it ultimately leads to deeper and more permanent change.

Clearly, to create real change and to effectively reduce stigma for those living with mental health illnesses, it is imperative to acknowledge the gender differences in the way stigma is experienced and applied. The only approach so far that seems to acknowledge this is a human rights-based approach. If gender is not addressed, an anti-stigma campaign could very well have the reverse effect—doing more harm than good for those living with mental illness.

Carolyn Shimmin is the Information Centre Coordinator at the Canadian Women’s Health Network.

WHO’S CARING for the CAREGIVERS?

Symposium focuses on the mental health of women health care workers

BY JOANNE HAVELOCK
From Prairie Women’s Health Centre of Excellence

Anxiety, depression, stress and addictions, as well many other symptoms associated with poor mental health, are increasingly recognized as a work-related issues for health care workers. In addition to social costs, poor mental health leads to loss of work time and financial costs to individuals and our health care system.

The mental health of our caregivers affects us all—health care providers, and their patients, families and communities. And women in particular bear the brunt of the effects. Almost one-fifth of employed women work in health care and women account for over 80% of the health care labour force. Women work as doctors, nurses, nurse aids, cooks, cleaners, dietary aides, clerks, administrators and laundry workers. And they provide the majority of unpaid personal care for family and friends—especially the direct physical care.

Researchers from across Canada gathered to examine this topic in detail at the Symposium on the Mental Health of Women Health Care Workers in November 2008 in Vancouver, British Columbia. Organized by Women and Health Care Reform (WHCR) in partnership with the BC Centre of Excellence for Women’s Health (BCCEWH), 50 researchers, practitioners and policy-makers with expertise on mental health, gender and health care work, were guided by four questions:

1. Why is this a woman’s issue?
2. What are the issues for women?
3. Which women?
4. What can be done and who should do it, at what level of government, organization or community?

Carolyn Shimmin is the Information Centre Coordinator at the Canadian Women’s Health Network.
“Women’s mental health is defined, experienced and treated differently than that of men,” says Pat Armstrong, Chair of Women and Health Care Reform, and professor of sociology at York University. “We need to think about women’s mental health issues in relation to the effects on their bodies while placing those bodies and women’s care work within the context of their lives.” Examined in context, says Armstrong, we see that the stress from women’s paid work affects their responsibilities and relationships at home while stress from caregiving at home may affect a woman’s ability to function well in her paid care work.

Researchers at the Symposium addressed a range of related issues. Elaine Enarson, a gender and disaster expert, spoke about “Women on the Front Lines: Care Work in Disasters” and how emergencies and disasters affect women as paid workers and volunteers. Carol Amaratunga, Dean of Applied Research at the Justice Institute of British Columbia, discussed her work on the SARS outbreak. And Cyndi Brannen, Research Associate at Dalhousie University, examined biological and psychological effects of caregiving and secondary stress for women in the military and for military families.

“If we had a superhero, she would be a caregiver,” said Brannen. But she added that the skills and efforts of health care superheroes remain hidden, and their stress and trauma endured silently, largely because this is women’s work.

Sessions on “Chronically Caregiving” and “Caregiving in the Home” looked at long-term paid or unpaid caregivers including nurses, health care aides, counsellors, home care workers and mothers. In addition to issues of health reforms that set the stage, presenters Cathy Walker, former Director of Health and Safety at the Canadian Auto Workers; Karen Messing, professor of biology at the University of Quebec at Montreal; and Margaret Denton, Director of Gerontological Studies at McMaster University, spoke about the working conditions that are critical to mental health, such as job security, workload, shiftwork, control over one’s work, gender and teamwork and work-family balance. Katherine Boydell, a Senior Scientist at Toronto’s Hospital for Sick Children, highlighted the need to recognize the care and advocacy provided by mothers of children with mental health problems living in rural and remote communities. Nancy Milroy-Swainson, Director of Chronic and Continuing Care Division at Health Canada, and Penny Ballem, a physician and former Deputy Minister of Health in BC, offered reflections on turning research into policy and future priority issues.

On day two of the Symposium, the focus was on the concept of place or location, beginning with the keynote address by Madeleine Dion Stout from the UBC School of Nursing, “Weaving Death and Dance Baskets and Unraveling Space and Place Concepts.” A panel on “Social Locations” brought in the perspectives of caregivers working with or from several communities: Anna Travers, Director of Rainbow Health Ontario, spoke about lesbian, bisexual or transgendered women; Axelle Janczur, Executive Director of Access Alliance

WHO’S CARING FOR THE CAREGivers?

CAREGIVING
A case for gender-based analysis

The mission of the Family Caregivers Advisory Committee of the Mental Health Commission of Canada (MHCC) is to help “create conditions that will promote full and meaningful lives for people diagnosed with mental illness and for their families and friends who often serve as their primary support network.”

Research done by the Canadian Mental Health Association (2004) shows that 80% of caregivers are women, mostly wives and daughters belonging to the “sandwich generation,” caring for young families and elderly infirm parents at the same time.

A Health Canada study in 2002 reported that caregivers are most likely to feel stressed in terms of their emotional health with close to eight out of 10 reporting that caregiving has resulted in significant (29%) or some (48%) emotional difficulties for themselves. Over one million working Canadians take care of a person diagnosed with a mental illness, and of these, one-third report that it interferes with their paid job due to chronic health problems, depression and excess stress when the burden of work or caregiving increases. Evidence shows that family members (mostly female) caring for those with serious and chronic mental illness play multiple roles including nurse, counsellor, advocate, crisis worker, home-care and income provider.
Multicultural Health and Community Services, spoke of work with immigrants and refugees dealing with gender, multicultural issues and racism; Ellisa Johnson, Senior Policy Analyst from Health Canada, brought forward the challenges of being a First Nations health care worker on a reserve; Josephine Etowa, Associate Professor at the Dalhousie School of Nursing, described the challenges for Black women dealing with the intersections of class, gender, race and ethnicity; and, Paula Pinto, a PhD student at York University, spoke of society’s exclusion of women with disabilities.

Lynn Skillen from the Faculty of Nursing at the University of Alberta presented her research on nurses in remote communities, and spoke about working with rural and farm women. And Patti Melanson, a Health Services Coordinator at the Phoenix Youth Program in Halifax, spoke about her work caring for young people at risk in the Halifax area.

The inclusion of Aboriginal opening prayers, ceremony and drumming brought an added dimension to the conference, including an oil lamp ceremony presented by Reepa Evic-Carleton, Program Therapist at Mamiyarvik Healing Centre, who also spoke about the impacts of geographic location and colonialism.

“We need to think about women’s mental health issues in relation to the effects on their bodies while placing those bodies and women’s care work within the context of their lives.”

And, finally, the Symposium provided a venue to launch the new book *Women’s Health: Intersections of Policy, Research and Practice*, edited by Pat Armstrong and Jennifer Deadman, and published by Canadian Scholars’ Press.

Following the Symposium, in an effort to move this research into action, researchers hosted a Policy Forum on the Mental Health of Women Health Care Workers in February 2009 in Ottawa for senior policy-makers from the federal government and national organizations. The Forum focused on three federal responsibilities: 1) health and human resources related to paid and unpaid caregiving; 2) emergency preparedness services; and, 3) First Nations and Inuit services. Participants clearly recognized the need for gender-based analysis in the area of mental health of health care workers and agreed to examine where the Symposium and Forum recommendations could lead to action within their areas of responsibility. A summary of the research presented at the Symposium and feedback from the Forum will be included in a publication to be released this year by the researchers at WHCR.

Joanne Havelock is a Policy Analyst with Prairie Women’s Health Centre of Excellence in Regina, Saskatchewan.

Marika Morris writes in *Gender-Sensitive Home and Community Care and Caregiving Research: A Synthesis Paper: Final Report* that in caregiving, women and men experience different socioeconomic contexts and gender role expectations, which result in “women giving more hours of unpaid care than men, performing more demanding forms of caregiving than men, traveling farther and more often to provide unpaid care than men, and more often having responsibility for more than one care recipient than men.”

Research by the Canadian Institute for Health Information (2005) has shown that women are more likely to care for parents while men are more likely to care for partners. Men are more likely than women to feel they have other options available to them when deciding to become a primary caregiver. It has been shown that women are more likely to experience difficulties as a result of providing care to someone diagnosed with a mental illness in particular; they were more likely to report difficulties in terms of their own physical and mental health. Yet men have reported being less likely to get a break from caregiving when they needed one.

By doing a gender-based analysis of caregiving, one can discover areas where men and women are equally affected and areas where their needs differ in caregiving for people with mental illness. Sex- and gender-based analysis is crucial in the work of the Family Caregiving Advisory Committee of the MHCC.
If a workplace is toxic, the employer is fined for pollution. Why can’t they be fined when the toxin is workplace bullying?

That logic, from a participant in a focus group on workplace bullying, may be prophetic. A few jurisdictions include workplace bullying in workplace health and safety or other employment legislation. It’s about time, since—as evidenced by the massive response to sessions held on the subject by the New Brunswick Advisory Council on the Status of Women—to raise the issue with women is to touch a nerve.

Some studies suggest women and men are about equally represented among the bullies, but women are more likely than men to be targets, and therefore to experience more of the negative health effects of bullying.

There is a pressing need to name the problem, prevent it and provide bullying victims, or “targets” as some prefer to be called, with recourse. Like sexual and racial harassment, discrimination based on ability or sexual orientation, wife battering and other hidden problems before it, few people call “workplace bullying” by its name when they see or experience it. In fact, the Canada Safety Council states that “bullying (general harassment) is far more prevalent than other destructive behaviours covered by legislation, such as sexual harassment and racial discrimination.”

According to Janice Bernard of the Nova Scotia Association of Health Organizations, “We’ve been talking about it for years, but not calling it what it is: bullying—corporate bullying, institutional bullying, serial bullying and residual bullying” (the toxic environment which may remain after a bully has left the workplace). Bernard says that bullying seems to be more prevalent in the health-care industry, which may seem strange for a “caring” industry, but it may be relevant to note that women and workers of colour make up the majority of support workers in health care. Sexism, racism and other forms of discrimination certainly come into play as bullies attempt to exercise power over co-workers.

Workplace bullying, also known in Canada as “psychological harassment,” occurs when employees are the target of repeated unreasonable behaviour that intimidates or humiliates them or their group. Maybe it’s parents bullying teachers, doctors bullying nurses, nurses bullying nurses, or a clique of people bullying a co-worker. It can include harsh and constant criticism in front of others, withholding of resources needed to do a job or being treated as an outcast.

In any case, it’s a form of violence and should be seen as such. Bullying carries heavy costs for the targets, the employer and the economy. Employers would be surprised to find how much of the sick leave, long-term disability, burnout and turnover is related to workplace bullying. A report commissioned by the International Labour Organization in 2001 estimated the costs to society of bullying, sexual harassment and physical violence at work are between 1% and 3.5% of GDP.

According to Statistics Canada, more women employees report higher levels of work stress than men—28% of women had high-strain and 17% had low-strain jobs, compared with 20% and 24%, respectively, for men. Almost one in five men and women who perceived their work days to be stressful took
at least one disability day in the previous two weeks.

While bullies rarely pay a price for their behaviour, the health and careers of the targets are sometimes changed dramatically by the experience. A 2007 survey of bullying targets conducted by the Workplace Bullying Institute in the United States found that 45% of the respondents experienced stress-related health problems, including anxiety, panic attacks, sleep problems or depression. Prolonged exposure to stress in the workplace can lead to other serious health concerns, such as problems related to cardiovascular, neurological and immune system health. Also, targets often decide to quit their jobs and end up trading the stress of bullying for the stress of being unemployed.

People are only beginning to recognize that bullies are not just in the schoolyard, but also in the workplace and that in fact bullying is sometimes the culture in workplaces or corporations. As one former target said, “Where’s the solution when the bullies are management?”

Targets of workplace bullying currently have few options in Canada, except in two provinces and some municipalities. Elsewhere, existing laws offer little protection. Few employers have anti-bullying policies. Human resource personnel “don’t want to get involved” or advise the victim to get a lawyer, according to bullying targets interviewed recently in New Brunswick.

Quebec was the first province with a law, in effect since June 2004, to protect workers from workplace bullying. “Every employee has a right to a work environment free from psychological harassment,” states Quebec’s Act respecting labour standards. Employers must take “reasonable action” to prevent it and must put a stop to it when they become aware of such behaviour. It’s defined as “any vexatious behaviour in the form of repeated and hostile or unwanted conduct, verbal comments, actions or gestures that affect an employee’s dignity or psychological or physical integrity and that results in a harmful work environment for the employee. A single serious incidence of such behaviour that has a lasting effect … may also constitute psychological harassment.” The employee or an employee rights organization can file a complaint with the labour standards commission (Commission des normes du travail) within 90 days of the last incident. A mediator can be appointed with the agreement of the parties. Employers can be ordered to offer compensation and support, including reinstating the employee, modifying the disciplinary record of the employee, paying lost wages and damages.

Since October 2007, the Saskatchewan Occupational

**COMMENTS FROM PARTICIPANTS AT FOCUS GROUP ON WORKPLACE BULLYING IN NEW BRUNSWICK ~ February 2007**

“I was told that if I filed a complaint I would be fired for insubordination.”

“He was evaluated as being a time-bomb waiting to explode, but he was simply transferred to another office in the same town.”

“I went to management to complain about the verbal abuse I was taking from co-workers. The manager told me I have a bad attitude.”

“I was in the same union as my boss, so what could they do?”

What would these former targets of bullying do if it happened again and they were living in a jurisdiction without protection? Responses varied, but most participants said they weren’t sure what they would do.

“I’ll never stand up to a bully again. The cost (to me and my family) was too great. Next time I’ll keep my mouth shut.”

“If I knew then what I know now, I would pursue my complaint, and not believe the supervisor’s threats that I would lose my job if I went forward with my complaint.”

“I tolerated it for too long. I will not tolerate it again.”
Health and Safety Act bans bullying. The changes followed the controversial case of Murdoch Carriere, a government manager in Prince Albert convicted of assaulting two of his former employees (and found not guilty of sexual assault). The provincial government agreed to pay Carriere $275,000 to settle a lawsuit he launched after he was fired. The opposition party said this was sending the wrong signal about workplace harassment and the government promised to toughen the workplace rules for harassment and bullying.

In Newfoundland and Labrador, the City of St John’s has a by-law prohibiting general harassment in the municipal workplace including city council, since 2006. The only female city councillor in St. John’s, Shannie Duff, had denounced then Mayor Andy Wells’ bullying tactics, which she had endured for years. She introduced an amendment to a by-law in 2006 to allow one city councillor to make a complaint against another. The by-law had been amended a dozen years ago to exempt councillors, since it was thought “aggressive” debate was part of politics.

When anti-bullying policies are toothless, victims may be labelled as troublemakers, putting them in an even worse situation. When the reporting line is to the person who is the bully or party to the bullying, there is a fundamental problem.

Not all workplaces have a bullying problem or if they do, sometimes responsible management will find a solution when the problem surfaces. One target of bullying in the sessions in New Brunswick told of working in a small office and being constantly subjected to sexist and racist comments from her boss. She complained to him numerous times to no avail. She then took her complaint to the owner of the business. He arranged a meeting with the three of them, and asked the woman what she wanted him to do. She told him she wanted him to tell her boss to stop it and tell him that if he does it again he will be fired. The owner agreed. The boss said he didn’t understand that his conduct upset her. This ended the problem.

In another case, a group of 18 workers in New Brunswick took their supervisor to a tribunal. The proceedings lasted three weeks and were extremely hard on the complainants, but in the end, the supervisor lost his license and job, and had to pay a fine.

Some targets used mediation to address the harassment, and each time it failed because there was no follow-up; no one enforced what was to have happened.

But prevention is also key. Even targets of bullying interviewed in focus groups—desperate for justice and a way to keep their jobs—put a lot of hope in education and prevention. After the fact, there is no totally satisfactory solution. And raising public awareness is key to prevention, so that the bully gets the message, the target knows there is help, the bystanders know how to react, and bullying is recognized as a social, not just an individual, problem.

Workplace bullying is a serious occupational health and safety issue with far-reaching social and economic consequences. Businesses, organizations and society as a whole also pay a high price for bullying at work. This unethical behaviour takes a heavy toll on the physical and mental health of workers, particularly women, who are overrepresented among the victims. But it is also through the courage and strength of many of these women that workplace bullying is finally being recognized and that the laws in Canada are beginning to change. 🗣

Ginette Petitpas-Taylor, of Moncton, is the former Chairperson of the New Brunswick Advisory Council on the Status of Women.

For more information, visit:

Safety Council website:
www.safety-council.org/info/OSH/bullies.html

Workplace Bullying Stops Here website by CUPE BC
www.cupe.bc.ca/stopbullying
BRIDGING the GAPS

Survey examines accessibility at women’s shelters

BY JEWELLES SMITH

From the DisAbled Women’s Network Canada

In 2008, the DisAbled Women’s Network (DAWN) Canada conducted the first phase of the National Accessibility and Accommodation Survey (NAAS) focused on shelter accessibility for women with disabilities. Slightly more than 10% of Canada’s women’s shelters and transition houses had participated by the end of August 2008.

DAWN-RAFH Canada conducted a previous survey of shelters in 1990 and found that many were lacking in terms of physical access and that acceptance of women with mental disabilities was even worse. Many shelter workers did not want to accept these women in their facility because they were perceived as making “too much trouble” for them. The NAAS was designed to re-address the issues and to discover if gains have been made in accommodating women with disabilities—to test how accessible shelters are; how programs and services (including outreach) were accommodating women with disabilities; and how shelters were addressing the needs of mothers with disabilities who were seeking safety from violence. There have been definite gains since the original survey in 1990. However, there is much more needed to make shelters fully accessible for women with disabilities.

Survey results

Many shelters are partially accessible for women with mobility challenges, meaning they have an accessible bathroom and one bedroom, and perhaps a ramp. However, other rooms in these facilities are often not accessible and women may not be able to use the kitchen, laundry room, or common rooms. Just over one-third of shelters have TTY phones (telephone typewriters) on their crisis lines. Although much work is being done nationally to address the needs of individuals with mental health issues, more than 10% of shelters have to turn away women with mental health disorders as they are unable to accommodate these women’s needs. Women who require personal support workers must bring their own workers. If this is not possible, most shelters are unable to assist these women and therefore must turn them away. Many shelters continue to turn women away because either the shelter is full or the adapted rooms are already in use.

Women with mobility challenges

Although 97% of shelters reported having accommodated women with disabilities at some time, 45% of shelters had turned these women away. In many cases, the reasons for not being able to accommodate these women were related to inaccessible spaces (such as entranceways, hallways, stairs, and bathrooms).
However, a number of shelters felt they could not accommodate these women as they maintained an “independent” model and could not offer supports for women with disabilities.

**Women with mental illnesses**

Shelters are unable to accommodate women with mental health disabilities more than any other group—more than 10% of the shelters had turned these women away. The reasons that shelters gave included: the complexity of the women’s needs; the difficulty that some women have living in communal spaces; or the inability to accommodate women who are not stable, who are on medication and who are not willing to enter treatment programs.

**Women who are deaf or hard of hearing**

There are still many shelters that deaf and hard of hearing women are not able to access because the shelters and transition houses do not have TTY phones. Without these phones, women who are deaf or hard of hearing cannot contact a shelter independently. As well, most shelters do not have door alarms, alarm clocks, or monitors that light up so that a woman who is deaf or hard of hearing will know that someone is at the door, that her alarm is on, or that her child is crying.

**Looking for solutions**

The majority of survey respondents are interested in finding ways to accommodate women with disabilities in their shelters. Many shelters commented that they were willing to accommodate disabled women and their children but were restricted by finances. When asked if shelters had done renovations recently to accommodate women with disabilities, 12 out of 22 shelters that had completed major renovations stated it was to accommodate disabled women. In their comments, six shelters acknowledged that funding was a huge barrier to making their spaces more accessible. Further, several survey respondents stated that a portion of their shelter and/or a portion of the rest of the space was wheelchair accessible. One shelter stated that there is no need for accessible space as they have no requests. Several shelters are in older buildings that cannot be renovated.

**SHELLEY’S STORY**

**BY JENNIFER TOWELL**

*From the DisAbled Women’s Network Canada*

“Shelley has told us and written letters to us about how DAWN has saved her life. When I am tired or overwhelmed with all the work we have to do, I call Shelley for inspiration and she reminds me of why we do this.”

~ Bonnie Brayton, Executive Director of DAWN-RAFH Canada

Shelley is a volunteer who has an unusually personal understanding of the needs of vulnerable women.

At the age of nine, she was raped three times by a 16-year-old neighbour and her childhood came crashing to an end. When she was 13, she succumbed to a rare illness that robbed her of her adolescence. As an adult, Shelley has continued to experience major losses and deals with disability and poverty—and the often-related disregard—on a daily basis. Yet through her faith and by reaching out, she has found support and personal awareness, prompting her to help other women. “I do have my bad days, but they do pass,” says Shelley, who will turn 40 next year. “There is light at the end of the tunnel.”
From the imaginary photo album – “Shelley and women’s shelters” – The first picture shows Shelley, her mother and older sister at Anderson House, PEI’s provincial shelter for abused women and children, in the early ‘80s. Shelley is a pre-teen. Her mother has left her father, but will later move back with her girls.

Shelley speaks evenly and displays a prodigious memory as she recounts her story. Though she admits to ongoing nightmares, she has obviously gained much perspective on her past. When she was raped as a child, she never told anyone because her abuser threatened to kill her beloved dog, who was her closest companion at a time of major life changes and resulting isolation. Until her late 20s, she suffered further incidents of sexual abuse by neighbours, relatives and men she dated, and each time found herself frozen by the fear instilled during the first incidents. She also realized early on that her mother had also experienced sexual abuse and either would or could not help her.

Photo album – Second picture: 1988, Anderson House. Shelley is feeling threatened following abuse. She turns to a familiar resource.

Her health issues prevented her from earning her high school education and a full sense of independence. Shelley suffers from a disorder of the parathyroid glands, which are responsible for maintaining the body’s calcium at the level required by the nervous and muscular systems. From age 13 to 17, Shelley was tired, depressed and unable to keep down food, and spent more time at hospital than at home. Doctors removed three of her parathyroid glands but a fourth has eluded them to this day. In addition to the effects of the disorder, Shelley battles with arthritis and the cumulative effects on her health of injuries from two car accidents in the last 10 years. She needs walking aids and has to carefully manage her strength and energy.

Photo album – Picture three: 2007, Anderson House. Worn out from the stress of dealing with a difficult tenant, Shelley has had to temporarily leave her marital home. In the years since her last stay here, she has lost considerable mobility and is grateful that the shelter, while located in an older building, has a ground floor room to accommodate her.

In September 2007, Shelley left her husband of 10 years because he had repeatedly cheated on her and let her down in...
safer for women with disabilities and have requested more information on accessibility. Small but specific changes make it possible for women with disabilities to be independent during their stay.

Lack of funds seems to be a major hurdle for shelters to adapt their spaces. Services and behaviour are the first step to making a space accessible. Although having ramps improves accessibility, open spaces, adaptive equipment and TTY phones will also greatly improve the accessibility of a shelter, as well as education on what accessible means and how to implement effective changes.

Shelters that are accessible or that have modifications in place as well as programs have to be able to reach the population that can use these resources. This would involve educating community outreach organizations, police and social workers, as well as the women themselves. If women felt that they could go to a shelter and find a welcoming and safe space, they would be more likely to reach out and leave abusive situations. As it stands right now, most large surveys on domestic violence and other forms of violence and on shelters do not include information about disability and violence or on the resources that women can turn to.

The NAAS is part of a larger project, “Bridging the Gaps,” funded by Status of Women Canada, which will continue to explore violence against women and issues around shelter access, outreach programs, housing, poverty, and transportation.

Adapted from the full report Disabled Women and Shelter Access: Early Findings of the National Accessibility and Accommodation Survey. More information is available at the DAWN-RAFH Canada website: www.dawncanada.net

Jewelles Smith has an MA in Women’s Studies and a BA in Women’s Studies and English, and she currently works as a gender and disability consultant for DAWN-RAFH Canada.

times of need. She first stayed with friends, but they were also experiencing major problems. Shelley broke down and spent some time in the hospital. Then she moved to an apartment building where, in January 2008, a man was brutally beaten outside her door. When the perpetrator of that incident set a fire in the building, Shelley had to find a new place to live.

Photo album – Picture four: 2008, Grandmother’s House, a smaller shelter in Charlottetown. The name likely had particular meaning for Shelley, whose first and most fondly remembered home was with her grandparents in New Brunswick. While Shelley found good emotional support at the shelter, the lack of ground floor rooms posed a serious problem as she had to navigate the stairs on crutches.

Since April, Shelley has been living comfortably in a one-bedroom ground-floor apartment with her beloved cat Princess. She is unable to hold a regular job, but when not sidelined by illness or depression, she is far from idle. In addition to studying towards the completion of her high school education, she works hard on behalf of others. She is a DAWN Board member and the Coordinator for PEI. She is also active with her church and with other groups including PEI People First, which advocates for the intellectually disabled. Her volunteer work is not only satisfying; it also provides her with an important social network.

Photo album – Two recent photos depict Shelley not as a shelter resident but as a DAWN coordinator. In one, she is visiting Anderson House to help develop an honest assessment of its accessibility to women with disabilities. In the other, she is receiving a speaker from the shelter at a monthly meeting of the DAWN PEI chapter.

Shelley is not living happily ever after. She will never outgrow her past horrors nor be cured of her present disabilities. But her experience and insight allow her to speak up, for her own benefit and that of others facing similar challenges. And she speaks of the possibility of making a living cooking for others, in their homes.

Last photo – It’s taken at the 1st World Conference of Women Shelters in Edmonton, September, 2008. Watching a poignant play about abuse, DAWN representatives introduce themselves to their table-mates…and learn that they hail from Anderson House in PEI. The scene is filled with tears, hugs, recognition—and hope. Even when she’s not in the picture, Shelley is, at last, being heard.

Jennifer Towell is a freelance writer and works as a Senior Administrator at McGill University.
Helping women help themselves

Brief Psychotherapy Centre for Women stands the test of time

From the Brief Psychotherapy Centre for Women, Women's College Hospital

“[Therapy gave me a] clearer understanding of my sense of powerlessness, when I am triggered by race/class…Confidence in my right to have and express feelings even when they are not mainstream or popular… I am now able to enter a situation [white middle class] without feeling “less than” or judged. When these fears do arise, they are less powerful and I am able to identify what is happening and recognize it as a historical trigger. As a result of this therapy, I feel I am able to move forward in [the] pursuit of [my career], which I did not feel equipped to do before.”

~ Woman speaking about her experience at the Brief Psychotherapy Centre for Women in Toronto

A mental health centre based on feminist principles and geared specifically for women is a rarity in Canada, which makes Toronto’s Brief Psychotherapy Centre for Women a model that deserves our attention and support.

Using a feminist, community-based approach to mental health for women, the Centre, part of Women’s College Hospital in Toronto, has completed therapy with over 2,200 women since it opened its doors in 1988. A self-managed team of women psychotherapists provides non-medical, time-limited psychotherapy by developing and implementing a “relational-cultural” mental health model designed specifically to meet the needs of women.

“Our philosophy and focus of therapy is the empowerment of women,” says Shirley Addison, psychotherapist.

Unfortunately, this is the only program of its kind in Canada, with its distinctive time-limited relational-cultural model of therapy at a centre for women.”

Brief feminist psychotherapy is a specific type of therapy. Focused and time-limited, it deals with particular problems or issues that women identify themselves. A woman refers herself to the Centre then works with a therapist to set goals that they will both work toward over the course of therapy. “That structure reinforces that women can identify issues that are important to them, set goals, work toward them and have the power to create change,” says Joyce Curry, psychotherapist.

In the words of one former client: “[The therapist was] very empathically minded—not just toward me, but for the people I was having trouble with; I got a real sense of the humanity of all the people.”

Women may choose individual psychotherapy consisting of 50-minute sessions each week for 16 weeks or group psychotherapy consisting of 90-minute sessions each week for 20 weeks. Both options include assessment sessions to determine suitability of the program, and two follow-up sessions approximately three months and a year after therapy has concluded. In addition, women who have completed individual therapy may refer themselves to a 12-week group at the Centre.

Brief Relational Cultural Therapy (BRCT) is based on Relational-Cultural Theory (RCT), which is a model of psychological development that considers gender, power and cultural factors within a relational context. The model evolved from the seminal work of Jean Baker Miller published in 1976 called Towards a New Psychology of Women. This approach locates the source of mental health difficulties, as well as their solutions, within both interpersonal relationships and societal structures.
This therapy examines the ways in which gender and other sources of inequity (race, socio-economic status, cultural differences, education, sexual orientation, age, ability, immigration, etc.) create differences in power, status and privilege, which affect the dynamics and quality of relationships and, in turn, the mental health of individuals. Therapy works toward empowering women to shape their relationships toward increasing equity, mutuality, and authenticity, that is, to develop more complex, growth-fostering relationships based on mutual empathy and mutual empowerment. This includes paying special attention to the pressures a woman may face in different aspects of her life—as a partner, worker, mother, daughter and friend—and how these roles affect well-being and physical and mental health.

The time-limited psychotherapy program includes an integrated evaluation process that is also client-driven. Women measure their therapeutic outcomes on a goal attainment scale at the mid-point and end of therapy. They also evaluate the program in a structured written narrative and program evaluation questionnaire. A recent review of the Centre found that 87% of the women clients reported improvement beyond their stated goals, and 72% reported that they took better care of their health since participating in psychotherapy.

The success and longevity of the Centre makes it an important model for others to emulate. Two key factors in the Centre’s success are the evidence-based, feminist therapeutic approach and a firm community foundation—a combination that has clearly stood the test of time.

As for community input, the Community Advisory Committee consists of 12 members of local community agencies and other sectors, former clients and a board member from Women’s College Hospital—providing input and support to the Centre’s programming and operations.

The Brief Psychotherapy Centre for Women serves a diverse clientele in terms of: ethnicity, race, age, socio-economic status, sexual orientation, religion, educational level, employment, health status, reflecting the population served within Toronto’s Central Local Health Integration Network (LHIN). Service is provided in English only, although Francophone clients have used the services.

While self-referral is a requirement, women often hear about the Centre from healthcare practitioners, including family physicians, hospitals, community and mental health agencies and former clients, their families and friends. Clients arrive at the Centre with a broad range of mental health problems, both complex and usually long-standing. Issues include: relationship issues, impacts of sexual, physical, or emotional abuse, depression/anxiety, loss and isolation, health/illness, aging, self-esteem, body-image, parenting, employment, education, financial, and stress related to poverty, work, legal issues, discrimination/cultural adjustment, among others. The Centre does not serve women with severe and active substance use problems or dependence, acute psychosis or those who require crisis intervention.

In recognition of the model’s effectiveness and the gaps in research, the Ontario Women’s Health Council funded a research project to study the Centre’s approach. According to Jane Pepino, the Council’s Chair at the time, “the assessments provided in the study contribute to meeting a vital need in women’s health research: models for best practice in women’s health. We need models such as these in order to develop a health care system that is equitable and accountable to the women it serves” (2004).

Through client interviews and psychometric questionnaires, the study found that clients at the Centre improved significantly on all outcome measures, and that these improvements were “virtually all maintained at three and six months following therapy.” Results indicated “outstanding client satisfaction with the model of therapy and clarity about their process of change.”

Part of the research process included the development of an adherence scale and a manual to measure the adherence to the Centre’s therapy model by therapists, which is in the process of being modified to create a BRCT training manual for publication. “The findings clearly showed that BPCW is an effective standardized psychotherapy practice in the treatment of women who present with diverse mental health issues,” says Anne Oakley, psychotherapist and Coordinator. “Given the waiting-list of 12-16 months, ideally the BPCW-BRCT model would be expanded and replicated in other settings.”

For more information, visit: Brief Psychotherapy Centre for Women website: www.womenscollegehospital.ca/programs/program68.html
A Real Deal

BY E. DAISY ANDERSON

The other day, I sat in a meeting room listening as my former psychiatrists and professional mental health workers pondered ways to obtain more money for mental health programs. I shook my head, saying to myself, “They know not what they do.”

For over 35 years, I was labelled “mentally ill” and endured many of the injustices which psychiatric patients face. I was a case to be managed, not a person with feelings, hopes and abilities. The medications dampened me down, dull. I lost my credibility. When I dared to say it like it was, I was deemed “difficult.” It was during these episodes that I risked being bullied, ignored or given more medication. I ended up confused, believing I was the problem and constantly asking myself “What did I do wrong?”

The chief of psychiatry spoke for a third time, “I have more to say, then Daisy can have her turn.” I was angry at being patronized, even if my attempts to speak were finally recognized. I spoke up and out.

I directed my message to the professionals who repeatedly said they needed patients’ stories of pain to back their pleas for funding. First, I pointed out that the major stakeholder group, those using psychiatric services, was noticeably absent. I went on to say we could help them. However, we need a voice, a voice that includes all of us. Community advocates would provide their wisdom. My message ended with “We have the answers, we know the solutions; however, we need opportunities to speak out effectively.”

I spoke assertively as those who had sidelined me over years had no choice but to sit and listen. It felt good. However, it was difficult and my thoughts vanished. Now I add the second half that I wished I had said:

We will save you health care dollars, lots. My out-of-pocket expenses to undo the psychiatric harm and regain my health were $100,000, a bargain considering the Ministry of Health spent 10 times more, that is, over one million dollars, to keep me suspended in a state of sickness. Over the years, I was prescribed more than 30 different psychiatric drugs in all
“For over 35 years, I was labelled ‘mentally ill’ and endured many of the injustices which psychiatric patients face.”

E. Daisy Anderson, MSc, worked for many years as a mental health nurse. Her professional background together with her experiences as “mental health patient” are invaluable in her work as a community advocate. She lives on Vancouver Island, British Columbia.

How I dealt with grief and depression

BY ANGELA BISCHOFF

The police greeted me at the door with the news of my husband’s suicide. The pain is still palpable two years later. The grief takes over in waves.

In touching his death, I welcomed my own. Thankfully I made it through those darks days, and am motivated to live and contribute once again. I chose to do it without drugs.

I relied on one girlfriend who called me every other day for the first six months, to help me process my feelings and experiences. She was loving, skilled, patient and generous. I also had weekly visits with a very compassionate therapist that taught me coping skills.

I openly grieved. I read books on spirituality and life-after-death, getting the most comfort from learning about near-death-experiences. I immersed myself back into work six weeks later.

I took immaculate care of my body, instinctively giving up all drugs such as sugar, alcohol, caffeine, and processed foods. I cooked my own organic, whole food and drank several pots of herbal tea daily. I journaled. I exercised daily (cycling to work and yoga practice).

I learned about the connection between antidepressant drugs and suicide, and used all my activist skills to share the information. By transforming my pain into knowledge that might help others avoid a similar tragedy, I found meaning in my partner’s death.

After the death of her partner Tooker Gomberg due to pharma-induced suicide, Angela immersed herself in issues of mental health, sustainable activism, big-pharma, and the potential dangers of anti-depressant drugs. She is currently writing, researching, networking and speaking about these issues.

Visit her website: www.greenspiration.org
I am a 43-year old Chinese-Canadian woman diagnosed with a schizoaffective disorder. Shy and quiet, I first showed signs of mental illness at the age of 14. I suffered in silence, hearing voices, afraid of peering eyes, confused, and out of touch with reality. I was hospitalized at age 15.

During the years that followed, despite taking medication, I continued to have symptoms. Through perseverance, I completed high school, a fine arts diploma and a degree in art history. I worked and married, but suffered a relapse, was hospitalized in 1998 and had to quit my secretarial job. I felt I was back at square one.

At the Art Studios, I attended free art and writing classes. It was a safe environment where we shared an unspoken connection. With encouragement from others, I rekindled my interest in the creative arts. After taking a creative writing class, the female writing instructor encouraged me to send out writing submissions for publication. She became a close friend and confidante.

The all-women staff consists of occupational therapists, rehabilitation assistants and a part-time clerk. Most of the instructors are people like me who have experienced mental health problems themselves. Other members volunteer to assist classes and during open studio time. We have semi-annual art sales to sell our creative wares such as paintings, ceramics, jewellery, prints and art cards. Annual silent auctions help us raise funds to enrich the program.

Staff members suggested I apply for a job as a traveling art assistant to mount exhibits of members’ art at offices around Vancouver. Without their input, I would not have applied and attained the position. The coordinator asked me to teach a creative writing class, and although I had never taught before I ended up teaching for a whole year. Again, I received positive support from others. I developed more leadership skills as a chairperson for the planning meetings.

I talked about discrimination with female staff. Their empathy and compassion consoled me. When I spoke to them in confidence about problems, their insightful, diplomatic responses were beneficial.

I was also hired to aid in a program evaluation of the Art Studios. We wrote a report on the ways in which the Art Studios had aided the members’ recovery, taught them skills and created community.

Through the Art Studios, I made contacts and gave talks on recovery to students, families and mental health professionals.

It took a long time for me to get past self-stigma. For a long time, I felt my gender and cultural background put me at a disadvantage on top of my illness. I learned to accept myself as a whole person.

As an artist, I can express myself without words. As a writer and public speaker on recovery, I can educate others about living with a mental illness. My experience at the Art Studios helped me find my niche. Out of the darkness, I have emerged—a little tarnished but with a candle of hope and joy for the future.

Sandra Yuen MacKay is a published writer and an artist and speaks publicly about recovery through the BC Schizophrenia Society.

For more information visit:
The Art Studios website: www.vch.ca/programs/art_studios.htm
Sandra Yen MacKay’s website: www3.telus.net/sandra_yuen_mackay
Health is not merely the absence of disease but a state of well-being in which the mind, body and spirit are balanced.

There’s much we can do without drugs to treat depression and anxiety, especially of the moderate sort, where it all starts. There’s no quick fix, but we can use a variety of effective alternative approaches to build sound mental health, approaches that cause no harmful side effects and are more likely to get at the root cause of the depression or anxiety.

Family and Community
Human interactions and relationships are at the core of good mental health care. At times we need to talk, cry, find ways to laugh and play, or ask friends and family for encouragement. We’re all vulnerable, and we all need support at different times. Reach out. Be generous.

Meaningful Work
Doing something you believe in can give meaning to everyday life. Working to change social, economic or other injustice, from expensive daycare to workplace racism to saving trees, can give life purpose and passion. Getting paid is important, but volunteer work also reaps enormous reward.

Talk Therapy
Psychotherapy, or “talk therapy,” has proven an effective alternative to drugs and teaches life-long coping skills. Patients treated with psychotherapy have fewer relapses than those treated with antidepressants. Find a therapist you respect, and who respects you.

Exercise
Our bodies are designed to move. Evidence shows regular physical activity is the best long-term treatment for depression and anxiety. Movement is how our bodies circulate lymph to carry away toxins. It focuses and calms the mind, burns fat and excess energy, aids digestion and circulation, tones muscles, strengthens bone, improves heart and lung function, gets endorphins flowing and, best of all, makes you feel good.

Diet
Changes in diet over the past 50 years are an important factor in the rise in mental illness. The UK Mental Health Foundation cites scientific studies clearly linking attention deficit disorder, depression, Alzheimer’s disease and schizophrenia to junk food and the absence of essential fats, vitamins and minerals in industrialized diets.

Many people have hidden allergies, especially to milk, wheat and corn. Try switching to alternatives, or get tested. Sometimes what you crave is what you’re allergic to.

Eat like your body is a temple of the spirit. Eat more organic, raw, low on the food chain and as unprocessed as possible: more fruits and veggies and less refined foods. Turns out, when fruits and veggies comprise the majority of our diet, they create an optimal, energetic blood acid-alkaline balance. Research shows this is the right biochemical state for our cells to create 16 times more net energy from each calorie than when we eat a typical North American diet dominated by acid-forming foods (non-fruits and veggies). With all that freed-up metabolic energy, you feel less tired and can cope better. You can do more and eat less.

Grains, seeds, legumes and nuts are nutritional powerhouses, supplying proteins, fatty acids and B-vitamins crucial to the nervous system. Many foods have unique properties needed by the brain: oatmeal, a rare but essential amino acid; apples, the trace mineral boron; herbs and spices, aromatic oils that help protect brain cells. Eating a variety ensures you cover the bases. Learn to cook for yourself as healthily as you can.

Nutrients for the Brain
Researchers have noted the mental, physical and emotional effects of stress and adrenal “burnout.” Many individuals suffer greatly from depleted hormonal and nutritional reserves, artificially stimulating the nervous system and destroying vitamins with caffeine, sugar and medications until they rollercoaster...
into systemic breakdown, manifesting in a myriad of symptoms. Medications act strongly on hormone systems and can easily damage delicate glands and organs. In many cases of depression, diagnoses miss both systemic deficiencies and increasingly common thyroid conditions (brought on by stress, lifestyle, medications, pollution, etc.).

Stressful, toxic environments and poor diets create an increasingly greater demand for essential nutrients to restore and replenish overworked and damaged organ systems. The nervous system is especially dependent on the B vitamins. Stress, caffeine, sugar, cigarettes, drugs and alcohol destroy B-complex and C vitamins. A high-dose, natural-source B-complex supplement should provide noticeable relief, but the coffee, tea or other chronic source of depletion has to be cut back. Eat C-rich fruits, cabbage, greens, peppers to protect cellular walls.

The brain and nervous system are high in fat as well as protein, and should stay that way for optimal health with essential fatty and amino acids from seeds, nuts, whole grains, legumes, avocados, olives, greens and even berries, as well as organic eggs and cheese. Essential fatty acids omega-3 and omega-6 (rich in hemp, flax and fish oils) can improve the behaviour of rowdy kids and help language skills, English researchers have found. Many toxins are fat-soluble and healthy dietary fats help to flush them.

**SOCIETAL CHANGES**

Societal change may be beyond our capacity as individuals, but people can—and do—work together to create social change. Depression may be a normal reaction to a life without adequate support: reach out for help.

**BALANCE**

Always make time for fun, friends, art, reading, dance, music, meditation, prayer, nature, journaling, yoga, sport—whatever it is that brings you peace and joy. These will strengthen your spirit and give your life balance and resiliency. Remaining engaged, whether in solo activity or community, is fundamental for sound mental health.

There are many other systems worth trying that have helped countless people suffering with depression—clinical nutritional therapy or orthomolecular medicine, naturopathy, acupuncture, massage, laughter therapy, therapeutic touch. But in the end, it all comes down to self-awareness. Notice what the therapy is doing for you and to you. Are the side effects worth it? Are you feeling better or worse?

The road to recovery may be short for some, or a life-long process for others. A variety of therapeutic approaches are often required to provide a comprehensive route to recovery. The process of healing is individual.

But don’t walk this journey alone. Confide in someone every step of the way to be sure you don’t fall off the rails. Remember—it’s all about growth. Embrace it. You’re worth it!

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This article was adapted from the original, which was published in Depression Expression, a newsletter published in 2006 by Health Mind, Body, Planet and available on the Greenspiration website: www.greenspiration.org

Miriam Hawkins is a health and environmental activist and communications consultant living in Toronto. Angela Bischoff is a long-time environmental and health activist now working on anti-nuclear power issues in Ontario.
FEATURE REVIEW

What People Need to Know about Psychiatric Drugs
By E. Daisy Anderson, MSc and Janet Currie, MSW
Psychiatric Medication Awareness Group (PMAG)
(Revised 2009)

By Ellen Reynolds

What People Need to Know about Psychiatric Drugs, recently updated for the second edition, is a must-read for anyone prescribed a psychiatric medication in Canada, or anyone considering a prescription for tranquillizers, anti-depressants, stimulants, anti-psychotics or mood stabilizers. Even those not taking psychiatric medications—or any medications—are likely to know someone who is taking a drug to treat depression, anxiety, problems sleeping or any number of symptoms associated with mental health issues.

This issue is of particular importance to women. Research shows that women and girls are more likely to be diagnosed with depression, seasonal affective disorder, eating disorders, panic disorders and phobias than men, and that women are twice as likely to be prescribed a psychiatric drug compared with men.

Co-authors Anderson and Currie provide a concise overview of research on the most commonly prescribed psychiatric drugs, lists of drugs and what they are prescribed for, and possible side effects or adverse reactions. Readers can quickly look up a drug for specific information and read further for more background. The goal is to empower people through information, and the booklet artfully achieves its goal as an accessible and informative resource.

What People Need to Know challenges some of the myths and misinformation about mental health that have no basis in scientific fact—myths such as depression is caused by a “chemical imbalance” or that bipolar or depressive conditions are mainly genetic. The authors point to social determinants of mental health such as poverty, family violence and unemployment, and steer away from stigmatizing people with the label of mental illness. The section of the booklet with questions to ask your doctor not only empowers patients, but may even encourage some physicians to take a second look at what they are prescribing.

Tips for helping yourself and references to other resources also make this a user-friendly and practical guide.

The use of psychiatric medications is ubiquitous in our society, yet comprehensive information about these medications is not. What People Need to Know about Psychiatric Drugs helps address this gap, and the “people” who “need to know” are all of us.

Ellen Reynolds is the Director of Communications at the Canadian Women’s Health Network and a board member of the consumer health organization DES Action Canada.

For more information or to download a copy of the booklet, visit www.psychmedaware.org

Hard copies of the booklet are available for $5 each (plus shipping).

Living as a Chameleon: A Guide to Understanding Girls’ Anger for Girl-Serving Professionals
Cheryl van Daalen-Smith (York University, 2006)

This groundbreaking collaborative study examines the role of anger and its relationship to depression in the lives of young girls. Conducted in partnership with girls, girl-serving professionals and organizations in communities across Canada, this study proposes that when anger is dismissed or silenced (due to narrow beliefs about femininity which continue to erode and deny young women of their right to feel and express anger), young women, out of fear of judgment, violence or rejection, take on chameleon-like lives, learning to change themselves in order to blend in and protect themselves from harm. Author Cheryl Van Daalen-Smith writes, “Like the chameleon, they live not for their own color, but for the color of their surroundings, striving to become undetectable, moving quietly and cautiously as they attempt to read their ever-changing surroundings.” Interviews with a diverse group of 65 girls were conducted to better understand what generates anger, how they are permitted to express it, its relationship to depression and to develop girl-driven recommendations that enable girls to live authentic lives.

www.atkinson.yorku.ca/NURS/vandaalen.html
Death by Prescription: A Father Takes on His Daughter’s Killer  
Terence Young (Key Porter Books Ltd., 2009)

On March 19, 2000, fifteen-year-old Vanessa Young died from complications resulting from a popular prescription drug, Prepulsid, that she had been prescribed to alleviate a stomach disorder. This book documents the heart-wrenching journey of her father, Terence Young, to find justice for his dead teenaged daughter, taking on a fight to battle the pharmaceutical and health care industries to make sure this kind of tragedy never happened again. Young would find out that every year hundreds of people die as a result of complications from prescription drugs and that most of these pharmaceutical companies and agencies supposedly created to safeguard your health, just don’t seem to care.

The Antidepressant Skills Workbook  
Dr. Dan Bilsker, RPsych and Dr. Randy Paterson, RPsych (Consortium for Organizational Mental Healthcare, Faculty of Health Sciences, Simon Fraser University, 2005)

The Antidepressant Skills Workbook is based on the experience of the authors and on scientific research about which strategies work best in managing depression. This self-care manual provides an overview of depression, explains how it can be effectively managed according to the best available research, and gives a step-by-step guide to changing patterns that trigger depression. Intended for individuals with depressed mood, concerned partners, family members or friends who want to help a depressed individual, and clinical providers that would like to use the manual as an adjunct to their treatment, this self-care guide shows how to use cognitive and behavioural methods to make important changes in thinking and actions that may help individuals to emerge from depression and make it less likely to recur. www.comh.ca/antidepressant-skills/adult/

Research Bulletin #2: Women and Homelessness Bulletin  
Sistering and Street Health (The Street Health Report, 2007)

Released jointly by Sistering and Street Health, this bulletin documents the health impact of homelessness on women’s health. The bulletin presents the findings of a survey of 97 homeless women in Toronto about their health and access to health care. It paints a detailed picture of women’s street homelessness today and its devastating impact and makes a series of recommendations for change. Calling homelessness a “life-threatening” condition for women, the study examines the staggering rates of sexual assault among homeless women and details health impacts that significantly reduce life expectancy. www.sistering.org/advocacyandissues/researchbulletin.php

The Age of Anxiety: A History of America’s Turbulent Affair with Tranquilizers  
Andrea Tone (Basic Books, 2008)

From Miltown to Xanax, Valium to Paxil, Andrea Tone’s extensively researched book on the history of anti-anxiety drugs delves into the rise, fall and rise again of tranquilizers inside the complex sociohistorical context of the second half of the 20th century. The book largely concentrates on the two most important tranquilizers of the 20th century: Miltown and Valium. Tone poses the question, to what extent has the pharmaceutical industry pathologized problems that are simply the normal boredom and unhappiness of suburban life?

NOW AVAILABLE!  
From the Canadian Women’s Health Network

Newly updated – Women, Mental Health and Mental Illness and Addiction in Canada: An Overview by the Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions.

Originally published by CWHN in May 2006 in response to the tabling of the Standing Senate Committee on Social Affairs, Science and Technology’s final report Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada, this report by the Ad Hoc Working Group discusses why sex and gender matter in mental health and addictions and includes information and recommendations for the new Mental Health Commission of Canada. To date, the Commission has not addressed sex and gender in their work, highlighting the importance and relevance of the document to this day.

Also, for the first time, this report is available in French, under the title, Les femmes, la santé mentale, les maladies mentales et la toxicomanie au Canada: tour d’horizon.

The report may be downloaded from www.cwhn.ca
WHAT WE’RE READING | recommended resources from our library

Committed to the Sane Asylum: Narratives on Mental Wellness and Healing
Susan Schellenberg and Rosemary Barnes (Wilfred Laurier University Press, December 2008)

Susan Schellenberg, a former psychiatric patient, and psychologist Rosemary Barnes recount their own stories, conversations and reflections about the contributions and limitations of conventional mental health care and their collaborative search for alternatives such as art therapy in this exciting new book. Through interwoven patient/doctor narratives conventional care and critical steps in healing are explored, and a myriad of perspectives are illuminated through conversations with experts in psychiatry, feminist approaches, art, storytelling, and business.

The ABCs of Disease Mongering: An Epidemic in 26 Letters
Alan Cassels (illustrated by Jeremy Gordaneer) (Emdash Publishing, 2007)

Visualize Dr. Seuss taking on an overmedicated and overdiagnosed culture and you have Alan Cassel’s newest book. Looking at an array of disorders, from A to Z, created by the pharmaceutical industry, this illustrated verse-form alphabet is meticulously footnoted for therapeutic use by consumers and health policy-makers. The outrageous humour in the book is only outdone by the outrageous facts revealed.

Action Steps for Improving Women’s Mental Health
The Office of Women’s Health, SAMHSA’s National Mental Health Information Centre (United States Department of Health and Human Services, 2008)

This report consists of the most recent research, resources, products, and tools on mental health issues in women and investigates the role gender plays in diagnosing, treating, and coping with mental illness. Though written in the United States, this report does offer a perspective on the burden of mental illness on women’s lives and steps that might increase women’s capacity for recovery.


Women’s Mental Health: What It Means to You
The Office of Women’s Health SAMHSA’s National Mental Health Information Centre (United States Department of Health and Human Services, 2008)

A consumer booklet about the stigma associated with mental health. Offers information on the signs and symptoms of mental illness and provides suggestions for preventing and coping with mental illness.


CWHN Info-Centre
Newly updated and improved!

The Canadian Women’s Health Network invites you to search our newly updated and improved women’s health database, a comprehensive bilingual collection of women’s health publications and resources from across Canada and the world. With more advanced search options, the CWHN women’s health database gives you access to over 13,000 resources—publications, research, articles, organizations, reviews, and projects covering a wide range of information on women’s health and women’s lives.

Search the CWHN Info-Centre at our website: www.cwhn.ca

Canadian Women’s Health Network
Le Réseau canadien pour la santé des femmes