Network

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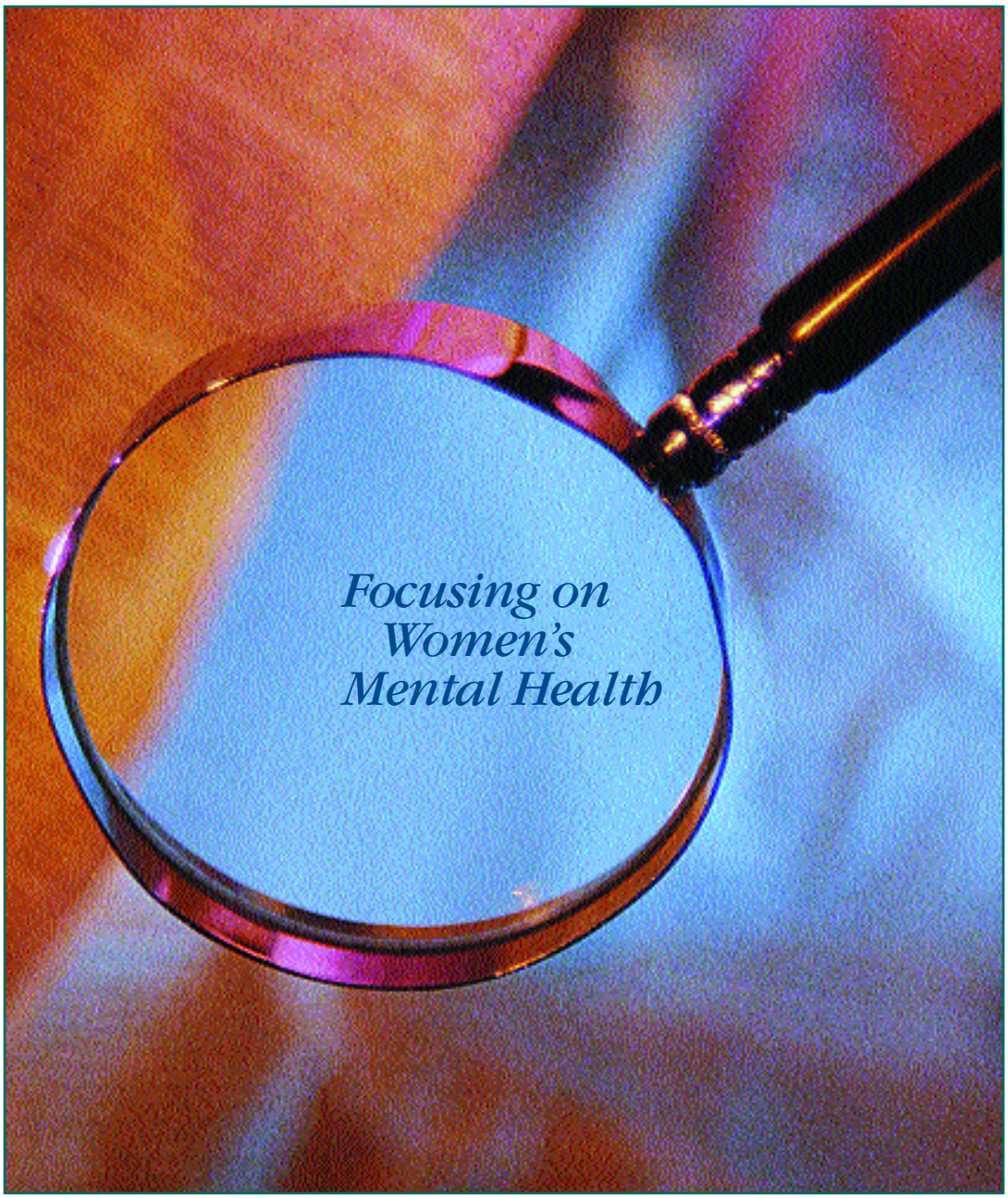

CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario

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OUR MISSION:
To advocate with and provide programs and services for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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Defining our Focus

GLENN R. THOMPSON
Executive Director

The Canadian Mental Health Association began to seriously examine women's issues in mental health with the 1987 release of the CMHA National Report, Women and Mental Health in Canada: Strategies for Change. This document provided a comprehensive analysis of women's needs in mental health services and supports, and outlined general strategies for the development of activities which promote women's mental health and well-being. In 1993, CMHA, Ontario Division completed a survey on women and mental health. Sixty-five percent of Branch respondents to this survey indicated that there was a need for more programs/services for women. In 1996 a paper was developed by the Women's Issues Task Force of the CMHA, Ontario Division Policy Advisory Committee. An edited version of those policy recommendations form the basis of our Social Policy column for this issue of *Network*.

Women form the majority of the population and are the major users of the mental health system. A range of models need to be examined in the crystallization of women's issues in mental health. The need to bring other social and psychological issues to light is perhaps best summarized by this excerpt from a 1990 CMHA, National report: "A number of studies on women's health have demonstrated strong links between health status and socioeconomic factors affecting women. Limited participation in public life, restricted decision-making, devalued role expectations, poverty, violence and sexual abuse encumber the potential for mental well-being. Social and economic stresses, coupled with the inequitable burdens imposed by role expectations, often have a negative impact on women's health, happiness and potential for personal fulfilment and achievement.
The health care system has often neglected the concerns of women, and traditionally women have had very little control over their own medical treatment, both for emotional and physical problems. Diagnostic categories, like many mental health classifications and theories created by men, have tended to locate the difficulties of women within the individual and to label women's behaviour in devaluing ways."

This issue of *Network* focuses on women's mental health and through a series of interviews examines the impact that depression, drug and alcohol dependence and the effects of violence have on women. From the internalization of gender role messages prevalent in our society, to the ways in which mental health problems can become a trigger to an addiction problem, the importance of being aware of and sensitive to women's issues is clearly expressed by Dr. Brenda Toner, Dr. Mary Seeman and Gloria Chaim. We thank each of them for their contribution.

Focusing on Women's Mental Health

Mental health problems are presently the leading cause of disability for women in our society. Depression, anxiety, eating disorders, drug dependence, and the effects of violence create extreme pain and suffering for Canadian women. During their lifetime as many as one in four women will seek help for a mental health problem. The following interviews focus on some of the unique ways in which women are impacted.

We lead off with Dr. Brenda Toner who is the Head, Women's Mental Health Research Section, Centre for Addiction and Mental Health and the Head, Women's Mental Health Programme, Associate Professor, Department of Psychiatry, University of Toronto. The Women's Mental Health Programme has taken a leadership role in facing this challenge and is committed to undertake research and clinical initiatives with the aim of easing the burden of mental health concerns in Canadian women.

Dr. Mary V. Seeman, who is a Psychiatrist at the Schizophrenia Division, Women's Clinic at the Centre for Addiction and Mental Health discusses the differences in how schizophrenia affects men and women, and the particular demands placed by society on women.

We round out our focus on women's mental health issues by speaking to Gloria Chaim, Clinical Director of Addiction Treatment Programs for Special Populations at the Centre for Addiction and Mental Health.

CHALLENGING THE GENDER ROLE MESSAGE

DR. BRENDA TONER IS THE HEAD, WOMEN'S MENTAL HEALTH RESEARCH SECTION, CENTRE FOR ADDICTION AND MENTAL HEALTH AND THE HEAD, WOMEN'S MENTAL HEALTH PROGRAMME, ASSOCIATE PROFESSOR, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF TORONTO.

The Women's Mental Health Programme began in 1990 and was identified as one of the priority areas within the Department of Psychiatry, University of Toronto. It was the first Women's Mental Health Programme in Canada and plays a leadership role in developing the Department's Women's Mental Health Programmes within teaching hospitals affiliated with the University of Toronto. The Programme is under the directorship of Dr. Brenda Toner. The Centre of Excellence for the Women's Mental Health Programme is located at the Centre for Addiction and Mental Health, Clarke Division and consists of two major components: the Division of Society, Women and Health headed by Dr. Barbara Dorian, and the Women's Mental Health Research Programme headed by Dr. Brenda Toner. In addition to the Centre of Excellence, the Women's Mental Health Programme has several initiatives located at the other major teaching hospitals affiliated with the University of Toronto.

Dr. Toner, perhaps you could begin by telling us what the mandate of The Women's Mental Health Programme is.

DR BRENDA TONER: The Women's Mental Health Programme is dedicated to facilitating initiatives that further our understanding and treatment of women's mental health issues. The overall goal of the Programme is to develop mental health care that is more responsive to the needs of women. Its primary mandate is to focus on social, psychological and biological factors that will further our understanding of the origin, expression, prevention and clinical treatment of mental health problems in women. We are interested in working in partnership with a diversity of women in furthering research that will be helpful to all women with mental health issues. A major goal is to identify factors that are often overlooked in the understanding and treatment of mental health problems in women. These factors include poverty, isolation, racial and sexual discrimination, sexual harassment, disempowerment, societal preoccupation with women's bodies and youth as a measure of self worth, role conflict, stressors in the workplace, and sexual, physical and emotional abuse. We are only now beginning to name and understand the full mental health impact of factors that serve to normalize and reinforce the silencing of women. Our Programme is focusing on how these factors, together with biological and psychological variables, contribute to the expression of devastating health problems in women, including eating disorders, chronic pain syndromes, addictions, anxiety and depressive disorders.

Would you talk a little bit about the gender role socialization scale you are developing?

DR. BRENDA TONER: As we start to identify factors that are overlooked, one of them is the influence of gender role messages that women learn in society. We've found that there wasn't any measure of this; there wasn't a formal understanding of the impact of those messages which was integrated into our mental health programme. This has actually been a project that we started six years ago and we've been working hard on this. We are in the process of developing a scale that measures the internalization of gender role messages – and those messages are often conflicting. For example, not only do women have to be the most self-reliant and not look needy, but we have been socialized to also take care of everyone else's needs and make sure that everyone is comfortable. These are some of the messages that face the modern woman today. And so what we want to do is try to get all of the different themes. Some have to do with relation-

ship issues – a good woman lives to give, so it's our responsibility to make relationships work; it's better to look good than to feel good, the emphasis that society has placed on youth and slimness and beauty as a measure of worth. We're looking at all of the different gender messages that girls and women receive.

Do these things cross cultures for women?

DR. BRENDA TONER: Our hope for this scale, which is a very ambitious scale because we are trying to have it culturally sensitive, is that we have a number of items that would be universal and then specific themes which would be more relevant to one culture versus another. And then we would like to test this on clinical groups as well as non-clinical. The exciting thing about this is that we could use it as an assessment tool to see how women have internalized some of these gender role messages that may not be helpful to their mental health and then offer a clinical intervention. We have started doing this, getting together groups that actually challenge some of these messages. It can be very supportive to get people to see what are the rules for the "good woman" that they have adopted and how these rules may have affected their sense of feeling good about themselves. The groups then discuss possible coping mechanisms, changing their circumstances or feeling empowered to have more choices. Or even to feel that if they give up taking care of everyone else's needs they are not an evil woman. We all struggle with gender role messages to different degrees. Some of these struggles may get expressed as health or illness, some get expressed more in relationship issues. The group that I am particularly interested in, persons experiencing chronic abdominal pain and irritable bowel syndrome, is a theme I see a lot in women who are trying to do it all and not look needy or vulnerable. They are the shoulder that everyone cries on but no one really knows what their needs are.

Is irritable bowel syndrome primarily a women's health problem?

DR. BRENDA TONER: It's interesting because we don't know a lot about men with irritable bowel syndrome (IBS). If you look at people in the general population, IBS is disproportionately high among women – 85-90% of those treated are women – and our hunches are that we're looking at some of the chronic stressors in the lives of women, past and present, that may influence the expression of the abdominal pain and symptoms. We are not saying that any of these things are causing it, it's just that these stressors are associated with flare ups. Stress doesn't cause irritable bowel syndrome, but there are a whole host of things in our social environment that can influence the severity, the frequency and the intensity and trigger the attacks. The biggest complaint women have is that it is trivialized. "They can't find anything wrong, therefore they think I am crazy." A lot of the disorders that are disproportionately represented among women tend to be trivialized. I think IBS is a great example of where we need to go in terms of legitimizing the real physical and emotional pain and suffering that these women experience. We are currently conducting a large multi-centred treatment study of IBS in which we are assessing both biological and psychosocial

Within any acute care psychiatric setting, as many as two-thirds of female patients will have histories which include childhood physical and/or sexual abuse.

"We all have a sense of invulnerability that allows us to get up in the morning and believe that bad things are not going to happen. That sense of invulnerability is destroyed after sexual assault; it's as though one is out in the world without a skin. Loss of sense of safety, and increased fears are often misdiagnosed. Our basic assumption, that if we do the right things in living our lives will be OK, is destroyed. Victims experience an absolute loss of trust in others and loss of sense of justice. Women's sense of self and sense of attachment are fractured. With that comes a profound loss of self-esteem and self-worth. Sexual violence violates the basic tenets of our being."

THE CANADIAN PANEL ON VIOLENCE AGAINST WOMEN, 1993.

aspects of the disorder. We plan to extend this study by including neuroimaging techniques to provide a more comprehensive analysis of the interaction between biological and social factors.

I see you are doing a study on suicide in female adolescents. What are you discovering in this area?

DR. BRENDA TONER: We're looking at some of the gender role issues. For example, role restrictions in terms of the fact that brothers can have certain freedoms which their sisters can't, and then if you add in cultural issues and religious issues there are a lot of restrictions. So we are looking at gender role conflict where what the girl may be struggling with may not be compatible with what society says she should be like. One avenue of escape for her is suicide. We are interviewing adolescent girls at the Hospital for Sick Children who have attempted suicide and asking them about their feelings and trying to get more of a qualitative analysis, more of a comprehensive analysis of what are some of the issues they are struggling with. And again it's trying to have a look at that factor and take it very seriously and integrate it into the psycho-social factors.

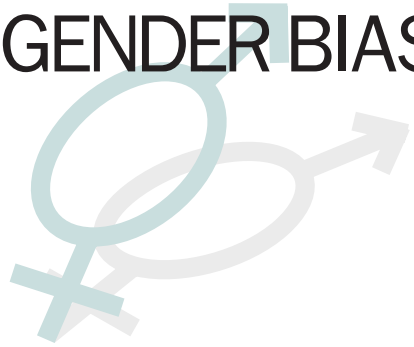
In the past violence and abuse of women has been covered up, there's been a lot of shame associated with that for women. Now it is being talked about. What are some of the consequences of abuse, in mental health terms, for women?

DR. BRENDA TONER: We've done a number of different studies on this and certainly it has a very high priority in the women's mental health program. I think we are just beginning to understand the various forms of chronic abuse of women, and so I think of it along a continuum: emotional, psychological, spiritual, sexual harassment right through to incest and sexual abuse. I think that this has been traditionally thought of as very private. Fortunately it's now coming out of the closet. Violence affects virtually all of us in ways that we are not even aware of. For example there was this great ad which ran on the radio about three years ago which said violence against women doesn't affect me. And then the interviewer started asking the woman questions and it became painfully clear from her answers that she had restricted her behaviour because of her fear of violence without even realizing it. I think it's one of those things that is so ominous that it affects all of us. It limits our potential, it has an affect on our trust, our body, because if we are always hyper-vigilant to the potential danger it puts constraints on us. So when we look at people, at women, who have been sexually or emotionally abused, their trust in people has been fractured, their sense of invulnerability has been destroyed. There are the physical consequences – the bruises and the broken bones – and there are the psycho-social consequences – depression, anxiety, substance abuse, feeling helpless and hopeless – and it really affects all aspects of the mind and spirit. There have been a lot of descriptive studies on the consequences so we are trying to push it further in exposing all different types of violence and see how we can be helpful to women who have experienced this and also empower them to become integrated and whole again.

"While on my knees before him as he swung the poker down again and again, so close to my head I could feel the wind from it on my face and hearing him say over and over "I could kill you, I could kill you," I envisioned my brains splashing on the carpet. I willed him to do it, to end it all quickly. I waited on my knees for the blow that would set me free once and for all. I believed at that moment that this was my destiny, that the reason I had been placed on this earth was to die at his hand and that his destiny was to kill me. That all roads led to here, to this particular moment."

THE CANADIAN PANEL ON VIOLENCE AGAINST WOMEN, 1993.

EXAMINING THE GENDER BIAS



Opened in the summer of 1996, the Schizophrenia Division Women's Clinic at the CAMH meets the special needs of women with schizophrenia. The interdisciplinary clinic does comprehensive assessments of women and their families and offers a variety of treatments such as medication counselling during menstrual cycles, pregnancy and menopause; parenting groups; women's issues groups; behavioural-cognitive counselling targeting depression; leisure time counselling, job and school preparation; marital and family counselling; residential and community linking. The clinic staff is sensitive to the social roles that women occupy and how these roles vary with age, cultural factors and socio-economic factors.

What are the symptoms that characterize schizophrenia?

DR. MARY SEEMAN: The primary symptoms of schizophrenia are hallucinations, delusions, and disorders of thought. And then there are others: the ability to think, to reason and to judge, the willingness to be interpersonally active and interested in other people or in activities are all affected and seem to become impaired later, although some people feel that this is actually the core of the illness. Hallucinations and delusions are phenomena that can happen in other illnesses too; what really characterizes schizophrenia is the difficulty in thinking and relating to others.

Are there major differences in how schizophrenia affects men and women?

DR. MARY SEEMAN: Yes, and the first big difference is that the illness begins earlier in men than in women. In men it's typically around age 19 and in women more typically it would be age 22 - 24. Only a few years later but it's a statistically significant difference, and it's all over the world, not restricted to just one culture. And that's counter-intuitive because women develop earlier and faster than men – the growth spurt, puberty, it all happens earlier in girls than in boys – so you would think that if it was a question of brain maturation the onset would be earlier in girls, but no, it's the other way around. And I think that is very interesting because trying to understand that could help us understand the disease. We also know that if you look into the histories of girls and boys who develop schizophrenia the girls have usually done better overall – they've done better relating, they've done better in school, they've done better personality-wise than the boys. The boys may have been a bit withdrawn or shy or not good students or rebellious – often there are these kinds of problems in boys before they develop schizophrenia. In the girls there is less of that. So the beginning is different. Then the actual symptoms are a little bit different too. They have to have the symptoms I mentioned in order to qualify for having the disease but the girls usually have more mood symptoms. They are either depressed or they are high, the fluctuations in their moods are there, while the boys tend to be fairly flat. In fact flat emotions are one of the signs of schizophrenia, but interestingly enough you don't see that so much in the women, and this sometimes means that it is more difficult to make the diagnosis in women. Some women fit the criteria in everything except in this area.

DR. MARY V. SEEMAN IS A PSYCHIATRIST AND PROFESSOR AND TAPSCOTT CHAIR AT THE UNIVERSITY OF TORONTO.

Would this often lead to mis-diagnosis then for women?

DR. MARY SEEMAN: Yes, exactly. There is a real danger of mis-diagnosis in both directions. You can get someone who has a manic-depressive psychosis but they are a woman so you say "Oh, they are going to be moody because they are a woman, so this is really schizophrenia". Or, vice versa, you are going to get someone who as it turns out has schizophrenia but you see a lot of labile mood so they get diagnosed with manic depressive. There is a category of illness called schizo-affective psychosis, which is really an in-between illness between manic-depressive psychosis and schizophrenic psychosis.

Is schizo-affective psychosis a diagnosis which is applicable to both men and women?

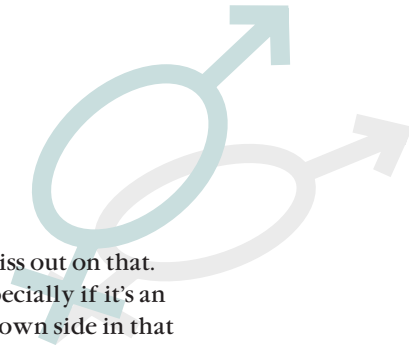
DR. MARY SEEMAN: It is applicable to both, but if you actually look at who gets the diagnosis it's almost always women. And that reflects a certain uncertainty on the part of the diagnostician as to what this illness really is.

What other differences are there between men and women with schizophrenia?

DR. MARY SEEMAN: Women tend to respond to medications at a somewhat lower dose than men do. And that probably has to do with the physiology of men and women, the fact that there are certain differences in absorption of pills and how much chemical actually gets into the blood stream, and how much from the blood stream gets into the brain. Because women have more body fat than men, and the drugs used to treat schizophrenia dissolve in fat, that increases the duration of action in women. Women do better, they recover better and they also have fewer side effects because they are on a lower dose. So they are happier with the treatment they are receiving, and they follow the treatment better. This may be because they have fewer side effects or it may be because in general women are socialized to obey, so they stick with their treatment somewhat better than men do. And that of course is very important because this is a recurrent disorder so if you stop treatment as soon as you are better, which of course tends to happen, then you're going to get sick again. And the more often you get sick the worse it is because it interrupts your schooling, it interrupts your friendships, it interrupts your work and your family life. It's terrible to get repeatedly ill. The first decade after being diagnosed with schizophrenia the women are actually doing quite well. They are taking their medication, their symptoms are at bay, they continue on with their lives and they are not doing badly at all. The men during this first ten years are having a much worse time. They seem to have a worst severity of the illness, they drop their meds, they are more aggressive, they are often in trouble with the law, they cause trouble for their families which results in alienation from families and friends. Suicides due to schizophrenia tend to occur in that first decade and there are many more for men. But then things seem to change. Over the next ten years the men plateau and the women kind of plateau too, and then the men start to get better. Schizophrenia is an odd illness. Most illnesses get worse with age but schizophrenia actually gets somewhat better within the older age groups. The symptoms seem to fall away and there is less stigma. For instance you may be on a disability pension and that's not too different from someone who's on an old age pension, so everything socially evens out for you. So by the time men are in their 50s they are actually doing relatively well. But something odd happens to the women in that their symptoms seem to get worse at that point.

Does it correlate to menopause?

DR. MARY SEEMAN: Roughly. It's never been correlated specifically to menopause but in terms of the age at which it happens it's roughly at that time. It could be hormonal and there are a lot of interesting things that the hormonal theory could actually fit. The fact that girls start to get ill later could be because female hormones, estrogen let's say, are protecting women in some way and so therefore they get ill later. By the same token, in



menopause estrogen drops away and women then get a resurgence of the illness. We are learning a lot about estrogen these days, and we are learning that estrogens are protective for brain function. For instance in Alzheimer's disease they protect against degeneration of the cells. They play many roles in the central nervous system. They prevent cell death, they make neurons or branches of neurons sprout, they do all kinds of interesting things in the brain. So the estrogen hypothesis is intriguing. It's not water tight by any means, there are a lot of observations that don't fit it, but it is one possible explanation for why women have this different pattern. But you could also think about it purely as a sociological issue, because what also happens around the menopausal age is that parents are dying and the women, because they haven't been that ill and because they have retained a lot of their inter-personal relationships, have often stayed at home and been the care givers for their dying parents. So there is this terrible sense of loss. For men this doesn't really happen because they've been alienated from their families.

So the loss has already taken place for men much earlier?

DR. MARY SEEMAN: Exactly. And you know that even men who have continued to live with their parents have become so dependent that when the parents die they are immediately taken care of by outside systems, because it never occurs to anybody that they could manage on their own. Whereas with women if they've lived with their parents they've usually taken care of them and taken care of the household too, so now they stay on alone looking after themselves. It's a different kind of societal structure for women. So for whatever reason the loss of parents doesn't seem to have the same magnitude of effect on men as it does on women.

There are other theories which are interesting too and they apply to women in general, not just to women with schizophrenia, in that women tend to have a larger social circle, a larger friendship circle than men do. Now having a large social circle is quite protective for mental health; you have someone to confide in, you have someone to share things with and you have someone to help you if you have a problem. Men miss out on that. But having a large social circle, especially if it's an intimate social circle, also has its down side in that when your friend has an illness, or is bereaved, or if you lose your friend, that affects you too. So it reverberates around the social circle. If you have a tight knit social circle and troubles happen to one of your friends they also happen to you. So again that's another possible reason as to why things get somewhat worse for women as they get older because troubles are happening to their friends.

Another phenomenon is that although schizophrenia usually starts early in life it can start in later life. This is rare, but it can start at age 35, 45 or very rarely as late as 70 years of age.

Is it harder to diagnose if it starts so much later in life?

DR. MARY SEEMAN: Well it is harder because you don't expect it. If someone is really old you put it down to dementia, but if you are really careful you do find people who develop this late in life. But the interesting thing is that these are almost exclusively women.

So there is a gender bias to this?

DR. MARY SEEMAN: Yes. It's actually rare after 35 for schizophrenia to start in men and very rare after 45 for men, but for women, although it is less than in earlier age groups, you do see it. There's one other thing I would like to talk about because it is important and that is the whole issue of women with schizophrenia who have children. Because many women retain their inter-personal skills they do get married and they do have children and they try to look after the children. Unfortunately, as they get worse, the problems of child-rearing become very very difficult. Unless they have a lot of support from a husband, parents, etc., their children get taken away from them by Children's Aid and are usually put into foster homes. Not only is it very sad for the parents it's also a tragedy for the children because they are generally not infants any more and they've now lost a mother to whom they are attached. And this is a quintessentially woman's problem.

SUBSTANCE ABUSE – IS IT MASKING THE PAIN?

At the Centre for Addiction and Mental Health, addiction treatment services for women are available at two sites – the Donwood Institute and the Addiction Research Foundation. The services span the continuum of care from case management and outpatient group and individual therapy to an intensive three week residential or day treatment program and continuing care. Client needs are assessed to see whether there is a fit with one of the programs offered by the Centre or whether a referral to another agency is indicated. These services are designed for women presenting with a primary addiction problem, but between 50 - 75% may also have a co-occurring mental health disorder, either diagnosed or undiagnosed.

Do mental health problems become a trigger that can push women into developing an addiction, or does an addiction pave the way for poor mental health?

GLORIA CHAIM: It's a bit of a chicken and egg situation. We see a lot of women who have both and it's hard to know if the substance abuse problem triggered a mental health problem or vice versa. I think that both can happen, and sometimes one masks the other. For example we see a lot of women who have a history of trauma – sexual or physical abuse, or other kinds of major traumatic life events – and some of these women are depressed or anxious, or are showing symptoms of post traumatic stress disorder which has not yet been diagnosed. Women come because they have a drinking problem or a problem with other drugs, but really when you start looking there are many other things going on that have brought them to this point. Some women will drink or use drugs like crack cocaine to dull their pain, and often they will find themselves in a cycle which is just too difficult to stop. The tragic part is that they often become re-traumatized as a result of their addiction, because they are putting themselves in risky situations, and opening themselves up to being vulnerable once again to being abused. Things like passing out in a bar and waking up and not knowing who you're with.

So you're saying that you can't cure the addiction problem in isolation? There might be other factors that have to be addressed?

GLORIA CHAIM: Absolutely. If a woman is feeling isolated, lonely and depressed and you take away the substance use but you don't help her find other ways to deal with these feelings or to change the things in her living situation that have contributed to her feeling the way she does, then she is going to be back in the same situation. All the triggers that may have led to her substance use will still be there. The other thing that sometimes happens, especially with women in their late teens or early twenties, is that their substance use can appear to trigger psychotic episodes. One of the key things that we try to uncover when we meet with women is to find out whether there is a mental health problem. Is the woman behaving in these ways or having psychotic episodes because she truly has a psychotic illness, or is it something that is totally drug induced or related to other factors in her environment.

Do you think the perspective on how women are assessed and diagnosed has a different focus to it now as compared to say 10 years ago? Is there a different way of looking at these situations to make sure that women are getting the correct diagnosis and the help they need?

GLORIA CHAIM: I don't know how far ahead we are but I think we are certainly moving in the right direction. We have services designed for women only and we are training people who work with mixed populations and general populations to be aware of and sensitive to women's issues and special needs. We now look at women's lives in the context of their personal and social histories and life experiences. We also have more information about how alcohol and other drugs affect women. For example, women metabolize drugs differently than men do. Women's bodies have a higher fat content than men's so they may excrete some kinds of drugs more slowly. They get intoxicated more quickly on less alcohol, that kind of thing. Having a knowledge of that – the fact that there are some different norms for

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women, their different physiology, etc. – is very important. And it's important for women to know this as well, not just the professionals, so that they can set appropriate goals for themselves and make informed decisions. Women also need to be aware of changes in their bodies as they age. For example, a woman may need smaller amounts of alcohol or drugs to get the same effects as before as she gets older.

Why is this?

GLORIA CHAIM: I think part of it has to do with hormonal changes that women experience as they age. In fact, hormonal changes may interact with substances throughout a woman's life including during pre-menstrual periods, pregnancy, etc. In addition, women seem to be diagnosed as having a mental illness such as a mood disorder more frequently than men and as a result are prescribed medication such as Valium that can make the situation worse instead of better, especially if these medications are then mixed with alcohol or other drugs.

Do you find that at certain ages women are more susceptible to becoming addicted to certain substances, or is this not age related at all?

GLORIA CHAIM: I think that women are certainly more susceptible at high risk times and transition points in their lives. Young women who are struggling with identity issues may be particularly susceptible to experimenting with drugs. Women's life experiences and their environment will influence how they experiment and what they get into. Women who have less support and more history of traumatic events, maybe health issues and other things like that, have more of a chance of becoming seriously involved with substances. Societal factors like poverty, violence, and isolation which appear to be affecting more and more of the women we see also make women more vulnerable. Older women who have experienced a loss – maybe the death of a husband or close friends, retirement, illness – may experience symptoms such as feeling extreme sadness, loss of appetite, or an inability to sleep, and it's very easy for them to get prescription drugs for "depression". They may go to more than one doctor and end up with several prescriptions and get very confused. "I had a pink pill and a yellow pill – I don't know what they are", we hear that all the time. And that's maybe what it is important for women to be aware of; that when they take a drink or take a pill to ease things it's very easy at that point in their life for it to get out of control. Depending on experiences with substance use, whether it's been a pattern, if there is a history of substance abuse in the family, then I think there is often a higher risk that one might develop problems. Not necessarily because of a genetic factor, but because this is a coping strategy that women have observed or learned by experience works. I think the other thing that's happening in society now which is making women susceptible is multi-tasking. There's a lot of pressure on women to perform in many different roles at the same time. These kind of pressures put women at any age at risk.

I think the "wonder woman" concept that we used to laugh about 10-15 years ago is still very much alive and well.

GLORIA CHAIM: Yes, it's a huge issue for women. And I think when we talk to women who have been fortunate enough not to have experienced some of the risk factors we have already talked about, like having a history of abuse or traumatic events, they say, "Oh well, I haven't experienced anything like that so I'm okay". But people who are doing very well in life, who have had all the advantages, are also susceptible because there are so many stresses – not only put on them by society and their families, but also self-imposed. I am thinking of someone I've seen recently who is a very high-functioning woman from the world's point of view, but when the world shuts down at ten o'clock at night, she drinks herself into oblivion. She has not been able to find other ways of relaxing, of separating herself from the pressure she is under all day long to be the best at what she does, and she can't face the tasks and demands that await her at home. Her relationship with her partner is suffering which exacerbates the stress she is already under and it probably won't be long before it starts impacting on the rest

of her world. She is under so much pressure to take care of everything in her life – her job, her family, her home – but she has forgotten, or never learned, how to take care of herself.

You mentioned something earlier about women taking a pink pill and a yellow pill and not knowing what they were. Do you think in general that women are becoming more aware and more concerned about what they are being prescribed?

GLORIA CHAIM: I think there is a change, but I think there is still a long way to go. I think particularly of older women and many young ones as well who have been taught to accept authority and listen unquestioningly to professionals, especially doctors. I believe that more women are becoming more aware, assertive, and prepared to exercise their right to ask questions and ensure that what they are being told to do is really in their best interest. However there are still too many women who will take whatever the doctor has prescribed and not ask questions. It is crucial that women become more aware of and able to assert their rights and to begin to demand answers.

I think for women of a certain age that was just the way they were brought up – you don't ask the doctor what he is prescribing; the doctor knows best.

GLORIA CHAIM: Exactly, and when you ask them if they told the doctor about their other health problems they say "no, he didn't ask me!" I think many women are still unquestioning, particularly if the medication makes them feel better – many women don't want to know. It's too difficult to deal with. I think it's compounded by being isolated and by other kinds of life events. If a woman has a lot of support in her life, whether she is single or not, if money isn't a huge issue, then these kinds of things can make a huge difference in how women function. But it doesn't prevent people from becoming involved in substance use either.

When you talk about substance use you're referring to alcohol and drugs?

GLORIA CHAIM: Alcohol and prescription drugs and street drugs. I would say that the street drugs you would see mainly with younger women, alcohol across the board, all ages, and prescription drugs across the board but primarily middle-aged and older women would be really susceptible.

I think that something that women are only fairly recently beginning to realize is that street drugs, which is the politically incorrect way of getting your drugs, and addictive prescription drugs through a doctor, which is the polite way of getting drugs, can end up having the same effect.

GLORIA CHAIM: Yes, and that's a very good point. It's also what makes it difficult sometimes for women to come forward and get treatment or be identified for treatment, because they are receiving medication from a doctor so it must be okay, or they are expected to be able to cope. So their drug use doesn't necessarily get addressed. The other part of the equation includes things like child care issues – having to go to work and still look after a home and children – there just doesn't seem to be any time for a woman to book an appointment and allow herself time to get help. So women end up being isolated and unable to reach out for some of the supports and treatment they could get.

You mentioned the fact that historically women have been cast as being "emotional". Is that still a very difficult area for women, or is what is behind these emotions being looked at more?

GLORIA CHAIM: I guess I am hoping that when women come forward they will find doctors or other professionals who are more educated about women's issues and more sensitive to their needs now, but, unfortunately, I think that in society and in families an attitude of "she's just being emotional" is still very prevalent. We see a lot of women here who will come in with their husbands and their husbands will minimize the issues they are dealing with. "What could she possibly be worrying about – she has it so good I

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Putting Aside the Mask: One Woman's Journey

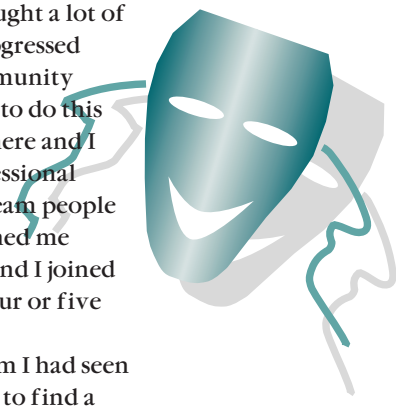
From experiencing the "low of all lows" to being able to put the old baggage on the shelf and begin to live and enjoy life, one woman shares her journey with us.

Several years ago I became a workaholic who burnt out, and that, along with some other major factors in my life, got me into the psychiatric system. My psychiatrist back then had a care-taking role. For several years most of his time was spent just trying to keep me alive. I had very poor coping skills and there was a very controlling individual in my life at that time which gave me an extremely low level of confidence. I was treated with anti-psychotic and addictive medication early on in therapy. Most of my time in psychotherapy was spent just trying to pick up the small remnants of what I had, which wasn't very much. I decided that I wanted to change my career and I went back to school. Unfortunately, due to many reasons, in my third year I had to give that up. I wasn't able to live alone any more, so I lived in a group home for about a year and a half. It was during this period of my life that the addictive medication was increased to keep me going. As I said, I had very few coping skills at that time and I wasn't really able to deal with major issues so my psychiatrist felt that this medication was beneficial just to keep me alive. I had made several suicide attempts, one almost successfully. After five or six years I decided, in conjunction with my psychiatrist, that I would try going off all my medications and this was done over a two month period. I ended up developing what is called a brain barrier; the 10% of the medication I was on was not reaching the brain. For six months I was only getting two hours of sleep a night. I had no permanent place to live, and on top of that there was a death in the family. The result was that I ended up going psychotic and was hospitalized for about six months. After coming out of the hospital I went into a work rehab program for about a year and half and then shared an apartment with a girl that I had met in the hospital. This was good for me because I still didn't feel I was able to live on my own and needed the support of others around me. It turned out that this girl was an alcoholic. I had had an alcohol problem about four years earlier and although I wasn't drinking at this point after two years of sharing the apartment with her I started again. The years between 1990 and 1992 were unbelievably bad. All I was doing was drinking and sleeping and continuing with all of my prescribed medication. It was a dangerous combination. I have a very high tolerance level for medication so it takes a lot for it to work on me. Over the years all of the addictive medication I was on had been increased until it got to the point of no return. My psychiatrist referred me to the Addiction Research Foundation and I met with a

woman counsellor who was unbelievable – very patient, very kind, I was extremely lucky. I saw her for a couple of years and she presented to me the scenario of going to a treatment centre outside of Toronto. I procrastinated for a couple of years but after being rushed to the hospital several times almost in a coma because of the diabetes that I suffer from, which was not helped by the alcohol, I decided to go. At this point I didn't have a life. I had reached the low of all lows. I would wake up around two o'clock in the afternoon, start drinking at three and continue to drink until around four the next morning. I have never known a darkness like it and I guess I decided I would give myself one last chance. And if that didn't work then that was it, I was leaving this world.

Through all of this I had not been in touch with my family – my brothers and sisters who I am very close to. They knew about the episodes, my hospitalization and everything, but they were your typical North American work ethic family. They believed that the individual on their own could deal with this sort of thing and that all I needed to do was keep busy and I would be fine. They didn't understand my illness; they didn't care to find out about it. I think they were afraid of it. Back in those days psychiatric institutions were not very good at bringing the family in and educating them. And also a family has to be willing to do this. The counsellor I was seeing at ARF contacted my family though, and they came to Toronto and we had a meeting, and they said they were supportive of my going to the treatment centre. So I went to Homewood in Guelph and it was a wonderful program. I was there for a couple of months and I'm glad I didn't know in advance how rigorous the schedule was going to be! I had been spending my days drinking and sleeping and here they had you up at six in the morning to walk a mile before breakfast! When I got to Homewood I didn't realize they would take me off my sleeping pills and Valium – I went there to be taken off alcohol. But as soon as I arrived they took me off everything except my anti-psychotic medication. I've never felt so scared and alone. They had a very confrontational approach and it was not a very sympathetic approach. I guess that's what I needed but my greatest fear was that without the sleeping pills I would go psychotic again. But they said no, we guarantee you'll sleep. Getting up at six, walking, then being in classes all day and attending AA sessions in the evening meant we didn't finish until 11 at night. I didn't have any problem sleeping! It was wonderful being introduced to AA, it was somewhere to go and meet people. At the end of my two months at Homewood they suggested that I go to a women's treatment centre in Waterloo to learn a lot more about myself. Basically the programme at Homewood was educational and you really didn't have that much time to focus on yourself. So I went to this women's treatment centre for a couple of months and it was only there that I started learning what I wasn't facing – what the alcohol and the drugs were masking. I also learnt that I am responsible for my life.

Just before I had left Toronto to go to Homewood I had started to participate in a women's group, a therapy group, and so when I returned to Toronto I went back to this group. I guess I have to say that when I came back a lot of things [in me] had changed. I wasn't socially isolated anymore. I went to AA meetings. I participated in things. I had a better support system. I was introduced to the outpatient program, which I hadn't even been aware of before, and the counsellors there were very encouraging in getting me back into a work environment and that really got me back on track. That was vital. I hadn't worked in several years, so now my confidence and self esteem started building. I was also in touch with my family again and that was really important and brought a lot of joy into my life. All kinds of things progressed from there. I was asked to sit on a community advisory board and I debated whether to do this or not. My confidence still wasn't up there and I didn't really feel I could relate to professional people, and I hadn't related to mainstream people in years. The person who had approached me continued to encourage me to do this and I joined the board and was on that for about four or five years. It did wonders for me.



Around this time my psychiatrist whom I had seen for many many years retired and I had to find a new one, which was extremely difficult. Again, I was really fortunate in finding someone. She came from a different school of psychiatry than my

Putting Aside the Mask: One Woman's Journey

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former psychiatrist. He was from the patriarchal school of psychiatry where they make all of the decisions for you. She told me that we would be a team and that she would not make decisions for me. It took me a while to adjust to her approach, but I believe it was one I needed. She has been a vital element of my road to recovery. She has been remarkable. We started reducing the medication I was on immediately and over the last four years we've reduced it even more so that's helped with my energy level. But it has also brought a lot of stuff that had been covered up for years to the surface. Medication does that, it covers up the things you can't deal with. I have not been on alcohol since I left Homewood, or on addictive medications, but I am on a very low dose of an anti-psychotic medication. I have learnt to take risks, explore and try new ways which has given me an overall empowering feeling. Over the last four years the big thing has been dealing with all of the issues that the medication had masked. I've been involved in part time work. I've joined other social and recreational programs outside of the hospital environment which has increased my social interaction. And I've learned a lot more about my family. Where am I today? I've come a long way, but it's taken a long time. I think the initial step towards change came after the treatment centre when I felt rejuvenated and had a new zest for living. A feeling for the first time in a long time that it was good to be alive. Before becoming ill I enjoyed many successful years working in mainstream society. Although I paid a high price when I became a workaholic, I am grateful today that I am aware of the importance of a more balanced lifestyle. Step by step I have been able to put the old baggage on the shelf and move forward.

SUBSTANCE ABUSE – IS IT MASKING THE PAIN?

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don't know what she's upset about", that kind of thing. And then also as much as we like to say that women have equal roles, there is still a real power differential in a lot of relationships whether they are family relationships like husband-wife or workplace relationships like employer-employee. It's difficult for women to speak up and express themselves in a way that they can be heard and not seen as just "emotional" in a relationship where they may feel powerless and vulnerable. There are also a lot of women out there who are single parents who are trying to take care of themselves and their children and put food on the table and that's not an easy thing to do either. It's many of these women who end up in the mental health or the addictions system or both. In the addiction treatment services offered to women at the Centre we are striving to provide an environment where women will feel safe and be able to explore "what's behind the emotions" so that they will be able to work towards the goals they set for themselves in all areas of their life in a partnership that will allow them to find ways to nurture themselves and develop satisfying and fulfilling lives.

Women's Issues in Mental Health

The following is an edited version of the policy recommendations contained in Women's Issues in Mental Health: A Policy Consultation Document. This paper was developed by the Women's Issues Task Force of the CMHA, Ontario Division Policy Advisory Committee, and was approved by the Policy Advisory Committee and the Board of Directors at their May 30, 1996 and June 20, 1996 meetings respectively.

CHOICE:

Mental health services must provide and fund a greater array of service options, including medical, social, self-help and alternative supports. In addition, all existing services must be made more responsive to women's specific mental health needs.

CULTURALLY AND RACIALLY APPROPRIATE SERVICES:

Mental health services must effectively address the language and cultural barriers relevant to women for whom they provide support. They must develop and implement an organizational change framework to identify and eliminate barriers to service for ethno-racial groups. Mental health services should support employment equity initiatives.

SENSITIVE TO DIVERSITY:

Mental health services must promote the full participation of women from diverse groups and situations, in all aspects of service planning and delivery. They must recognize that although women are faced with certain access barriers and needs which should be addressed, it is not appropriate to categorize women as a "special needs group".

RECOGNITION OF AND RESPONSE TO VIOLENCE:

Mental health services must develop organizational guidelines for dealing with all forms of violence occurring in programs. Guidelines should be developed within a "zero tolerance" philosophy. Mental health services must assist women in addressing their need for safety as it relates to their housing, supports, communities and neighbourhoods, and relationships, and must implement supportive models/interventions which respond directly and effectively to women's experiences of violence. Mental health services should support all community initiatives which are directed at reducing and preventing violence.

SUPPORT TO FAMILY MEMBERS:

Mental health services must examine and develop mechanisms for comprehensive support to those women who are primary caregivers for a person living with a mental illness and for families of women with serious mental health problems. Mental health services should enhance their focus on children's mental health, especially with respect to violence in families, and children who have a parent struggling with mental health issues. Mental health services should help families to develop their own support groups and initiatives.

SUPPORT TO SERVICE PROVIDERS:

Mental health services must effectively address and support the individual learning needs of persons providing service to women with serious mental health problems.

ETHICAL RELATIONSHIPS:

Mental health services must develop, maintain and monitor ethical stances regarding the nature of relationships among service providers and between service providers and clients.

RESPECT FOR INDIVIDUAL CIRCUMSTANCES:

Mental health services must develop specific measures and policies to encourage workers to analyze and respond to support needs, with women, rather than for women.

ADVOCACY:

Mental health services must evaluate the effectiveness of existing advocacy efforts regarding the enhancement of women's mental health and societal status. New strategies for effective advocacy in these areas must be developed.

REDUCING ACCESS BARRIERS:

Mental health services must construct creative solutions to address childcare, transportation and information barriers for diverse groups of women in the community, and attempt to eliminate the inaccessibility of existing services to marginalized women.

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Women's Issues in Mental Health

WOMEN-CENTRED APPROACH AND EMPHASIS ON WELLNESS:
Mental health services must further examine how an emphasis on wellness and individual strengths can be incorporated into services for women. Mental health services which are designed for women must facilitate and encourage women using the services to provide leadership in making services women-centred in nature.

RESEARCH, TRAINING AND EDUCATION:
Mental health services must develop both informal and formal staff training programs which foster an understanding of women's mental health issues. It is important that training initiatives include an examination of women's needs from a range of perspectives, including psychosocial rehabilitation and alternative approaches to service delivery. This examination should be coupled with a sensitivity to the impact of racism, sexism, poverty, violence, homophobia, disability, life stage and culture on women's mental health. Mental health services must support public education efforts which present women in a wide variety of valued roles, including those which reflect leadership and social importance. CMHA, Ontario Division, in collaboration with CMHA, National must advocate for a wider range of research regarding women's mental health.

The following CMHA, Branches are holding two day training workshops on Suicide Intervention using the Living Works model for intervention.
Please contact the Branch for further information:

CMHA, Grey Bruce, Owen Sound, Ontario
April 9 and 10, 1999.

CMHA, London-Middlesex, London, Ontario
April 22 and 23, 1999.

CMHA, Lambton County, Sarnia, Ontario
May 13 and 14, 1999.

CMHA, Oxford County, Woodstock, Ontario
(workshops will be held in Elmhurst, Ontario)
May 13 and 14, 1999.

CMHA, Brant County, Brantford, Ontario
November 2 and 3, 1999.

Division of Society, Women and Health

The Division of Society, Women and Health functions jointly between Women's College Hospital and the Centre for Addiction and Mental Health, Clarke Site. The Division is a joint initiative of Women's College Hospital, the Centre for Addiction and Mental Health, Clarke Site, and the University of Toronto.
The Division is headed by Dr. Barbara Dorian, Assistant Professor, University of Toronto, who is also Psychiatrist-in-Chief of the Department of Psychiatry at Women's College Hospital. The services of the Division of Society, Women and Health include an inpatient unit at Women's College Hospital, together with the outpatient Women's Therapy Centre at the CAMH, the Brief Psychotherapy program at Women's College, the Psychopharmacology and the Dependence Treatment Research Unit, Peripartum Disorders Clinic, Mood and Trauma Clinic and Clozapine Clinic, all at Women's College Hospital.
One of the goals of the Women's Therapy Centre is to learn more about the things which affect women's emotional health. To accomplish this, ongoing research is conducted. The Women's Therapy Centre offers time-limited therapy, at no cost, to women who have mental health difficulties. The team of professionals from various backgrounds aim to provide expert care and is also involved in research and education. Unlike some other forms of therapy which focus primarily on diagnosing illness and reducing symptoms, the Women's Therapy Centre concentrates on issues that affect women's emotional health – e.g. upsetting events, conflict situations, prejudice against women. The Centre works with women to increase their sense of personal strength and confidence.

Your response to our technology issue

Dear Editor:
My family had the experience of videoconferencing a psychiatric consultation with Dr. Broder *(see Network, Vol 14. No. 4, Winter 1999)* through the Integrated Services for Northern Children and Infant Development. This was an amazing process. We were able to spend a very valuable one and one half hours with a specialist. It took us five minutes to get to our appointment and both my husband and I were able to attend. Our other children were not disrupted and very little work time was missed by either of us. This would have taken at least three days of our time if we had to travel to Toronto and probably only one of us would have made the trip with our child leaving the assessment somewhat incomplete. I understand from Dr. Broder that this funding is in jeopardy as this was a pilot project. I would like to suggest that the Child Mental Health Committee of the CMHA advocate to keep the program going. We have so many children who are in need of this service and so many frustrated families.
CONCERNED FAMILY FROM KIRKLAND LAKE

Dear Editor:
I think you did a disservice to your readers in the sites you elected to publicize in your last issue. *(Winter 1999).* You would better serve your readers by directing them to those that publish responsible information i.e., www.schizophrenia.com/ami. If you want more controversial, yet still responsible sites, I would suggest www.psychlaws.org.
D.J. JAFFE
CO-FOUNDER, TREATMENT ADVOCACY CENTER
ARLINGTON, VIRGINIA
Your comments are timely, given the proliferation of information available on the Web. It has always been the case that you can't believe everything you see written down, but with the expansion of the Web this message needs to be stressed even more. It is always a pleasure to see that Network provides useful information to our readers and we are pleased to hear that the information has relevance beyond our province and country. You have raised a very good point - what does a publication of a particular web site in Network mean? Our editorial policy has always been to allow the contributors to have their say. The list of web sites was not meant to be presented as having been screened by the editorial committee, perhaps that should have been made clearer in the publication. Thank you for pointing this out. If you have been reading Network for a while, or have read any of our other policy statements, you will know that we have continued to support a full range of services. We are striving to put forward a strong forum for mental health issues and your supportive criticism is very much welcome.
ALLEN FLAMING
COMMUNITY MENTAL HEALTH CONSULTANT
CMHA, ONTARIO DIVISION

This column is designed for you, our readers. Please take a few moments to send your comments for publication to:
The Editor,
Network,
Canadian Mental Health Association,
Ontario Division,
180 Dundas Street West, Suite 2301,
Toronto, Ontario
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or fax them to
(416) 977-2264.

Letters may also be e-mailed to:
division@ontario.cmba.ca

CALENDAR

May 3 - 10, 1999

National Mental Health Week - "Strike a Balance - Making Mental Health Matter". Contact your local Branch for activities and events in your area.

June 10 - 11, 1999

"From Patchwork to Integrated Mental Health Care: Action for a New Millennium". The CMHA Ontario Division Annual Conference and Annual General Meeting, Northern College, Timmins, Ontario. Featuring Four Streams of Workshops: "Building Community Through Technology"; "Pathways to Bridging the Gaps in Forensic Services"; "Stitches in Time - Best Practice, Technology & Research"; and "Quilting in the New Millennium: Framing the Issues for Women with Disabilities", plus Information Displays, a Trade Fair and much more. For more information contact Allen Flaming, CMHA Ontario Division (416) 977-5580 ext. 4121.

October 20 - 22, 1999

Take the Next Step with PSR 5th Bi-Annual Conference. Sheraton Fallsview Hotel, Niagara Falls, Ontario. Choose from Six Streams: Recovery and Consumer/Survivor Empowerment; Wellness and Health Promotion; Partnerships with Communities and Families; Multiculturalism; Research, Evaluation and Accountability; and Recovering the Excitement of PSR. Keynote speakers include: Julie Flatt, from the Consumer/Survivor Development Initiative, Ontario and Judi Chamberlin, from the Center for Psychiatric Rehabilitation, Boston. For more information call Sheila Bristo at (905) 641-5222.

Mental Health Week

MAY 3 - 9, 1999

Making Mental Health Matter is our theme for 1999 and our focus is on promoting mental health. This year will encompass all aspects of a healthy and balanced lifestyle, focusing on mental health issues and the importance of coping with stress in the workplace.

Workplace stress has a negative impact on community life, as over-stressed workers have less time to devote to their families and community activities. Health care for stress related illnesses is an added financial burden on the community.

During Mental Health Week many of the CMHA Branches across Canada will participate in health fairs or stage special displays to promote mental health. Call your local Branch of the Canadian Mental Health Association to find out more. Make Mental Health Matter.

Finding a balance in life can change your mental health!

May 3 to 9, 1999, is Mental Health Week.

Find out how stress affects your mental health, and why mental health really does matter!

This is your opportunity to discover how a balanced lifestyle may mean the difference between mental health and mental illness.

See for yourself what the Canadian Mental Health Association is doing for mental health. Call your local CMHA Branch for more information about Mental Health Week.

Making Mental Health Matter

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Network
Vol. 15 No. 1 Spring 1999

MAIL POSTE

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

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