



BC's
Mental
Health
Journal

Visions



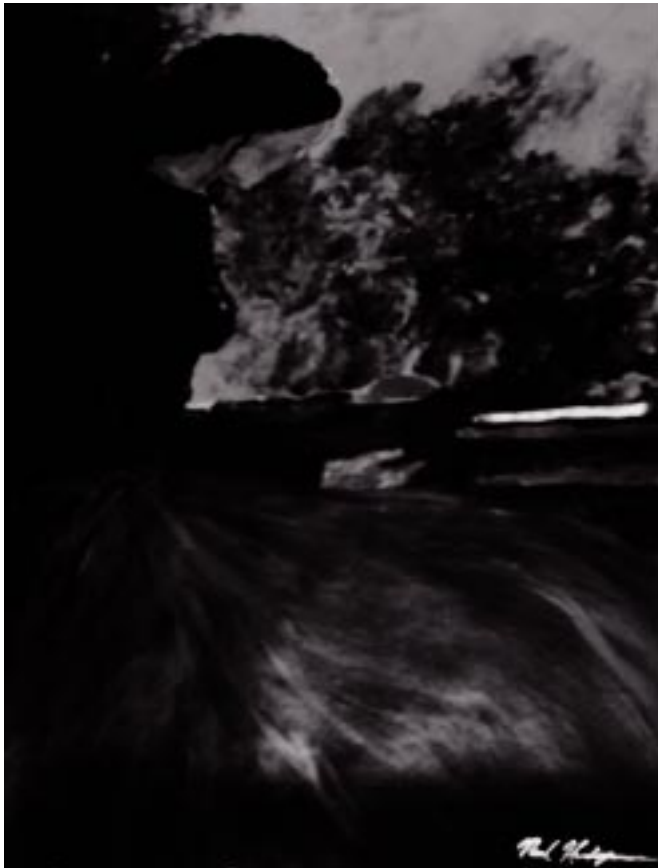
Sexuality, Intimacy, and Relationships

How do we include
sexuality as a part of
recovery and
rehabilitation?

How are relationships
affected by mental
illness?

What is healthy
sexuality? When is
it a problem?

© "Cheryl and Matthias: Two as One" by Neil Henderson ▼



BC's
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Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers, and community. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association invites readers' comments and concerns regarding articles and opinions expressed in this journal. Please e-mail us at office@cmha-bc.org or send your letter with your contact information to:

Visions Editor
CMHA - BC Division
1200 - 1111 Melville Street
Vancouver, BC
V6E 3V6

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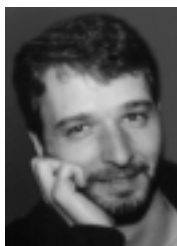
The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division or its branch offices.

■ Thank you to **Neil Henderson** for his art contribution for this issue's front cover. Neil — businessman turned artist, environmentalist, and vegetarian— took up painting only seven months ago at the **Art Studios** (a program supported by the Greater Vancouver Mental Health Service). This is his fourteenth painting. Art, like every other worthwhile endeavour is a talent acquired through training, dedication, and persistence. It is not, as many believe, something one is either born with or without. Neil says he would like this piece to evoke depths of emotion, whatever those emotions may be.

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■ The Canadian Mental Health Association is grateful to the **BC Ministry of Health** which has assisted in underwriting the production of this journal.

■ This issue of *Visions* is dedicated to the memory of former Canadian Mental Health Association, BC Division staff member, **KENNETH (Ken) P. SMITH**. Ken lived in North Vancouver, BC. He was born October 2, 1961 in Vancouver, and died April 11, 1999, at the age of 37. Ken lived with HIV/AIDS and died of lung cancer. He will be remembered by many who worked with him as a creative and ever-journeying soul. The prayer here is one he chose to be part of his memorial, before he died:



Ken Smith
1961 - 1999

*Lord, make me an instrument of thy peace
Where there is hatred let me sow love
Where there is injury; pardon
Where there is doubt; faith
Where there is despair; hope
Where there is darkness; light
Where there is sadness; joy*

*Divine Master, grant that I may not so much
seek to be consoled as to console
To be understood as to understand
To be loved as to love.*

*For it is in giving that we receive
It is in pardoning that we are pardoned
It is in dying that we are born to eternal life.*

St. Francis

We are all in relationship with each other in one form or another. And the nature and depth of our relationships differ with each person. For some of us, we choose to be less intimate, even preferring the company of animals or nature. For others, we need friendship, warmth, touch, physical and/or sexual intimacy, or a combination of these.

This issue of *Visions* gives life to a topic which can often be overlooked in the rehabilitation efforts of recovery from a psychiatric diagnosis. Sexuality, intimacy and relationships can easily be forgotten in the search to find the right treatments, the supports needed to sustain a quality of life, and the right support people to help you along the way. But the humanness of our need to be in relationships must be acknowledged and be included as part of our vision of recovery for ourselves and for those we work with who live with mental illness. Hopefully, this issue of *Visions* will help to make this happen.

I leave the editor role of *Visions* to begin studying in a new (but not unrelated) field in September, 1999. I leave a journal which I've seen grow from newsletter to national award-winning publication (*Visions* received the 1998 National Media Award from the national Canadian Mental Health Association). I hope you continue to read and be informed, supported, inspired, and hopeful.

Dena Ellery

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Sex and Rehabilitation: Condoms in the bathroom are not enough

Condoms in the bathrooms of mental health centres make all of us feel better — as if we are actually *doing* something in the area of safe sex to help people with mental illness. While condoms in the bathroom no doubt send an important message, they might also be seen as the mental health equivalent of the doctor who provides the patient with a book instead of talking about a sexual problem when it surfaces.

What do condoms in the washroom have to do with rehabilitation of people with mental illness? One incontestable answer is that rehabilitation must take place in an environment that is safe. If that concept includes sexual safety, and if talking about the details of acquiring and preventing STDs is best accomplished within the context of talking about sexual matters generally, then sexuality will have to join such issues as housing, transportation, and vocational rehabilitation in the list of goals for working with people living with mental illness.

Given the attention to sexual issues in the rehabilitation of those with a physical illness, one might wonder why this same concern has been minimal in the care of those with a mental illness. Apart from STDs and drug side effects, the answer to the question “what else needs to be discussed?”, partly depends on one’s definition of the word “sex.”



William (Bill) L. Maurice MD, FRCP(C) works at the Division of Sexual Medicine, Department of Psychiatry at the University of British Columbia, and at the Greater Vancouver Mental Health Service’s (GVMHS) Sexual Medicine Consultation Clinic. His recent book, a guide to addressing sexuality issues in primary care, is reviewed in this issue of *Visions*.

Knowledge about sexual matters is reasonably included in the definition of “sex” and, therefore, we must talk about information deficits. People with mental illness, especially those who have schizophrenia, may have come from families in turmoil and as a consequence, lose the opportunity of seeing the affectionate exchanges between parents that Masters & Johnson identified as being instrumental in the sex education of a child. In addition, people with mental illness have often foregone the relationship and sexual experimentation of adolescence, and may (for example, in the case of those who are heterosexual) be missing basic information about the opposite sex.

Sexual function is unquestionably included in the definition of “sex”. That being so, why do mental health professionals so often wait until someone who is ill indicates a concern about their sexual function instead of taking the initiative and posing some questions? Could it be that similar to the early days of attention to sexual issues in those with a physi-

cal illness, we sometimes think that people with a mental illness should be grateful for the help they are already receiving, and that sex should be a secondary and subsidiary consideration? Could it also be that we avoid regularly asking about sexual side effects of medications because we don’t want people in our care to make the connection and thus stop using their medication (similar to the idea of not asking a client about suicide because it might suggest that very notion to them — a discredited idea)?

In thinking about sexual function, one could ask such questions as “How are you managing sexually when you are alone?” “What about when you are with a partner?” And if there are problems “What do you think is the reason for those difficulties?” (People with mental illness and clinicians both struggle daily with the difficult task of trying to distinguish drug side effects from the sexual consequences of the illness itself.)

Reproductive issues are naturally included in the defi-

nition of “sex” and when considering rehabilitation, so many questions arise: What does the mentally ill person think about the connection? What is the effect of pregnancy on that person’s illness? What is the effect of the illness on that person’s pregnancy? How well is someone with a mental illness equipped to manage child-care? Is the person using any form of birth control? If so, what kind?

Other issues may be included in the definition of “sex” and may be grist for the mental health professional mill including the capacity for intimacy, sexual orientation, gender concerns, and paraphilias (previously known as perversions).

Since *Visions* is a quarterly journal rather than a book and space is therefore limited, it is possible to consider only some of the components of the word “sex” in this issue. However, the crucial point is not to be comprehensive, but for us to always consider the subject in the rehabilitation of people with mental illness. In the days of the mental hospital, sexual issues were ignored until patients ended up in bed with one another. In the days of deinstitutionalization, HIV/AIDS, Viagra, and the Internet, there is no way that mental health professionals could convincingly say that they are providing comprehensive care to people with mental illness without also addressing their sexuality in a manner that is explicit, skillful, and regular. ■

Dr. Bill Maurice



Friendship, Intimacy and Sexuality among Persons with Serious Mental Illness

William R. Whetstone, RN, PhD, & Ann C. Rich, RN, PhD

Excerpted with permission from the California Alliance for the Mentally Ill Journal, "Relationships, Friendship, Intimacy & Sex."

How can one ever describe the mysterious chemistry that goes into the making of our friendships, intimacies, and sexual expressions?

Unfortunately, for persons with mental illness, the intimacy of friendship too often remains an unknown. The opportunity to acquire friends or experience the caring warmth and deep personal satisfaction of friendships is frequently limited because of circumstances beyond the individual's control.

Take for example, John, in his mid-forties, who was born with his right arm and leg smaller than his left. John has been physically disabled since birth and became mentally ill when he was in college. Even while in college, and, as he feels now, he sees himself as an outsider; vulnerable and not trusting of other people. He goes to movies with his manager, but he is unable to name other friends with whom he has any social contacts. He withdraws from touch. His one source of friendship is with animals. He goes to the city zoo two or three times a week. He considers some of the animals to be his friends. He says it is a place where he feels secure and at peace.

core of helping one feel alive. *Touch* plays a fundamental role in the life of all human beings, no matter how much it is suppressed by our cultural values and mores.

Touch can express many things in a positive way. It can show concern or affection; it can offer support or security. It can be a form of therapy or healing. In a most substantive way, it gives the recipient attention and establishes a bond between two persons. It is hard to separate touch from friendship. Touch entwines friends. Friends touch each other in supportive ways. They meet; they often hug in a mutual exchange of greeting. To some of our mentally ill patients, touch can be either an invitation to intimacy or an anathema. The tolerance of touch varies with each of us. From the time we are born, human touch of some kind remains a dominant quest.

Sarah, 43 years old, lives with her aging adoptive mother, who is her primary source of support on many levels. She lives in an affluent suburb, where she is usually comfortable on the streets and is regularly seen walking and window shopping. When asked about dating, she comments that she doesn't feel "authentic" when she dresses up and goes out with lots of people, and hasn't done so since she was in college.

She does have a special man friend, but she has rebuffed his physical advances noting

that she doesn't like him "in that way." She confides that she was molested by her brother when she has difficulty imagining herself being physically responsive. She cannot imagine touching herself sexually. At times, she longs for a "normal" life with a family, including children, but she feels that will never happen.

As a human drive, love evolves out of friendships. As one author put it, love happens between people. Gender is immaterial. Sexuality is the ultimate expression of intimacy, touching and caring between individuals.

The expression of sexuality takes many forms with persons who have mental illness. Stephen, a thirty-something gentleman, indulges in sensual massage by a same sex person who is loving and caring. This provides him with his need to be touched, for intimacy, and sexual gratification. Along with sensual massage, he has found another approach to meeting his needs for sexuality. He can satisfy himself while looking at pictures of either "hunky" men or "beautiful" women in *Playgirl* or *Playboy*. He believes massage is much more satisfying. Sensual massage provides the human touch, connection, or skin contact he requires for self affirmation: "I exist!" is what he says it tells him. The biggest problem he has is managing his money, so he can afford the \$50 to \$60 dollars to pay for his various "services." Fortunately, he lives in an

area where these services are readily available, "...so it doesn't require cab fare."

Some sexual friendships can be either with the same sex or the opposite sex. With any of these combinations, persons with mental illness must have assistance in how to work out the boundaries of these relationships. They need to know what's involved; the necessary give and take required, and the glue which holds these relationships together. (And where is that taught? And what qualifies the "teachers"?)

Typically, women involved in same sex relationships are better able to handle the circumstances than are men. For most men, sexual release appears to take priority over the caring aspects of what such a union can offer.

The mere thought of friendships, intimacies, and sexuality creates discomfort and unease among most families, caregivers, and virtually all health professionals. However, these issues are real and central to a person's well-being, because they relate to the essence of life and **aliveness**. Without the joy and pleasures of warm friendships, caring intimacy, and sexual expression, the quality of life for anyone is less than what should be acceptable. ■

Friendship, intimacy and sexuality are interrelated and integral to interpersonal contact. They are at the

[...]



In Praise of a Loving Reflection

Patricia Wilkinson

I hear the door thump shut downstairs, and gentle fumbblings as belongings are dropped. John is home. I am lying in bed and the TV is on low. It is 6 pm. Part of me has been calling out to him silently all afternoon, “come home, I need you.” But now that he’s here I’m not sure I can bear to have another person around. “Hello,” he sings as he climbs the stairs.

“Hi,” I reply quietly. This is the third night in a row John has come home to this scene. Ordinarily it happens maybe several times a year, but the frequency has been escalating recently. We both know what this means: it’s time to talk about depression.

Never before have I had someone to talk with about depression, especially the way we do. When we began living together eight years ago, depression would hit me like a stormy sea hits the shore. The depression was deep and wild and unpredictable. One day I was fine and the months would go by when I was exhausted and irrational. With John’s help and four years of treatment with a skilled psychiatrist, these episodes are now few and far between. But they haven’t stopped, and we’ve had to come to terms with the possibility that they never will.

John enters the bedroom quietly and surveys the now-familiar scene. “Still feeling pretty bad,” he states gently. I nod and stare at the TV. He knows that part of my experience is that I find it difficult to have a conversation. My concentration is very broken, and it’s hard to connect my thoughts together. I can’t look at him and listen at the same time. It can take several minutes to come up with even simple responses. John sits beside me on the bed and strokes the back of my head. “What can I do for you?” he asks.

I’ve learned to take this question seriously. John will do virtually anything for me — buy ice cream, try to find a mango at 11 pm, run me a bath, take me for a drive. Knowing that I’ll get what I ask for, if at all possible, I find I don’t want much at all. And even if what I really want is unattainable, I get to say it out loud.

“Oh just shoot me, I hate living like this.”

“Left or right temple?” he inquires.

“Left, I don’t have the energy to turn over.” Lovingly he puts the imaginary gun to my head and shoots. On some level I realize we’re acting out a mutual fantasy — this isn’t much fun for him either. John’s special gift at any time is his ability to accept whatever is happening. It’s a particularly treasured gift at times like these. On the one hand it helps me to recognize early on that I’m getting depressed, because I don’t have to pretend otherwise. On the other hand, this attitude creates opportunities to step in and out of depression and it’s easier to get better faster. This second point is critical.

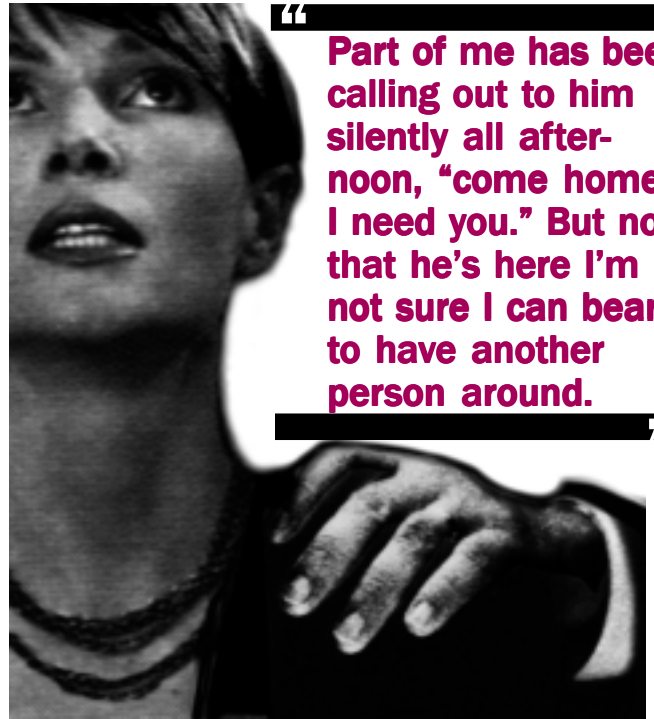
We’ve discovered that, even in the worst points of the depression, I’ll occasionally be able to turn it off, even if only for a few minutes. In that window I maybe can smile, or do the dishes, or go for a walk. Very quickly my mood may change again to confusion and hypersensitivity, but the more I can take advantage of the window, the easier it is to move out of the worst of the feelings. John allows me to be inconsistent. He’ll finish

cooking the dinner if I’ve started but can’t finish. He understands that what is possible one moment may not be possible the next. I’m pretty sure that if he gave me a hard time, I’d stop trying, and there would be fewer opportunities for the mood to shift. For

me, he is a loving reflection — he doesn’t actively try to change things. Yet by virtue of his acceptance of the way things are, the world is profoundly changed.

This acceptance of the ebb and flow of life is a hallmark of our relationship. John is so good at it, I can’t help but return the favour. Several years ago, a friend observed my end of a phone conversation John and I were involved in. She knew I was really struggling at that time. John had called to see how I was doing, and offer a few words of comfort. Then he proceeded to tell me about his day, which wasn’t going well. I clucked and offered my own soothing words. When we hung up, my friend was smiling and shaking her head. Asked about her reaction, she said she was impressed that, knowing I wasn’t well, John still looked to me for support. And I was able to provide support. Until that moment it hadn’t seemed remarkable — it was just me and John talking. She illuminated the beauty of our relationship for me.

I asked John to write part of this article, to tell his side of what goes on when I’m depressed. He said I taught him how to help by explaining, when I could, exactly what was going on inside me, and telling him what helped and why. I wouldn’t have told him if he hadn’t asked. John, thanks for asking. ■



“Part of me has been calling out to him silently all afternoon, “come home, I need you.” But now that he’s here I’m not sure I can bear to have another person around.”

Patricia Wilkinson is an administration coordinator for a professional association. She also provides conflict resolution and communication skills training to groups, and provided this service to mental health consumers in her former position with the Canadian Mental Health Association.



“And Depression Makes Three . . .”

The path romance takes when one half of a couple lives with severe depression

Sarah and Chris



SARAH'S POINT OF VIEW

ATTITUDES Going In

Abraham Maslow's hierarchy-of-needs pyramid, a dim memory from Psych 100, has ended up having so much relevance in my life. Maslow said that fulfilling needs was like climbing a pyramid or ladder; more abstract human goals like friendship or intellectual achievement are only attempted when more basic needs like food or safety have been met. Obvious, yet easily forgotten.

When I knew I was going to crawl through a dark, ugly tunnel of depression near the end of '96, the first thing I did was empty my shopping cart of burdens. I was not about to concern myself with what had suddenly become "luxuries"

like career, looks, fun, and of course, men. Food, water, sleep, hugs, and a modicum of routine were all I could handle. It's funny the way priorities have a way of smacking you in the face when you're diagnosed with severe depression, weeping 4-5 days a week for half-hour blocks, not feeling hunger pangs for months on end, and napping all the time to escape the bite of those "black dogs." Boyfriends could easily wait.

So there I was, shocked as hell, to find myself in a relationship at 19 — my first ever steady one at that! I imagine Chris was equally shocked to find himself clicking with someone in my sorry state.

The ADMISSION

Chris and I had a very fast, close friendship develop (mostly via e-mail in fact) in the month and a half before we went on our first date. In the preceding months, I had already gained a lot of e-mail support from fellow consumers around the world whom I met on the Internet. As a result, I was already accustomed to bringing my mental illness out into the open sooner rather than later.

More than that though, I have since recognized three important facts that contributed to my telling Chris about my illness just two weeks after we first spoke:

- (1) there was safety in the fact that he was a friend and good friends did share important parts of their lives after all (or so I reasoned).

- (2) I was determined to help destigmatize the illness and the best way I knew was to tell people what I was going through without shades of shame or pity-seeking.

- (3) I was vulnerable and sceptical of men. Since a romance wasn't ruled out in our banter, I wanted to lay out all the sticky stuff early. This would give him a chance to make a clean getaway from the relationship (if he so chose) without dragging my battered heart with him later on. Ah, self-preservation is a powerful force.

Chris' reaction was surprising and phenomenal. He wrote something empathetic to the effect of "everybody's broken in one way or another." It helped to level us. I was reminded then that it was okay; we both had our demons.

INTIMACY Impacts

I think Chris is right that the core of our relationship has really not been touched much by the *illness* of depression, per se. But I'd say that the subtle ways depression has ended up influencing my behaviour have definitely had negative impacts on my capacity to become emotionally vulnerable.

One of the changes was a direct reaction to my overwhelming feelings of helplessness at having some invisible brain-chemical force jerking my emotions around. I compensated a lot for my powerlessness by being much more analytical and controlling than I ever was before. For instance, I'd make lists to analyze why I was angry at Chris for something; I never used to do stuff like that! But by doing it, I found com-

fort in being able to lay claim to emotions that I felt were my own and not symptoms of my illness.

Poor guy. I asked so many questions of him, but I just had to be able to gauge his feelings to prepare myself for any possible emotional pain. I felt little security in life and every cell in my body urged me to protect myself from further hurt.

Having only met me for the first time 6 months into my depression, Chris had nothing to which he could compare these bizarre, annoying, information-seeking compulsions. No wonder he couldn't separate personality from illness. I didn't give him much of a chance.

SPELLS

My "spells" are the hardest symptom of my depression, both for me and the people I love. They're the term I have for the half-hour (or longer) crying episodes I would suffer from too frequently. The technical term for it, 'tearfulness,' always makes me laugh. Tearfulness is what happens when I'm cutting onions; these are emotional earthquakes that come from nowhere I know or nowhere I can control. For Chris, I can guess that watching or hearing me have a spell is as painful and frustrating as it is to have one. I also know the

helplessness and anger he feels must remind him of what his family had to go through with his mother's cancer.

For many reasons, I try and have spells alone and seek the hugs afterward. But since I can't foresee let alone schedule the episodes, and since we spend so much time together, I knew from the onset that I couldn't prevent Chris from witnessing this aspect of my illness. It's taken a lot of time not to feel guilty or weak doing so.



Having started out as friends living in different cities, Chris and Sarah have now been exclusively dating for 2 years during which time they've fallen in love. Chris is currently 26 and out of school. Run-ins with mental illness in his lifetime have been few and far between and never personal. Sarah, 21, was diagnosed with severe clinical depression in the winter of 1996 and only began recovering from her 'episode' in the fall of 1998. In the real-life case history below, each of them tells their unique perspectives of witnessing mental illness become another ingredient in the intimacy stew.

CHRIS' POINT OF VIEW



My preconceptions concerning mental illness were typical — based solely on television and news media coverage. I'd never suffered from deep depression, and had no personal experience with any type of mental illness.

I knew that depression existed, but had never formed an intelligent distinction between “the blues” and clinical depression. I had met people who suffered from various forms of mental illness, but only briefly, and at each turn they seemed quite ordinary.

My opinion of the medical community, for personal reasons, was extremely low. From my perspective, the hardest periods in Sarah's recovery have come as the result of anti-depressant experiments. Fairly or unfairly, that factor has also lowered my opinion.

I don't think Sarah was looking for anyone when we met; she had enough on her plate without having to deal with the emotional turmoil of a boyfriend. The fact she wasn't “desperate” helped ease us into the relationship naturally — no apprehension at all on my part.

ATTITUDES
Going In

Chris' reaction was surprising and phenomenal. He wrote something empathetic to the effect of “everybody's broken in one way or another.” It helped to level us. I was reminded then that it was okay; we both had our demons.

I wasn't apprehensive or shocked when I was told, but my first reaction was more the result of ignorance than open-mindedness. I was most surprised to learn that depression had serious physical symptoms. I had assumed its symptoms were entirely emotional or mental.

Basically, I didn't have a clue how depression affected Sarah's life, or how it would affect a relationship. There were also surrounding factors that distanced the disease's impact on me, namely, that at that point I was a friend living in a different city. She was a scholarship student, had already advanced her way into the labour force, and had strong family ties. In short, she had a stable life and wasn't “fragile.”

The ADMISSION

Sharing emotions and communicating are difficult in any relationship. When I have withheld a painful opinion, or on the one instance when I even remotely considered ending the relationship, depression never entered the equation.

As for whether I was more wary of getting close to her because of the possibility of a breakup and what that would add to her plate, I can't really say I know. Reluctance to hurt someone is a complicated thing to dissect, but it has more to do with the appearance of fragility than the reality of mental illness. Ours has been a very open and frank relationship, even at the risk of treading on clinically-depressed toes.

Sarah does possess idiosyncrasies common in adolescents — modest neurotic tendencies, sometimes with vivid splashes of melodrama thrown in for good measure. At the outset, it was hard to distinguish personality traits from symptoms, but over the course of a relationship, separating the two has become easier, as has honest communication.

Most communication breakdowns have been typical and I don't think related to depression. We're both more disposed to discussion than yelling. If anything, trying to maintain emotional balance in response to Sarah's depression has opened and stabilized our intimacy, not hurt it.

INTIMACY
Impacts

It's terrifying and emotionally grueling to hold a loved one as they suffer a depressive spell. My inability to control the situation, and my lack of understanding in terms of what triggers them, are major frustrations. Even harder is being separated from her during a particularly bad night. Holding, hugging, stroking are far superior to any treatments that can be conveyed over a phone.

I was immediately struck — though in a very detached way — by the similarities between my father's relationship with my mother and my relationship with Sarah. My mother died of complications resulting from cancer surgery. While the diseases are obviously very different, I found the relationship pattern intriguing — which has more to do with my relationship with my father, than my relationship with Sarah.

SPELLS



SARAH'S POINT OF VIEW

SEXUAL IMPACTS

Depression and many drugs I've been on to treat depression have all conspired to deaden my body's sexuality. I say "body" because I still had sexual feelings and cravings but not the explosive bodily reactions that should have gone with them. Unfortunately, the only tools I had to express these emotions externally — words, looks, gestures, and sexual responses — were dubious at best to an ego-battered boyfriend who was finding it more plausible to believe that I was sparing his feelings (by using depression as an excuse) rather than depicting a real medical problem.

Add to all that the following decision: since I wanted my first time to be idyllic as many young women do, I felt I had to at least give my full sexuality a chance to return if I was to get any real satisfaction from intercourse. And that meant absti-

nence while I tested out various medications. It was only 9 months ago that my body's sexual responses finally caught up with my drive and convinced Chris of the very real impact drugs were having on my sexual being.

But the real challenge in our sexual relationship has been that illness, treatment, and relationship factors all overlap and it's not always clear what the source is. There have always been other reasons behind my opting for abstinence that can tend to get lumped in with the depression factor. In fact, any illness can impact behaviour which in turn impacts a relationship; it's just easier to separate things, I think, when the physical ailment is something you can see and be reminded of more constantly.

THE FUTURE

The drug I'm currently on has got me to about 80-85% of where I was before. However, I consider myself 'in recovery' since I haven't felt this great in a couple of years and am tired of trying new drugs. I don't know what my chances are for relapse but if I should 'go under' again, I'm afraid of what it would do to Chris more than myself. Not only would the recovery-remission-relapse scenario mimic his mother's bouts with cancer all over again, but Chris would be a live-in witness to the ordeal rather than the arm's-length witness he is now.

At least time has overcome the depression-related intimacy and sexual challenges once and for all. I'm less inclined to

dissect my emotions in lists; Chris is less inclined to feel sexually unwanted.

The only future encounter with depression to think about if we marry is the high chance of passing it on to any children given the strong genetic predisposition for the illness down my maternal line. If that should happen, I only hope we both stay enough in touch with what has happened in *our* relationship over the past 3 years to see any other members of our future family through it.

Sarah

CHRIS' POINT OF VIEW



SEXUAL IMPACTS

Depression has hindered Sarah's sexual development during some pretty formative years: 18 to 20. The disease, and some antidepressants, numb sexual pleasure. Those side-effects, combined with her cultural background and personal preferences, have caused Sarah to abstain from intercourse. The root cause — depression vs. environment — has been at the heart of some heated arguments.

Depression's symptoms, along with its ability to corrode any sense of sexual empowerment, has made me feel either inadequate or undesirable. Past relationships didn't particularly help counter those feelings in the face of more

immediate, very personal, feedback.

Sarah's lack of sex drive has also hampered her ability to sort out her own motivations and communicate them to me. That factor, in particular, has isolated me from her and her family. Again, the question of where depression ends and environment begins becomes very critical within the relationship.

Patience has been rewarded in this case — and it may sound pat, but I think time and empathy have been the saving graces for us.

THE FUTURE

The prospect of living with Sarah through a relapse or another round of prescription testing is scary. Fighting depression is a war on many fronts; medicine, environment, physical exercise all come into play. As the "significant other," you become hyper-sensitive to any factors and issues that might impact your loved one. It can be mentally grueling.

I haven't made any real attempt to learn more about depression. I do know more about the assorted medications, symptoms, treatments, but only within a very narrow, emotionally charged context. I still feel ignorant of the broader reality of depression because my filter, or access point to understanding, has been one exceptional case.

Chris ■



Commitment: In sickness and in health

Recent events in my life have caused me to examine my fundamental value structure, the principles of life that I deeply believe in, that are a part of my very core being, that I use as a structure to make daily decisions, both profound and mundane. One of my strongest beliefs is in family, in an ultimate lifetime commitment to husband and children. I find this value contradictory to commonly held values in our society today. Perhaps most people do not share this value of commitment for life to a spouse and to children. I have also learned that for me to violate my value structure for any length of time causes me great distress and depression, no matter how I try to rationalize it.

My husband suffers from a serious mental illness. This illness has robbed us both of peace, security, love, companionship, and the intimacy and partnership of marriage. I have no peace because I'm afraid and isolated. I have no security because he has difficulty holding a job, and medical expenses may ultimately wipe out our finances. I do not have his love and companionship because he is unable to relate to me, con-

sistently, at any other level than as an adult child to a caretaker. There are many days when he just isn't "there" for me.

This illness is not his fault, it's a brain malfunction that no one knows how to repair. He suffers greatly, more than most with debilitating physical illnesses, because this condition affects his innermost being . . . his personality, his belief structure, his thought processes.

I believe very strongly in staying with him as long as I can function safely. How can a wife turn her back on a husband who has become disabled, incapacitated? I believe that, if I left him, he would either commit suicide or become a homeless person on the street. How could I do that to someone I have promised to love, honour and cherish in sickness and in health till death do us part? Society does not condone abandoning a child who became disabled. Why then do we abandon spouses so quickly when misfortune strikes?

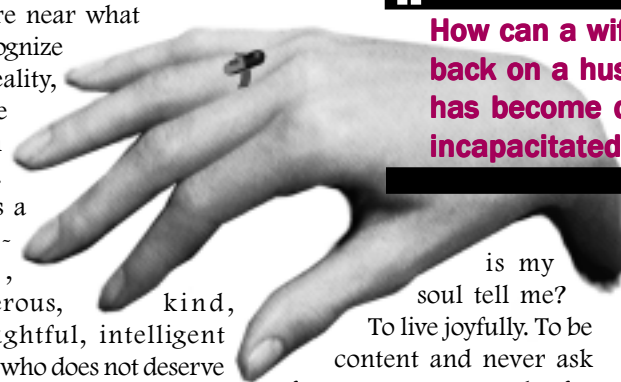
Please don't ask me if I "love" him. I don't think I know what that word means anymore. Certainly the ramifications of true love for

another person extend far, far beyond the romantic pulp concepts paraded before us in today's media. I am committed to trying to make his life the very best it can be. I admire his courage, greatly. When he is somewhere near what I recognize as reality, I like him a lot. He is a caring, generous, kind, thoughtful, intelligent man who does not deserve the cards he's been dealt. But, do I love him unconditionally? I wish I could answer, yes, and mean it. Am I willing to abandon a person I love because the going gets tough? I think not. I hope I'm better off than that.

This value of commitment isolates me from nearly everyone. I am often asked, "Why don't you divorce him?" I am often told, "Don't throw away your life for this guy, take care of yourself!" Or my motives are called into question, "You must be as sick as he is to stay in that relationship. Are you co-dependent? Or, do you just enjoy a power position?"

So, in my private moments, when my children are asleep, and I lie there alone in my bed and listen to my heart beat and feel the years slipping away, what does that inner voice I like to think

Kathleen A. Bayes



“**How can a wife turn her back on a husband who has become disabled, incapacitated?**”

is my soul tell me? To live joyfully. To be content and never ask for or expect sympathy for the decision I have made for myself based on my own values and my own sense of profound rightness. My challenge is not to second guess myself and not to accept guilt for making this decision. For me, it's not a dark tunnel I'm passing through. I am walking in the light as I see the light never blaming my husband or myself for the outcome, and not dancing to the music of a disposable society. I've exercised my own free will, consciously and with as much information as is available to me. And now, I'm walking the walk . . . and keeping my promise. So help me God. ■

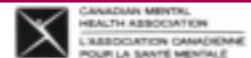
Kathleen A. Bayes co-edited the California Alliance for the Mentally Ill's Journal on relationships. She lives with her family in Fort Wayne, Indiana where she is in the Underwriting and Issue Department of Lincoln Life. She is also a past president of Indiana Association for the Mentally Ill. Reprinted with permission from the California Alliance for the Mentally Ill.

A.G.M. Invitation



It's time for the Canadian Mental Health Association, BC Division's

Annual General Meeting



☒ **Saturday, August 21, 1999**
2:30 – 3:30 pm
Curtis Law Building: Room 101/102
The University of British Columbia, Vancouver

☒ All members are welcome to attend!



I. e. roze

I.e. roze is the pen name of a woman who lives in Vancouver and is in the process of writing the full version of her story under the working title 'The Redemption of Camille Gold-bloom'.

People do not believe me when I tell them that I was the Queen of Freaking-Out. When I was a small child I threw rageful, violent tantrums in order to get my parents' attention. My parents were emotionally, mentally and physically abusive and I started seeing a psychiatrist at the age of thirteen. I was institutionalized for the first time at the age of fifteen. At the age of twenty-seven I was diagnosed manic depressive and finally schizophrenic, when my marriage broke down and my husband incarcerated me in a psych ward. I lost custody of my two little boys and was left to make my way in the world alone. The evolution of my healing soul and maturity is remarkable.

Growing up I was berated and put down endlessly by my family. Hence my self-image and self-esteem was very low. It often felt as if I would never see the end of my pain and suffering. I longed for my children and somebody to love and to be loved. I spent over fourteen years on disability while I tried out various jobs, and developing personal, innovative and creative projects that inspired me in my determination to help myself and others like me.

During those years, life was a roller coaster of ups and downs. I'd fall obsessively in love with one guy, or girl or another which would ultimately develop into a psychosis where I believed that this relationship would help me win back my children and grant me the life I was so desperately searching for. Not once in those years did I voluntarily check into a psych ward. I was always picked up by police, hand-



Balancing Life

...cuffed, thrown in the back of a cruiser, and taken to one. And I inevitably, upon release, had to start life all over again. And again. And again.

Eventually I left the big city in Ontario where I grew up and settled in a little cabin by the sea on Vancouver Island. That is where the healing started to accelerate, even though it's all been very gradual. Tiny steps mixed with cathartic realizations, patience, and goal-setting ventures. It is my pleasure to share with you, the readers of *Visions*, how I learned to balance my life, love and relationship(s).

I was deeply driven and motivated to rid myself of pain and suffering. It wasn't easy but I became acutely aware that I, and I alone, was responsible for my behaviour. Therefore it was up to me to control my episodes, to prevent them from occurring. Taking control, being at the helm of my life meant changing and it wasn't and isn't always pleasant. For one, I had to let go of people whom I adored but were not positive influences. I was diligent and still am about attracting stable, healthy, positive people into my life, and with love and compassion and some pain, letting go of those who are not.

I learned to live with my eyes open and become aware of everything that is stressful and over-stimulating and

counteractive to my goal of harmony. I had to accept and live with loneliness which I believe was a huge milestone in the face of having to let some people in my life go. To counteract loneliness I wrote poetry, I started keeping a journal, walked, and went swimming and ultimately learned to enjoy my own company. I had a relationship with a guy who had broken his back and was practicing yoga. He originally taught me yoga and I went on to take workshops and learn from other friends and teachers as well. Yoga presented an opportunity to focus on my body and my breathing. A tremendous clarity of thought and perspective evolves from the practice of yoga.

I became aware of how language affected me and how my own self-talk, usually negative, played a role in my actions and feelings of low self-worth. I therefore decided to delete words like freaking-out, sick, ill, and unwell from daily use in my vocabulary. To change my self-talk from negative to positive, I learned to become aware of my thoughts and change them on the spot.

Above all, I had to learn to balance work, school, family and personal issues prior to being in a healthy relationship. I needed to establish a grounded, balanced relationship with myself first and foremost. I promised myself I would not just hook up with any old guy or

girl. Beyond the personal qualities I looked for in a partner, it was imperative that he or she be mentally and emotionally grounded and financially stable. There is no question in my mind that having a good sense of humour and learning to lighten-up along the way has been of great benefit. Although I've always prided myself on my sense of humour, I had a tendency towards seriousness that was at times detrimental. One day a therapist said to me "I.e., lighten up! Take yourself to a funny movie or rent one." And that's what I did. I learned to hear the good advice and always listen to my guts.

I have been in a wonderful relationship now for two years. We are both basically independent and share what I consider to be a quality life together. I work part-time in mental health, I volunteer on a distress line, and give stress management presentations to high school students. I still write, and have wonderful friends and family relationships. I don't do anything, or hang out with anybody, if it doesn't feel right to me.

My children are adults now and I am blessed with three grandchildren. The relationship with my children has been a huge part of the healing process. They too are healing from being deprived of a good, loving mom. Our souls are healing together.

These days I eat well, sleep well and when I need to talk things out I do so with the appropriate sources, i.e. either a friend or counselor. I am able to remain still and calm in the eye of potential chaos. I am grateful that I am alive. Life is truly beautiful. ■



Sex in Residential Settings:

Panel discussion identifies range of issues

Sexuality has long been a taboo in the mental health field. Dr. Bill Maurice recalls that in medical school, a patient's sexuality was only mentioned in passing. "You were told to be careful not to have patients end up in the same bed together," he stated at a panel discussion on sexuality organized by the Mental Health Residential Services (MHRS) division of the Greater Vancouver Mental Health Services Society (GVMHSS).

Mental health consumers living in residential facilities now benefit from a greater understanding that they too have needs for intimacy, relationships, and healthy sexuality. In Vancouver, the Vancouver Adult Care Regulations assures that the personal privacy of a resident and his or her bedroom, locker, and storage space are respected. The regulations also state that residents are allowed to have visitors. As Catherine Battye, Adult Care Consultant for the Vancouver/Richmond Health Board, explained at the panel, the visits must be "occasional" and not cause disruption of care to any resident. As well, the visitor must not need care from the staff. The visits include overnight stays.* According to Catherine, these regulations are to be applied at the discretion of the facility as each case is individual, but the health and safety of all consumers must remain the top priority.

Sometimes the needs of the residents must be met at an even more basic level than having overnight guests. Some of the residents who have spent most of their lives sheltered from sex education and media depictions do not have a well-rounded understanding of sexuality. Dr. Maurice commented in his speech that he has had many consumers come into his office looking for answers on simple issues that most people of the same age would have known for years. He recalls one instance when one man who came to talk to him reached into his pocket and took out a piece of paper with a set of questions including: "What's the relationship between urine and semen? Where do you actually put a penis? Does it hurt a woman when you have sexual relations?..."

Throughout the panel discussion, sex education was felt to be an important issue in the holistic rehabilitation of people with mental illness. Some residences such as Crossroads, an all-female residence in Vancouver, tries to incorporate sexuality discussions into their educational program. About twice a year they also bring in experts to talk to the residents. Beatta Zaleska, nurse and manager of care at Crossroads expressed that the lack of education around sexual issues is alarming. She found that books made for children were useful in educating young women who live at Crossroads. Along with basic knowledge, residents also need to be filled in on contraception, STDs, and AIDS.

Often, people in mental health facilities are not ready for the emotional and physical intimacy of a relationship. Zal-

eska notes that many residents are also coping with histories of sexual, physical, and/or verbal abuse; dysfunctional relationships or families; and childhood diagnoses that interrupted regular social-skills development. This doesn't mean, however, that sexuality is therefore a dead issue for these consumers. Education about healthy sexual fantasizing and masturbation (and appropriate places to do so) must be encouraged so that residents do not feel ashamed for wanting to enjoy their sexuality by themselves.

Other issues facing residents are the obstacles they must conquer before being able to meet people both outside and inside the residences. Anne Bullock, Acting Director of MHRS, points out that each house and each individual are different when it comes to meeting other people for possible relationships. Each individual may also want social interaction to varying degrees.

To determine whether more social programs are needed, MHRS is surveying all 437 residents in the 43 housing facilities of the Vancouver/Richmond Health Board region. The survey asks questions about what activities the residents would like to have, if they would like to meet residents from other branches, and whether particular settings would make them feel safer. The results of the survey will determine what programs need to be developed. Activities may include dances, bowling, or any other suggestion given by consumers in the survey. A newsletter directed at resident consumers is also in the works.

Marie-Claude Lacombe

Marie-Claude Lacombe is a communications student at Simon Fraser University in Burnaby, BC. She is on a work term with the Canadian Mental Health Association, coordinating National Depression Screening Day.

“Some of the residents who have spent most of their lives sheltered from sex education and media depictions do not have a well-rounded understanding of sexuality.”

The survey and the newsletter are a collaboration of MHRS, All Consumers Housing Council and is funded by the Consumers Initiative Fund. If you want more information on the survey, the results, or the newsletter, you can contact Sheila Gamblen at GVMHSS, by phone 604/734-5265, or by e-mail at fgamblen@yahoo.com ■

* These are regulations for the City of Vancouver. Other regions may have different guidelines.



Coming Out:

Similarities in being at odds with mainstream society due to sexual orientation and mental health disturbance

Jill Stainsby

It is a real challenge to be a member of two distinct and separate marginalized communities. Both live at odds with mainstream society, much in the same way that visible minorities are isolated. The combination of having a mental health diagnosis and being a member of a sexual minority, while difficult, has both good and bad aspects.

I see parallels between the experience of being a mental health consumer/survivor and of being a member of a sexual minority, and I will explore the similarities in the course of this article. There are, of course, significant differences. For example, a mental health disturbance is a debilitating illness, and sexual orientation is not — though it can be incredibly isolating. Mental health disturbance is usually episodic. Sexual orientation usually remains the same for a lifetime (though not always). There is a system of support set up for people with a mental health diagnosis, flawed as it might be. Mental health consumers often receive support from others who do not have a diagnosis. Lesbians and gay men need to provide support to each other, as society at large does not usually directly help individuals with a sexual identity crisis.

Addressing the Sexuality Needs of an Aging Population

Edith Hamilton

I recently had the opportunity to attend a panel presentation on sexuality issues of residents in care. This workshop provoked me into exploring the sexual needs of the aging population in a psychiatric care facility. The more I thought about the topic, the more overwhelming the task seemed.

Many people with a non-mainstream sexual orientation came into contact with the mental health system when they were first discovering they were gay or lesbian. This is a significant issue. We are all aware that one in ten people with schizophrenia commits suicide. Did you also know that 62.5% of teen suicide attempts are made by those who are dealing with the issues and isolation of being gay or lesbian? (This, from a study by Burnaby's McCreary Centre Society in a provincially-released study, May 19, 1999). It is not an easy world, if you belong to either of these minorities, and belonging to both can be devastating.

Edith Hamilton is a registered psychiatric nurse and manager of Birchwood Care Facility, Birchwood House, and Magnolia House in Vancouver.

I asked myself, am I equipped to deal with the sexual needs of an aging group of people who come from different cultures, different religions, different values and beliefs, and different generations? And how compatible is my culture, religion, beliefs, and generation with others?

An interesting fact about membership in both communities is that both are “invisible” minorities. If I don't tell people I'm a consumer/survivor, they perceive me as a mental health service provider. If I don't describe my lifestyle, I'm not necessarily perceived as a lesbian. This makes it a matter of choice whether I disclose my mental health history or my sexual orientation on any given occasion. I choose not to live in any closets, even though the alternative is risky.

The answer became clearer when I asked myself, where do my responsibilities begin, overlap and end? My job is to provide quality health care to a group of people, who live together as a family. It is my responsibility to see that this family is taught

It is, however, a constant temptation to remain “in the closet” about one or the other of these two parts of my experience and personality. In fact, many people do. I have met several service providers in the mental health field who have disclosed to me that they have experienced a mental health disturbance themselves, but they have not shared that with their employer.

- how to build self-esteem
- how to develop quality relationships
- ways to avoid sexually transmitted diseases
- ways to practice safe sex
- birth control
- menstruation
- menopause
- normalization of sexual thoughts, feeling and actions
- how to incorporate the expertise of individuals and agencies who work specifically with sexuality needs

At an event I attended recently, two women who attended as partners were ignored by other women whom I believed to be lesbian, possibly because the other women were “in the closet” about their orientation. They would have been concerned that acknowledging the two women who were obviously lesbian would have made it obvious that they were too — something they didn't want to happen. Both groups of

The workshop I attended was a kick start in the right direction, but it was only a start. I believe we must involve mental health consumers and become more skilled and educated before we walk where angels fear to tread! ■



women lost the chance to receive support from each other.

In either the mental health field or in terms of sexual orientation, the closet is a very difficult place to be. There is a need to keep on guard constantly. Spontaneity is virtually impossible. Authenticity suffers. That is the reason I was willing to write this article when asked. None of us should be required to hide parts of ourselves in order to be accepted in our workplace, in our social lives, or by the people from whom we receive support.

There are other common threads between the experience of becoming a mental health care recipient and choosing a non-mainstream sexual orientation. Mental health consumers often find it difficult to access support, employment, housing and so on due to stigma. Lesbians and gay men are constantly reminded that they are not part of traditional culture, and suffer from greater or lesser degrees of homophobia. Homophobia and stigma are both words that describe the experience of being rejected by society for belonging to a group that is not perceived positively by many other individuals. I think it is telling that each of these communities has found a word of its own that describes this experience of being rejected by mainstream culture.

One of the things about being a member of a marginalized community is that it *is* a community. For both mental health consumers and lesbians or gay men, members of these groups have formed a community of support. In the community mental health field, peer support workers and advocacy groups are formalized ways to create community among mental health care recipients. Psychiatric survivors have created a strong community-based support system in the form of their rebellion against the way the mental health system controls the people who are recipients of care.

There is a strongly supportive lesbian community as well, though it can be both a positive and a negative force when dealing with mental health issues. I would possibly not be alive today if it were not for the crucial support I received from friends, who were also lesbian, during my hospitalizations. People who experience discrimination based on their membership in a minority band together to support themselves because they must.

The other side of the coin in terms of support from the lesbian community is the fact that there is a significant “anti-psychiatry” movement within it. This has led, in my experience, to a belief in the community that we are better off without mental health system intervention in our lives. In many cases this can be true, especially if you have a homophobic worker, but it can mean that people refuse needed medications and treatments. This is not always a successful strategy.

In both communities, there is denial. People commonly do not accept their mental health diagnosis easily, and can spend a decade, or even a lifetime, in denial. Many lesbians and gay men can describe a time in their lives when they did not know or accept their sexual orientation. In both cases, they

can be experiencing internalized stigma or homophobia, which they come by honestly. (We all learned jokes as children about “crazies” or “the loony bin;” we were almost all raised in heterosexual families.)

Lastly, in both cases, the “coming out” process – the process of letting other people know about your mental health diagnosis or sexual orientation – is a lifelong one. It is necessary to be alert when making statements that indicate that you are a consumer or a lesbian. Homophobia and stigma can be found everywhere, and they have a significant, sometimes deadly, effect on the lives of people with one or both of these labels. Internalized homophobia or mental illness can lead to suicide, as I mentioned earlier. In addition, gay-bashing is a lethal risk many people face, from small communities to the Downtown East Side of Vancouver.

Sexual orientation and mental health issues have in common that they are realities of our existence over which we have little, if any, control. And they are both negatively perceived by society. As a result, people who belong to these minority groups often look “inward,” to their own group, for their support. The experience of belonging to each of these minorities is very different, but the social fallout — the violence, stigma or isolation — can be similar. We need to accept each other’s difference. ■

Jill Stainsby is a mental health consumer advocate, currently employed as a patient relations coordinator at Riverview Hospital. She also works as a consultant.

Vision Correction



There are six points which need to be amended on page 11 of the Winter 1999 edition of *Visions* (Poverty, Unemployment and Income). The article is called “The facts about CPP (Canada Pension Plan).”

Under the title “**Criteria for Eligibility**” the third bullet should read “applicant does *not* have to have a specialist’s report, but this is helpful.” The fourth bullet can be changed to state “the applicant is able to attend school full-time, but be considered incapable of pursuing any gainful employment.”

Under the heading “**Other facts about CPP,**” under the second bullet, CPP is taxable income. People may apply for the disability amount \$4,233 to help reduce their taxes owing. This non-refundable tax credit is in addition to the basic personal amount of \$6,456. Also, under this bullet, the maximum CPP disability rate is \$903.55 per month. This is based on the contribution a person made while working. If a person receives less than \$771 a month, they **may** be eligible for a top-up by the provincial income assistance program.

CPP is mainly considered an income security program; but depending on the context, it could also be looked upon as a social program.



Jehan

Her name was Mariam. She ruled my world. We were both 13 and she was my first crush. Although I wanted to proclaim my love for her to anyone who would listen, I felt ashamed and terrified of my feelings because I was not the opposite sex. Thus began my reign of shame and secrecy which was to last for 19 long years.

That same year, my family moved from Tanzania to Vancouver. Although I was fluent in English, I had trouble understanding the Canadian accent and found it hard to keep up with the speed at which people spoke. I dreaded going to school. Some classmates would pepper me with spitballs almost on a daily basis. At lunch time, no one would want to sit near a “Paki.” After school I would be spat on, pushed, and called “Paki” and “Hindu.” I couldn’t understand such hostility. I was sure that something had gone wrong with me as soon as I had arrived in Vancouver. Back home, people didn’t react this way. I remember feeling angry, lonely and frightened. I wanted so desperately to go back to Tanzania, to Mariam.

I don’t know when I started to equate being brown with being inferior, but I remember so clearly being ashamed of my skin colour, accent, and culture. I hung out only with white girls, started smoking, and practiced speaking ‘Canadian English.’ At home, I refused to speak Gujarati, my mother tongue, and opened my bedroom window wide, even in winter, to keep out the smell of curry from my clothes.

In grade nine I fell in love with Anna. What luck and joy — not only was Anna

A long journey: When cultural and parental attitudes toward sexual orientation lead women to anguish and to mental health services



white but she was a lesbian! This bubble burst, however, when some boys from our class caught us kissing. From then on, we were taunted unmercifully and “Paki” was replaced with “Butch” and “Lesbo.”

At home I became mouthy, sullen, and angry. My parents would hold marathon lecture sessions reminding me that good Muslim girls didn’t behave this way, and that being the eldest child, I was not setting a good example for my sisters.

The taunting at school didn’t abate and in utter desperation, I begged my parents to change schools. Determined to make a fresh start at my new school, everything seemed to be going well until a friend of the family saw Anna and myself in a “compromising position.” My poor parents. I was wracked with guilt and sadness for them. I felt I had failed them.

My Dad asked, Was I a lesbian? I said, “Yes.” He hugged me and made arrangements for me to see a psychiatrist. I felt so despondent and shameful. Not only had I committed a sin, but there was something wrong with me mentally.

I felt ashamed and at the same

time relieved to see a psychiatrist. I was confused and I wanted an explanation for my “craziness.” Yet the very act of seeing a psychiatrist was a testimony of my “craziness” and I felt deeply ashamed of my perceived abnormalities.

The hourly sessions consisted of me venting and him writing voluminously in a note-book. I enjoyed the feeling of talking and having an adult take me seriously. At times I felt that he was a spy for my parents. Accordingly, I would edit my “confessions.” When I still wasn’t cured after a few months of therapy I felt even more ashamed and scared that I was truly mentally ill.

After a number of sessions with me, the psychiatrist explained to my parents that I was a borderline lesbian. My parents felt hopeful that I would eventually fall on the “right” side of the border. Even I felt hopeful that I could be “cured”!

Unfortunately for them, and despite my best intentions, I fell in love with another woman. My parents abandoned the psychiatrist and turned to God, churning out prayers in a fever pitch. When the incense smoke cleared, I was secretly relieved to find

that I was still a lesbian. I reasoned that if God wouldn’t intervene, then just maybe, loving a woman wasn’t a sin.

My parents felt that it was time I got married. Even I wanted relief from my life. Thus began the quest for a husband. My parents knew of a “good Muslim man” in England.

I went through the myriad preparations for a lavish wedding in a numbed and sometimes panicked state. Finally, on the eve of my wedding, I blurted out to my parents that I couldn’t go through with it. My Dad said, “Do you want to go through life as a lesbian?” I wanted to say “Yes, Yes.” But I didn’t have the courage. So I got married. I was 25 and he was 34. The marriage lasted four months. My parents were humiliated. I quit university and went to work in the family business in repentance.

As my 30th birthday loomed closer, I felt that my youth had gone and, being a repeat offender, I was past rehabilitation. As fate would have it, I started working in the heart of the gay district where I couldn’t help notice the homosexual goings-on. At first I was disgusted at the sheer audacity of “these people,” kissing and holding hands in public. Gradually, I began to see them as individuals. My journey of self-acceptance had finally begun. In my more daring moments, I even saw myself being in an open relationship with another woman. Venturing into a gay bookstore was a deliciously nerve-wracking experience. Glancing through rows of books about lesbians made me feel naughty and giddy with excitement. It didn’t take long to come across a torrid lesbian romance. I bought it ▶



People Just Want to Connect!

Can psychosocial rehabilitation programs help people enter the dating game . . . even to find love?

Dena Ellery

In the emphasis to treat mental illness, many mental health providers and support programs can overlook one of the most important aspects of a person's recovery — their sexual and/or relationship health. Some mental health support workers when interviewed said that they have worked with men who are virgins at the age of 40. These men said explicitly that they would like to have a girlfriend. Yet the opportunities for dating are restricted, and organized support for helping people to enter the dating game are limited, if not nonexistent, say support workers.

Barry Niles, Executive Director of the Mental Patient's Association in Vancouver, says that the need to address sexuality specifically within the context of rehabilitation has been largely ignored. "People assume that they're mentally ill and don't have the same urges as anyone else."

Niles developed a program on sexuality education for people with mental illness which he says has been stuck on a shelf due to lack of funding for over nine years. In his researching for this program, Niles found that people with mental illness had little or no ideas about creating healthy sexual boundaries, were exhibiting inappropriate sexual behaviour, and had less access to education about sexually transmitted diseases.

Mental health workers interviewed for this article said the same thing. One support person said he observed men who had no contact with women on a regular basis except for the women who worked at their clubhouse. "The women there are friendly to them and many men become infatuated . . . and you end up with a worker who has 15 men following her," the support worker (who asked not to be identified) said.

"Psychosocial rehabilitation programs don't talk about sexuality," says the support worker, "we sweep them under the carpet." This is echoed in a report published by the Psychosocial Rehabilitation Journal, where a review of 15 years of journal articles revealed only three articles devoted to sexuality (with none appearing since 1984)¹.

Niles agrees that people basically want to connect. His education program would suggest that drop-in centres or clubhouses host a 'Loveability Group' for example. A support group such as this would help people with dating skills by addressing personal hygiene and appearance as a starting point for attracting someone. "I suggest to people they go look in the mirror and tell me what would be attractive?" The group would help members identify what members would have to do to enter the dating game.

And as people progress along the dating game, Niles points out that disclosure of one's mental illness is always a key question. In his own dating, Niles found this to be a sticky situation. "When does somebody disclose?" he asks. Niles found that timing was an interesting dilemma, since revealing his history of mental illness could slow or stop the progress of a relationship altogether. On the other hand, he found that waiting too long to tell someone made them feel as though he was deceiving them. "It can have a major impact on whether it [the relationship] is successful or not," he says.

Niles and others agree that more education and openness about sexuality is a positive aspect of recovery for anyone living with mental illness. "When you see what really drives people, they're looking to connect. It's a huge driving force," says the mental health worker. ■

Dena is the editor of *Visions*

¹ *Psychological and Social Aspects of Psychiatric Disability*, LeRoy Spaniol, Cheryl Gagne and Martin Koehler, eds. Boston Centre for Psychiatric Rehabilitation, 1997. (page 20)

on the spot. I had tasted forbidden fruit and I wanted more.

I had been aware of various lesbian coming-out support groups and finally summoned up the courage to go to one. In my eagerness to belong, I downplayed my "South Asianness," hoping that the all-white group would notice only my lesbian connection. I had an unquestioning belief that lesbians couldn't be racist. Finding out otherwise sad-

dened and angered me a great deal. Only Alicia, the facilitator, seemed to treat me as an equal.

Alicia was seeing a lesbian therapist and spoke glowingly about how she had helped her cope with difficult issues. Although wary of therapists because of my earlier experience with the psychiatrist, the prospect of a lesbian therapist appealed to me.

My therapist was understanding, compassionate and

non-judgmental. What struck me most was the reassurance that I could talk about my sexuality without going into an automatic censor mode or fearing that the listener might recoil in disgust. Gradually I felt strong enough to talk to my parents.

On the day of "the talk," I felt none of the catatonic fear or shame that I thought I would. My dad's reaction was, "Well, if it's sex you want then have it. But one day you will have to settle down with a man."

My mom was surprisingly calm. I sensed that even though I had confirmed her worst fears about me, she felt relieved that it was finally out there. We had, and still have, many discussions: heated, sad, or even funny.

Throughout this period I never once regretted facing the truth about myself. Dealing with homophobia, both internal and societal, was a lot easier than facing the terrible prospect of living a lie for the rest of my life. ■



The Decision to Become a Parent



ne possible outcome in an intimate, sexual relationship is to become pregnant and have a baby. Bringing a child into this world is a decision that should be made with careful thought and planning. This decision is even more grueling when you add mental illness to the equation. The articles below focus on different aspects of parenting and how these are impacted by mental illness. However, in no way do they encompass the whole topic.

Marie-Claude Lacombe, with Sharon von Volkingburgh

Schizophrenia, Women, and Children

As is often the case with issues dealing with mental illness, research on schizophrenia and pregnant women is limited. There have been some studies published but the bulk of the data relating to antipsychotic medication was collected on women who had health problems other than schizophrenia, and the medication was usually administered in lower doses.

Women living with schizophrenia must especially weigh their choices when deciding to become mothers. There are many obstacles to consider. Unplanned risks include the chance of passing on schizophrenia to the child, the chance that the woman's mental health may

worsen during pregnancy, and the risk that the child may be affected by the mother's medication. In this case, awareness of the issues may be the next best solution to planning.

Having said this, having a child can also be a truly positive experience for some women living with schizophrenia. It has been found that 59 percent of women who live with schizophrenia report that their mental health worsens when they are pregnant. However, 29 percent of women (nearly a third) actually report seeing an improvement in their mental health during their pregnancy.¹ "And for many women, having children to love and be responsible for is an important key to being in recovery from mental illness."²

Making the decision

Here are some questions to ask when making the decision to have a child:

1. Is my illness sufficiently under control? If I have to work full-time in order to support my children, can I do it?
2. Will the stress and expense of raising children cause me to become ill again?
3. What if my children inherit the illness?
4. Is my partner a capable person who can help provide a secure and peaceful home for a child?³

Statistics show that the child

of a person living with schizophrenia has a 10 to 15 percent chance of developing schizophrenia. When both parents are affected, the chances jump to 40 percent. As well, one in two children with a parent who lives with schizophrenia will develop a mental illness, including depression, schizophrenia or another illness.

The questions above imply that in the ideal case, one should be able to keep and raise one's own children. In the past, most women living with schizophrenia lost their child to social services at birth. Now, the majority of women are able to keep full or partial custody of their children.

Medicating during pregnancy

Once pregnant, the woman living with schizophrenia must decide whether to keep taking antipsychotic medication or to stop medication and risk a psychotic episode. Both options include risks to the mother as well as the child.

Rola Khalil-Priatel, Pharmacist Coordinator at UBC's Seniors Medication Information Line (SMIL), explains the importance of an open discussion with your doctor. "In general, some psychiatric medication can be used during a pregnancy but the benefits must outweigh the risks." And because each individual is different, she adds, "an assessment should be made by a specialist." (For

specific medication information you may call the pharmacists at SMIL: 822-1330 or 1-800-668-6233).

As of 1996, the US Food and Drug Administration had not yet approved any type of antipsychotic medication to be used during pregnancy. However, some drugs do not carry as many risks as others do. A woman living with schizophrenia should discuss the following risks and side effects of the medication with her doctor:

The possibility of

- Birth defects
- Accumulation of the drug in fetal serum (fluid in the womb)
- Symptoms of withdrawal a child may have from the drug
- Effects on the child's growth
- Jaundice in premature children

According to the National Institute for Mental Health, trifluoperazine and haloperidol are two drugs that show the least side effects for both the mom and the child. Clozapine and chlorpromazine should be avoided as they have serious side effects on the baby. In addition, cigarette smoking while on antipsychotic medication may also increase the risk of birth defects in babies.

It's a girl! It's a boy!

Once the baby is born, Mom must face many other issues that affect both her and the baby's health. It is important for a mother not to neglect herself. To be the best mother she can be, a woman must have good mental and physical health. Among many parenting challenges, the most common among mothers with schizophrenia is their difficulty seeing, un-



derstanding and figuring out nonverbal cues expressed by their children. It has also been reported that many women who have schizophrenia are afraid, with reason, of having their child taken away by social services. In fact, this remains the dark reality for many women who have a mental illness (read Dawn's story below). However, custody is often better off kept by the mother. According to the National Institute of Mental Health, if the child's basic needs are met and there are no signs of abuse or neglect, children should be left in the mother's custody.

It's often said that to become a parent is one of most rewarding experiences in life. Women living with schizophrenia should not be afraid to think about becoming mothers. However, a future mother should be aware of her options and resources including all the support and help available to her from the community, the medical field, and her family.

Mothers in transition

Dawn has 31 moms. She is a busy volunteer worker who runs 'Mothers in Transition,' a support program for mothers living with a mental illness whose children have been apprehended. She finds it easy to relate to the mothers as she too has lived through it before. Dawn explains that most mothers are single and have had their children taken away. She attributes this to the lack of support and understanding women have found within their family and their community.

"Most of my moms just want contact with their children; they love them terribly," says

Dawn. The majority of the time, Dawn meets each mom individually and lends an ear to them. She may offer counselling on the next steps the mothers should take, but what they need most, she says, is somebody to listen to their plight. Dawn is much like an attentive friend there when her moms need her.

Dawn sees child apprehension as a life sentence for mothers. The best she can do for her moms if this happens, is to be there for them and listen to them express their feelings. Depending on the situation, she also suggests they get job training. In addition, she suggests that mothers find employment, which can help her moms gain back their confidence and prove that they can take care of themselves. For more information, call Dawn at 604/871-0151.

Parents with mental illness: specific issues

(Sharon Van Volkingburgh)

Parents have spoken about the benefits of raising children, such as the love and pleasure that both the parent and the child enjoy, and the pride that they have in their parenting skills and their children. Children provide meaning and a vocation in life, as well as motivation for many people to keep well.

The symptoms of mental illness can cause parents to be unable to provide the quality of care their children need. During a mental health crisis, the parent may not be able to communicate well with others, or to properly focus on their child's needs. In some cases the illness may cause the parent to be unable to care for themselves, and the parent may

either depend on the child to become a caregiver, or they may lose custody of the child, which is many parents' worst fear. It is important for parents who have an illness with severe recurrent symptoms to make plans for the care of their children, in case they suffer a relapse. When there is a plan, care can be provided for both the ill parent and the child in alliance with the parent's wishes.

Developing a care plan is therapeutic in itself, as the parent realistically faces the impact of his or her mental illness on the child, and takes steps to build a support network for the family. Parents who have made such a plan have been surprised at the positive response of friends or family when they have asked them to make a commitment to help in the case of a future crisis. Friends, family and community workers often stand back when problems related to the illness are developing, wanting to help, but worried about going against the ill parent's wishes. Knowing in advance what role the parent would like them to take gives people confidence that they're doing the right thing.

Proposed adult guardianship legislation, under the Representation Act, will allow adults to authorize a representative to hold particular powers that the person agrees to in advance. For example, representatives will be able to arrange for the temporary care, education, and financial support of children, as described in the agreement. Materials to help people develop representation agreements are available from the Coalition of People with Disabilities in Vancouver. Although this act

is not yet in effect, these materials can be very helpful as a model of a care plan.

A basic model of a plan for the care of children in case of a mental health relapse should include the following elements:

- **Who:** list people named in the agreement and phone numbers; list people to be informed about the agreement.
- **Purpose:** e.g., "The purpose of this agreement is to provide a clear set of guidelines to be taken by members of my support system if I exhibit symptoms of my illness which interfere with my ability to provide good care to my child."
- **My symptoms:** list symptoms that the person making the agreement would like others to notice and respond to, and describe the most helpful way to respond.
- **Plan of action:** Record how the writer would like to deal with the issue of confidentiality and attach signed consents if desired. Even with consent, no more information than is necessary for the implementation of the agreement should be shared.
- **Record the writer's wishes for support services:** These are wishes for the care of the child; include any information about special needs.
- **Cancellation:** describe the manner in which the agreement can be cancelled. The purpose of the agreement is so that it cannot be easily cancelled when the writer is acutely ill, so it's wise if the process of cancellation requires a period of time and a set of steps.
- **Review:** Describe how



and when the agreement will be reviewed (at least annually).

A working group recently formed at Greater Vancouver Mental Health to develop better practices to assist parents and children in families where a parent has a mental illness. Your input is welcome; phone Sharon Van Volkingburgh at 874-7043.

When kids are in control

Life can be tough living with a parent who has a mental illness, especially for pre-teens. This is why the British Columbia Schizophrenia Society (BCSS) put together a program for kids ages 8 to 13 who have a parent with a serious mental illness. The Kids in Control Support Group Program is a form of primary prevention that offers information, education and support. BCSS has observed that these kids face unique challenges. These challenges put them at a greater risk. They don't fit in as well in their social circles at school or extracurricularly. And they have a higher risk of being diagnosed with a mental illness themselves.

The Kids In Control support program is a series of education sessions that helps kids learn more about mental illness and helps them find ways to cope with being the child of a parent with a mental illness.

For more information on the Kids in Control program, please contact Hylde Gryba at 604/864-9604.

New program for mothers

The Mental Patients' Association also has a support program in the works. The program is for unmarried, mentally-ill mothers who are pregnant or have a child under the age of two. The program will offer individual support to a small number of women and will aim to keep families together as much as possible. The program recognizes that for many people, having children to care for and love is an integral part of recovery and rehabilitation, and has a non-judgmental approach to parenting. For more information, please call Jirina Judas at 604/738-2811 ext.128. ■

Upcoming Forum:

A group of community agencies, including the BC Schizophrenia Society, North Shore Family Services, Chilliwack Mental Health, CMHA, BC Women's Hospital, and GVMHS are planning a provincial forum on the topic of Parental Mental Illness on September 30, 1999 at the Roundhouse Community Centre in Vancouver. Information about registration will be available soon at the agencies listed above.

¹ Percentages taken from "Sexuality and Family Planning in Women with Schizophrenia," by Laura J. Miller, 1997 — Medscape, www.medscape.com/govmt/NIMH/Schizo...04/sb2304.06.mill/pnt-sb2304.06.mill.html

² National Post, "Giving birth to madness," March 9, 1999, p. B1

³ Questions from the BC Schizophrenia Society Booklet, "Basic Facts About Schizophrenia: Youth's Greatest Disabler," March 1999

Greater Vancouver Offers Unique Help

A part from the serious issues of drug side effects and concerns about HIV/AIDS, many of the sexual needs of those with a mental illness are given minimal attention by health professionals. At the same time, sexual problems in those with a mental illness are probably more common than in a healthy population (see page 3). In an attempt to remedy this situation, we established a service for those who have both a mental illness and a sexual concern, and who are also receiving care from the Greater Vancouver Mental Health Service (GVMHS).

Who we are

Both of us have had a long-standing professional interest in sexual issues. One (RS), has written a sex education-focused two-volume book in Punjabi. The other (WLM) has worked as a Sexual Medicine specialist within his career as a psychiatrist, has taught Sexual Medicine to medical students and residents while working for UBC, and has recently published a book for health professionals — *Sexual Medicine in Primary Care* (see "Book Reviews"). Our past clinical experience had primarily been with individuals and couples who may have had some psychological or interpersonal difficulties, but were otherwise physically and mentally healthy. Nevertheless, our collective knowledge and experience allowed us to redirect our focus in recent years to people with a mental illness.

What we do

Most of what we do is clinical (i.e., understanding and suggesting treatments for sexual problems) but some is also educational. Whatever we do clinically almost inevitably includes an educational component as well. In thinking about sexual matters, the two issues are difficult to separate.

Each person with a mental illness cared for by GVMHS is assigned to both a psychiatrist and primary therapist, and referrals to our clinic are made by either individual. In spite of the notion of privacy that most people associate with talking about sexual matters, we discovered early in our experience that GVMHS clients are almost always more comfortable meeting with us while their primary therapist is also present. We candidly discuss sexual concerns, provide educational input when needed, and report to the referring professional with recommendations. Increasingly, we are also arranging follow-up visits.

We also encourage continued discussion of sexual matters after the visit between the primary therapist and the person who has been referred. Part of the purpose of seeing both the primary therapist and person with a mental illness together is related to the comfort and continued attention to the individual's sexual matters. This also enhances the comfort and skill of primary therapists in talking to



Sexual Medicine Consultation Clinic for Individuals Experiencing Sexual Problems

people, for whom they are professionally responsible, about sexual matters.

In addition to talking to individuals who have been referred, we have also met with groups from several GVMHS teams to provide sex-related information and answer related questions.

How we do it

Sometimes the two of us work together. At other times, one of us (WLM) will see the person with a mental illness and sexual concern together with a UBC psychiatry resident (a physician who is studying to be a psychiatrist). The purpose is to provide an educational experience for the resident to consider sexual matters in the care of those with a mental illness.

Problems we see

Our definition of the word “sex” is quite broad, so we encourage referral of a wide

range of problems. (We are far from expert in everything; if we can’t help di-



The Sexual Medicine Clinic is located at the South Team of Greater Vancouver Mental Health Service. Both clients of the mental health system as well as providers can contact the service at 604/266-6124.

rectly, we usually can find others in the community who can.) Most difficulties are related to sexual function (e.g., erection and ejaculation problems in men, sexual desire concerns in both men and women, orgasm and coital pain difficulties in women). However, people have also come to us with concerns about gender issues (unsure if they are a man or woman), sexual abuse in childhood, and dilemmas about sexual orientation. Two cases follow:

A 30 year old man was referred because of his continuous use of “poppers” (nitrates) to enhance his sex-

ual arousal. He had a bipolar disorder, was treated with medications and

psychotherapy, and was living alone. His erection, ejaculation and orgasm function were all normal. He was mostly unaware of the harmful effects of nitrates and after lengthy discussion about the health consequences of their use for the purpose of sexual arousal, he concluded that this practice would be substantially diminished. When we saw him again, later, he reported that he had not used poppers since the previous visit.

A 50 year old woman was referred to the clinic because of diminished sexual desire. Her psychiatric diagnosis was schizophrenia and this had been treated with various medications since her disorder began about 10

years prior. Within one to two months of beginning risperidone several years before the current visit, she noticed an even more substantial decrease in her sexual desire level. Her serum prolactin level was found to be high and this was thought to be one of several possible explanations for her sexual concern. She was switched to another medication which did not have the same effect on her prolactin levels and she noticed beneficial effect on her desire, though not to the level that existed prior to the onset of her illness.

Future Considerations

The most urgent priority in planning for the future of our service is the inclusion of a woman health professional. In an area as sensitive as sexual issues, and in a service that is available to both men and women who have a mental illness, having representation by both genders on a treatment team is, in our view, essential. ■

Rajpal Singh, PhD and William (Bill) L. Maurice MD, FRCP(C)

Rajpal Singh, PhD works with the South Mental Health Team of the Greater Vancouver Mental Health Service and at the GVMHS Sexual Medicine Consultation Clinic.

William (Bill) L. Maurice MD, FRCP(C) works at the Division of Sexual Medicine, Department of Psychiatry, UBC and at the GVMHS Sexual Medicine Consultation Clinic.

When You’re Scared to Death of Sex

In a sex-focused society like ours that encourages the pursuit of physical pleasure, people whose sexual problems are rooted in fear and avoidance of sex can often feel like “abnormal” outsiders. But their problem is more common than they may think with sexual avoidance as the major complaint of many people seeking sex therapy.

So how does the beauty of human sexual intimacy become a frightening and unrewarding experience? With help from Dr. Helen Kaplan’s book *Sexual Aversion, Sexual Phobias, and Panic Disorder* (Brunner/Mazel: 1987), this article will attempt to shed light on this disorder.

What are sexual aversions and phobias?

Dr. Kaplan suggests there are two classes of sexual avoidance behaviour. The milder one, *sexual aversion*, describes people who are comfortable enough engaging in sexual activity but who avoid it out of disinterest. At the other extreme are people with *sexual phobias*.

People can develop phobias — unrealistic fears and panic for specific objects or situations — to a lot of things. Snakes, heights, elevators, and flying are possible scenarios that can make a lot of us uncomfortable, petrified, or some feeling in between.

over ►

Sarah Hamid

Sarah is an SFU Communications and English undergraduate doing a work term with CMHA-BC. She coordinates the Open Mind Media Watch Program and is a mental health consumer herself.



People with sexual phobias have very strong and active aversions to sex though they may experience normal feelings of desire and arousal during masturbation. Unfortunately, a partner's touch revolts them. They usually realize the fears are illogical but feel powerless to change them. Instead, individuals are left with feelings of anxiety, depression, and guilt for the effect the aversion is having on their relationships.

Triggers

Some people are totally phobic or scared of sex and have panic attacks in response to most erotic sensations. In other cases, a person's phobic response is limited to a specific aspect of sex such as

- being seen (or seeing someone else) naked
- genitalia (your own or your partner's)
- the act of penetration or being penetrated
- orgasm
- sexual fluids/odours

In these cases, people may enjoy sex and function normally as long as they can manage to avoid their particular phobia.

Response Intensity

People living with sexual aversion disorders will instinctively avoid sex as much as possible. Sometimes though, they find themselves "trapped" into having sex because of love, pressure, or fear of losing their partner. Once they are actually in a sexual situation, there's a considerable range in the intensity of their response.

People with mild phobias are often able to calm themselves of their pre-intercourse jitters to the point of actually enjoying sex. Others with more severe responses cope

by detaching or distracting themselves, feeling as if they're in a dentist's chair (as one woman put it) and if they just hold on a bit, it will soon be over.

WHY do these disorders exist? — Four Explanations

Fear

Psychoanalysts believe it's sex and fear coupled early in life that lead to sexual phobia. Parents who convey negative-, guilt-, or fear-based attitudes toward sexuality create sexual conflicts in their children that could persist into adulthood.

Trauma

According to learning theorists, sexual phobias result from a person experiencing sex and *pain* together (both physical and emotional pain). The body's memory of this association between sex and pain is strong enough that the central nervous system decides to defend itself against future trauma by avoiding whatever it was that took place when the pain occurred — in this case, sex. This learning theory is most relevant for cases of rape, incest, humiliating sexual failures, or painful disappointments in love that have led to future anxiety.

Habit

According to another kind of learning theory, sexual anxiety comes from the guilt about sexual pleasure that many youngsters come to feel when they internalize their family or culture's repeated, negative sexual messages. For instance, the young bride who has lived through years of being terrified and disgusted with premarital sex may still feel sexually terrified and disgusted come honeymoon time.

Chemistry

This theory claims that people with sexual aversion disorder live with a biological problem which leaves a person with an unusually low physical threshold for the fight-or-flight "stress" response. This dysfunction would make it easy to develop phobias as the body's way of making sense of these anxious "alarm" responses. Certain antidepressants have proven useful in helping to relax an easily-agitated nervous system.

Seeking Help

Absence of physical sexual gratification aside, sex is a fundamental human experience with profound impacts on a person's entire being. When the fear of sex controls a person's life, love, intimacy, marriage, children, and gender esteem may all suffer as well.

Anyone can have a sexual phobia. You can be single, dating, or even married. You can be male or female. You can even have a history of pleasurable sexual experiences. Whatever your situation though, there is help if you are motivated to recover your ability to be sexually intimate. Your family doctor can refer you to a relationship or sex therapist. Local mental health clinics can also hook you up with support groups for other people with psychological sexual problems or other people wanting to break free from the chains of a phobia. For even more proof that there's hope, just consult Dr. Kaplan's book. It's filled with case studies of couples who have been treated successfully and are now able to enjoy sexual intimacy — either again or for the first time ever. ■

What Sexual

Society and psychiatry have a habit of making distinctions between what is "normal" and "abnormal" behaviour. And perhaps nothing has felt the impact of this practice more than the spheres of sex and mental health. Like the mentally ill person, the sexually deviant person is also seen by many to live on the side of the must-be-abnormal and the must-be-treated. The problem created by this judgment is one of social "norms" and perceptions.

Cultural norms and perceptions about sex may prefer to be marked out in concrete but they end up sketched out in shifting sand. What may seem "deviant" or eccentric sexual expression to one person may appear "normal" to another. So where do we get our ideas of what deviance is versus behaviour that abides by norms of social acceptability? And at what point would a sexual practice cross the line and be considered a mental health problem? This is where psychiatry comes in.

In the psychiatric field, sex and mental health come together in the *Diagnostic and Statistical Manual of Mental Disorders* or *DSM-IV*. In this manual, used by psychiatrists and mental health clinicians to determine the nature and scope of a person's mental illness, a specific section is devoted to sex-related disorders. **Paraphilias**, the various kinds of sexually deviant activities outlined in Table 1, are a



is “Normal” Sexuality, Anyway?

‘deviants,’ social norms, and mental health

group of sexual disorders in this section.

Paraphilias can be defined by frequent and intense “sexual urges, fantasies, and behaviours that involve unusual objects, activities, or situations” (*DSM-IV*, 493). People with paraphilias are considered by both the medical and lay communities as the sexual ‘deviants’ of our society — the so-called “weirdos” who “get off” in “unusual” ways. But despite the incredible stigma attached to this perception, paraphilias receive little debate by the very communities that define them as deviant.

Possibilities for defining deviance — and why they don’t work

Three models come easily to mind as ways of defining and thus identifying deviance:

Deviance is that which is uncommon or unpopular: i.e., “Nobody else does that”

But does that mean that your neighbour who collects troll dolls needs to be treated?

Deviance is that which isn’t socially accepted and so makes others uncomfortable: i.e., “Nobody ever does that here”

So what about the student who’d rather sing in the school hallway than yell? Should she be treated? Why — if she’s not hurting anyone?

Deviance is that which causes distress: i.e., “I don’t feel good or right doing that”

Does that mean pedophiles shouldn’t be treated if they aren’t distressed about their behaviour? Whose distress matters more? Who has the right to decide?

Other cultural biases that cloud the issue

Media. The only deviants we know are the ones who are brought into the open. And the media makes sure the deviants we find out about are the sensational and extreme examples somehow

shown to be linked with criminal intent or mental illness. In the process, the media urges citizens to ignore all the other unknown people taking part in similar sexually deviant behaviour but who are discreet and legal about the activities performed in the privacy of

Sarah Hamid

▼ **TABLE 1:**
Name and Focus of Clinically-Recognized Paraphilias *

Name of Paraphilia	Source or behaviour leading to sexual satisfaction
fetishism	inanimate objects (called "the fetish." E.g., shoes, boots, undergarments, leather. Does not include objects such as vibrators which are specifically designed to stimulate the genitals.
transvestic fetishism	cross-dressing (when not related to gender identity problems)
voyeurism	spying on others, usually strangers, while they engage in some private behaviour (e.g., going to the washroom, undressing, having sex)
mixoscopia	watching others engaged in sexual acts (a specific form of voyeurism)
exhibitionism	exposing genitals to unsuspecting strangers in public places
frotteurism	touching or rubbing against a non-consenting individual. Usually occurs in crowded places (e.g., rubbing genitals against victim's thighs or buttocks, fondling genitals or breasts with the hands)
sexual sadism	discipline. Humiliating and/or inflicting pain on others
sexual masochism	bondage. Humiliation, suffering, and pain at the hands of others
pedophilia	exclusively desiring sexual activity with pre-pubescent children
gerontophilia	exclusively desiring sexual activity with the elderly (when no genuine affection exists)
telephone scatologia	phoning a non-consenting individual and trying to obtain and/or deliver information of a sexual nature (i.e., "obscene phone calls")
sexual self-mutilation	inflicting pain and/or damage on one's own body
autoerotic asphyxia	artificially restricting one's own oxygen supply
partialism	exclusively desiring and fantasizing about a specific part of the body that is not a genital organ (e.g., feet)
saliromania	deliberately dirtying or damaging women's clothing, statues, or paintings of nude females
zoophilia / bestiality	desiring sexual activity with or around animals
necrophilia	desiring sexual activity with or around corpses
coprophilia	sexual activity involving feces
klismaphilia	sexual activity involving enemas
urophilia	sexual activity involving urine

* this list goes beyond those paraphilias listed in the *DSM-IV*; many exist in combination

Sarah is a 4th-year student at SFU and oversees the Open Mind Program at CMHA's BC Division Office. She is also a mental health consumer.



their bedrooms.

Clinicians' Education. Psychiatrists and psychologists take courses in abnormal psychology in university. Does studying mental health issues as deviant, disordered, or abnormal reinforce society's conception that psychological differences mean someone is deviant and abnormal? Should everything that is "different," "un-

between consenting individuals — and a paraphilia. Table 2 could be a guide here, though by no means a definite answer. Unfortunately, when it comes to private behaviour most of us won't even readily admit to when surveyed, there's no way of knowing where that line is or just how many of us really secretly love to dance near it. Of course, the more of us that do, the less deviant 'deviance' becomes.

"... there is no form of sexual activity that is not deviant at some time, in some social location, in some specified relationships, or with some partners" (Gagnon and Simon, 1968: 107)

other Eastern cultures, for example, citizens are taught to enjoy masturbation and even childhood intercourse without feeling guilty, yet have the cultural taboos we normally attach to sex directed instead at food (Plummer, 70). Sexual norms, then, are only what we make them.

In sum then, social groups around us create deviance by making rules that when upheld make one "normal" and when broken make one "deviant." So why is this useful to know? Plummer says that being aware of society's role in constructing deviance helps remind clinicians and the general public to consider the 'deviant' in relation to those groups and individuals who define him or her as one. Then, if sex and deviance are indeed negotiable and evolving ideas (for example, as we have seen them be for homosexuality and masturbation in recent years), we may be better able to identify opportunities to advocate for gradual revision of the rules over time. ■

Table 2: ▼
When Should You Think About Seeking Treatment or Changing Your Sexual Behaviour?

When should you seek treatment?

If your behaviour:

- breaks the law
- hurts or victimizes others physically or psychologically
- stops being a private activity
- involves non-consenting individuals (including individuals unable to give or deny consent)
- causes you psychological distress
- endangers your life or physical well-being
- so preoccupies you that the compulsion to perform it interferes with your normal daily activities and relationships
- in its intensity and/or frequency, is even beginning to cause resentment or discomfort in your consenting partner(s)
- has become a substitute *for*, rather than *part of*, a meaningful relationship with another person; that is, the solitary behaviour allows you to avoid intimacy

A better definition

A more adequate definition of deviance in terms of our discussion of sexuality might include

- an acceptance that deviance as we know it is simply *norm-violating behaviour*, or in other words, behaviour that has rebelled against the "norms" or codes of proper conduct promoted by a particular society (but which may

known" or "other" undergo rehabilitation?

Sexual liberation movement. Since the sexual revolution of the '60s, we have been encouraged to tear down sexual barriers and bring fun, experimentation, and exoticism into our sex lives. While there are clear laws defining the criminal nature of certain paraphilias, there's definitely a grey area between an exotic turn-on — the harmless, non-compulsive playing out of 'naughty' or 'kinky' fantasies

not harm anyone or be criminal in nature)

- a change of language from 'deviance' to 'differentiation' or 'variation' (or 'crime' if a deviant behaviour becomes a criminal issue)
- the existence of a checklist like Table 2 with an array of points to consider when deciding whether a sexual deviant ought to be treated at all

"Normal" Sexuality = What a culture decides is acceptable

The quote above stresses the importance of recognizing how culture and circumstance help make concepts like "normality" or "deviance" flexible. For the purposes of our discussion, we'll define culture as a social group, its environment, and the unwritten code of behaviour we are supposed to consent to when we choose to live in a particular part of the world. Sociologist Kenneth Plummer notes that deviance in Western culture (i.e., English-speaking countries) is defined by an unspoken social understanding that "normal" sexuality has three requirements for cultural acceptance:

1. the biological goal of heterosexual vaginal intercourse (including sexual arousal toward a person of the opposite sex rather than an object or animal) (from Mother Nature)
2. a straightforward sequence of "normal" sexual development from childhood to adulthood (from Freud)
3. and for many still, the need for marriage first (from various religious doctrines).

These perceptions are part of the North American cultural heritage that influences our judgments about what is healthy sexuality and what isn't. We may feel guilt if we deviate from such norms because these perceptions often become tied to *moral* equations of "normal" as "right" and "abnormal" as "wrong." However, Western morality is not universal. In

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When Interest in Sex Resumes: What to know

excerpted from the BC Schizophrenia Society newsletter

Dr. Ruth Dickson

Dr. Dickson is an Associate Professor of Psychiatry at the University of Calgary; Chief, Division of Specialized Services, Department of Psychiatry, Calgary Regional Health Authority; and advisor to the Schizophrenia Society of Alberta.

When an individual's interest in sexual relationships resumes, it is usually a sensitive issue for both the individual and family members. With reduced symptoms and fewer drug side effects, persons who have expressed little or no interest in romantic relationships may begin to do so. This may be a signal that an individual is feeling solid in their sense of self and feeling more prepared to seek intimate relationships.

The older antipsychotic drugs and risperidone usually work for people with schizophrenia by blocking dopamine, an adrenaline-like substance produced by the body, at the pituitary gland. This process, however, may cause the body in turn, to produce high levels of the hormone prolactin. Prolactin can contribute to sexual dysfunction, menstrual disturbances, and may cause

leakage of milk in individuals who are not breast-feeding. These side effects are not visible but may be bothersome and embarrassing to the person experiencing them. Alternatives to older antipsychotic drugs and risperidone are *clozapine, olanzapine and quetiapine*, which are *prolactin-sparing*. Switching to these compounds may resolve some side effects.

For example, a woman may have stopped having regular menstrual periods, a known side effect of antipsychotic treatment. With a change to a new drug, her periods may resume, along with her ability to conceive. It is important that patients are aware of the possibility of resuming sexual relationships and receive education about contraception, sexually transmitted diseases, and relationship issues. ■



Depression medicines can kill women's sex drive; activity can increase it, find BC researchers

Commonly prescribed medicines for high blood pressure and depression can kill a woman's sex drive, according to West Coast researchers who have taken an inside look at female arousal.

Their work, conducted at the University of BC and the University of Washington in Seattle, is leading to new understanding of how the nervous system affects sexual activity in women.

"There's a very, very high incidence of sexual side-effects associated with antidepressants," says Dr. Cindy Meston, who notes that 10 to 40 percent of women on Prozac and other antidepressants report a decline in sexual drive or inhibition of orgasm.

More than seven million prescriptions for the drugs are now filled by Canadian pharmacists each year.

Contrary to common belief among sex therapists, female arousal involves a lot more than being in the

right mood, Meston says.

It's been assumed for more than 30 years that female sexual arousal is aided by a state of deep relaxation, she says, and not by physiological changes such as increased heart rate and blood flow.

Meston has found that such physiological changes are key to arousal. And she says sex therapies that focus on inducing a deep state of relaxation in women are actually counterproductive.

Her research indicates that women with arousal problems might be well-advised to hop on an exercise bike before jumping into bed. Vigorous exercise can have a very a significant effect," says Meston.

Meston's research was conducted by getting her volunteers, heterosexual women 18 – 44, to ride an exercise bike for 20 minutes to increase their heart rates. The women then insert a tampon-shaped device called a photoplethysmograph into their vaginas. It measures vaginal swelling and contractions. Meston then gets her volunteers to watch short videos, one a travelogue on Antarctica and another a sexually explicit film clip.

Meston has shown that the vigorous bike ride facilitated arousal in women with normal sex function as well as those with low sex desire. The photoplethysmographs monitored a marked increase in vaginal blood flow and pulsing in women who'd ridden the bike before viewing the movie. ■

Excerpted from the Vancouver Sun

The 1999 BC Woman Show

October 2nd & 3rd
Vancouver Trade and Convention Centre

Presented by *BC Woman Magazine*, the focus of the show is to provide women with ideas, information and inspiration for their health, home, business, money, beauty, leisure, safety and well-being. Please call 1-800-555-8222 in September for more information.



Medications and Sexual Problems



Dena Ellery

Table 1 below is a list of medications used to help with symptoms of mental illness. These same medications can sometimes affect normal sexual functions. If you are taking any of these medications and have experienced decreased sexual desire, problems having an orgasm, inability to have or sustain an erection or if you're a woman, to lubricate, consider talking to your doctor about your concerns. It may feel uncomfortable at first, but be persistent. You and your

doctor can work to find alternatives so that you can have a healthy sexual life.

Many other drugs can have an effect on your sex drive and your ability to have problem-free sex (see Table 2). For example, many anti-hypertensive medications can cause problems such as difficulty having an erection or orgasm, as well as a decrease in the desire to have sex. Some birth control pills, diuretic medications and other prescribed medications can also have an effect

on your sexual functions.

In addition, some non-prescription and illicit drugs can impact your sex life. For example, niacin may, in some people, decrease their desire to have sex. Even some antihistamines have had a negative impact on some people. And of course, illicit drugs and/or abused drugs — from alcohol, cocaine, and marijuana to amphetamines and even tobacco have shown some effects on people's sex lives.

It's important to talk openly and honestly with your doctor about any substances you are taking. This way, your doctor can get a clear picture about where your problems might be coming from. And you will get the best possible advice and help for addressing problems you might be having.

Most importantly, you and your doctor can often work out a way for you to control the symptoms of your mental illness and maintain your sexual relations too. Sometimes, it might mean reducing the amount of your medications. Other times, your doctor can prescribe additional medication to help control side effects that interfere with your sex life.

For example, bethanechol and neostigmine are sometimes prescribed to help men who have problems with erections. Cyphroheptadine can sometimes be prescribed if one of the side effects you're experiencing is lack of orgasms. Lack of sex drive can be treated with bromocriptine. However, these drugs have their own side effects, including causing a relapse of psychiatric symptoms. So it's very important to discuss this fully with your doctor before you start any new or changing of your medication.

In all, an honest discussion with your doctor is the best starting point for getting help to manage side effects of your medication that may be interfering with your healthy sexual life. ■

Table 1: ▶▶
Antidepressants
Associated with
Sexual Disorders

Medication	Sexual Side Effect(s)
amoxapine (Asendin)	erectile disorder (frequent side effect); inhibition of orgasm (infrequent side effect); in a very few cases, people report decreased desire or retrograde, painful, delayed or no ejaculation
bupropion (Wellbutrin)	decreased desire (infrequent side effect); erectile disorder (infrequent side effect)
desipramine (Norpramin, Pertofrane)	in a very few cases, people report decreased desire; erectile disorder; ejaculation without orgasm; retrograde ejaculation or painful orgasm
doxepin (Adapin, Sinequan)	in a very few cases, people report decreased desire or problems ejaculating
fluoxetine (Prozac)	decreased desire (very frequent side effect), delayed or no ejaculation (very frequent side effect), lack of orgasm (frequent side effect)
imipramine (Tofranil, Janimine)	erectile disorder (frequent side effect); painful, delayed, or retrograde ejaculation/delayed orgasm in women (frequent side effect); in a very few cases, people report decreased desire or increased desire
maprotiline (Ludomil)	in a very few cases, people report decreased desire or erectile disorder
nortriptyline (Aventyl, Pamelor)	in a very few cases, people report decreased desire, erectile disorder, or no orgasm
paroxetine (Paxil)	erectile disorder, inhibited ejaculation, no orgasm (infrequent side effect)
phenelzine (Nardil)	retarded or no ejaculation; delayed or no orgasm, for men and women (frequent side effect); in a very few cases, people report decreased desire or erectile disorder
protriptyline (Vivectil)	in a very few cases, people report decreased desire, erectile disorder, painful ejaculation
sertraline (Zoloft)	delayed orgasm, no orgasm (very frequent side effect)
tranylcypromine (Parlette)	erectile disorders (infrequent side effect); in a very few cases, people report decreased desire
trazodone (Desyra)	in a very few cases, people report increased desire (in women and men); retrograde or delayed ejaculation; priapism (frequent side effect)
trimipramine (Sumontil)	in a very few cases, men report delayed ejaculation
venlafaxine (Effexor)	abnormal ejaculation/orgasm (frequent side effect), erectile disorder (infrequent side effect)



Glossary

priapism: prolonged erection (i.e. hours)

erectile disorder: distress caused by not being able to have or keep an erection until a sex act is completed (sometimes caused by diabetes, vascular disease or substance use — including

alcohol and prescription medications, or psychological/social factors)

inhibited ejaculation: distress due to a delay in orgasm, or in “coming” (slang), after a normal time of sexual excitement and/or activity

retrograde ejaculation: muscles that usually help to direct seminal fluid (semen, or “come”) forward, out of end of a man’s penis, do not work properly. Instead the fluid travels backward, toward the bladder. Sometimes called “dry orgasm.”

◀ **Table 2:**
Other
Psychiatric
Medications
Associated
with Sexual
Disorders

Medication	Sexual Side Effect(s)
alprazolam (Xanax)	decreased desire (infrequent side effect), delayed or no ejaculation (infrequent side effect), inhibition of orgasm (frequent side effect)
barbituates	decreased desire (frequent side effect), erectile disorder (frequent side effect), inhibited ejaculation (frequent side effect)
buspirone (BuSpar)	decreased desire (infrequent side effect); in a very few cases, some men report erectile disorder, delayed ejaculation, priapism
chlordiazepoxide (Librium, Mitran, Reposans-10)	in a very few cases, some men report erectile disorder, delayed ejaculation
chlorpromazine (Thorazine)	erectile disorder (frequent side effect), priapism (infrequent side effect); in a very few cases, some people report decreased desire, retrograde or delayed ejaculation
clomipramine (Anafranil)	decreased desire (very frequent side effect); erectile disorder (very frequent side effect); delayed, retrograde, painful or no ejaculation (very frequent side effect); inhibition of orgasm (frequent side effect); in a very few cases, some people report spontaneous orgasm when they yawn
clonazepam (Klonopin)	in a very few cases, some people report decreased desire, erectile disorder, inhibition of orgasm
clozapine (Clozaril)	in a very few cases, some men report priapism
diazepam (Vallium, Zetran)	in a very few cases, some people report decreased desire, delayed ejaculation, retarded or no orgasm in women
droperidol (Inapalme)	in a very few cases, some men report erectile disorder
fluphenazine (Prolixin, Permitil)	decreased desire (very frequent side effect); erectile disorder (very frequent side effect); in a very few cases, some men report inhibition of ejaculation, priapism
halperidol (Haldol)	in a very few cases, some men report erectile disorder, ejaculatory failure, painful ejaculation
lithium (Eskalith, Lithonate)	erectile disorder (frequent side effect); in a very few cases, some people report decreased desire
lorazepam (Ativan)	in a very few cases, some people report decreased desire
meprobarnate (Equanil, Miltown)	in a very few cases, some men report erectile disorder
mesoridazine (Serentil)	in a very few cases, some men report retrograde or no ejaculation, erectile disorder, priapism
molindone (Moban)	in a very few cases, some men report priapism
oxazepam (Serax)	in a very few cases, some people report decreased desire
perphenazine (Trilafon)	decreased or no ejaculation (very frequent side effect); in a very few cases, some men report priapism
pimozide (Orap)	erectile disorder (very frequent side effect); in a very few cases, some people report decreased desire, no ejaculation
prochlorperazine (Compazine)	in a very few cases, some people report erectile disorder, changes in desire, inhibited ejaculation, decreased responsiveness in women, priapism
risperidone (Risperdal)	in a very few cases, some people report priapism
sulpiride (Supril, Sulpitil)	erectile disorder (frequent side effect)
thioridazine (Mellaril)	erectile disorder (very frequent side effect); delayed, decreased, painful, retrograde or no ejaculation (very frequent side effect); in a very few cases, some men report priapism
thiothixene (Navane)	in a very few cases, some men report erectile disorder, spontaneous ejaculation, priapism
trifluoperazine (Stelazine)	in a very few cases, some men report decreased, painful or no ejaculation, spontaneous ejaculation, priapism

The information here is drawn from several sources: “Medications That May Contribute to Sexual Disorders: A Guide to the Assessment and Treatment in Family Practice” by William W. Finger, PhD, et al., in *The Journal of Family Practice*, Vol. 44, No. 1 (Jan), 1997 and “Anti-Psychotic Medications and Sexual Difficulties, by Donna Ames, MD, in *The Journal, California Alliance for the Mentally Ill*, Vol. 5, No. 2.



Over 1 million Canadians likely to have significant sex and sleep problems because of their antidepressant

The First Canadian National Survey on Sexual Dysfunction and Sleep Disturbances released two years ago revealed that one-in-every-two Canadians (50%) experience specific sex-related problems on a regular basis. And two-in-every-five (42%) have trouble sleeping at least once a week.

...sus 15%) to take sleep medications in addition to their antidepressants.

“The survey confirms what physicians have been suspecting for some time now, that sex and sleep problems can be caused by antidepressant medication, as well as [by] depression itself,” says Dr. Irvin Wolkoff, consultant psychiatrist at Bayview Community Services in Toronto.

“These side effects are very often seen with the newer generation of antidepressants, such as Prozac. This family of antidepressants has really been a breakthrough in depression therapy. But the reality in my daily practice, is that patients are either dropping off their medication because it’s affecting their sex life and causing insomnia, or tolerating these serious side effects to stay well.”

Another disturbing statistic is that the overwhelming majority (over 90%) of patients on antidepressants did not realize their medication was contributing to their sex and sleep problems.

“Many patients don’t associate medication intended to heal them, with such side-effects.

And many of those that do make the connection, are too uncomfortable to discuss it with their doctor,” says Dr. Assalian.

“There are over 20 antidepressants on the market, and each has different side-effect risks. Clearly, physicians and patients must consider this at the very beginning, when choosing an agent, to ensure therapy success in the long run.”

One antidepressant called Serzone (nefazodone) is an alternative for depressed patients who want to avoid these drug-induced problems. Scientific studies comparing Serzone to Prozac and other SSRIs, show Serzone is as effective as these SSRI antidepressants, while having the least side-effects.

Serzone *can* cause blurred vision, lightheadedness, constipation, dry mouth and nausea. But researchers say almost all of these problems disappear within the first weeks of treatment.

The nation-wide survey on 1,300 Canadians was conducted by COMPAS Inc., in collaboration with the Canadian Sex Research Forum, the

Canadian Mental Health Association and funding from Bristol-Myers Squibb.

Other survey highlights: 58% of Canadians say that they are at least somewhat active sexually, compared to 36% of people taking antidepressants.

Canadians taking antidepressants are three times more likely than the general public (35% versus 12%) to report that they “always” experience at least one of the sex-related problems examined (i.e., lack of desire/interest and difficulty with orgasm among men and women, difficulty with lubrication, difficulty maintaining and obtaining an erection, painful erection and ejaculation, taking longer to ejaculate among men). A full 78% of people taking antidepressants say that they experience at least one of these problems sometimes compared with 50% of the general public.

Women taking antidepressants are more likely than their male counterparts to say that they experience a lack of interest/desire for sex (77% vs. 66%) and problems with orgasm (64% vs. 42%) with some frequency. Serzone patients reported a stronger net improvement in their sex drive/interest due to their antidepressant than did people taking all but one of the other antidepressants. ■

Adapted from the 1997 COMPAS study, released by the Canadian Mental Health Association, the Canadian Sex Research Forum and Bristol-Myers Squibb

Dr. Pierre Assalian, Executive Director of the Canadian Sex Research Forum and the Director, Human Sexuality Unit at Montreal General Hospital says, “some of the most disturbing findings relate to the sex and sleep problems experienced by a key audience targeted in the study: Canadians taking antidepressants.”

The study found that these Canadians are three times more likely than the general public to say that they “always” experience sex problems.

Canadians taking antidepressants are also four times more likely than the general public to experience sleep problems every night (30% versus 8%).

It also found that people taking antidepressants are also four times more likely than the general public (60% ver-

Abuse May Make Relationships and Healthy Sexuality Difficult

Significant numbers of men and women who have experienced trauma early in their lives show up in mental health treatment services. Their relationships are challenged both by their experiences with mental illness, as well as a history of abuse and/or trauma. For caregivers,

this means adequate attention is required to address people’s mental health concerns as well as their histories of abuse which can affect all aspects of their lives.

A recently-released study from the BC Centre of Excellence



in Women's Health confirms that violence, trauma and mental health concerns represent one of the priority issues for women, their caregivers and service providers. The report says that the number of people with serious mental illness with abuse histories are significant, particularly for those who ended up in hospital because of their illness. The report cites a 1998 study by Dr. Patricia Fisher at Riverview Hospital in Coquitlam, which showed that 58 per cent of women and 23% of men had been sexually abused before the age of seventeen. Other studies in the US have found that up to 83 per cent of women and men with mental illness have had experiences of severe physical or sexual abuse as children or adults.

Some mental illnesses appear to occur as a result of abuse. These include dissociative disorder (formerly multiple personality) and borderline personality disorder. (It is interesting to note that researchers Marina Morrow and Monika Chappell from the BC Centre of Excellence in Mental Health chose the term "response" rather than "disorder" for their report. They said this language choice puts emphasis on the context of women's lives and sees mental illness as a natural response to a woman's life experience, particularly in the case of trauma. In addition, this term recognizes that mental illness is more than a biological/medical concern, acknowledging that it is, a biological, psychological and social response or adaptation to life experience.) In addition, drug and alcohol abuse, depression, bipolar disorder (formally manic depression) and post-traumatic stress disorder are also considered common outcomes of severe abuse.

What this means for mental health providers, family members and therapists is the question of "What do I treat: the mental illness or the history of abuse?" Researchers Morrow and Chappell from the BC Centre of Excellence in Women's Health concluded from their interviews that most psychiatrists are hesitant to deal with histories of abuse. Instead, women said their treatment focused on the diagnostic label of mental illness and its treatment and not necessarily on the childhood trauma which preceded their illness.

Researchers suggest that mental illness may be the collection of symptoms which are a response to their childhood abuse in the first place. Dr. Patricia Fisher adds that best practices in mental health are changing. There is now more knowledge shared between experts in trauma and childhood sexual abuse (from transition home workers to emergency mental health practitioners) and psychiatrists and others who work with mental illness. Fisher says that as a result, many women are now helped more effectively at various entry points in the mental health system.

Still, with treatment focused on mental health issues, relationship and intimacy problems (even those which arise as a result of abuse) get forgotten. Yet, relationship issues are central to mental health. Aspects of building healthy relationships, including trust, intimacy, healthy self-esteem and body image, feeling comfortable in one's own body and an ability to enjoy sex are some of the elements of relationship which can contribute to recovery from mental illness. How-

ever, women who have experienced abuse are at risk for unhealthy life patterns which affect relationships.

Building trust is an issue which keeps many people who've been abused from entering into fully committed relationships. Building trust becomes impossible if someone has had their trust broken by an abusive father, brother or other seemingly trustworthy family member or friend. Not trusting in someone close may become a learned response to trauma and this effectively limits relationship-building.

People whose personal boundaries have been violated, from unwanted touching or sexual violations for example, sometimes lose their sense of protecting or valuing their boundaries. For example, women the author has known had been in a series of casual sexual relationships which became intimate before the women would have preferred. These women report that their ability to say "stop" essentially does not exist. They have been repeatedly violated in the past, and were not ever able to control or stop their abuser, thus learning that saying "stop" has shown no effect.

Researchers Morrow and Chappell also found that women who are not able to articulate personal boundaries may be vulnerable to ongoing incidents of abuse, particularly at times when their mental health problems leave them disoriented or vulnerable.¹

Women report decreased sense of self-esteem and body image as a result of trauma. Some who dissociate their personality say they sometimes cannot feel themselves having sex, since they have become skilled in "leaving their body" during repeated sexual abuse. It is a challenge for therapists working with abuse survivors to help people live, or "stay" in their bodies and enjoy sexual pleasure as a positive experience.

Alcohol and/or drug abuse is another response which keeps people's senses deadened to memories of childhood trauma, as well as to current relationship-building.

Dr. Fisher says she salutes the people who have the courage to move into relationships. "The risks these women take are significant", says Dr. Fisher. The effects of childhood abuse are felt at many stages within a relationship: developing intimacy, having and loving children, learning healthy ways to keep sexually active are some examples. Fisher acknowledges that women entering into healthy relationships are always on a healing journey, facing deep and powerful issues that take commitment and courage throughout a relationship. ■

*Dena Ellery,
with Dr.
Patricia Fisher*

Dena Ellery is the editor of *Visions*, and has been a personal support worker for individuals with dissociative identity disorder and schizophrenia.

Dr. Patricia Fisher is a psychiatrist with Mountain Counselling Group and has researched, written on, and worked with women living with a mental illness who have a history of childhood sexual abuse and/or trauma. Dr. Fisher consulted on this article.

¹ "Revisioning Women's Mental Health Care," BC Centre of Excellence for Women's Health, July 1999, page 28



Talking about Sex

Sally Breen

As a sexuality counsellor who has worked both in private practice and in hospital-based sexuality clinics there are times when I imagine that I have heard every sexual concern that there is. Not true. Every person has their own unique story, life experience, and question about sex and this makes it challenging to write in a brief way about sex and mental illness.

Sally Breen is a nurse, sexuality educator, and counsellor in private practice with Dr. Bianca Rucker and Associates in Vancouver, BC.

Staying focused on sexual problems associated with various psychiatric illnesses is only part of the story. More importantly, in the process of moving from a human being to a human becoming, the focus should be on sexual health and open communication between professionals and consumers to prevent sexual problems, treat the problems that do exist, and to promote the sexuality and sexual expression of people with mental illness. Why? Well, the Canadian Guidelines for Sexual Health Education (amongst others) say that sexual health is a major, positive aspect of personal health. Everyone is entitled to sexuality education to help them achieve positive outcomes (self-esteem, non-exploitive sexual satisfaction) and to avoid negative outcomes (unwanted pregnancy, sexually transmitted diseases, sexual coercion and sexual dysfunction). The desire for love, intimacy and yes, pleasure is a universal one. Having a satisfying sexual relationship is a very effective stress release!

It is true that there are a number of sexual and relationship problems associated with mental illness. Some of them are related directly to the diagnosis, that is, the disease itself can cause sexual changes. For example, depression frequently dramatically decreases sexual interest and can cause changes to erections. Other problems arise from the treatment; for example, many psychiatric medications have sexual side effects (see other articles in *Visions*).

Common sexual concerns include lack of or heightened sexual desire, difficulty with erection or reaching orgasm, not feeling like a sexually attractive person, fearing intimacy, having difficulty in coping with anxiety-producing situations, being vulnerable to unwanted sexual advances because

of low self-worth, finding a relationship, and maintaining a relationship. There are effective treatments and therapies for sexual problems and the challenge is to find ways for professionals and consumers to talk about them (See sidebars below). Every person has the right to have their questions answered and to have their sexual concerns addressed. If past experiences with sex have been negative or harmful, it is vital to get professional help.

Like many things in our lives, talking about sex in an open, yet appropriate way gets easier the more we practice it. If we can't talk about it, we hint, using body language or behaviour and that just makes everyone uncomfortable. Pulling the shutters down on the topic of sexuality and mental illness only makes it harder to see our way to a better way of dealing with the problems. Talking about it sheds light and it is only in the light that understanding can flourish. ■

What your doctor or mental health professional could ask

- Many people with this (illness or treatment) have questions about changes to sexuality or relationships. Have you noticed any changes?
- Are you worried about these changes?
- Would you like to talk to someone about this?

What you could ask your doctor or mental health professional

- I have noticed (name it) and I am worried about it. Is there anything I can do or someone I can talk to who can help with this?
- Does this illness have any sexual or relationship implications?
- Does this treatment or medication have any sexual side effects?
- Where can I get help for my partner to help them in dealing with this illness?

Marie-Claude Lacombe

Ways to Build a Positive Sexual Self-image

No need for a partner: Tips you can follow on your own:

1. Develop a "healthy selfishness." Treat yourself just as well as you treat others by indulging in a bubble bath or buying yourself a new outfit.
2. Strip for yourself in front of a mirror. No need for a partner; find your sexy self while only one pair of eyes is watching.
3. Go to a clothing-optional venue. Notice that everybody there has a different body type, and that you're no different.

4. Exercise, Exercise, Exercise! (but without skipping meals.) Research shows that it may be one of the best ways to get "in the mood."
5. Don't read beauty magazines. They never write about the parts of the models they airbrushed away.
6. Dance. Even if it's just in your living room. Become aware of how your body moves.
7. Pay attention to Special K ads. They may be trying to sell you cereal but they're also selling you the idea of different body types. (One ad features the phrase "Picture a 200 lb. firefighter" followed by the picture of a healthy woman firefighter.)
8. Do away with "fat postures" and "fat clothes." Fat postures are the poses you take to appear smaller, for



Don't Forget the Children

Many adults in today's world did not grow up with parents who talked openly and honestly about sexual health. Schools also often failed to teach students about sexuality with any kind of comfort. Role models are not common and parents truly struggle to talk to their children in the '90's.

When a parent also struggles with mental illness, sexual health education can be a very low priority. I would like to encourage everyone to remember that it not only saves lives but enhances lives.

Educated children are confident and resilient in their daily interactions but also resistant to sexual exploitation and abuse. Sometimes, adult survivors and others will say "I want to keep my child innocent, I want them to have a childhood. They don't need to know this at a young age."

These are dangerous statements. There is no one less innocent than an abused child. Abuse destroys childhood and they can avoid abuse or limit the abuse if

they are educated. Here are some simple ideas to start.

Begin the day they are born, using the scientific names for all body parts: elbow, nose, chin, knee, penis, scrotum, testicles, vulva, vagina, uterus and urethra. Abusers look for children who have no language about sexual health or who only have baby words or slang.

Be an advocate for your child. Listen to their hunches and disclosures about other people; who do they feel safe around and who do they mistrust? Talk to them often about who in your family they can turn to: grandma, auntie Jane, Mrs. Jones next door, or to call 911 if they need to. Remember that it's OK if you cannot always be there, physically, emotionally or mentally for your child, as long as someone else who is trustworthy is there. The best, most devoted parent in the world cannot be there 24 hours a day, forever! Your child's life may depend on 911.

Remember your sense of humour. It is fun to laugh with your child about sexuality, bathroom humour and

yes, even farting! But grab every teachable moment to add to their store of solid, accurate information about sexual health.

Books can be tremendously helpful especially for parents who find it difficult to talk about sexual health. There are great books for children these days. There are a collection of publications in the 'Resources' section of this issue of *Visions*. These are available from bookstores and from libraries. Children with disabilities need extra help as do children who have been abused.

Parents may also recognize that their own knowledge base needs work and updated information. There are wonderful books for you too — even some with humour!

Parents with a mental illness tell me that they feel exceptionally vulnerable and at risk of being labelled "unfit parent." They worry that if they ask for help, the professional will "turn them in to the authorities." Some parents have also expressed a fear that if their children demonstrate too much knowledge in the communi-

ty, the teacher or neighbour will report them for poor parenting. I can understand those fears; any parent's worst nightmare is losing their children.

The cardinal rule is that children need and have a right to be safe. Safety is education. All parents need help from time to time. When you are feeling well and competent yourself is the time to reach out, ask for help, establish a relationship with the teacher, or parent of your child's friend. Then, when you have a bad patch and cannot be as available to your child, that person can be there and will not be judgmental.

But above all, your child needs to be safe and sometimes, for any child in any family, that means calling for help. One anonymous help line you might want to post on your fridge is :

**NATIONAL CHILDREN'S HELP PHONE:
1-800-668-6868**

Please! Don't forget the children. ■

Meg Hickling

For the past 25 years, Vancouverite Meg Hickling has been talking to children, parents, teachers, and other professionals throughout the province about sex. The health educator and registered nurse is known for her sensitive and humour-filled approach to sex education, and has received numerous awards and much recognition for her work, including the Order of British Columbia. See the review of her book in this issue of *Visions*.

example, crossing your arms around your body, or hiding behind another person. Fat clothes are what you wear on days when you don't feel at your best like those loose, dark clothes. If you're feeling 'blah'— Do the opposite! Stand straight, show yourself, and wear bright, well-fitting clothes.

9. Think healthy, not thin. Thin may not be healthy for your body type. Thin may not even be attractive.
10. Don't assume that if you're not thin, you're fat. Remember, Marilyn Monroe was no size 5 and no one doubts she was sexy.
11. Go to a plus size store and discuss with the clerk what would be the most flattering clothes for you to wear. (e.g.: vertical lines, long skirts)

12. Project yourself as being confident, and confidence will come to you. Go up to the person you never dared to talk to, and engage in conversation.

It takes two to tango — Tips for you and your partner:

1. Get your partner to draw a picture of you. Draw one of yourself as well. Compare and discuss. Your partner may see things you never saw in you before. Reverse roles.
2. If bright lights during close encounters of the intimate kind are uncomfortable, regain your confidence by making love by candlelight.
3. Masturbate and get your partner to watch or even help you. Don't forget to engage in foreplay with yourself. Get your partner to do the same. ■

Note:
Tips 1, 8 and 9 are from *Women's Conflicts About Eating and Sexuality: The Relationship Between Food and Sex* by Rosalyn M. Meadow and Lillie Weiss, 1992.



Prozac Nation

by Elizabeth Wurtzel

Review by
Christopher
J. Finlay



Houghton Mifflin,
1994; 317 pp.;
\$12.95

Chris Findlay is a student at Simon Fraser University. He is studying political science.

At the age of sixteen and deep within the chemically-imposed confines of a dark depression, I found this woman's memoir. The acidic humour of the young depression survivor spoke to me because she did something original; she refused to tell me that everything would be all right. Instead, she opted for a cutting and cruel description of the depths of her own depression. In outlining the gory details of her screwed-up youth, she offered me something unique: camaraderie in my hurt.

Elizabeth Wurtzel, a brilliant Jewish Harvard grad who managed to wrangle a deal with *Rolling Stone* for sum-

mer internships, was a depressed young woman. Her bouts with depression first manifested themselves as she entered puberty, in solo wrist-cutting experiments, complete with Patti Smith in the background for mood music. Thus starts the amazing adventures of a girl who is so full of promise that she can't seem to get out of her bed for most of the memoir. To Elizabeth Wurtzel, and myriad other individuals living with depression, every detail of life, every interaction, every waking moment is an assault on her ability to cope with her existence.

The feelings of alienation are brilliantly evoked in her many

descriptions of attempts at a sexual life. From her illicit street alley affair with a rock-group member in Dallas to chasing people around Harvard Yard with knives because her sexual libido and depression have uncorked her, Wurtzel spares no details. Candid and comic, as seen in the chapter entitled "The Accidental Blow Job," the memoir is able to evoke the ambiguous role that sex and sexuality play during an episode of depression. Is sex a desperate attempt at finding comfort? Is it an attempt at finding poetry and meaning among the ruins of a life consumed by depression? Is sex physical, disgusting and shameful? Sex is confusing

enough when it isn't mixed up among the millions of confused and dangerous emotions that haunt a depressed person's life.

Wurtzel is a survivor of a personal war, complete with old battle wounds and war stories. Her ultimate war story is *Prozac Nation*. Brilliant in its simple language and haunted personal revelations, *Prozac Nation* offers no remedies or apologies. To me, and other people living with depression I suspect, it offers camaraderie. To the world at large, *Prozac Nation* stands as a valuable tool in helping to deconstruct and comprehend the complexities of depression. ■

Speaking of Sex: Are you ready to answer the questions your kids will ask?

by Meg Hickling, RN

Review by
Marie-
Claude
Lacombe



Northstone,
1996; 192 pp.;
\$17.95

Marie-Claude Lacombe is an undergraduate communications

As a child, I felt I could speak to my mom about anything and everything. She was very open and wanted my brother and me to be informed about our bodies and about sex. Unfortunately, not all parents are like my mother. Meg Hickling, author of *Speaking of Sex*, realizes just how hard it can be for some parents to discuss sexual issues with children.

Meg is a "leading sex educator" who has helped many parents ease into the sex talk by holding workshops for parents, and visiting students. Now, an additional resource if you can't catch her in person is this book in which she promotes an open ongoing discussion between parents and kids without allusions to birds, bees or storks. She asks children to "think like scientists" and for example, think about why testicles are on the outside of a man's body. She touches on every subject you

may want to discuss with your child, from body anatomy to teen pregnancy, homosexuality, and honesty.

Meg does not give set-in-stone answers to many of the questions, and she acknowledges that many are judgment calls that have to be made by parents. She does, however, give broad guidelines to follow concerning just how much knowledge children of certain age groups should have about their sexuality. She sees knowledge as power; children who have an open ongoing discussion with their parents are more likely to recognize sexually inappropriate or abusive situations. They are also less likely to hide from their parents that they were victims of an abusive act. She also writes that children who know all the information will make better-informed decisions about their own sexual activities.

The last chapter addresses the compatibility of religion with sex education. Meg, an active Christian, believes that you can have both and be happy.

As emotional maturity must be reached to achieve sexual maturity, Meg included a section on emotional development in which she introduces the "sads, glads and mads." Although she does mention clinical depression, the two sentences where she differentiates between normal "sads" and clinical depression should be extended to at least a paragraph or even a page-long explanation.

Hickling also overlooked teen suicide. It is mentioned in passing in the sexual orientation section. However, nowhere in the book does it give guidelines for parents on how to deal with suicide and prevent it. The McCreary Centre in Burnaby published a study in June '99 that confirms it is

a crucial issue: gay and lesbian youth are three times more likely to attempt suicide than heterosexual teens. Of the youth interviewed, 46 percent had attempted suicide before. This just proves how much of a link there can be between sexual issues and suicide, but Meg does not seem to quite make the connection.

The most appealing part of *Speaking of Sex* is that it draws you in. You can jump around from one section to the other as much as you want. The real-life anecdotes that Meg has gathered from over 20 years in the field are at times refreshing, humorous or even shocking. Written in the language that you would use to speak to your own child, the book makes it easy to transfer what you've read into your own discussions. This book is definitely the starting point for a parent who is uneasy about the potential questions that a child may ask. ■

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student coordinating National Depression Screening Day 1999 for CMHA-BC Division.



Sexual Medicine in Primary Care

by William Maurice

Sex is not usually the first thing people think about making an appointment with their doctor to discuss. But with the release of Viagra recently in Canada, Dr. Bill Maurice's new book is especially timely. The book recognizes that most people don't feel comfortable addressing sexual issues with their doctor. Yet doctors and other primary care providers are in a position to be able to screen, diagnose or refer people, and provide treatment for many sexual health problems. As a result, Dr. Maurice places the onus on doctors or primary care providers to become more comfortable and skilled at asking the questions which need to be asked if caregivers are going to be able to uncover and adequately address people's sexual health concerns. And while this is a text book for primary care givers, it will also help anyone going to a doctor to know exactly what to expect.

Dr. William (Bill) Maurice is a native of Vancouver. In his book he draws significantly on his practice as a psychiatrist specializing in sexual medicine, as well as his work teaching sexual medicine at the University of British Columbia. Case studies are used liberally throughout the book to illustrate the points he makes. They give the book its balance between theory and practice and keep the reader focused on how people experience sexual problems — from interfering with relationships to understanding sexual orientation and dealing with obsessive sexual habits.

The book is divided into two parts: "Sexual History-Taking, Interviewing and Assessment," and "Sexual Dysfunctions in Primary Care: Diagnosis, Treatment and Referral." The first half of the book is dedicated to learning questioning skills and techniques. In the second half, which focuses on detailed descriptions of specific sexual problems and how to identify and treat them, primary caregivers are reminded here, of the questions they are to ask to uncover sexual problems.

One of the key strengths of this book is that Maurice spends much time on the value and importance of sensitive and thorough questioning and patient/caregiver relationship-building. He suggests primary caregivers must:

- develop rapport
- ask questions in a manner which both the interviewer and patient are comfortable
- ask the right questions in order to get at the more explicit

sexual functioning information, which is needed if a patient is having problems

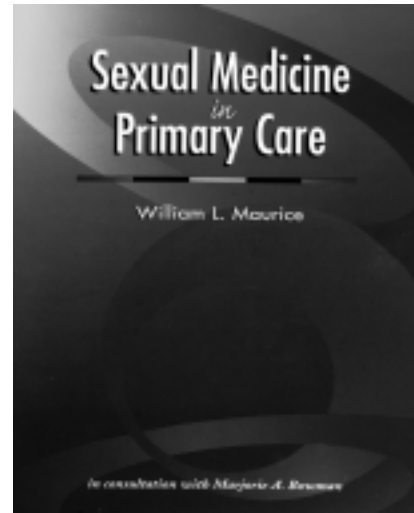
Maurice tells caregivers that most patients want to be reassured that they are "normal," and encourages doctors to provide a context for patients so they understand that they are not alone. For example, he suggests caregivers preface their questions with "Most people do/think/feel (about a particular sexual practice or situation) . . . How is this for you?" Maurice also instructs caregivers how to develop a non-judgmental attitude, by suspending their own values and attitudes. He is also careful to include patients feelings about sexual issues, past experiences and current problems in the questioning process, seeing these as valuable information in the questioning process.

In addition, Maurice suggests health professionals can play a valuable role in providing education about healthy sexuality/sexual functioning. But he emphasizes that it must be communicated in a language which people can understand. Sometimes, with the permission of a patient, Maurice says that more slang terms (i.e., "come" instead of "ejaculation") might be used in describing sexual issues/problems.

While the book is essentially a textbook for health professionals who are in a primary care positions, its greatest value is in the thorough inclusion of psychiatric issues and disorders — even for psychiatrists and other mental health workers (Maurice says that "Some health professionals (particularly nonpsychiatric physicians) and many people in the community believe that psychiatrists and others who work in the mental health field are especially knowledgeable about sexual issues . . . In truth, in talking to patients about sexual problems, psychiatrists, for example, seem no more and no less knowledgeable and skilled than other physicians.")

With his background in psychiatry, Maurice is careful to ensure that mental illness and how its treatment affects sexuality, as well as psychiatric disorders of a sexual nature are extensively addressed. Maurice even brings case studies from the mental health field into the text to illustrate his points. As a psychiatrist, Maurice has been able to bring to all primary caregivers a perspective which will ensure that doctors include mental health issues in their considerations of patients' sexual histories. ■

For more information, visit the following web site:
<http://www.interchange.ubc.ca/maurice/>



Review by
Dena Ellery

◀◀
**Sexual Medicine
 in Primary Care**
 Dr. William (Bill)
 L. Maurice;
 Mosby, 1999;
 366 pp.

Dena Ellery is
 the editor of
Visions.

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**Books for preschoolers and primary children**

Come Sit By Me by Dr. Margaret Merrifield. Stoddart Kids (1998) and **Morning Light**. Stoddart (1996). Two exceptional books about AIDS for preschoolers.

A Very Touching Book...for Little People and for Big People by Jan Hindman. Alexandria Associates (1983). An amusing and non-threatening book, teaching privacy.

Books for youngsters approaching puberty

Changes in You and Me: A Book About Puberty by Paulette Bourgeois, Martin Wolfish, and Kim Martyn. Somerville House (1994). A pair of Canadian books on puberty, one for boys, one for girls. Clever transparent pages to catch the attention. Excellent for younger kids.

Books for parents and older teens

Take Charge Of your Body: Women's Health Advisor by Carolyn DeMarco. Well Woman Press (1995). Super for girls and women.

Private Parts: An Owner's Guide by Yosh Taguchi. McClelland & Stewart (1988). For boys and men now in paperback.

Speaking of Sex: Are You Ready to Answer the Questions Your Kids Will Ask? by Meg Hickling. Northstone (1997). A lighthearted and easy-to-read guide for parents.

Sexual Abuse Information Series 1 from Health Canada — Includes 10 booklets for abused children, teens, adults, and their parents and partners. Contact Health Canada's National Clearinghouse on Family Violence, Family Violence Prevention Division at 1/800/267-1291.

Videos

SEX: Spelled out for parents — with Meg Hickling, RN. Four half-hour programs for parents that want to talk with their children about sex. Contact Magic Lantern Communications Ltd. toll free at 1/800/263-1818.

Books for Adults in Heterosexual Relationships

A Woman's Guide to Overcoming Sexual Fear and Pain by Aurelie Goodwin and Marc Agronin. New Harbinger (1997).

The New Male Sexuality by Bernie Zilbergeld. Bantam (1992)

For Each Other: Sharing Sexual Intimacy by Lonnie Barbach. Penguin (1984).

The "Go Ask Alice" Book of Answers: A Guide to Good Physical, Sexual and Emotional Health by Columbia University's Health Education Program. Henry Holt (1998).

For Each Other: Sharing Sexual Intimacy. Lonnie Barbach, Penguin Books (1984).

Love and Friendship. Allan Bloom, Simon and Shuster (1993).

The New Joy of Sex. Alex Comfort, Crown (1991).

Our Sexuality. Robert Crooks and Karla Baur, Benjamin-Cummings (1990).

Sex in the Golden Years. Deborah Edelman, Donald I. Fine (1992).

Sex is Perfectly Natural but Not Naturally Perfect. Sue Johanson, Viking Press (1991).

Gay and Lesbian Relationships

Positively Gay: New Approaches to Gay and Lesbian Life. Betty Berzon, Celestial Arts Publications (1992).

Gay Relationships for Men and Women. Tina B. Tessina, G.P. Putnam's Sons (1989).

Web Sites

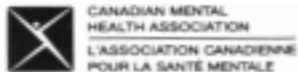
<http://www.plannedparenthood.org/sti-safesex/index.html> "A Woman's Guide to Sexuality" and "Sex: Safer and Satisfying" are especially great general resources.

<http://www.plannedparenthood.org/parents/index.html> Check out the Parenting & Pregnancy index.

<http://intimacyinstitute.com> Sinclair Intimacy Institute.

<http://sexuality.about.com> From the famous web site offering advice on various facets of human living.

<http://www.siecus.org/pubs/fact/fact0000.html> Sexual Information and Education Council of the United States fact sheets.



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BC Division
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