Setting the Mood: How Men Navigate Disclosure of Mood Disorders in Intimate Relationships

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Abstract

This is a qualitative study using the phenomenological method. This study draws on diverse fields including psychology, sociology, political science and disability studies. The study seeks to locate itself within and contribute to the field of Peace and Conflict studies by establishing intimate relationships as a space in which peacebuilding can occur. The socialization of men to conceal their feelings and emotions has had consequences for men's health and contributed to a gendered imbalance of emotional labour in intimate relationships. Five men who live with mood disorders were interviewed about their thoughts, feelings and experiences with respect to disclosing their mood disorders to intimate partners. This study demonstrates that when men display vulnerability by disclosing their mood disorders to intimate partners, they are helping to develop healthier forms of masculinity and stronger intimate relationships, and ultimately contributing to greater goals of gender equality, which is essential for the realization of positive peace.

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TABLE OF CONTENTS

INTRODUCTION

Engaging in intimate relationships is a complex part of the human experience. Sharing oneself with another person is a rewarding experience, but it does not come without risk. Certain aspects of one's identity are ultimately easier to share than others, and a person's propensity for sharing and help seeking is influenced by their gender (Danielsson and Johansson 2005, 165) as well as the information itself (Omarzu 2000, 175; Cameron, Holmes, and Vorauer 2009). Men living with mood disorders are faced with the decision of whether to disclose this potentially stigmatized aspect of their identity to intimate partners. This challenge is in addition to the other aspects of mood disorder management that men who live with them must deal with.

This study is inspired by my own personal experiences; as a woman with a mood disorder I have had to disclose this aspect of my identity to intimate partners. I contemplated my own feelings about being a woman with a mood disorder: I have often feared that once disclosed, my mood disorder would be used against me in intimate relationships based on my own perceptions of women being portrayed as overly emotional creatures. I have feared that disclosing my mood disorder to an intimate partner will result in the other person dismissing my thoughts and feelings as me "over reacting" or being "crazy".

Though I do not consider myself to be particularly outspoken with respect to my own experiences with mood disorders, I have felt stigmatized as a result of my mood disorder. Hearing people talk about mental illness and mood disorders using stereotypes and other negative connotations has been a part of my life for as long as I remember. The stigma I perceive has contributed to my reluctance to disclose and seek help for my mood disorder at both the onset of my disorder as well as in times of crisis. I consider my mood disorder to be an aspect of

my identity, one that at times influences my other identity roles as daughter, sister, friend, employee, romantic partner and student. I continue to struggle with the idea that being open about mental health issues and mood disorders is crucial for the reduction of stigma, as I believe that a person has to be their own advocate first and act in their own best interest with respect to disclosure. I believe that people ought to only disclose in situations where they feel safe to do so.

I considered my perception of men in relationships, how they are often expected to be strong and less emotional or rather that they are permitted to only display certain emotions, for example pride and anger. I reflected on the challenges men may face that were different than my own, how men may have less experience and comfort with sharing their feelings or showing vulnerability and weakness. I considered the gender labour imbalance that exists in the private sphere, in familial and intimate relationships where women are responsible for more of the emotional labour, and how this contributes to gender inequality more broadly.

This is an interdisciplinary study which draws on diverse fields, including sociology, psychology, political science and disability studies. In particular, this project seeks to locate this analysis within the field of peace and conflict studies in order to keep issues of social justice, human rights, and positive peace central to the study. The ability to be who you are, and reach your full potential, without being marginalized, isolated, punished, or murdered based on your identity is a fundamental aspect of positive peace (Galtung 1969). Johan Galtung developed a typology of violence which helps us understand the difference between personal or direct violence and structural violence, or social injustice. Positive peace is the absence of all violence, including personal and structural violence (Galtung 1969). To obtain positive peace, wherein we would have an "egalitarian distribution of power and resources" structural violence must be eliminated (Galtung 1969, 183). People are oppressed by violence, both physical and structural,

and violence can involve the use of objects and be physical or psychological (Galtung 1969, 173). Negative peace would be the result of eradication of personal or direct violence but structural violence and social injustice would still be present (Galtung 1969, 183). In a society where structures dictate how people are treated based on their membership to a particular group, for example their gender or their health, the structures create inequality between people and therefore the people effected experience structural violence as a result of their identity or identities.

Structural violence can be addressed at the interpersonal level. In order to experience significant change with respect to gender equity and social justice, "Social and political institutions would have to be changed radically, but, more significantly, so too would human relations, both social and personal" (Reardon 1996, 84). This establishes interpersonal behaviours and exchanges as spaces in which meaningful change can occur and eventually inform the broader structures that have traditionally governed private aspects of life, including intimate relationships. Rather the existing, violence perpetuating structures informing how we conduct ourselves in our intimate relationships with one another, we as human beings have the capacity to change the structure by changing our behaviours.

Inclusion means being able to bring all of who you are, and not deny aspects of yourself, into an encounter or community. On a larger scale, inclusion is paramount to the realization of a culture of social justice (Sapon-Shevin 2003), and social justice is a key feature of positive peace. Inclusion is also important to intimacy because it requires being able to reveal and accept different ideas in a relationship without being rejected or rejecting the other. In an intimate relationship, the parties involved practice inclusion by allowing each other to be their authentic selves and engage in open and clear communication with one another (Lerner 1989, 8).

In the first section of the thesis I provide descriptions of mood disorders and the symptoms associated with them. I also discuss the prevalence of mood disorders and gendered differences in the ways people experience and express their mood disorders. We often look at stigma in terms of how it operates at the social level. This study is concerned with the operation of stigma within developing personal relationships, whether the relationship is one in which people share life's journey for a span of years, have a family, or with whom to share most of one's life and resources. This study will recognize various types of intimate relationships, not only heteronormative monogamous relationships, but also non-monogamous relationships, marriages, common-law partnerships, casual sex, dating, as well as others.

Some sources of stigma are readily apparent, such as a visible disability or physical attribute. Some sources of stigma are less visible, can potentially be hidden, and require disclosure. Examples of invisible sources of stigma that could require disclosure include the diagnosis of a sexually transmitted infection, or the experience of sexual assault. This study looks at the disclosure of living with a mood disorder in the context of an intimate relationship. Mood disorders are conditions which do not always have physical signifiers and thus while there is stigma attached to them, they are not necessarily visible to others.

While this analysis is at the interpersonal level, there is the recognition that understandings of potentially stigmatized identities are the result of how knowledge is socially constructed (Goffman 1963, 65). This study seeks to reverse that process by learning from research participants (here called "consultants" as per Grace Kyoon-Achan (2013)). Of course, socially constructed identities are intersectional (Crenshaw 1989). People have multiple identities which overlap, and when one aspect of identity is focused on, the other identities are effectively minimized or erased. This is important because in the context of men with mood

disorders, if we tried to understand men's experience of mood disorders from a perspective of abledness, we would lose the other bases for which men might experience additional marginalization (Crenshaw 1989, 140). For example, the challenges of having a mood disorder as a man, or a man of a certain socioeconomic class, or a man of a certain race, sexual orientation or age. Not all experiences of abledness or mood disorders are equal. As such, other aspects of a person's identity must be acknowledged in order to fully understand their experiences and the ways they experience discrimination, not solely due to one aspect of their identity, but based on all aspects of their identity and how they function together. This study will provide a consideration of the social construction of mental health, gender, and how these identities impact men's decisions to disclose their mood disorders to intimate partners.

In the literature review I discuss the social construction of identity and provide a definition of identity. I discuss more specifically the social construction of gender, and how this has influenced men's propensity for risk taking, and the resulting consequences for men's quality of health. I discuss how the social construction of gender influences behaviour in intimate relationships with respect to the type of emotional labour people engage in. Gender is involved in everything we do, and when people are unable to meet the expectations associated with their gender identity, it can result in conflict on an interpersonal level as well as on a larger scale (Snyder 2009, 51). However, in these instances where people do not conform to gender roles, there is also potential for positive outcomes which contribute to the reshaping and rethinking of gender roles and ultimately a reduction of conflict (Snyder 2009, 51). The social construction of gender and the resulting expectations for men's behavior impact how men make decisions about disclosing their mood disorders to intimate partners. I provide an overview of the literature that

addresses men's experience of mood disorders. I also provide definitions of intimacy and disclosure and describe the relationship between these concepts.

This study was conducted utilizing a phenomenological approach to interview five male individuals over the age of eighteen about their intimate relationships, however they may define them, and the decisions they have faced regarding disclosing a stigmatized condition, specifically having a mood disorder, within their intimate relationships. A phenomenological approach recognizes individuals who have lived experience of the phenomenon to be studied as experts, and recognizes that a true understanding of a phenomenon would be incomplete without the inclusion of said expert perspectives (Starks and Trinidad 2007, 1373). Rich detail about the phenomenon is collected through interviews with the experts, resulting in valuable insights that could not be found elsewhere. This study will take the position that for men, intimacy and disclosure are forms of emotion work (Hoschild 1979), and that to engage in the disclosure of a mood disorder is to take an emotional risk, which differs from the type of risk-taking behavior typically associated with displays of masculinity.

The information harvested from the interviews conducted with the experts in this study – men who have lived experience of having mood disorders and considered disclosure in intimate relationships – reveals that a person's gender identity does impact not only their experience of a mood disorder but their own thoughts about having a mood disorder. The findings from this study enhance and contribute to our current understandings of how gender influences men's decisions regarding their health and also how they function in intimate relationships. A review of the literature shows that men have a propensity for risk taking when it comes to making decisions about their health and well being insofar as they will often choose to act in a way that compromises their health in order to solidify or enhance their masculine identity (Courtenay

2000, 1389). When men are open and disclose their mood disorders to their intimate partners, they are, at least in part, risking part of their masculine identity by a) showing vulnerability generally by sharing personal information and b) showing vulnerability specifically by acknowledging their mood disorder. Men's propensity for risk taking behavior is therefore considerably greater when the risk in question is likely to enhance their masculine identity. It is considerably more challenging and less appealing for men to engage in a risk which has the capacity to threaten their masculinity.

This project is of significance to the field of Peace and Conflict studies as it demonstrates that intimate relationships are a place wherein peacebuilding can occur. When men disclose their mood disorders to their intimate partners their actions are helping to shape new modes of masculinity, and when men's partners accept these actions they are also helping to encourage new modes of masculinity to flourish. The acceptance of both different forms of masculinity as well as the acceptance of mood disorders at the interpersonal level will contribute to greater levels of social justice more broadly.

Mood Disorders, Stigma, and Disclosure

This chapter will provide definitions of mood disorders, explain the ways in which people are affected by them and the stigma attached to them. People living with mood disorders are affected by them at several levels, including at the personal or individual level as well as in the various relationships they have in their lives. Mood disorders are associated with stigma, and people living with them may encounter stigma related to their mood disorders in the context of the relationships in their lives. A person with a mood disorder may feel stigmatized as a result of disclosing their condition to other people, or they may encounter stigma regardless of whether or not they disclose as a result of the stigma attached to mood disorders that exists in society more broadly. Disclosure and intimacy will be defined and the significance of disclosure in the context of intimate relationships will also be discussed. Gendered differences in the experiences of mood disorders, intimacy and disclosure are also addressed.

If an individual with a mental illness has a negative experience after disclosing their illness to an intimate partner, several consequences can arise. A negative response from a partner can reinforce a person's experience of self-stigma, which is the process wherein a person internalizes and believes to be true the negative stereotypes about their condition (Corrigan and Rao 2012, 465). The existence of self-stigma and the consequences that may arise from both negative and positive responses to disclosure must be considered when examining the disclosure of mood disorders to intimate partners. The stigma attached to mood disorders has a significant impact on whether or not an individual will seek help, take prescribed medication, attend counselling, and also their ability to be reintegrated into their family and community following treatment (Public Health Agency of Canada 2006).

How People are Affected by Mood Disorders

Mood disorders, also known as affective disorders, include unipolar and bipolar depression, depressive disorders and anxiety disorders. The *Diagnostic and Statistical Manual of Mental Disorders (*2014) identifies several depressive disorders, including "disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), substance/medication-induced depressive disorder, and depressive disorder due to another medical condition" (DSMMD 2014). The common features of depressive disorders are "the presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (DSMMD 2014). Depressive disorders differ with respect to their "duration, timing and presumed etiology" (DSMMD 2014).

Anxiety disorders are characterized by "excessive fear and anxiety and related behavioral disturbances" where "fear is the emotional response to real or perceived imminent threat, and "anxiety is anticipation of future threat" (DSMMD 2014). While fear and anxiety are experienced by anyone, anxiety disorders cause people to feel fear and anxiety for prolonged periods of time as a result of specific or unique circumstances that serve as stressors, and are attached to specific thoughts and beliefs (DSMMD 2014). Examples of anxiety disorders include separation anxiety disorder, panic disorder, social anxiety disorder, generalized anxiety disorder, and phobias (DSMMD 2014).

Bipolar disorder diagnoses include bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder (DSMMD 2014). Bipolar disorders are characterized by mood

instability featuring bouts of mania or "highs" and depressive episodes that can last for varying amounts of time and at different levels of intensity depending on the specific diagnosis a person has. Manic episodes often manifest dangerous and risky behavior including drug or substance abuse, gambling, and unsafe sexual practices (DSMMD 2014).

Mood disorders are grouped together largely because they share similarities and high levels of co-morbidity, that is, they are illnesses that often occur together (International Society For Affective Disorders 2016). It is estimated that 10% of the population has a mood disorder, with depression being the most commonly experienced mood disorder (Canadian Mental Health Association 2016). People with mood disorders are affected by them on a daily basis; they interfere with the ability of people to live their lives and carry out ordinary tasks, and people must deal with emotional and psychological symptoms including depressed moods, and in the case of bipolar disorder, periods of mania interspersed between periods of depression (Canadian Mental Health Association 2016).

The causes and sources of mood disorders are vast, and many people will never identify the specific cause of the disorder with which they are diagnosed, and thus many people blame themselves for their disorder or their inability to overcome it (Canadian Mental Health Association 2016). There is evidence to support that mood disorders may arise from environmental sources, such as trauma, or that they may be hereditary, or in some cases result from a combination of environmental and biological causes (Canadian Mental Health Association 2016). People with mood disorders may be treated with therapy, such as counselling; medication, including antidepressants and mood stabilizers, or both; and are often advised to make healthy lifestyle choices, monitoring what they eat, how often they exercise, and to

practice good sleep hygiene, all of which are said to help manage mood disorders (Canadian Mental Health Association 2016).

According to the Canadian Mental Health Association, 20% of Canadians will have a mental health issue at some point in their life. Within that population, 8% will experience depression and 1% have bipolar disorder. The Association estimates that approximately half of the individuals who experience depression or anxiety do not seek treatment (Canadian Mental Health Association 2016). Many people who live with mental illness describe the stigma to which they are subjected as being more painful than the symptoms of the condition itself, and according to the Canadian Mental Health Commission, an estimated 60% of people will not seek the treatment they need because they fear the stigma that would result from being "labeled" (Mental Health Commission of Canada 2016). Despite the fear of being labeled, the number of male Canadians over age 12 diagnosed with mood disorders has increased. In 2011, 707,388 males over the age of 12 were diagnosed with mood disorders, and 2014, 885,907 were diagnosed (Statistics Canada 2016).

A study that utilized data from prescriptions, and hospital and physician visits in Manitoba found that the prevalence of mood disorders amongst Manitobans aged ten years and older has changed very little in the ten-year period between 2002 and 2012 (Fransoo et al. 2013, 121). In the same 10-year period, mental illness was among the top 5 reasons for visiting a doctor in the province of Manitoba (Fransoo et al. 2013, xxviii) and was also one of the most common reasons for a hospital stay (Fransoo et al. 2013, xxix), and the 7th most common cause of death (Fransoo et al. 2013, 44).

Mood disorders not only impact the individuals who have been diagnosed but also the families, friends, coworkers, and partners of people who live with mood disorders. The story of

Reid Bricker illustrates the wider impact of mood disorders. On August 28, 2016, over 100 people gathered at the Manitoba Legislative Assembly in Winnipeg, Manitoba to raise awareness about mental health and wellness, and with an aim to fight the stigma that surrounds mental illness which deters people from seeking and receiving the treatment they need. The rally was in honor of Reid Bricker, a 33-year old Winnipeg man who suffered from depression and attempted suicide three times before he eventually died by suicide shortly after being released from Health Sciences Centre in 2015 (CBC 2016). Before the rally, Bricker's mother Bonnie spoke of the impact her son's death on her as a parent, and also of his struggle leading up to his death "He was fighting to live and he's still fighting for other people to live through us…I don't want anybody else to go through what we went through — losing a child — no parent should have to survive a child" (Brohman, 2016). At the rally, Ms. Bricker explained the need for action from others "[People] can't be complacent, they can't hide behind their doors, they have to get involved…we can't afford to be lazy and not involved in this" (CBC 2016).

Gender-Related Differences in Experience of Mood Disorders

When it comes to the onset of depression symptoms and diagnoses of chronic depression in youth, gendered differences have been identified. A study found that females experience depressive symptoms and receive diagnoses at a younger age than males, and more females than males experience clinical depression by age 20 (Salk et al. 2016, 33). However, by age 20, both males and females experience depression of equal chronicity, or total number of days during which they experience depression (Salk et al. 2016, 34). The earlier diagnoses of depression for females does not necessarily mean that girls experiences symptoms earlier than boys but rather it may be related to the early socialization of boys to suppress certain emotions.

There is evidence to support gendered differences with respect to both the physical and emotional aspects of mood disorders. Men and women differ when describing the physical symptoms they experience because of their anxiety and depression. While women are more likely to report having stomach related issues, men more frequently describe chest pain, blood pressure, and other issues related to cardiac functioning (Danielsson and Johansson 2005, 174). Men blame others for their depression while women blame themselves, and that men "try to *act out* their emotions while women *feel* their depression" (Hart 2001, 28). Men may engage in this acting out of emotions through their work and also through destructive practices like violence and substance abuse, while women may openly cry and speak to others about their feelings (Hart 2001, 28). These differences in how individuals process their depressive symptoms are related to their gender identities and the societal expectations of how people ought to behave based on their gender, or societal gender norms.

The difference between men's and women's depression lies not in the "experience" but rather in the "expression" (Brownhill et al. 2005, 922). The gendered differences in the external expressions of mood disorders are caused in part by the internalization of socially constructed gender role expectations imposed on people by society. There are different sets of rules for men and women regarding what is acceptable behaviour when it comes to illness, including mood disorders, and the expression of symptoms as well as asking for help or sharing details about one's health. The social construction of what it means to be healthy and mentally stable encourages all people, regardless of gender, to project an identity of a healthy and stable person even when they do not feel mentally healthy or stable.

The most glaring consequence of the difference in these gendered expressions of depression is that women are diagnosed with depression more frequently than men, and when

men do experience depression, they experience the stigma attached to the mental illness itself as well as the stigma that results from men experiencing or expressing what they are taught to believe are feminine emotions, such as vulnerability or weakness (Real 1997, 22; Danielsson and Johansson 2005, 175). The over-representation of women in mood disorder diagnoses further supports the notion that mood disorders are a "women's illness," thereby forcing men who experience them to sacrifice their masculinity in order to ask for help.

The conditioning of people to either display or exhibit certain emotions based on their gender is one that begins in childhood, and is damaging for adults dealing with depression, regardless of their gender; as a result, depression in men is "both shame-filled and shameful" (Real 1997, 24). Boys are taught from an early age by nearly everyone around them that displays of more feminine emotions or behaving in a way that is weak or vulnerable will result in their humiliation and rejection, and this in turn coaches them to keep vulnerabilities hidden so as not to endure further humiliation and rejection from others (Maas 2006, 61). The consequences for failing to adhere to gender norms is often far greater for men than they are for women within the context of interpersonal relationships (Michniewicz et al. 2015). The ways in which men and women are taught and expected to deal with their emotions, and the emphasis put on which behaviours are appropriate and which ought to be repressed according to a person's gender become the ways in which many people try to manage their mental illness. Gender and the expression of mental illness are thus closely connected.

Various studies investigating the experience of stigma related to mood disorders have found that men report experiencing higher levels of both personal stigma (Griffiths, Christensen and Jorm 2008, 6) and perceived stigma (Alonso et al. 2008, 308). An exploration of men's attitudes toward help-seeking for health concerns revealed that men often identified depression

and depressive symptoms simply as "stress" and reported feeling pressure to conform to widely held notions of masculinity by coping with extreme amounts of psychological and emotional distress without complaining (O'Brien, Hunt, and Hart 2005, 511). Being perceived as unable to cope was to be perceived by other men as "weakness," and many of the study's participants spoke specifically as to how having depression impacted their gender identity, making them feel distant from other men and also distant from themselves (O'Brien, Hunt, and Hart 2005, 511). While women speak frequently of shame when discussing their personal experiences with mental illness, men tend to speak of feelings of anger and aggression (Danielsson and Johansson 2005, 175).

The process of coming to terms with one's own mental illness and subsequently seeking professional help is a daunting task for most, regardless of gender, due to the fact that once treated, many people will have added to their identity one of the damaging labels associated with "psychiatric labelling" (Prior 1999, 25). With respect to gender and help-seeking behaviour, women are more likely to seek out psychiatric help for themselves and be more descriptive of their symptoms, while men seek psychiatric help less frequently, tend to downplay their symptoms, and are more apt to seek psychiatric help on the advice of someone else (Rogers and Pilgrim 2005, 69).

Women's socialization has been identified as a likely source of their greater ability to seek help, as they do not receive as much pressure as men to be self sufficient and solve their issues in isolation, rather they are encouraged to communicate their issues to others (Danielsson and Johansson 2005, 165). A study of Swedish men and women, aged 17-25, revealed that some young men, in response to symptoms of depression, experience and act on urges to reject their emotions and instead aggressively display their strength by personifying a "bad boy" and thus

trying to ignore their feelings of shame and more vulnerable emotions (Daneilsson et al. 2010, 5). This behaviour is an example of men's feeling obligated to overcompensate for the perceived loss of masculinity they feel due to their emotions they are experiencing related to their mental illness.

There are stark differences between the experience of mental health for men and women with relation to suicide and self-harm. The rates of suicide and self-harm are higher amongst men, and men's suicidal and deliberate self-harm behaviours are characterised as more violent than those of women, whereas women's self-harm attempts are more frequently categorized as demonstrations of help-seeking behaviour (Hawton 2000, 484). It has been theorized that the disparity between male and female suicide rates can be attributed in part to the fact that men are forced further out of their traditional gender roles through their experience with mental illness than women are, which causes them to experience immense shame from which only suicide can allow them to escape (Danielsson and Johansson 2005, 177). If this is accurate, reduction of stigma around mental illness, particularly with respect to the symptoms that are largely considered more feminine, is in turn an important aspect of suicide prevention for men, who must be able to disclose their symptoms and condition in order to have access to life-saving resources.

Wirth and Bodenhausen (2009) conducted a study to determine how gender a-typicality of mental health symptoms impacted how inclined strangers were to help individuals who had mental illness symptoms that were typical or atypical of their gender. They began with the stereotypes theorized by Ottati, Bodenhausen, and Newman (2005) that relate to gender and mental illness, specifically that gender typical symptoms for males are "violence/dangerousness" while symptoms for women are "dependency/incompetence" (Wirth and Bodenhausen 2009).

Participants in the survey were then asked to report on how strongly they felt compelled to help individuals described in the case studies, and to what extent they felt the man or woman in the case study was actually mentally ill (Wirth and Bodenhausen 2009).

Wirth and Bodenhausen (2009) concluded the following: first, people felt more sympathetic toward individuals with gender atypical symptoms, which translates to a lower amount of stigma attached to individuals with gender atypical symptoms. With respect to the gender of the participants, men were less inclined to help case study subjects who exhibited gender-typical symptoms, while women were more inclined to help overall, which the authors stated could be attributed to women's socialization (Wirth and Bodenhausen 2009). Overall Wirth and Bodenhausen (2009) deemed gender to be a factor which influenced stigma and also identified gender-typical mental illness symptoms as something which made participants view the case study subjects as more responsible for their illness. The labelling of people with gender-typical symptoms as being more responsible for their conditions could result in these people experiencing more stigma than people with symptoms not normally associated with their gender.

While people appear to react more positively to and show more compassion for others experiencing gender atypical mental health symptoms, a study measuring men and women's reactions to being diagnosed with several gendered disorders revealed that people were less likely to be accepting of a diagnosis of a gender atypical disorder for themselves (Michniewicz, Bosson, Lenes and Chen 2015). The study revealed that men in particular perceive diagnoses of mood disorders to be especially threatening to their own masculinity (Michniewicz et al. 2015, 9). The study identified antisocial personality disorder, drug addiction, alcoholism, and narcissistic personality disorder as gender atypical conditions for women, and eating disorders, depressive disorders and anxiety disorders as gender atypical conditions for men (Michniewicz et

al. 2015, 309). Male participants in the same study also identified mood disorders as conditions which they would be least likely to seek help for (Michniewicz et al. 2015, 9). Women did not exhibit the same concerns about their gender identity, nor did they express the levels of concern men did when considering being diagnosed with a gender atypical condition (Michniewicz et al. 2015, 10). There exist well established gender-based expectations of normal emotional behavior which illicit strong responses in those who witness said behavior. Knowing what is and is not expected of them, men may feel as though they must suppress the emotional symptoms of mood disorders to avoid criticism or rejection from those around them.

Stigmatization from Family and Friends

Family members of individuals diagnosed with a mental illness may engage in stigmatizing practices including avoiding those relatives with mental illnesses, or conversely by becoming overprotective of them (Thornicroft 2006, 208). In the case of adolescents, family may react by blaming or pitying people with mood disorders for their conditions, or by gossiping about them to other family members (Moses 2010, 988). Some family members react to a loved one's disclosure of mental illness diagnoses by advising that relative to refrain from disclosing their diagnoses to anyone else, a response that, even when well intended, can result in feelings of shame and rejection (Thornicroft 2006, 267).

In addition to experiencing stigma within their own families, individuals with mental illnesses may feel stigmatized by the families of their partners or potential partners. For example, there have been cases where family members have expressed that they do not wish to see their relative in a relationship with someone who has a mental illness (Thornicroft 2006, 30). A study investigating the attitudes of masters of social work students toward serious mental illness,

specifically schizophrenia, bipolar disorder, and depression revealed similar ideas to the aforementioned ones about family members marrying someone with a mental illness (Covarrubias and Han 2011, 321). Nearly 50% of respondents indicated they would not allow their children to marry someone with a serious mental illness, and almost 60% felt that people with mental illnesses should not be able to foster or adopt children (Covarrubias and Han 2011, 321).

A qualitative study examining the experiences of individuals living with bipolar disorder revealed that some participants reported feeling stigmatized due to the reactions of family members sharing with family their diagnoses and engaging in discussions of receiving treatment. Participants described that they experienced feelings of shame and being judged by family members and also that their disclosures of diagnoses and treatment were met with silence from some family members, even when family members to whom they disclosed had experienced mental illness themselves (Michalak et al. 2011, 8). This finding illustrates the consequences of both self-stigma and public stigma on individuals. While confiding in a relative with a shared experience with mental illness may yield support, it could lead to further stigmatization if said relative experiences self-stigma as a result of their own illness and experiences.

There is a lack of qualitative and quantitative research which provides insight into whether or not, and, if so, how much, stigma people with mood disorders experience within their friendships. A study conducted in Australia utilized vignettes describing individuals experiencing symptoms of mood disorders to illicit responses from Australian youth as to how they would respond to a person in the early stages of a mental health crisis. The study revealed that the youth participants responded to friends and family in mental health crises in "detrimental ways" (Yap and Jorm 2011, 476). The detriment here being the result of the tendency of youth to

desire social distance between themselves and mentally ill individuals, as well as their inability to correctly identify mental illness in others (Yap and Jorm 2011, 476). However, the youth were inclined to seek help for those individuals whom they perceived to be dangerous as a result of their mental illness (Yap and Jorm 2011, 476).

The implications of the aforementioned study suggest that more education is required around mental illness to foster awareness in young people that will ultimately translate to more understanding and effective provision of mental health first aid when necessary. Specifically, a greater understanding of the spectrum of signs of mental illness, both dangerous and not dangerous, would contribute to youth's ability to identify that someone was having a mental health crisis and seek help as appropriate. A further implication of these findings is that a people with mental health issues who engage in help-seeking behaviour by disclosing their situation to young people may be deterred from seeking additional help because of the response of youth to those having mental health issues.

Stigma in the Workplace

A study that explored the experiences of individuals living with mental health issues in their workplaces uncovered accounts of both positive and negative experiences (Pelletier 2016). One participant described that, although he was candid with friends and family about his mental health, at work he spends considerable time and effort "fronting" that he does not have a mental illness. This practice of trying to act "normal" is due to his awareness of the negative stereotypes held by his colleagues and employers, and his need to protect himself from any judgement others may pass on him (Pelletier 2016, 39). This individual has chosen to selectively disclose his

illness to people around him with whom he feels safe, reserving his "fronting" efforts for work where perhaps he feels they are most needed.

Another contributor to the same study described her experience with disclosing her illness during an interview after the interviewers asked why she had taken a leave at her previous job (Pelletier 2016). The interviewers pressed her for more information, specifically what the nature of the medical leave was. She disclosed her mental illness, was not the successful candidate for the job, and questioned whether the stigma attached to her mental illness was a factor in their decision, describing that people with mental illness who take sick leave are less productive, and employers do not want to hire unproductive workers (Pelletier 2016, 51). Although it was never made explicit to this individual whether her mental illness created an obstacle to the employment opportunity, this experience served to reinforce the idea that she and others with similar conditions may be viewed as less valuable in the workforce when the specific nature of their illness or condition is known.

An investigation under the Mental Health Commission of Canada in 2010 examined the relationship between employees' levels of stress and the attainment of treatment for mental health or emotional issues in the past year. The findings showed a correlation between those employees who reported the most amount of work related stress also being the employees who had received mental health related treatment (Szeto and Dobson 2013, 193). Stress is an indicator of mental illness, and those workplaces which have anti-stigma initiatives are more likely to see their workers get help. In workplaces without anti-stigma initiatives in place, employees are less likely to seek help and admit they are stressed because stress is seen as a mental health indicator and they fear that admitting stress will increase their stigma in the workplace. The study concluded by asserting the importance of anti-stigma related initiatives in the workplace, noting

that if employees became aware that describing their work as highly stressful may also indicate that they have mental illness, their jobs may be in jeopardy and as a result they may resort to under reporting their stress levels (Szeto and Dobson 2013, 194). A survey of Canadians conducted in 2008 found that only 23% of respondents indicated they would feel "comfortable" speaking to their employer about their mental health (Mental Health Commission of Canada 2016). In the world of work, where the stakes are high, it appears that individuals living with mood disorders do not view self-disclosure as an act that will increase their quality of work or life. People who feel the need to "front" about their mental illness by concealing it in the workplace may experience added stress if they were not able to stop "fronting" when alone with their intimate partners. For those who cannot be open about their mental health at work, it may be extremely important to feel safe and secure enough in intimate relationships and be open about mental health at home.

Stigma in Intimate Relationships

Individuals with mental illnesses are sometimes regarded by others as less desirable for marriage or other related activities including child rearing (Thornicroft 2006, 208). Economist Marina Adshade's work identifies connections between sex and love to economics, as well as the mechanisms within the marriage market, where courtship, dating, marriage, and the like occur. Certain stigmatized characteristics of potential partners have been identified as potentially decreasing one's value on the marriage market, and subsequently deterring others from engaging in relationships with them. These characteristics include how many sexual partners a potential mate has had and whether or not someone has experienced rape or sexual assault (Adshade 2013).

At this time, little is known as to whether or not mood disorders affect individuals' desirability in the marriage market, and, if so, to what degree. Due to the significant amount of stigma experienced by individuals with mood disorders, it is worth investigating whether people living with mood disorders factor their diagnoses into considerations of their own marketability and appeal to potential partners in the marriage market or any other romantic context. An individual's perception of how their mood disorder may impact their "marketability" may influence to what extent they feel they should be "out" about their mental illness to friends, family, colleagues, and intimate partners.

As a way to avoid the stress associated with disclosing mental illness diagnoses in intimate relationships, Jim Leftwich, who lives with a condition known as schizoaffective disorder, developed the first dating website intended exclusively for people with mental illnesses (White, 2013). NoLongerLonely.com states on its homepage that it is a "welcoming community that understands the trials and pitfalls of managing a mental illness. Find friends or seek romantic relationships knowing that everyone on this site has some form of mental illness. […] No worry here of stigma or disclosure" (NoLongerLonely.com). The site's tagline openly acknowledges what many individuals fear in silence: the stigma associated with mental illness and the uncertainty of how to address it in a romantic or intimate context.

NoLongerLonely.com has over 30,000 users; and through bringing people together, it has resulted in over 30 marriages (White 2013). In addition to facilitating romantic relationships between individuals with mental illnesses, it is also a space in which people can enjoy a sense of community; they can connect through chatrooms and various forums, and even share their art (White 2013). The accessibility of this site is particularly helpful for those who may not have the time to attend a physical support group, as well as for those who live in a place where support

groups and other resource are not accessible. They are also important for those to whom stigma is of such great concern that the anonymity of an online community is the only means by which they feel truly comfortable speaking about their mental health related experiences. The mere existence of this website demonstrates that for some individuals living with mood disorders, disclosure in intimate relationships is of concern, possibly to the extent that they would seek to avoid it altogether by choosing to exclusively date others with similar conditions.

People who avoid contact with individuals diagnosed with mood disorders may do so for a variety of reasons, but one of which could be fear of experiencing "courtesy stigma," or stigma by association (Goffman 1963, 30). Tensions can arise in relationships between stigmatized individuals and those who experience courtesy stigma as a result of their proximity to the individual with the stigmatized condition (Goffman 1963, 30). Men with mood disorders who are aware of the stigma attached to mental illness may interpret that awareness as a deterrent to disclose to their intimate partners as a way to protect them from experiencing courtesy stigma or to avoid experiencing stigma directly from their partners upon disclosure.

Disclosure of Mood Disorders

The decision to disclose that one has a mood disorder or whether to conceal one's mood disorder is a significant and deeply personal one to which there is no right or wrong answer. Rather, it is decision that is made against a range of potential outcomes to be considered. Disclosure is not a single landmark event in the life of a person living with an mood disorder, but a process in which they may engage several times. This is because individuals with mood disorders are continuously faced with the decision of whether or not to disclose their illness to the people around them, including their family, friends, superiors, and colleagues at work, and

their intimate partners. Furthermore, if one chooses to disclose, they will have to deal with the repercussions of their disclosure.

Mood disorders differ from some physical illnesses in several ways. For example, some physical illnesses may be identifiable and apparent to others and thus individuals with more physically identifiable conditions may not have a choice when it comes to disclosure. A person may begin to question if and to whom they ought to disclose their mental illness around the same time they first experience the on set of symptoms (Thornicroft 2006, 207). This initial onset or realization of one's symptoms is hereafter referred to as "internal disclosure".

Concealing one's mental illness is one way in which individuals may be able to decrease the amount of stigma they experience (Corrigan 2005, 257). A person's habits and preferences regarding disclosing their mental illness, or "coming out," exist on a spectrum. Some individuals may choose to weigh the potential risks and benefits that could arise from disclosing their mental illness in each specific context where disclosure is a possibility. For example, an individual may be open about their mental illness to family, but not coworkers; to friends, but not family. This is known as either *selective disclosure* (Corrigan 2005, 269), or *judicious disclosure* (Michalak et al. 2011, 9). Other people may choose to not be selective at all and instead engage in *indiscriminate disclosure* whereby they make no effort whatsoever to conceal their mental illness from anyone, and accept whatever outcomes or responses that arise from their disclosures (Corrigan 2005, 269). No one is beholden to any one style of disclosing, and people may change their disclosure habits throughout their lifetime.

The process of disclosure exists on a spectrum, and where a person falls on the spectrum of a given opportunity to self-disclose will depend on a variety of things. These include their relationship to the person they are considering disclosing to, the outcomes of their previous

experiences with disclosure, the information they are considering disclosing, and their perceived risks and rewards in the situation. For example, a man may be more inclined to tell a serious intimate partner that he has depression than he would be to confide on a first date that he sometimes gets the blues in the winter.

The risks associated with disclosing a concealable source of stigma appear to be lower for individuals who have stronger support networks (Thornicroft 2006, 211). From this information it can be inferred that those whose early experiences with disclosure are positive are more likely to feel comfortable disclosing, and also that initial experiences of disclosure will influence future decisions of whether or not a person chooses to disclose. It may further suggest that if a person's early experiences with disclosure are positive, they may be less likely to be affected by negative responses later, and view the opinions of those with negative responses as less valuable than those who responded positively to their disclosure.

When deciding whether or not to disclose one's experience with a mood disorder, individuals may consider the potential positive and negative outcomes beforehand. Positive outcomes may include getting support from the person(s) to whom they disclose, or getting access to treatment and wider support networks from individuals with similar experiences, such as therapy or a support group (Thornicroft 2006, 207). Support groups offer a safe space in which individuals can come together and share their experiences, offer encouragement and understanding, and do so with less fear of judgement or rejection than they might be subject to in situations where individuals without firsthand experience with mental illness are present.

A study conducted with the participation of 500 outpatients of a mental health facility in Denmark revealed that respondents were most likely to disclose their mental illness to the people with whom they were closest. Specifically, the majority of the participants in the study disclosed

their mental illness to their parents as well as their spouses (Bos et al. 2009, 511). Respondents disclosed less frequently to other family members and friends, and they disclosed least often to co-workers and acquaintances (Bos et al. 2009, 511). With respect to coworkers and acquaintances, respondents reported experiencing high perceived levels of stigmatization and low perceived levels of potential social support (Bos et al. 2009, 511). The study concluded that factors which positively influenced disclosure included the respondent's perception of stigmatization, as well as their perception of potential social support from those to whom they disclose (Bos et al. 2009, 511). These findings could indicate that individuals with mental illness may be less likely to disclose their illness to people whom they have just met, whether it be in a social, professional, or romantic setting.

Individuals who endeavor to conceal their stigmatized conditions can experience significant stress and other harmful psychological consequences as a result. In addition to the stress endured each time they must decide if and when to come out about their illness, people also experience anxiety as a result of worrying that their secret will be revealed (Pachankis 2007, 328). Individuals also become distressed or fearful when questioning who around them may know or suspect what they are concealing, feelings of isolation from others who have the same condition, and a sense of detachment from their authentic selves (Pachankis 2007, 328).

While individuals with visible or obvious stigmatized conditions have no choice but to deal with the reactions of those around them to their stigma, people with invisible stigmatized conditions must engage in an ongoing process of evaluating the effectiveness of their concealment and adjusting their social interactions accordingly so as not to out themselves (Pachankis 2007, 335). For this reason, many individuals decide to "front" or act as if they do not have a mental illness around those to whom they are not "out" about their mental illness, an

energy-consuming practice that may have adverse effects on those who engage in it. Individuals living with invisible illnesses can avoid stigma by choosing to engage in judicious disclosure, evaluating opportunities to disclose and then choosing a course of action they feel most comfortable with.

With respect to concealing one's condition in close relationships, the amount of time a person waits to disclose their mental illness to their partner can impact their partner's reaction to the disclosure. Keeping part or parts of one's life hidden and therefore not sharing one's whole self with a partner can be emotionally damaging, and result in the concealer experiencing feelings of guilt (Pachankis 2007, 335). Late disclosure can damage a romantic relationship in situations where a person who delays disclosing their mental illness condition to their partner. In such situations where disclosure does not happen earlier in the relationship, the eventual disclosure may be met with a less positive reaction than would have been experienced if the discloser was forthcoming early in the relationship (Pachankis 2007, 337). This may be true of disclosure in general, as it could be argued that the negative reaction to perceived late or delayed disclosure is a result of someone feeling betrayed or that their partner was deliberately hiding something, and not necessarily exhibiting a negative reaction to the mental illness aspect of the disclosure. When planning when to disclose their mental illness, individuals may want to be prepared to preface the disclosure with their rationale. For example, they may explain to their partner that they had to feel ready to be rejected or face other fears they have about disclosure.

The website "Heads Up Guys" (headsupguys.org) advertises itself as a site to "manage and prevent depression in men." The website is an offshoot of the Movember campaign, a month long mustache growing competition taking place in November. Movember was initially conceived of by four Australian men in 2003 to draw attention to men's health and get men more

involved in their own health (Jeffcott, Cagiannos and Zorn 2012, 111). The campaign and its competition took place in Canada for the first time in 2007 (Jeffcott, Cagiannos and Zorn 2012, 111). The primary health concern that the campaign draws attention to is prostate cancer, but it has expanded to include other men's health issues, including depression. Heads Up Guys offers advice and information about resources to help men who are dealing with depression, including advice on physical health, diet, as well as tips about sex and relationships.

With respect to disclosure to partners, the website stresses the importance of being forthcoming with one's partner when experiencing depressive symptoms or a depressive episode, stressing the importance of open and honest communication not only for the mental health of the individual but for the health of the relationship itself. Conversely, the website's advice for men who are in newer relationships is to proceed with caution when considering disclosure to a new partner. It cautions men who are involved in the dating scene and actively seeking relationships to "know when and how" to talk about their depression, and to wait until the relationship has progressed into something more serious before disclosing to a new partner that they have depression (Headsupguys 2016). The advice provided on this site, encouraging men to disclose to more serious and long-term partners while exercising caution around newer relationships, is consistent with the disclosure patterns identified in the aforementioned research articles.

The availability of support and resources for men who are considering disclosing their mood disorder diagnoses is important. There is evidence of a pattern of individuals choosing to disclose primarily to people with whom they have greater amounts of trust and, who they perceive will be most supportive. However, it is unclear if or how the suggestions provided by online resources or health care professionals have a real impact on the decision making processes of men. The resources do not explicitly address any potential concerns men may have regarding

how their masculine gender identities may be compromised in the process of disclosure. Greater insight is needed as to how men with mood disorders navigate the decisions they make regarding their self-disclosure. More information regarding what they perceive as potential risks, as well as rewards, will lead to a greater understanding of what self-disclosure means to them.

Conclusion

In addition to the physical and emotional pain and personal challenges inflicted by mood disorders on those who are living with them, it is clear that the experience of stigma, perceived, personal, and otherwise, can serve as barriers to effective treatment and overall well-being. Furthermore, it influences the ability of people living with mood disorders to see themselves as valued amongst family, friends, co workers, and intimate partners. A qualitative study in which men speak openly about their experiences managing their mental illnesses in their intimate relationships will add an important perspective to the larger discussion of mental illness disclosure and stigma. It will also enrich our understanding of the challenges faced by men living with mood disorders.

Experiences of stigma and processes of disclosure are human experiences that cannot be fully appreciated if reduced to statistical analyses or other forms of quantitative data alone. The men's experiences reveal two ways in which they are engaging in building positive peace. Firstly, they are challenging hegemonic masculinity by acknowledging their mood disorders and engaging in emotion work typically done by women. Secondly they are strengthening their intimate relationships by engaging in emotion work. Together, these actions address structures which enforce hegemonic masculinity and contribute to the experience of both personal and structural violence and thereby constitute significant barriers to the realization of positive peace.

Studies have been conducted which address patterns and frequency of disclosure amongst people with mood disorders, differences in experiences of mood disorders attributed to gender. There is a breadth of literature addressing the relationship between stigmatization and disclosure of mood disorders, which will be explored in the literature review. However, there is limited insight into the specific decision making processes of men who are faced with the decision of whether to share their diagnosis with their intimate partners. Intimate relationships and efforts to maintain them are more typically associated with 'women's work'. This research conducted for this study revealed that intimate relationships are for the benefit of all people, regardless of gender, and that parties involved in intimate relationship have equal obligation to contribute to them and in doing so will more equally access the rewards of intimacy.

LITERATURE REVIEW

This study examined the intersection of three identities: gender identity, specifically masculinity; intimate partner identity; and the identity of good mental health. Each of these identities has attached to it a set of expectations, and these expectations are maintained and perpetuated by cultural and societal environments. The extent to which individuals meet these expectations reflect how well they are perceived to represent their gender, relationship or health identities. The research undertaken is guided by theories that explore stigmatization and the various ways in which people experience it from the different people in their lives. Other theories addressed include those which explore and explain the social construction of identity, specifically the construction of male gender identity. I draw from theories of psychology and sociology that address the experience of intimacy in romantic relationships and the processes of self-disclosure which help to create and sustain intimacy in romantic relationships.

In particular, the social construction of masculinity is examined in order to understand the issues that are facing men and boys who are working to maintain their masculine identities every day. I will also provide examples of the consequences that certain aspects of masculine identities have for men's intimate relationships, as well as the impact on men's mental health. I will discuss the concept of emotion work as it relates to men and their management of mood disorders generally as well as how emotion work is done in intimate relationships.

The field of Peace and Conflict studies is concerned with the experience and perpetration of violence. Peace is not only the absence of physical violence but also a state in which people are empowered to reach their full potential (Galtung 1969, 168). Socially constructed systems, such as those that regulate and perpetuate binary categories of gender, can act as constricting forces on individuals, and in so doing they inflict structural violence on people who wish to

perform their gender in an alternative way but feel they cannot for fear of the repercussions. Structural violence is also experienced by those who do choose to engage in their own gender performance and suffer physical violence or oppression as a result. In the context of intimate relationships, men who do not perform their gender as prescribed by choosing to engage in emotional disclosure may face rejection by their partner, thus experiencing structural violence. Individuals who experience a lesser level of intimacy in their intimate relationships due to reservations they have about disclosing personal information are thereby not realizing their potential as intimate partners. They also may face barriers in realizing their potential as men and as human beings.

The risk-taking propensity of men in relation to the expectations of men to adhere to the performance of hegemonic masculinity has further implications for men's health with respect to their ability to ask for assistance in health related crises. While men have been conditioned to participate in risky or dangerous behavior in order to display and prove their masculinity, little is known with regard to how men evaluate emotional risks, including self-disclosure in intimate relationships. For some men, disclosing their mental health issues poses significant risk with no guarantee of even the slightest reward. A deeper, more detailed understanding of the challenges men face when disclosing their mood disorder diagnoses to their partners will foster greater understanding and empathy among those who are being disclosed to, as well as those who are providing support to men who are considering engaging in disclosure.

Identity and Peace

Identities are socially constructed (Berger and Luckman 1966, 163). Within the field of peace and conflict studies, it is well established that identities, both individual and collective,

have significant bearing on the involvement and experiences of individuals and groups in conflicts. According to Celia Cook-Huffman (2001), "identity plays a vital role in social conflict, as it is fundamental to how individuals and collectivities see and understand themselves in conflict" (19). Discussions of both group and individual identities are relevant to this project, as they respectively consider how people conceive of themselves as members of a particular group, based on their relationship status, gender, or as individuals with unique characteristics, such as the presence of a mental illness.

The term identity is one that is frequently used and yet at the same time difficult to pin down into a single, universal definition. As explained by James Fearon (1999) identity can be understood as "social" or "personal"; social identity "refers simply to a social category, a set of persons marked by a label and distinguished by rules deciding membership and (alleged) characteristic features or attributes" (2). In the personal sense "identity is some distinguishing characteristic (or characteristics) that a person takes a special pride in or views as socially consequential but more-or-less unchangeable" (Fearon 1999, 2). Acknowledging both the social and personal senses of identity allows us to recognize both the "social categories" as well as "the sources of an individual's self-respect or dignity" (Fearon 1999, 2). Using this definition, we can see that living with a mood disorder can be related to both the social and personal senses of identity.

Firsthand accounts of individuals who live with mood disorders reveal that there are vast differences amongst people with respect to the extent to which they feel their mood disorder is part of their identity. There is a distinction for some between having a mood disorder and being a mood disorder, this is the case for Andrea Paquette, a woman living with bipolar disorder who recalls stating in front of a crowd "My name is Andrea and I have bipolar disorder but I have

learned that I am *not* bipolar disorder" (Paquette 2015). Paquette describes this as something she has learned and therefore we know this has not always been how she has viewed her disorder with respect to her identity. Her personal assessment of having bipolar disorder rather than being bipolar disorder is consistent with the personal sense of identity insofar as she is naming it as a characteristic about herself but not something that defines her (Paquette 2015).

J. Karen Reynolds also lives with bipolar disorder and her perception of her relationship with the disorder has evolved over time. She recalls how she felt when she received her diagnosis:

> I saw the illness as my enemy. I was its victim. Recovery was war. I assumed I could separate myself from the disorder…I learned that I could not defeat bipolar disorder. I grew tired of feeling like a failure and wondered if learning to live with bipolar disorder might improve my quality of life. Instead of fighting the illness, I sought ways to embrace it. (Reynolds 2008, 185)

Reynolds's embracing of bipolar disorder resulted in a shift in "recovery from to recovery with" wherein there was a redistribution of power between herself and the disorder (Reynolds 2008, 185). Rather than fighting her illness she has accepted it and this acceptance has allowed her to better cope with it. The acceptance of a disorder or any other characteristic also implies that the characteristic is unchangeable, and thus Reynolds conception of her illness is compatible with the "personal" sense of identity as a characteristic a person recognizes about themselves that is "more-or-less unchangeable" (Fearon 1999, 2). While Reynolds perception of her disorder has changed, the disorder itself is still present.

It is stigmatizing to suggest or infer that having a mood disorder is inherently problematic. After engaging in conversations about their own experiences of living with depression, Mandy Fraser and Jennifer Matwee found "a new feeling of strength" in their "identities as depressed women" (Fraser and Matwee 2008, 49). They discussed the labelling

associated with depression, for example "crazy" and "normal" (Fraser and Matwee 2008, 51). These labels are also effectively social categories that relate to the social sense of identity. In their piece, Fraser and Matwee conclude:

> Depression is most certainly a part of our identities, a part of ourselves. Just like our personal identities are always shifting, so too are our experiences of depression. Labels like "depression" and "chronic illness" have a way of being incorporated into identities. But whereas labels are static, identities are forever in flux. It is therefore relevant that we find healthy ways of incorporating "depression" into our identities instead of trying to entirely eradicate it. (Fraser and Matwee 2008, 51).

This confirms that in fact there are ways in which people can positively identify with respect to their mood disorders. Furthermore, these more positive associations between identity and one's mood disorder can also constitute effective coping skills for people living with mood disorders. How strongly a person views their mood disorder as part of their identity is something that will vary based on different people's individual experiences and over time for individuals themselves.

Peacebuilding processes involve not only large scale efforts among and between groups, but also efforts that target the individual. Included in John Paul Lederach's goals to guide peacebuilding are "developing opportunities for transformation, both personal and systemic" as well as "pursuing social empowerment as the nurturing of individuals and community" (Lederach 1996, 23). Critical to peacebuilding is the formation and maintenance of relationships, which directly impact quality of life and contribute to the eradication of violence (Lederach 2005, 35). In order for an individual to experience any kind of transformation, or feel empowered, they need to feel that they have the support of those closest to them, including their friends, family and intimate partners with whom they engage in relationships. Lederach explains constructive social change and the qualities of the interactions that will help us achieve it:

> *Constructive social change:* the pursuit of moving relationships from those defined by fear, mutual recrimination and violence toward those characterized by love, mutual respect and proactive engagement. Constructive social change seeks to change the flow

> of human interaction in social conflict from cycles of relational violence toward cycles of relational dignity and respectful engagement. (Lederach 2005, 42)

Men motivated by the pressures to maintain a gender identity consistent with hegemonic masculinity may act out of fear in intimate relationships and opt to withhold personal information, including the presence of a mood disorder, from their partners rather than engage proactively and contribute to the level of intimacy in their relationships.

If people of all genders can act out of mutual respect by encouraging men to share without fear, their identities may be able to transform. Less men may turn to violence out of an inability to deal more openly and effectively with their mood disorders if they feel they can share with their intimate partners and receive support with respect to their mood disorders as well as other aspects of their lives. Intimate relationships are a place where peacebuilding can occur through the transformation of identities that in their dominant form serve to perpetuate both personal and structural violence.

The various facets of a person's identity will interact with and influence one another, and thus they cannot be understood separately. Different aspects of identity influence how people perceive themselves introspectively and also how they perceive themselves relation to others (Black 2003, 148). This is an important notion when considering how someone who has a mood disorder may think about disclosing this information to a partner who does not have a mood disorder and also when considering how a person's gender identity influences how they feel about having a mood disorder.

The Social Construction of Gender

The formation and maintenance of gender identity are increasingly contentious topics in society. While it was once assumed that gender was fixed to biological sex, and remained static over time, it is now argued that external factors, or what is referred to as "nurture" in the nature vs. nurture argument, bears greater influence on a person's gender, and that sex is not limited to a binary system of categorization (West and Zimmerman 1987, 125; Fausto-Sterling, 2012; Messner 1997, 30). While sex is something physical, prescribed onto a body, gender is something a body does, and the process of doing one's gender is guided by cultural, societal and psychological norms in which a body exists.

The distinction between sex and gender is crucial because it illustrates that sex and gender are not fixed to each other. If we accept that gender is in fact separate from sex, we see that a male body does not necessitate masculinity just as the presence of a female body does not automatically signify femininity or a feminine person (Butler 1990, 9). Then we are left to question where in fact gender comes from if not from our physical bodies and the sexes they represent. Gender is not a binary biological category but in fact a socially constructed phenomenon that exists along a continuum.

The process by which gender is achieved and maintained is one that is ongoing and exists both when a person is alone and also when they are present in society or at large. Gender is not something a person "is" but rather something they demonstrate to themselves and to others through actions and interactions (West and Zimmerman 1987, 127). These actions serve to convey that gender is "natural" rather than something that requires a great deal of effort to attain, and whether someone perceives us as male or female is "optional" because we in fact choose

how others perceive us by choosing how to communicate our gender (West and Zimmerman 1987, 130).

The socialization of girls and boys from an early age serves to establish gendered differences in behavior that people will potentially adhere to for the rest of their lives. One of the ways in which their gender training differs is the emphasis that is placed on relationships. For example, young boys are often praised for their physical achievements, and taught to hide or ignore their emotions, whereas girls are encouraged to pursue success through relationships with others, and engage in emotional labor (Derlega and Chaikin 1976, 376). As time passes, this gender difference manifests itself as women's emotional expression, and so the act of self-disclosure is more acceptable for women than men (Derlega and Chaikin 1976, 376). As a result of this socialization, by the time most men engage in their first intimate relationship, they have already been conditioned to refrain from sharing, and as a result are unable to participate fully in intimacy.

Masculinity. Men and the male identity are frequently associated with having more freedom relative to the freedom enjoyed by people of other genders (Reeser 2010). In reality, masculinity can be more clearly conceptualized as a set of strict constraints within which men must live and behave in order to ensure that their masculinity, and the power that comes along with it, remains unchallenged and unquestioned (Reeser 2010). In North America, the constraints of masculinity dictate that men must be "brave, dependable, strong, emotionally stable as well as critical, logical and rational" as well as "wealthy" and "in a position of power over others" (Coston and Kimmel 2012). The performance of masculinity is not a passive act but rather "a full time job" (Pittman 1993, xiv). Masculinity emphasizes strength and resilience but in fact does not consistently result in the bulking up or strengthening in those who strive to be masculine;

rather it forces men to engage in the "cutting away at chunks" of themselves and continually making sacrifices in order to maintain their membership in masculinity (Pittman 1993, 9).

The term hegemonic masculinity refers to the dominant version of masculinity that is upheld by practices and imagery which dictate how ideal masculinity ought to be performed. These standards are displayed and upheld by both "real" men, for example high-powered businessmen, as well as fictional characters in popular films (Connell 1987, 185). Hegemonic masculinity is not only a guide by which men model their own masculinity after but also an institution, the maintenance of which serves to cement the superiority of the male gender over women, and also over other men based on their class, race, and sexuality, (Connell 1987 186) and socioeconomic status (Courtenay 2000, 1390).

More recently, there has been a call to acknowledge the limits of hegemonic masculinity, with respect to its ability to explain power relations, more specifically its failure to address the power relations within masculinity (Christensen and Jensen 2014, 21). The power dynamic by which other genders are subjugated to men and masculinity can be understood as "external hegemony," while relations that exist among men are referred to as "internal hegemony," which allows for masculinity and its power structures to be analyzed with an intersectional approach (Christensen and Jensen 2014, 21).

As previously discussed, meanings of manhood and masculinity vary depending on its historical context—both the historical era in which one lives as well as the stage of one's life. Expectations of how one ought to perform their masculinity change based on an individual's age. Masculinity is also influenced by one's cultural context, sexual identity and preferences, and racialized identity. The constraints of masculinity are so strong that even those men who would not meet the diagnostic requirements of a psychological or mood disorder may still experience

some of the symptoms as a result of the expectations attached to their gender roles (Brooks 2003, 28). These symptoms can fester and manifest themselves in dangerous behaviors that contribute to men's quality of physical and emotional health as well as their propensity for risk-taking (Brooks 2003, 28). The institution of masculinity is being challenged all the time, and as much as this may cause confusion for men, it also presents the opportunity to reshape the expectations of men and masculinity (Messner 1997, xiv).

Sylvia Walby (1990) identified six specific structures of patriarchy that serve to maintain hegemonic masculinity, all of which impact women in different ways depending on other aspects of identity, including race and class. The structures Walby identified are paid employment, household production, culture, sexuality, violence and state. What is meant by structures of patriarchy with respect to these six areas is that they are structures which serve to oppress women while benefitting men and ultimately maintaining inequality between people based on gender in every single aspect of life (Walby 1990). The exploitation of women occurs in both the public and private spheres thereby contributing to women's overrepresentation in the experience of both personal and structural violence, which thereby constitutes an extremely significant barrier to positive peace.

The realization of gender quality is critical to realizing a culture of peace. Understanding, tolerance and solidarity are among the contributions to a culture of peace typically associated with women (Stephenson 2009, 134). With respect to men's disclosure and sharing in intimate relationships and help-seeking with respect to mood disorders and other stigmatized conditions, understanding, tolerance and solidarity are actions that will encourage men to engage in new expressions of masculinity, thereby contributing to gender equality and social justice. If people can understand and tolerate different expressions of masculinity as well as different health

circumstances, the stigma around these circumstances can be reduced. When a man discloses to an intimate partner that he has a mood disorder and he receives a response from his partner that comes form a place of tolerance and understanding, the man and his partner are acting in solidarity with respect to furthering goals of gender equality.

Limiting discussions of gender and hegemonic masculinity to zone in on men's dominance over women limits our understanding of the implications of patriarchy for the attainment of peace, and suggests that the ills of patriarchy can be resolved simply by increasing women's representation in areas traditionally reserved for men (Wilmer 2015). As Franke Wilmer explains:

> patriarchy can be transformed by addressing the underlying problem of dissociation by engaging in relationship, affirming connection reconciling historical injury and its present effects…Our capacity for connection is impaired by patriarchal socialization, the traumatic loss of intimacy and its emotional consequences. Violence and conflict are effects of the patriarchal propensity to rationalize violence by stereotyping and dehumanization. The remedy is to restore connection where it has been damaged or obstructed. (353)

This explanation demonstrates that the impact the patriarchy has on peacebuilding efforts, society and intimate relationships. Intimate relationships are a place wherein efforts to combat the patriarchy can begin. Intimacy and connection are integral to peacebuilding and efforts should be made on the part of all people, regardless of gender, to deconstruct the rules that govern how people act in intimate relationships.

Masculinity and Help-Seeking. The constructs of masculinity, which dictate how men and boys must behave in order to be perceived as such, have gained increasing attention due to their damaging effects on men's health. Relative to females, males engage in considerably less healthy lifestyles and engage in risky behavior more frequently (Courtenay 2000, 1387). A person's health-related practices and beliefs are part of the way in which they perform or

communicate their gender to others. Refusing to address their health-related needs and concerns is one way in which men express their masculinity.

Men's conformity to hegemonic masculinity and the performance of traits or behaviors that serve as identifiers of one's masculinity have consequences for men's health and therefore quality of life. The likelihood of men asking for help may depend on whether they perceive the issue they are experiencing to be one that is experienced by most people, in which case asking for assistance or advice may be an easier task to execute, or if they perceive the issue as less universal, which could discourage them from seeking help (Addis and Mahalik 2003, 11). More specifically, men's comfort levels with asking for help may be especially high if the subject in question is one in which the person they seek help from may in turn ask them about it, for example home renovations, or one's golf swing (Addis and Mahalik 2003, 11).

Power relations and perceived losses of power are also an important consideration when identifying factors that influence men's help-seeking behavior. With respect to masculine identity, the practice of asking for and in turn receiving assistance may be associated as a loss of power if it requires a man to admit a lack of strength or knowledge in a particular area (Addis and Mahalik 2003, 11). Men's ability to ask for help is inextricably linked to power relations within masculinity, and the consequences for a failure to conform to hegemonic masculinity affect not only men but those around them, as stated by Evans and Wallace (2008):

> Dominant forms and codes of masculinity can serve to legitimize violence, both towards others and the self, as a means of dealing with emotional pain, while talking about difficult feelings or asking for help would only lead to a loss of masculine power. (486).

Acts of domestic violence by men against their partners in intimate relationships is a means by which men both perform their gender and exert control over others (Engle Merry 2009, 3). Gender-based violence is frequently used as a tactic in armed conflicts, where men, women, and

children are victims of sexual violence (Leatherman 4, 2011). Conforming to and reinforcing hegemonic masculinity by inflicting violence against others is also a practice that has been engaged in by Canadian peacekeepers sent to Somalia who "saw themselves as defending their own manhood and the manhood of their nation" (Razack 130, 2000).

Intimacy, Authenticity, and Self-Disclosure

Intimacy is a concept which, despite being abundantly theorized, has yet to be bound by a single definition or set of conditions. The experience of intimacy between human beings is one which is said to be essential for human health and wellbeing insofar as it provides physical and emotional security, and allows people to feel valued and safe (Collins and Feeney 2004, 170; Prager 1996, 171). While self-disclosure has great potential to provide individuals support within the relationships in which they disclose, it also presents risks. For example, disclosing that one has a stigmatized condition, or fearing that said disclosure may compromise one's masculine identity, presents risks to men with mood disorders. This makes self-disclosure a more uniquely challenging situation to navigate for men with mood disorders.

Harriet Lerner (1989) defines an intimate relationship as "one in which neither party sacrifices or betrays the self and each party expresses strength and vulnerability, weakness and competence in a balanced way" (3). Lerner's definition addresses the aspect of self-disclosure in its inclusion of vulnerability. In order to share one's true self with another person, one must first summon the courage or strength to divulge information that may not be accepted or well received by a partner, and be prepared for the vulnerability that results from allowing another person to learn things about you that you may only share selectively. The vulnerability experienced here is also a result of the uncertainty one experiences when engaging in self-

disclosure, as they can only predict how their audience might react. They also cannot be certain that their disclosures will be kept in confidence. Furthermore, men are not necessarily rewarded by society in the same way women are for being vulnerable or emotional in intimate relationships, and thus engaging in self-disclosure or sharing one's true self may present a set challenges that are unique to men (Lerner 1989, 8).

The concept of self-betrayal is also important as it speaks to the idea that people in intimate relationships are those in which people feel secure enough to present their whole authentic selves to their partners, even if doing so means that the discloser must break a promise to themselves to protect specific information in order to engage more fully in intimacy. People who are unable to do so may resort to a defensive behavior when they sense that their partner(s) expect them to share or open up (Prager and Roberts 2004, 45). The danger in resorting to this type of behavior is that it becomes emotionally exhausting for individuals who must exist as though they have two identities, their authentic and non-authentic selves, and only existing as the former when they are alone (Prager and Roberts 2004, 45). As a result, their romantic partners are never exposed to and therefore cannot know their authentic selves.

Self-disclosure or the divulgence of personal information, is a feature that is repeatedly included in conceptions and descriptions of intimacy (Mashek and Aron 2004, 1; Prager 1995, 23; Prager and Roberts 2004, 45). Self-disclosure is "the process of making the self known to other persons" by sharing information with "target persons" (Jourard and Lasakow 1958, 91). This explanation of self-disclosure reveals that it is not a passive act, but rather one that may require preparation and certainly effort on the part of the discloser. The use of the word "target persons" implies that disclosure itself is not directed at random, but in fact to persons with whom the discloser desires to share more of themselves with.

As established by Cozby (1973), "the basic parameters of self-disclosure are (a) breadth or amount of information disclosed, (b) depth or intimacy of information disclosed, and (c) duration or time spent describing each item of information" (Cozby, 1973, 75). Omarzu added to the parameter of "depth" the qualifier of whether the information being disclosed is "potentially negative or embarrassing" for the person disclosing it (Omarzu 2000, 175). Disclosures involving more intimate or embarrassing information may constitute a greater risk than those which involve sharing less embarrassing information about oneself.

It is important to note that intimacy, like gender, is influenced by its environment, meaning it is influenced by culture, ethnicity and other factors (Mashek and Aron 2004, 74). This study draws primarily from literature exploring Western concepts of romantic intimacy and thus does not seek to be relevant outside of Western discussions of intimacy. Furthermore, there is a distinction between intimate interactions and intimate relationships. The distinction is that a single experience of intimacy between people does not automatically result in or signify an intimate relationship, but rather an intimate relationship is one in which intimate interactions, including self-disclosure occur on a "regular and predictable basis" (Prager 1995, 23).

We can conclude from the literature around intimate relationships that there is an expectation that those engaging in intimate relationships will share with each other some degree of personal information throughout the relationship. Similarly, intimacy between people in a relationship is said to increase along with the amount of intimate interactions they experience together (Prager and Roberts 2004, 46). Intimate relationships can include familial relationships as well as friendships, but for the purpose of this study, the notion of intimate relationships was restricted to those of a sexual and/or romantic nature. One of the functions of self-disclosure and

other revealing behaviors, whether verbal or non-verbal, is to ensure that one's partner can be informed of one's needs, and ultimately satisfy those needs (Prager and Roberts 2004, 45).

A study that examined self-disclosure and liking revealed that both male and female strangers felt more favorably toward both men and women who adhered to their traditional gender roles with respect to their levels of disclosure. Men who disclosed very little were seen by strangers as displaying more emotional health, and more likeability, whereas were women who disclosed more were seen as emotionally healthy and more likeable (Chelune 1976, 1002). This study reinforces that disclosures of an emotional quality may be of higher risk for men than for women. Another study examining the norms governing men and women's self-disclosure revealed an obvious "double standard". The study found that males who disclosed more were considered "less adjusted" than men who did not engage in a lot of disclosure. Women who engaged in more disclosure were more well liked than woman who did not disclose much (Derlega and Chaikin 1976, 379). With respect to disclosure, the expectations for men and women are completely different.

Despite the fact that some engagement of self-disclosure is seemingly necessary to maintain and build intimacy in romantic relationships, individuals may choose to actively avoid disclosing personal information which they perceive will cause their partner to react negatively toward (Baxter and Wilmot 1985, 264). A study conducted by Cameron, Holmes, and Vorauer concluded that individuals with low self-esteem can experience further erosion of any self-esteem they do have when faced with the task of disclosing information they perceive as unfavorable to a romantic partner (Cameron, Holmes, and Vorauer 2009). The study found that when considering whether to disclose negative information about themselves to their partners, individuals with low self-esteem may fear that their partner will leave them upon hearing the

information (Cameron, Holmes, and Vorauer 2009, 221). In cases where a person is considering disclosing embarrassing or extremely private information, the perceived risk may be the relationship itself.

An examination of gender differences in perceptions of intimacy as well as practices of intimate behaviors within same-sex friendships reveals that both men and women largely agree that revealing personal information is an intimate practice. However, women are more likely to engage in this practice than men (Reis, Senchak, and Solomon 1985). Men's fear of experiencing shame and humiliation by disclosing their emotions may stem from the fact that men are socialized to conceive of sharing as a women's practice (Addis 2011, 168); that is, men may feel that engaging in emotional disclosure is engaging in feminine performance, or that it will result in a loss of their masculinity. For this reason, many men exist in a sort of paradox wherein they must participate in disclosure to participate in intimacy, but in doing so they sacrifice or compromise their masculinity.

There is no strict guideline or exhaustive list of what qualifies as personal information with respect to disclosure in intimate relationships, or what people ought to or must disclose with respect to personal information. Nonetheless it is clear that those personal details that are integral to one's identity ought to be disclosed if one is concerned about their partner's ability to understand and support them. Moreover, not sharing or disclosing significant personal details or keeping aspects of one's identity private is often experienced as a burden. This is especially true if such aspects of one's identity are significant enough that a person cannot be their authentic self with their partner and must conceal certain elements of their identity and therefore exist as multiple versions of themselves.

In the context of an intimate relationship wherein a man felt secure enough to disclose his diagnoses of having a mood disorder to his partner, he would be effectively helping his partner to understand him, and potentially react in a supportive manner to future disclosures related to his mood disorder. For example, if a person can first tell their partner, "I have anxiety, which for me, means...," they would be able to subsequently disclose "I feel anxious about…and I need…" or "you can show support by…." As a result of these acts of disclosure, a man's partner would be more informed and able to support him as a result. The relationship would also be able to enjoy increased intimacy and closeness as a result of subsequent acts of self-disclosure.

Inclusion and Peace. Related to intimacy and integral to peace studies is the notion of inclusion. Conversations about inclusion as it relates to peace often involve large scale peacebuilding processes and stress the importance of making sure everyone has a seat at the table. Inclusion is also increasingly used in business practices when addressing diversity in workplaces. These larger scale discussions of inclusion and its importance can be mined to reveal truths about inclusion that are valuable to our understanding of inclusion as it relates to intimacy and interpersonal relationships.

A recent study on the relationship among diversity, inclusion, and business performance provided the following description of inclusion:

> Inclusion is tangible. The concept of inclusion incorporates both an active process of change (verb: to include) and an emotional outcome (I feel included). More specifically, feelings of inclusion are driven by perceptions of (i) fairness and respect and (ii) value and belonging. These two elements build upon one another sequentially (Deloitte 2013).

Deloitte's findings have implications not only for professionals in the business world but can also speak to inclusion in intimate relationships and the disclosures that occur within them. We can think of the active process of change as the experience of entering into and maintaining an intimate relationship, more specifically by engaging in acts of disclosure. If a person receives a

positive response from an intimate partner after an act of disclosure, the resulting outcome would be that the discloser feels included, respected, valued, and as though they belong in the relationship. Conversely, if a person experiences a negative reaction from their partner to an act of disclosure, they may feel rejected or devalued.

Emotion Work, Gender, and Disclosure. Emotion work is a concept developed by Hoschild (1979) who explored the governing of emotions, which are generally thought to be ungoverned or incontrollable, by social rules (551). Emotion work is "the act of trying to change in degree or quality an emotion or feeling" and includes the efforts made to suppress an emotion but not attempts to prevent an emotion (Hoschild 1979, 561). Hoschild distinguished emotion work into two categories, evocation, which is the effort to summon an emotion that is not naturally present or occurring, and suppression, which involves undesired emotions (561). Emotion work is triggered by a "pinch" which Hoschild describes as a "discrepancy between what one does feel and what one wants to feel" (562). Hoschild identifies three techniques used in emotion work: cognitive, which aim to "change images, ideas or thoughts in the service of changing the feelings associated with them," bodily, which relates to changing the "physical symptoms of emotion," and expressive emotion work, which is "trying to change expressive gestures in the service of changing inner feelings" (562). Individuals who have mood disorders may engage in emotion work with respect to the emotions they feel as a result of their disorder, for example emotions associated with depression, anxiety, as well as the emotions they feel about their disorder (e.g., shame, sadness).

Emotion work is also done "by the self upon others" (Hoschild 1979, 562) and includes "the enhancement of others' emotional well-being and the provision of emotional support" in the contexts of familial settings and intimate relationships including marriages (Erickson 1993, 888).

The spectrum of emotion work goes beyond one's internal management of their own emotions and emotional displays to include and recognize actions directed at enhancing the emotional health of others. Studies have shown relational emotion work in intimate relationships to positively impact relationship satisfaction (Curran et al. 2015, 168). However, it can negatively impact individuals and relationships when a person sacrifices or loses their sense of self for the sake of doing emotion work (Horne and Johnson 2018, 2).

Included in relational emotion work are acts related to the maintenance and eradication of boundaries in intimate relationships. Emotion work targeted at boundaries in intimate relationships may involve disclosing personal information to one's partner or encouraging one's partner to disclose personal information or feelings (Umberson, Thormeer, and Lodge 2015, 543). Emotion work can also involve the efforts put toward avoiding sharing one's feelings (Umberson, Thormeer, and Lodge 2015, 543). Women tend to engage in emotion work that involves the removal of boundaries, while men are more apt to engage in work that upholds them; men's behavior in this regard is consistent in both heterosexual and gay relationships (Umberson, Thoremeer, and Lodge 2015, 543). As men work relatively harder than women to uphold boundaries in intimate relationships, engaging in acts of disclosure may therefore be more challenging or alien to men.

Masculinity, Health and Risk-Taking

Men's propensity for risk-taking behavior and the subsequent toll this behavior takes on men's health is a consequence of men's adherence to the socially constructed and perpetuated category of masculinity. Men engage in behavior that directly impacts their physical health, such as drinking, smoking, fighting, and also in behavior that indirectly impacts their health, by

refusing to ask for help when something is amiss. As previously discussed, a man's performance of masculinity is influenced by various factors, including socioeconomic status. A man's relative place in his society will also influence the type of risk taking behavior he engages in; depending on whether he is an upper, middle class or impoverished man, the types of risky behavior he engages in to assert his masculinity will vary (Courtenay 2000, 1399). As Will Courtenay illustrates, "by dismissing their health care needs, men are constructing gender […] masculinities are defined *against* positive health behaviors and beliefs" (Courtenay 2000, 1389).

Men's risk-taking with regard to physical behaviors has been theorized and yielding powerful insight into the impacts of masculinity on men's health. Less theorized, however, is men's behavior with respect to emotional risk-taking. While it is certainly a risk to abuse substances, neglect personal safety, and leave potential health concerns unaddressed, it is also a risk to engage in self-disclosure by confiding in a partner, family member, friend, or even physician that one is concerned with one's health and that one may be experiencing illness. This is particularly true of men who are concerned about their mental health, because for a man to admit that he is experiencing issues with his mental or emotional health can be viewed as a source of weakness or vulnerability in the realm of hegemonic masculinity.

Men are far more likely than women to take risks even in situations where it is obviously "a bad idea". When engaging in decision making processes that involve weighing one course of action against another, the differences in behaviour between men and women are less pronounced than when the decision making involves the possibility of engaging in risky behaviour (Byrnes, Miller, and Schafer 1999, 378). With respect to decision-making, the riskiness of a decision can serve as an enticement for men. It is yet to be seen whether men who

are thinking about disclosing their mood disorder to an intimate partner may view the decision as a "to disclose or not to disclose" situation, or alternatively, as something that is a "bad idea."

Men are diagnosed with depression less frequently and therefore receive treatment for depression less frequently than women (Courtenay 2000, 1396). Men's under-representation in depression diagnoses is related in part to men's socialization to suppress their own feelings and refrain from seeking help (Courtenay 2000, 1396). As psychiatrist Frank Pitman (1993) wrote regarding men's experience of depression:

> Men are trained to feel defeated if they acknowledge emotional pain or a need for someone else, they try to fake what they feel […] faking feelings full-time deepens the shame and leads to deeper loneliness and isolation (219).

It is clear then, that engaging in dangerous activities and avoiding help-seeking for physical and mental health symptoms are two types of risk taking behavior that men engage in with the goal of ensuring their masculinity remains intact and unquestioned. Furthermore, men's attempts at mitigating their emotional or health related issues by ignoring them can result in additional and potentially more severe consequences. Investigating their health-related concerns as well as disclosing their concerns to others constitutes a risk for many men, but it is a type of risk that differs from those that they engage in to preserve their masculine identities.

Disclosure Diffusion and Risk

To engage in the self-disclosure that is required to reap the rewards of intimacy is to take an emotional risk. This is because engaging in self-disclosure can result in the discloser being attacked or criticized by their partner after sharing personal information or feelings, which can in turn lead to the discloser being less open as a means of self-protection (Prager and Roberts 2004, 51). Furthermore, someone considering disclosure may consider the diffusion of disclosure and the associated risks. While an individual may be in control of whom they disclose to directly,

they are unable to control who they disclose to indirectly, as the person to whom they disclose, their intended audience, may tell other people.

Self-disclosure may also be seen by men as risking a loss of power in the context of the relationship in which they are considering the disclosure. So long as a man maintains his mood disorder diagnosis as a secret, he is able to thereby control who else has access to this information, and maintain a level of personal privacy. Sharing personal information with someone else is effectively surrendering to that person the power to potentially share said information with others, and results in a perceived loss of power for the discloser. Individuals who are considering engaging in self-disclosure will weigh the anticipated risk against the anticipated utility; what they perceive will be the respective negative and positive results of their disclosure (Omarzu 2000).

Conclusion

Gender is a social construct which has significant influence over nearly every aspect of our lives. Gender influences not only how we show care, or in some instances a lack of care, for ourselves and our health, but also how we care for others in the context of intimate relationships. Our gender is but one aspect of our identity, yet it dictates how we deal with other aspects of our identities, including our disclosure of personal information in intimate relationships. Aspects of one's identity have stigma attached to them, and a person may be more reluctant to disclose information that they feel are stigmatized. Decisions about disclosing personal information are influenced by a person's gender as well as the information itself.

METHODOLOGY

The purpose of this study is to gain a deep understanding of how men with mood disorders deal with disclosing their mood disorders to their intimate partners. This information is best discovered by consulting experts – men with mood disorders – to engage in collaborative interviews using open ended questions. The information gathered from the interviews conducted provide insight into the thoughts and feelings men have when considering disclosure, which in turn provides a deeper understanding of the challenges they have faced and may continue to face, as well as positive experiences they have had. These insights stand to benefit men with mood disorders, their partners, therapists as well as those who study mood disorders, intimacy and disclosure, masculinity and Peace and Conflict studies.

Approach to the Research

This study was conducted using a phenomenological approach. A phenomenological approach operates under the premise that relying or fixating solely on objective facts can only provide a partial representation of an event or process (Bogdan and Biklen 2007, 25) and human experience is what we must examine in order to have a full representation (Groenewald 2004, 42). Phenomenological approaches seek to understand the subjective experiences and feelings of "ordinary people involved in a particular situation" (Bogdan and Biklen 2007, 25). In order to do this, a person undertaking a phenomenological study must endeavor to abandon what they may already know or think that they know about a phenomenon from theories and other sources, and instead prepare to study "life as it is lived" (Moran 2000, 5). The goal of a phenomenological study is to "describe the meaning of the lived experience of a phenomenon" (Starks and Trinidad 2007, 1373). A phenomenological study is conducted by interviewing people who have lived the

experience of the phenomenon, and who are thereby the experts on the phenomenon because of their lived experience (Starks and Trinidad 2007, 1373). By recognizing those with lived experience of a phenomena as experts, the phenomenological approach brings forth perspectives on a set of circumstances to be studied that are missing from disciplines or modes of thinking such as science or philosophy (Sokolowski 2000, 209).

The phenomenological approach to qualitative research has been heavily influenced by the sociologist Max Weber. The Weberian concept of *verstehen* recognizes that individuals have their own unique biases and experiences, and researchers must be cognizant of and reflect upon their own biases when conducting research (Bogdan and Biklen 2007, 25). Researchers must ensure that they appropriately deal with any preconceived notions of how others experience situations (Bogdan and Biklen 2007, 25). In order to conduct this study using a phenomenological approach, I had to acknowledge and reflect on my own feelings about masculinity. I also had to reflect on how I think men act in intimate relationships, which is heavily influenced by my own personal romantic history. I reflected on how people manage the disclosure of mood disorders and other potentially stigmatized aspects of their identity, which is something I have personally experienced as both a discloser and a person to whom information is disclosed.

This study was not conducted with the goal of determining scientifically if or how men disclose their mental illnesses to their intimate partners, nor does it seek to produce any normative or prescriptive statements with regard to whether or not people ought to disclose their mental illness to their intimate partners. Phenomenology emphasizes rich description over explanation (Sadala and Adorno 2002, 283). Rather than focus on why the consultants make the decisions they do, this study focused on the individual experiences of a specific phenomena:

being male, having a mood disorder, considering disclosure to an intimate partner.

The resulting information from this study displays a variation in experiences of men who have similar circumstances. The information collected demonstrates that individuals with mood disorders may have additional considerations when participating in intimate relationships that others without mood disorders do not. Another goal of the study was to identify if particular reactions to disclosures of mood disorders influenced subsequent decisions regarding disclosure.

This study was conducted with the use of individual interviews using open ended questions. The particular situation(s) that individuals were asked to reflect on were the situations in their personal lives when they have been intimately involved with another person, and considered disclosing to this person that they have a mood disorder. The consultants were asked to reflect on various situations where they have been faced with this decision, and recount, in as much detail as possible their thought processes and feelings as related to their experiences with disclosing their mood disorders to intimate partners.

Recruitment and Selection

The minimum age for consultants was 18 years old at the time of their participation in the study. Initially I intended to make the minimum age older, at around 24, with the presumption that by this age, men may have had more experience with relationships as well as their mood disorders. My committee helped me recognize that a younger person's experience is equally valuable and that the more restrictions or criteria I set for consultants the less interest I might be able to generate. The goal of the selection was to find consultants with a broad range of relationship experience, including people who are currently or have been in common-law relationships, marriages, people who have been divorced or separated, people who have engaged

in casual sex, and people who have been in serious dating relationships. Of the five consultants I interviewed, two were married, one was exclusively dating someone, and two were single at the time of the interviews.

As this is a small study phenomenological study and the thoughts and ideas of the consultants are at the centre of the analysis, no demographic information was obtained from the consultants. Were I to do the study over, I would seek a more demographic information in order to provide more background and contextual information in the portrayal of the consultants. The lack of this information in the portrayal of the participants can be seen as a limitation of the study.

A key principle of qualitative research is that the size of the sample sought for a qualitative study should be chosen based on whether or not it will be large enough to answer the research question (Marshall 1996, 523). Simply put, the aim of this study is to answer the question, "How do men with mood disorders think about disclosing their mood disorders to intimate partners?" In order to address this question, I decided that a reasonable amount of consultants would be four people, and I ended up interviewing five. This number of participants provided me with a manageable amount of data with which to engage as I transcribed and analyzed it. Another consideration with respect to determining the amount of consultants was the richness of the data to be mined from each interview. In the field of health care studies, for example, it has been demonstrated that while smaller samples may not lend themselves as well to generalizability, they yield more information from each case or interview conducted, so the resulting data are richer and more detailed (Curtis et al. 2000, 1003). As the purpose of the study is not to identify generalizations but to investigate different experiences of the same phenomenon, a smaller sample size was most appropriate for this study.

Recruitment for the study began as soon as I received approval from the Research Ethics Board on July 26, 2017. The individuals who participated in the study, or consultants, were recruited by sharing posters on my personal social media accounts, specifically Facebook and Instagram. There are several practical reasons for seeking consultants via social media. First of all, I hypothesized that because respondents would most likely be known to myself in some capacity, any pre-existing relationship I had with the consultants may help to establish a level of comfort - and ultimately trust - which could potentially contribute to more openness when discussing experiences of a personal nature, namely the respondent's relationship experience and their experience with having a mood disorder. The use of social media to recruit consultants to participate in qualitative research, and share information with said consultants, has been found to aid greatly in the building of rapport (Lunnay et al. 2015, 104). Secondly, respondents were able to view and respond to the post discretely from their mobile phone or computer, thus helping to maintain confidentiality from the very beginning of the process. I considered that men who engage in selective disclosure may not respond to a poster hanging in a public space, declaring that it was seeking male participants with mood disorders if they have to stop and read the poster and then record contact information if they are interested in participating.

Social media has been identified as a means by which to recruit persons with stigmatized conditions such as HIV/AIDS and depression, to participate in online surveys (Yuan et al. 2014). It has also proven to be a successful way to connect with "hard to reach" populations and recruit said populations to participate in studies (Martinez et al. 2014). For these reasons, I expected social media to yield positive results in terms of recruitment for this study due to the fact that consultants who may also feel stigmatized could respond to my poster privately. I shared my posts on my personal Facebook and Instagram accounts, and enabled the posts to be shared by

others, allowing me to reach audiences beyond my personal Facebook friends list and Instagram followers.

Recruitment via social media is also a convenient, cost-effective process, particularly because the recruitment poster can be shared multiple times, giving it the capacity to reach a number of potential consultants in a number of demographics (Allsworth 2015). Anyone with whom I am connected via social media will be capable of sharing the posters on their accounts, thus broadening the scope of recruitment. Individuals who see the posters on social media accounts other than my own personal ones may chose to ask their "friends" about my work and engage in an informal vetting process before deciding to contact me personally with questions or to express interest in participation.

In addition to being cost effective, using social media to recruit participants was also efficient with respect to time (Yuan et al. 2014). Maintaining and posting on my personal social media accounts required no monetary commitment, and also saved me a considerable amount of time because posts can be shared within a matter of seconds and thus I was able to share my post as soon as I received my ethics approval. It also allowed me to save time that would otherwise need to be spent travelling to various locations around the city to physically hang posters. I was able to respond quickly to inquiries from interested persons who viewed the poster.

Rather than having to physically visit posters in order to ensure they were still intact and on display, I was able to monitor the posters from my phone and laptop to see if they had been viewed or shared. I reposted the recruitment poster several times on both Facebook and Instagram to increase its exposure, which took a matter of seconds each time. I did not need to obtain permission from any other entity to share the recruitment posters on my personal social media space, while I would have to obtain permission from groups or organizations to post

physical posters in physical spaces. The time and money saving aspects of social media with respect to displaying a poster are significant. Furthermore, recruitment via social media allowed potential consultants to reply and correspond with myself quickly and discreetly.

There were of course limitations to using social media as a recruitment tool for consultants. Firstly, not everyone has social media. Even those that do have it may not have easy access to it, and those that do may simply scroll past the poster; social media posts can be easily ignored. There is potential for the group that is recruited to share certain biases, for example social media users tend to be younger and use the internet more often (Khatri et al. 2015). I was prepared to reach out to Mental Health organizations within Winnipeg, including the Canadian Mental Health Association[1] and the Mood Disorders Association of Manitoba[2], in the event that I was not able to generate enough interest from my social media posts alone, and request permission to display my recruitment poster physically at their respective offices. I was able to interview five men and therefore did not seek to display my poster elsewhere.

The posters explained that I was looking to interview people for my MA thesis and that I want to learn more about how men with mood disorders think and feel about disclosing their mood disorders to intimate partners. The posters also stated that in order to participate, people had to be over 18, identify as male and have a mood disorder. To my delight and relief, I received messages through Facebook the same day I shared my post. Of the five men I

[1] The Canadian Mental Health Association's Winnipeg office is located at 930 Portage Ave. The organization "facilitates access to the resources people require to maintain and improve mental health and community integration, build resilience, and support recovery from mental illness." https://mbwpg.cmha.ca/about-cmha/our-vision-mission-and-values/

[2] The Mood Disorders Association of Manitoba is located at 100-4 Fort Street. The organization provides "support, education and advocacy for those living with a mood disorder, co-occurring disorders or other mental health illnesses". http://www.mooddisordersmanitoba.ca/about-us/

interviewed, three responded to my original Facebook post, one responded after his wife saw the post on my Facebook page, and another responded after seeing the post on my Mom's Facebook page.

All correspondence between myself and those who expressed interest, but ultimately did not participate, was permanently deleted from my personal password protected computer and/or laptop. Several people contacted me with whom I shared more information about the study, including my consent forms and sample interview questions. When some of these men did not respond after receiving the material, I found myself feeling a mix of concern and also disappointment in these situations. Some of the men included in their initial messages how eager they were to talk about their mood disorders. For these men I felt especially concerned, as I recognized how hard it must be for them to feel as though they have no one to talk to. Ultimately I had to remind myself that I am not a counsellor and that there are limits to how much I could help these men if at all, and when some of the men did not respond after several exchanges I found myself hoping that they were alright and that they had access to resources to help them with their mood disorders.

I made sure not to be too aggressive with potential consultants and some of the communication between myself and potential consultants sort of fizzled out after a few exchanges. I would check in with men after about a week of sending them the consent forms and other information about the study, and if they did not respond after that I ceased to contact them and assumed they were not interested in proceeding. When men were interested in participating, I endeavored to arrange a time to meet as soon as was convenient for them. I wanted to secure interviews as soon as possible so that I could resort to advertising my study outside social media if necessary. I did four of the five interviews over the course of two days, three in person and one

over FaceTime. The fifth and final interview was conducted a week after the first four. I initially intended to space the interviews out in a way that would allow me to fully transcribe one before moving onto another and also to avoid any burnout on my part. However, in the interest of conducting the interviews as soon as possible, the first four were conducted over two consecutive days. An unforeseen benefit of conducting the interviews close together was that the conversations were so fresh in my mind that I was able to draw connections between different interviews as they were happening. This helped me considerably as I wrote my analysis and also reinforced that my chosen subject matter was of significance.

Consent and Confidentiality

I ensured that each potential consultant was made aware of the nature of the study, what I hoped to learn from it, and how the findings would be disseminated, in order to obtain informed consent. Consultants were provided with thorough details regarding the type of information they would be asked to provide, how it would be stored, and how it would be destroyed, before the interview began. Although every effort was made to ensure potential consultants understood the aim of the study and the nature of their involvement, there was of course a possibility that consultants could change their minds about participating at any time in the process, and reconsider whether or not they are willing to share, or the scope of what they are willing to share (SANE 2017). Before each interview was conducted, consultants were reminded that they could stop at any time during the interview. Therefore, consent was informed and also ongoing.

The time of the consultants was very valuable and I recognized the importance of giving consultants an estimate of how much of their time will be required in order to complete the interview. I included on my posters that the length of the interview would be approximately sixty

to ninety minutes. I knew that the duration of each interview would depend largely on how much each consultant chose to share, and that my participation in the process would predominantly consist of listening and asking questions. In reality, the shortest interview was less than thirty minutes long, and the lengthiest was around three hours.

Consultants were provided with all information regarding the study via email so that they had a copy of it to refer to while deciding whether or not to participate in the study. These measures were undertaken to ensure all the potential consultants were able to provide informed consent. The consultants had my contact information and instructions to contact me with any questions or concerns they may have regarding their participation. I advised the consultants that we would go over the consent forms together at the time of the interview, at which point we would sign them. The signing of the consent form and checklist ensures both parties are aware of their rights and responsibilities within the process. I stored the signed consent forms in a locked cabinet to which I alone have access.

The purpose of using pseudonyms is to protect the identities of the consultants. I presumed that all the consultants would choose pseudonyms to be identified with in the transcripts. However, after some consideration I realized that as important as it is to protect a person's privacy, it is also equally important not to silence those who are open about their mood disorders. Consultants therefore had the option to choose their own pseudonyms prior to meeting for the interview itself, as well as pseudonyms for anyone they might discuss or mention over the course of our conversation, such as friends, family members, and current or former intimate partners. Those consultants who did choose to use pseudonyms will be identified by them in all subsequent publications that result from this research. No physical document or recording will exist that connects the true identity of the consultant to the information they provide in order to

ensure confidentiality and privacy are maintained during the study as well as following its completion.

Because the study requires consultants to reveal personal information about themselves, I considered that a public setting, such as a coffee shop, might not provide the privacy required to enable the consultants to feel safe. Using a public place could result in consultants feeling anxious about being overheard by people around them, and potentially encountering people they know. In addition to the safety and comfort of the consultants, finding a space quiet enough to record the consultation and not an excess amount of background noise was a secondary concern. In order to secure a space that addresses all of these issues, I was prepared to contact the University of Manitoba and the University of Winnipeg to obtain access to private meeting rooms where the interviews may be conducted[3]. I also researched community centers and other places within the city, such as branches of the Winnipeg Public Library, that could be used at little to no cost and offer the privacy required for consultants to feel safe and comfortable. I consulted fellow PACS students who had conducted interviews for their research to gather additional recommendations regarding appropriate interview spaces within Winnipeg. Every effort was made to ensure that interviews took place at a location that is both comfortable and geographically accessible to consultants.

A list of counseling services which includes the addresses, hours and phone numbers for the services, was provided to all consultants at the beginning of the interview.[4] This was done to

[3] I contacted Jason Brennan, Business and Operations Manager at the Mauro Centre (204)474-7273 re: rooms for interview use as well as the Winnipeg Public Library at Millennium, Henderson, Louis Riel, and Sir William Stephenson Libraries re: their tutorial rooms which are available at no charge

[4] Klinic Crisis Line (204)786-8686,1-888-322-3019, (204)784-4097;Manitoba Suicide Line: 'Reason to Live'1-877-435-7170; The Men's Resource Centre (204)415-6797,1-855-672-6727;Manitoba Mood Disorders Association Peer Support Line (204)786-0987

ensure they have information regarding counselling assistance in the event that they became distressed during or following the interview. The provision of such a list is particularly important when interviewing people about sensitive or personal topics ("Research on Sensitive Topics" 2017). When necessary, I asked consultants if they already had access to resources that they are presently or generally comfortable using, and referred back to them as appropriate. Consultants were informed prior their interviews that they may stop any time, whether they need to take a break and collect themselves or to stop the interview completely. Every effort was made to present participants with an exhaustive list that offers several services that are accessible to consultants in terms of cost, location and hours of operation.

The Consultation

The study is designed to hear the stories of men with mood disorders who have had to decide whether or not to disclose their mood disorders within their intimate relationships. Therefore, the aim of the study could not be satisfied by surveys or statistical analysis. It could only be conducted through a conversation between myself and individuals who have lived this experience and are willing to share it. For this reason, those who responded to the poster and decided to share their story engaged in a collaborative process. Without their willingness to share, the study would not be possible. The information they shared with me guided the study, and therefore their contribution goes beyond just the mere presentation of data.

The interview itself consisted of a series of open-ended probing questions designed to encourage consultants to discuss their relationship history as well as their experiences with mood disorders. Open ended questions were used to allow for a broader range of information to be collected as closed ended questions may not have served to encourage consultants to divulge as

much information, as they can often be answered with few words. The goal of the interviews was to collect a sort of oral history from each consultant. Oral histories from individuals are used in order to collect personal information, and may focus on a specific event or series of events in time or history (Babbie and Benaquisto 2014, 337). Oral histories can provide researchers with insight into not only the experiences of those they consult with, but also the lives of others with similar circumstances (Babbie and Benaquisto 2014, 337). Through the course of these interviews I asked consultants to reflect on the events of their diagnosis or cognizance of their mood disorder, the intimate relationships they have participated in following their diagnoses or awareness, and their experiences of disclosure. I encouraged participants to share the feelings they had during these experiences.

The information that the consultants were being asked to share may be deeply personal or highly sensitive, depending on each consultant. It is the task of a researcher to encourage consultants to disclose and divulge personal information, and doing so requires the researcher to develop a rapport with their consultants (Dickson-Swift et al. 2006, 856). The more personal the information is, the greater the challenge for the researcher, and in situations where personal information is being shared, more personal settings may be called for, such as the researcher and the consultant running an errand or sharing a meal together (Dickson-Swift et al. 2006, 856). The researcher must balance the need to develop a rapport with their consultants with the also ensuring that they maintain professional boundaries. I did feel that by the time I met with each interviewee some rapport had been built between us, either by virtue of our relationship prior to their interest in the study, or as a result of our exchanges about the study leading up to the meeting.

Interviews began by engaging in casual conversation with consultants, touching on

subjects that were discussed through initial communication when the consultant first became interested in the interview itself. The goal here was to establish a rapport and a comfort level between consultants and myself, as rapport and empathy are crucial to a phenomenological study (Lester 2014, 2). When it was time to shift from the initial conversation to the interview portion, I opened the interview portion of the discussion by asking each consultant how long they had been living with a mood disorder. From there consultants went on to discuss their personal experiences with their awareness of their mood disorders, coping skills, and what it feels like to have a mood disorder. When a question was triggered in my mind based on something a consultant said, I hung onto it mentally while ensuring I was still actively listening, a practice that became easier with time.

Consultants were thoroughly prepared for the nature of the interview. They were provided with the interview guide immediately after confirming their interest, in order to ensure they were able to provide informed consent and comfortable with the subject material. Some qualitative researchers describe the interviews they do as having therapy like qualities, both for themselves and for participants, due largely to the intimate nature of the discussions that take place (Dickson-Swift 2006, 860). I do not have any professional training in crisis management or counseling that will enable me to de-escalate a distressed person, nor am I trained therapist. I had to be aware throughout each interview of my limitations in this regard and not attempt to "counsel" any consultants, as doing so could have negative consequences for the consultants, myself and ultimately the work I am trying to do (Dickson-Swift et al. 2006, 860). None of the consultants became distressed during the interview itself but at times they did describe situations in which they experienced pain, rejection, fear and other emotions.

I did find myself at times relating to consultants'' feelings and experiences due to my

own personal circumstances. I also grappled with feeling empathetic toward them but remaining outwardly objective throughout our conversations. For me this meant that at times I had to resist the urge to commiserate with consultants or compare my own experiences to those described by the consultants. I concentrated on engaging in active listening practices in order to keep the focus on the consultants and their experiences.

As a responsible researcher, I considered the ways in which my own personal safety as well as the safety of the consultants could be at risk during the interviews, despite the precautions I took before the consultations. The Social Research Association (2017) identifies the following potential risks for researchers engaging in fieldwork:

- physical threats or abuse
- psychological trauma, either from listening to subjects' traumatic experiences or from actual or threatened violence
- comprising situations, where you could be accused of inappropriate behavior
- causing psychological or physical harm to others
- increased exposure to risks of everyday life and social interaction, such as road accidents and infectious illness.

In order to minimize the likelihood of experiencing any or all of the safety risks, I took several precautions. Firstly, in consideration of both my safety as well as the safety of consultants, I ensured that the interview locations provide enough privacy for the interviews not to be compromised, but not so much privacy that if a crisis arises, I was able to remove myself from the situation and seek help for a consultant in distress if necessary. Fortunately, this was not an issue.

All interviews took place in locations I was familiar with and therefore I was aware of where the exits are located, as well as the proximity of the rooms to other people should I require assistance ("Interviewing For Research - Safety" 2017). I had a contact person who I kept apprised of the time and location of each interview I conducted. I did not conduct an interview

unless this contact person was available, and I notified this contact person once an interview was completed and I was leaving the location. I ensured my mobile phone was fully charged and brought it with me to each interview ("Interviewing For Research - Safety" 2017). I used my mobile phone to record the interviews but ensured all alerts were disabled so as not to interrupt or distract from the interview process.

Preparing the consultants beforehand by providing the questions and information about the purpose of the study, as well as being open to answering questions at every stage of the process, helped to ensure that there was little to no risk for the consultants to experience psychological trauma as a result of their participation. With respect to the potential for psychological trauma resulting from hearing consultants' potentially difficult or painful stories, I made available to myself the same counseling resources I shared with the consultants. If, for the sake of my own wellbeing, I needed to discuss aspects of interviews with a professional, I knew I was able do so without breaching confidentiality (McCosker, Barnard and Gerber 2001, 6). I consistently behaved in a professional and ethical manner in order to avoid being perceived as or accused of inappropriate behavior during any of my correspondence or interactions with consultants. It was extremely important to convey to consultants that I take my project seriously and would treat them with respect.

Knowing the consultants on a personal level outside the study created more opportunity to discuss matters unrelated to the study and thus I ensured that during the interviews themselves we stayed on topic in the interest of time and also consistency in our discussions. I considered my own physical health as well as that of consultants when scheduling interviews to minimize the risk of spreading any contagious illnesses that might befall anyone, and exercise general common sense and consideration to avoid other injuries or incidents. When I met outside in

parks with two of the consultants, I ensured we had somewhere that was comfortable enough to sit for a longer period of time. I also made sure we were not close to any other stationary park goers who could overhear our conversation, or close to any background noise that may affect the quality of the interview recording. At one point during our interview, which took place in a public park, John and I were interrupted by someone wanting to speak to us about an app that translates the Bible into sign language. When we saw the person approaching, we ensured that we stopped our conversation before the person was within earshot, and did not return to it until they were far enough away.

Data Handling and Analysis

Each interview was recorded on a digital audio recording device, with the written permission and consent of the consultant. I transcribed each interview and saved the transcriptions on my personal password protected laptop as close as possible to the completion of the interviews. Doing the transcribing myself was cost effective, and also allowed me to engage more with the material. Furthermore, transcribing can sometimes require a degree of interpretation on the part of the transcriber (McCosker, Barnard and Gerber 2001, 6). As the conductor of the interviews, I was better suited to engage in said interpretations than someone who was not present at the interview. Other than the consultants themselves, I am the only person who knows who used a pseudonym and who did not. Doing the transcribing myself also ensured extra privacy for the consultants.

As I conducted the interviews, and later, as I worked through the transcriptions, I made note of several themes, some of which I anticipated would arise, and others that I was not expecting. The anticipated themes included the men's experience of stigma as well as the impact

that both positive and negative experiences with disclosure had on their future disclosures. I also expected that even those men who felt relatively more comfortable discussing their mood disorders did not feel that disclosing them was something they would do early in a relationship; that disclosure is something that happens after some intimacy and trust are built to provide a sort of foundation for disclosure.

There were themes that I did not expect to uncover. One of the most consistent and significant was that disclosure is a process rather than an event, and furthermore there is a sort of disclosure to oneself or internal disclosure that may occur separately from external disclosures to intimate partners and other people. Two of the men discussed their experiences with disclosing other stigmatized information, one regarding his sexual orientation and another regarding his diagnosis of a viral sexually transmitted infection. There were also two men who described their experiences with dating women who also had mood disorders. All of the themes will be discussed further in the analysis section.

All of the men expressed interest in reading the study upon its completion. Each consultant was sent a copy of the transcript of their interview. In the interest of ensuring they felt they were properly represented, I emailed them each a copy of the analysis section. I encouraged them to provide me with feedback, asking them to identify any information that they would like omitted, and also to add any information to the existing dialogue if they had more to say about a topic or wanted to add to a thought someone else posited that they did not speak to in their own interview. This was important as it allowed the consultants to engage with their contributions in the larger context of the project rather than only seeing the transcriptions of their individual interviews.

The information that arose from the interviews is linked to information from my Theory

and Context sections where applicable. These findings are used in my Masters Thesis defense and could potentially be used in Academic Journals or presentations. The study has the potential to bring new information to several fields including Peace and Conflict Studies, Masculinity Studies, Mood Disorder Studies, fields addressing Intimacy and Disclosure, and Stigmatization. It has the capacity to be of particular interest and benefit for therapists, men with mood disorders, intimate partners of men with mood disorders, as well as friends of men with mood disorders whom they may consult with when considering disclosing their illness to intimate partners.

CONSULTANT CONVERSTATIONS

Presentation of Data and Discussion

In response to my social media posts, I met with five men who agreed to speak candidly about their mood disorders and their romantic relationship history. At the time of our interviews, John and Andrew were in their late twenties, Alex and Shane were in their early thirties, and Brad was in his early forties. Their relationship statuses varied at the time of their interviews: Andrew and Alex were single, Brad was dating someone, and Shane and John were married. The purpose of the study was to learn through the experience of the consultants rather than to collect a set of data from which to draw larger conclusions. The men discussed their individual experiences with mood disorders, sharing stories of the onset of their mood disorders, how it feels to live with a mood disorder, their coping skills, and the stigma they have faced. Some of the men spoke about how they came to disclose their mood disorders to intimate partners, how partners' reactions to their disclosures made them feel, as well as their personal beliefs regarding the importance and significance of disclosure in intimate relationships.

The onset of a mood disorder and one's ability to recognize a mood disorder for what it is is a complex process; one cannot effectively disclose information to another person without having at least some understanding themselves of what it is they are trying to disclose. In this sense, the men described two types of disclosure processes, what I call external and internal disclosure. External disclosure entails the disclosing of one's mood disorder to partners whereas internal disclosure is the process of disclosing to oneself or developing one's own awareness that something is not right with them, and that perhaps one needs help in identifying or managing what they are experiencing. Internal disclosure may prompt a person to seek help from a friend,

family member, or medical professional, or to do research on one's own about what they are experiencing. External disclosure is the process of sharing oneself with another person. A person's choice to disclose their mood disorder to their partner may reveal how they feel about the relationship in addition to being a revealing act about them personally. A partner's response to another's disclosure may impact how the discloser feels about themselves as well as the relationship as a whole.

The men recounted their experiences with disclosing their mood disorders to intimate partners, which revealed that disclosure is better understood as a process than an event. Men described their experiences with external disclosure as well as the reactions they received from their partners, both positive and negative. Men discussed the range of factors that influenced their decisions about disclosure, including the seriousness of commitment in the relationships as well as their own acceptance of their mood disorder, and the response they expected from their partners to the disclosure.

The choice to disclose can be attached to a sense of responsibility in two ways. Firstly, some men identified a responsibility to themselves as part of caring for their own mental health, to be open with those close to them. This openness about their disorder and how it affects them ensures their partners know when and how to assist them. Secondly, building trust is important in a relationship, each person in a relationship is responsible for being honest to their partner, and part of that is being honest about their health and who they are; in this sense disclosure represents adhering to the principle of being honest in a relationship for the sake of the health of the relationship.

Men spoke about asking for answers, support, and the impact of other's reactions to their disclosure. Two of the men provided additional insight into their experiences with disclosing

difficult subjects other than their mood disorders. One man spoke about disclosing his sexual orientation, and the other discussed his diagnosis of Human Papilloma Virus and his subsequent experiences with disclosing this to potential sexual partners. Both men compared their experiences with disclosing these other personal details with those of disclosing their mood disorders to intimate partners. The sections that follow are based on the themes that emerged from the conversations with the consultants. Some of the themes I anticipated, such as Disclosure as Risk, others, such as Internal Disclosure, were a complete surprise.

Internal Disclosure

I opened each interview by asking the person how long they had been living with a mood disorder, rather than asking if or when they had received a formal or official diagnosis. This was done in order to avoid putting people in a position where they may feel they needed to prove or justify their mood disorder. An unplanned or unexpected insight from this question was that it drew attention to the process of realization each man went through on their own, of their own coming to awareness of the symptoms they were having, which eventually lead them to identify what they were experiencing as a mood disorder.

Alex, whom I interviewed first, stated "I was diagnosed with clinical depression and seasonal affective disorder when I was fifteen, so I mean, that's when it became apparent but like I was acting out and stuff before, so that was probably a function of that I would think." Shane estimated he has been affected by his mood disorder for the past fifteen to twenty years, and Brad stated he had been living with a mood disorder since his early twenties. John reflected on his diagnosis, which he received about two years before our interview. Like Alex, he was able to look back after his diagnosis and recognize things that may have been indicative of it earlier on,

"it feels like I've been living with it for a lot longer… I did not think there was any disorder but in hindsight all the signs were there." During his initial experiences with the symptoms of his mood disorder, John did not know the cause of his experiences. Now that he has received a diagnosis, he is able to reflect on his experiences and identify indicators of his mood disorder.

Andrew was able to pinpoint a precise moment in which he realized something was not right with him. He had this realization while he was working in an isolated camp shortly after he graduated from university:

> I was hanging out with my buddy. Russell was sort of my right hand man at work.
> And there was a song, and it was called "Watching Airplanes" by Gary Allan. It's a country song.
> And he's like, "Do you know what this song is about?"
> And I was like, "No, absolutely not. I just figured it was a breakup song."
> And he's like, "No, the guy's wife killed herself."
> And it was really weird, 'cause like, just that statement, it was like the needle skipped off the record. And just like, everything about my thought process changed after that.
> And being in a very isolated environment—where I was in charge at work, there was like 20 guys there, and I was the one in charge—became very overwhelming.
> And then I found that conversation was just sort of like all I could really think about. (Andrew)

Andrew's experience illustrates how a person's awareness of their own mood disorder is something that may develop over time, and can even take someone by surprise. This is especially true because it is not the only challenge someone will be facing in their life; a person's job, educational pursuits, family, friends, and living environment are among the numerous obligations a person may be dealing with in addition to a mood disorder. These additional strains on one's energy and self awareness may affect their ability to zone in on the mood related symptoms they are experiencing.

One's knowledge of mood disorders generally as well as knowledge about their own experience of their mood disorder, symptoms, effectiveness of various treatments, triggering of

episodes, has significant bearing on their ability to engage in both internal and external disclosure. It can lead to self-awareness, or lack thereof, and the development or acquisition of the strength and words to determine for oneself whom to disclose to and when. For someone with little awareness of mood disorders, the act of disclosing as well as being disclosed to are near impossible tasks. This issue could be avoided by more education about the prevalence of mood disorders, which would serve to eradicate some of the hesitancy people may feel to acknowledge their own experiences of mood disorders and seek help for them, or for people to recognize the symptoms of a mood disorder in others, and listen not only to what people may be saying but also to what they are not able to say, and to know which questions to ask.

It is also important to consider age with respect to how someone copes with their mood disorder. Alex was diagnosed as a teenager. He explained his progression with becoming more accepting of his mood disorder over time:

> As you grow and you get older, you become, you know, more mature.
> And then I think that probably also makes it easier to deal with, because you're not fighting with yourself so much cause you're not a kid, right
> Like kids and teenagers in your adolescence, everything is changing so quickly, so rapidly
> Your life is changing, your body is changing, everything's changing, your mind is changing, and like its just a lot to handle and then you sprinkle on top a little bit of depression and you're just like "fuck, sweet man, awesome, let's do this"
> But as you get older, I think it becomes easier and easier to deal with because you, you're mature about it and you've gone through life experiences, everybody has that shit, you know what I mean, so, you just become more aware of everything and aware of people around you (Alex).

As Alex experienced firsthand, adolescence is difficult in itself. As a person gets older, they may develop coping skills to deal with various challenges in life, including mood disorders and their symptoms. The age at which a man experiences internal disclosure as well as the time in which they live can both influence his experience and perception of his mood disorder.

Official diagnoses are also often accompanied by the provision of resources. Resources may include medication or counselling, and the resource of language, which allows someone to identify to themselves and others what they are experiencing, and conduct research to better understand their own condition and the needs they have relating to their condition. Of course a man's access to medical treatment for and information about mood disorders will be influenced by his socioeconomic status as a well as both where he lives geographically and the culture in which he lives.

Knowledge can facilitate self-acceptance, which has been demonstrated as a key factor in both coping and disclosure, as it is perhaps easier for someone who has accepted their condition as a trait rather than something that defines them to explain to others what it is, how it affects them, and how others can best support them. A mood disorder is one more facet of a person's identity which they need to grapple with. If a person living with a mood disorder is unable to identify their mood disorder and understand what it means for them as an individual, they experience internal conflict and be unable to live as the best version of themselves. The ability to reach your full potential is a fundamental part of positive peace. A person who is internally struggling with any part of their identity, including a mood disorder, is thereby experiencing a form of structural violence.

Responses to External Disclosure and Support Seeking in Intimate Relationships

For men, help-seeking as well as receiving help are often associated with weakness and a loss of power (Addis and Mahalik 2003, 11; Evans and Wallace 2008, 486). Men are more likely to seek help for mental illness or psychiatric issues on the advice of someone else rather than going straight to a professional (Rogers and Pilgrim 2005, 69), and men list mental health issues

amongst the health concerns they are least likely to seek medical attention for (Michniewicz et al. 2015, 9). For these reasons, responses to men's external disclosures of mood disorders and displays of help-seeking behaviour can have significant consequences for men's health with respect to the likelihood of men seeking professional help when necessary. Responses to men's disclosure of mood disorders will also affect men's propensity to engage in subsequent external disclosures.

Shane recalled trying to communicate what he was experiencing to his first girlfriend. This conversation took place prior to Shane receiving any diagnosis or being able to name or identify for himself what he was feeling:

> I remember being on the phone with her once. And I think maybe we had broken up, and we were just talking. And I really like missed her, so I said something along the lines of, like, "I feel sick" or "I'm sick."
> And she said "what the fuck are you talking about?"
> And I said like "I just feel, like sick."
> And she was like, "You're not sick. You're fine."
> And I was like, "Okay, I guess I'm fine."
> Before that, we had dated for like two and a half, three years, before I said anything.
> But I can remember like laying in the bed that I was laying in, talking to her on the phone, and saying it really quietly.
> And her saying like, "You're not."
> And I was like, "Okay, I guess I'm not." And this person had a degree that was related to mental health.

From Shane's recollection of this attempt to disclose, it is obvious that this was a challenging situation for him. He did not explicitly identify a mood disorder or any specific symptoms in his conversation with his ex-girlfriend, and she did not invite him to explore or elaborate on what he was trying to share, and he was effectively silenced as a result of their conversation. Shane's process of internal disclosure here was overlapping or intersecting with an attempt to make an external disclosure to his girlfriend, but her response contributed to him ceasing to explore either disclosure any further at the time. Shane's reluctance to disclose his mood disorder to others

after the negative experience he had with his ex-girlfriend is characteristic of individuals who feel attacked or criticized after sharing personal information with their partners (Prager and Roberts 2004, 51).

Shane's experience highlights an important consideration stemming from a scenario that others have likely faced and will continue to face. Because disclosure is a process rather than an event, a person may take a step toward disclosing in an attempt to gauge their partner's reaction. A discloser may just brush the surface of the topic or downplay it in order to protect themselves in case they sense that their partner does not appear to be accepting of what they are saying. It is also possible that a partner may inadvertently dismiss the disclosure by trying to provide reassurance or comfort, but ultimately have the effect of being silencing and cutting off an effort to talk about the discloser's experience.

Shane's recollections of his attempt to disclose his mood disorder illustrates that the onset of a mood disorder can predate a person's cognizance of what it is like to have one. Their experiences show that it may take time to recognize what is happening to you, and therefore it takes time to find the words to express it effectively to someone else. Even if you do summon the courage to talk to someone about your mood disorder, there is no guarantee you will be heard. Being silenced or rejected by someone you disclose to could lead to you deciding not to disclose to that person again, or anyone else. It could even prevent you from further investigating your feelings or symptoms on your own and therefore interfere with the process of internal disclosure as well as future external disclosures.

The act of disclosure involves anticipation: the discloser anticipates or hopes that they will receive a response from the person to whom they disclose. A disappointing or even dismissive response is always a possibility, making each disclosure a risk. When disclosing a

mood disorder, the discloser may want to first consider who they are disclosing to and their relationship to the person that they intend to disclose. For example, if a person were considering disclosing that they are experiencing issues with their mood to their doctor, they ought to first think about their doctor-patient relationship. They may prepare for the disclosure by describing to their doctor the symptoms they are having in anticipation that the doctor may administer tests or other methods to apply a diagnosis and eventually a course of treatment.

In the context of a romantic relationship, however, a discloser should consider their relationship to their partner and the type of help or response they anticipate. A partner cannot provide the same response to a disclosure as a doctor or other health care professional because the contexts of their relationships and the duties attached are different. A partner may, however, provide compassion, attentive listening, and help the discloser arrange to see a doctor and ultimately get answers in addition to support.

John described the challenges he faced in communicating his feelings with his partner before he received an official diagnosis from his doctor. He explained two types of behaviours that he engaged in when trying to discuss how he was feeling with his partner, which he calls "answer-seeking" and "support-seeking." Answer-seeking involved John asking his partner specific questions about what he should have been doing to handle the difficulties he was having with his mood, whereas support-seeking is what John identified as asking for help. He elaborated on the difference between the two types of behaviours:

> It was more like, "What should I do?" rather than, "Can you help me through this?" So I wasn't actually getting results.
> If I was more support-seeking, I probably would have got it immediately.
> Because I was answer-seeking, she didn't know how to give answers for those kinds of things 'cause you really have to be a professional to do that.
> So I wasn't getting the answers I wanted and that put a lot of strain on us in some cases, just because I would get frustrated with those answers.

John came to recognize that his partner's role is different than those of professionals that may assist him with his mood disorder. He also found that expecting her to provide the kind of support that she does not have the training or experience to provide was unrealistic and at times damaging to their relationship, it also did nothing to help John individually with what he was going through. The way John manages his mood disorder now is more balanced; his medication was provided by his doctor and he recognizes his wife as a source of support rather than answers.

Shane stated with respect to his own experience with a mood disorder that some things are "better to tell your doctor." He described his early expectations of what a relationship may do for his mood disorder (though at the time he had yet to identify it as such):

> Yeah I think something that comes to mind is that I thought maybe a relationship would help it.
>
> I thought that it would help it and sort of, like, having a girlfriend that loved you was a cure for feeling like shit.
>
> Initially it did work and then I learned, actually I learned and then forgot again,
>
> How would I describe it?
>
> It would make me feel really good and then as soon as an obstacle or something would come between us, I would realize like "this isn't actually a cure its just something that is good to have."
>
> It's nice to have a partner, but it can be more of a detriment than a help sometimes, too. (Shane)

What Shane has come to learn is that while an intimate partner can provide support, that support will look different than and not necessarily overlap with resources provided by other sources, such doctors, therapists, or support groups. Furthermore, if you are experiencing difficulties in coping with your mood disorder, issues that arise in your intimate relationships can potentially make things even harder.

Alex has spent a lot of time learning how to cope with his mood disorder, and a big part of coping has been learning how to talk to others about it, which Alex admitted can still be a challenge despite all the progress he has made:

> Even though I'm so open about it and whatever, it still, you know, can be kind of difficult to talk about.
>
> And like a lot of times, people don't want to hear it. You know what I mean? That kind of shit. People aren't like super into having a conversation about feelings and about like, "Listen, man, I just—, I feel awful right now, and I need to talk." You know what I mean?
>
> I don't want to bother people and stuff like that. (Alex)

Mood disorders can be a challenging topic for people that have them, but also for people who do not. The awareness that not everyone is willing to discuss them can serve as a deterrent to disclosure, or prompt people with mood disorders to be more selective about to whom they disclose.

The value of support provided by partners of people living with mood disorders is immeasurable. However, there are consequences to one's partner being the sole source of support that impact the well-being of the individuals in the relationship as well as that of the relationship. Seeking advice and answers from professionals with knowledge and expertise related to mood disorders, and support from partners, may enable disclosers to manage their expectations with regards to disclosure and get the type of help they need from the appropriate parties.

The external disclosure of a mood disorder in the context of an intimate relationship is a process rather than a single act or event. This process may begin as early as when the discloser and their eventual partner meet for the first time. Before one can even subconsciously start considering how to disclose, they must first be able to identify what it is they are disclosing, and this will depend in part on whether or not they have had a formal diagnosis or how aware they are of mood disorders generally.

> We didn't have just a single conversation. I didn't sit her down and be like, "Listen, you need to listen to this."
>
> But over the course of the relationship, there'd be little things that would happen. And I would tell her, you know, "This is because of this." (Alex)

Alex's disclosure in the context of this relationship was an unfolding process wherein he shared with his partner more information about his mood disorder over time by continuing to engage in external disclosures as their relationship progressed.

Brad explained what led to his disclosure of his mood disorder to his current partner. His description illustrates a sort of paradox that exists between intimacy and disclosure:

> When he started saying, "Oh, I really like you. I really like you," I thought, "Okay, now I have to start being more open and honest with this person."
>
> And then I told him. And he was totally accepting of it, which was great.
>
> And I thought, "Okay, I can be myself around this person, and it doesn't matter." We could just be sitting on the couch doing nothing, or we could be out having fun, or not doing anything too terribly exciting by normal standards or by other peoples' standards, but I mean, we enjoy each other's company because you can just be yourself.
>
> And it just makes such a difference. (Brad)

Prior to Brad's disclosure of his mood disorder to his partner, they had built a level of intimacy within their relationship that encouraged Brad to disclose. His partner was accepting of the disclosure, which was a positive reaction, and it fostered more intimacy between them. A positive reaction to a disclosure of a mood disorder can benefit not only the person or persons in the context of the disclosure process, but an intimate relationship overall as it yields increased trust and empathy between the people in the relationship.

Andrew also spoke about revealing personal details to one's partner and what a partner's response may reveal in terms of how committed they are to the relationship overall:

> It's about opening up and then letting that partner see what's in there and making a decision about how involved they wanna be.
>
> I've had some very healthy relationships since my first experience with it.
>
> And that goes a long way to helping, like, ease any of the symptoms. Right?
>
> Knowing that you have that person that's got your back no matter what goes a long way for just improving confidence in myself. Right? Not that that's ever been lacking but, uh, but it definitely helps in a way.
>
> Sort of creates more of an intimate bond that like you've sort of let them behind the mask, and that they saw what's on the other side and didn't leave.

> Then its kind of like, "Well, you must like me. Right? 'Cause I've shown you like the worst side of myself, and you're still here." (Andrew)

Andrew's description reveals that there can be a sense of obligation to be open with a partner so that they are fully aware of who they are committing to. It also shows that a positive response from a partner can confirm that the partner is not only accepting of the mood disorder but also committed to the relationship as a whole; people's decisions to disclose as well as how people respond to disclosure are influenced by the level of commitment in their relationship.

Disclosure as Risk

A consistent theme amongst the men regarding the way in which they disclosed was that it appeared to be a sort of calculated risk; no one indicated that disclosing a mood disorder was something that they would do on a first date or early on in a relationship. Instead, they indicated that it was something they did once they perceived that the relationship was going to continue to progress. As Brad explained:

> I think there's certainly a time. I mean you don't wanna just like go on a coffee date with somebody and "Oh, hey, I'm on all of the following pills, and I have all the following issues." (Brad)

Disclosure is a risk, and a person considering disclosing a mood disorder, or any other stigmatized condition to an intimate partner, risks being stigmatized, and risks facing a change in their relationship, whether for better or for worse. As Brad explained,

> There was a period in time where I didn't do that [disclose]. I just refused to.
>
> I didn't want that label. I didn't want somebody thinking there was something wrong.
>
> I didn't disclose it initially to certain people. And I wish that I did because it did cost me friendships. It did cost me relationships that could have been something great. But I mean, it didn't happen, and probably because I was not up front and honest about it. (Brad)

Choosing to conceal rather than disclose personal information in an intimate relationship can have consequences for the individual hiding the information as well as the relationship; it can lead to feelings of guilt and be emotionally damaging (Pachankis 2007, 337).

Like Brad, Alex discussed how timing factors into decisions regarding disclosure. He went on to address the expectations one might have before they disclose, as well as some of the thought processes that precede a disclosure:

> I think that probably when people feel comfortable enough to tell their partner about their mood disorder, depression, anxiety, whatever, it is that they have—. It takes so much strength for them to get to that point that they expect a positive response. Right?
>
> Like if you don't get the response that you think you should get, who knows what that will set off in your own mind?
>
> First of all, like, "Is this the person for me? Should I be with this person if they don't understand it? If they're not willing to?"
>
> Depending on what disorder you have, that could spin itself into a whole other thing. So if you don't hear some positive reinforcement, you're not gonna wanna do that again—ever. 'Cause you probably just feel so rejected and horrible about yourself.
>
> It's heavy and its hard to talk about because I don't know that the language exists to talk about it, you know what I mean.
>
> I think now I'm probably more aware, even when I first meet a person, if this is the type of person that could, maybe down the road, be able to sit down and have this conversation with me. (Alex)

Alex's explanation identifies that disclosure is a risk and also that the outcome of an external disclosure, or how it is received by another person, can impact your future decisions regarding whether or not to disclose to others.

Andrew agreed that it takes time to build up a level of intimacy to foster disclosure in a relationship, but also acknowledged that he did so early in his latest relationship and had positive results:

> It maybe wouldn't be first date conversation—like, "Oh by the way I've been suicidal a few times." That might come on a little strong.
>
> But at the same time, I'm a very extroverted person. I just put myself out there.

> The most recent relationship I was in, I told her that I get pretty depressed. Right from the beginning. And she was nothing but supportive of it.
>
> So in terms of talking to partners about my mental health issue, it's been nothing but positive results 'cause it turns out when when someone cares about you, all they want is for you to be happy. (Andrew)

Andrew's explanation touches on the depth of disclosure; he identifies that certain aspects of his mood disorder and experiences he has had as a result of having a mood disorder are not things he would discuss early in an intimate relationship. Andrew self identifies as extroverted; it is a part of who he is as a person, and therefore he might be comfortable disclosing earlier than someone who is more of an introvert. He also recognizes that the relationships he has been in have been with people who really care about him and do not see his mood disorder as a negative characteristic about him.

Some of the men described disclosure as a sort of two-fold responsibility. One aspect of this responsibility is related to trust-building in relationships, when you engage in external disclosure you are sharing part of yourself rather than hiding from your partner and therefore you contribute to building trust in the relationship. The other responsibility is related to sharing your diagnosis and engage in external disclosure as a means of ensuring your own well-being. External disclosure is necessary to ensure your partner can recognize if or when you experience difficulties with your mood disorder and act appropriately by providing or helping you access the support you need. As Andrew explained, "If you see me showing signs of it, you might know what's up, right?"

Alex reflected on the consequences of not disclosing to the first girlfriend he had following his diagnoses:

> I never explained anything to her, and we just fought and like went crazy.
>
> I didn't care about anybody else's problems. You know what I mean? I just cared about mine and not telling anybody about them.
>
> Ultimately [the relationship] ended. It was a fairly amicable split.

> I never really thought about it until right now, but probably—. I mean it all probably comes back to how I chose to behave and stuff like that.
>
> And becoming aware of my disorder that I have, and learning coping mechanisms over the years. (Alex)

Brad also discussed potential issues that could arise if someone does not disclose their mood disorder to their partner. He articulated how behaviour caused by a mood disorder could be misinterpreted by others and result in the person displaying the symptoms to be abandoned when in fact they may be in dire need of help:

> I think its more of a concern if you withhold that information from somebody.
>
> I think if you know about something, then you need to address it with that person in case something happens. Whether it be, say, in the case of bipolar for instance, if you become really low or really high. You know, "This person's making some really irrational decisions. I need to intervene."
>
> Or, you know, maybe something is going on in your life that you need to identify. And I think its very important to disclose, just for those reasons, as opposed to, "Oh, this person's acting irrationally. I don't know what's wrong with them. I think they're messed up. I don't want anything to do with them." (Brad)

These reflections on disclosure as a means to ensure one's partner is able to identify and satisfy one's needs echo the findings of Prager and Roberts (2004, 45). Furthermore, disclosing at a time when you feel safe and secure is important for obvious reasons, but it can also help someone avoid being forced into disclosing when they are in a time of crisis and already experiencing stress. Brads comments prompted me to consider that having to disclose and explain a mood disorder when one is experiencing heightened symptoms of their mood disorder is not an ideal situation and may have a less than ideal outcome and intensify an already daunting task. In this way, disclosure becomes part of one's own mental health regimen. In addition to counseling or medication or meditation, its also being honest with the people in your life so that they can be aware of what's going on with you; they can be made aware of your needs in advance of a crisis situation.

Men's Experiences with Mood Disorders and Coping

Men spoke about their help-seeking tendencies and coping strategies, which prompted me to consider if and how their gender factored into their experiences. My discussions with these men affirmed that gender does factor into the disclosure considerations of some male individuals with mood disorders. Andrew reflected on the tensions he has felt between his masculine identity and asking for help:

> There certainly is a—, not really a denial thing, but there's a bit of an avoidance—like, sort of like, that male ego. There's something difficult about admitting that you need help.
>
> But at the same time—I've done it a number of times now—and it does seem like each time it got easier. (Andrew)

Andrew's explanation that he has felt an "avoidance" but not a "denial thing" demonstrates that an internal disclosure or acknowledgement of a mood disorder to one's self does not alleviate the stress associated with engaging in external disclosures. John acknowledged that asking for help is challenging, stating "I'm a very independent person, so not being able to to handle something is more of a stab on my pride than anything else." While asking for help can yield positive results, for some men it may come at a cost.

Alex recalled the feelings he had about external disclosure in the first intimate relationship he had after receiving his diagnoses of depression and seasonal affective disorder. At the time he was 17 or 18 years old, and he was extremely determined not to disclose his mood disorder to his girlfriend at the time:

> I was a selfish kind of guy. I really only thought about myself. And I had this—and I don't know where it came from—but I had this massive inflated ego. I thought I could walk on water, like Jesus Christ type of stuff.
>
> I just kind of kept everything bottled up.
>
> I never really talked to her about [my mood disorders], but I wish I had.
>
> I remember being like, "I gotta keep this in here" so nobody can see that. Right? Cause I don't want anyone to see any chinks in my armour. (Alex)

While Alex previously coped by putting significant effort into concealing his mood disorders, he is now aware of the detrimental effects this had for him personally as well as for his relationship. Alex's recollection of feeling like he had to keep things bottled up may have resulted from the experience of a "pinch" where he recognized feelings he was having as being feelings he should suppress by engaging in emotion work (Hoschild 1979, 562).

Now, Alex is a big proponent of talking things out, and sharing how he is feeling with others. While sharing is helpful, Alex explained it can only do so much to mitigate the disorder's impact:

> Talking does help but sometimes the disorder or whatever just gets a hold of you and makes you do crazy things. You know what I mean?
>
> Like just take to bed for several days. Or like a little fight will turn into something just huge in a second—like a match into a can of gasoline or something. (Alex)

Alex's description shows that a mood disorder and its symptoms may be challenging for disclosers to explain, and also hard for people hearing the disclosure to understand. His explanation speaks to the power that a mood disorder can have over a person, and the loss of control they may experience. It also reflects findings in the literature involving gendered experiences of mood disorders which states that men are more apt to speak of anger and aggression when discussing their mental health issues (Danielsson and Johansson 2005, 175).

Shane spoke about the coping mechanisms he turned to following his attempt to open up to his ex-girlfriend about what he'd been feeling, and the efforts he made to conceal his mood disorder:

> I certainly did a lot of drinking and a lot of like abuse towards myself.
>
> That was something I would do to sort of cope with it, and also approach women with it so they would just see like, you know, loose, confident party animal kind of guy.
>
> It was definitely something that I didn't want to bring to attention" (Shane)

After his initial and ultimately unsuccessful attempt to disclose to his ex-girlfriend that he was "sick," Shane went on to attempt to make similar external disclosures to less serious partners. He did not divulge particularly detailed information to these women, and developed a pattern of behaviour that consisted of him meeting women with his party-guy persona, but ultimately this reached a point of "diminishing returns," as he explained:

> Everything would be fun. It'd be great.
>
> And then it would tip over to this like crying in a bar, you know, being the opposite of what I was trying to show people.
>
> And then that kinda started to work for me in a weird sort of way. Like I would attract a certain type of person I think, who wanted to help. And to help while having sex. You know what I mean? Like they could be the one to nurse my brain back to health or whatever. (Shane)

Shane was opening up to these women, insofar as he was being vulnerable with them. While he knew something was wrong, he still had not internally disclosed to himself or identified what he was experiencing as a mood disorder and therefore was unable to outwardly identify it to others as such:

> I would talk about not something wrong with me, but more like events that were, say, traumatic for me, or things I was really ashamed of. I would kinda say, "I'm sick" by telling them a story about something that's upsetting me. (Shane)

Even when the identity he tried to project – of a man who was fun and relaxed – started to fail, Shane managed to save face in a way and reach some degree of intimacy with the women he met.

Learning how to function in an intimate relationship and learning how to function with a mood disorder are two challenging prospects on their own. Doing both simultaneously presents its own unique set of challenges. After being diagnosed and learning some healthy coping mechanisms for his mood disorder, John's eyes were opened to how his disorder can affect his relationship, he explained:

> There's some days when if I'm more stressed, the disorder comes out more. I definitely snap a lot quicker. I can be very cruel. And I'm starting to identify that a lot more. (John)

John has developed an awareness of himself and more specifically how his disorder influences him in his relationship.

The influence of gender on the ways in which mood disorders manifests and also the impact of gender on help seeking behaviour were themes addressed by nearly every man with whom I spoke. Men often opted to try and display more traditional forms of masculinity and emphasize strength and capability in times when they needed support from others. When men did not disclose their mood disorders, they sometimes resorted to unhealthy or risky behaviours, such as drinking and displays of anger toward others. Men seemed to strive to display independence and self efficacy over the perceived weakness they associated with admitting to others close to them that they were struggling. It is critical that moving forward, society begins to recognize and encourage men to view help-seeking and the disclosure of mood disorders as practices that will enable them to take control of their health and well being.

In terms of understanding what a mood disorder feels like, the men I spoke to provided very vivid descriptions about how their mood disorders make them feel. Shane remembers explaining to his wife how his mood disorder affects him. It is particularly illuminating that both Shane and Alex described their mood disorders as having weight to them, and a significant weight at that. Alex and Shane's descriptions illustrate that mood disorders can be a burden for them to carry:

> I remember explaining to my wife once—. Like there's this line in a play where this guy, he's a Texan that went to Vietnam, and he's back now and his life sucks basically. And one of the things he says is like, "I just can't seem to get nothin' started no more," which is exactly how I felt.
>
> Like I always just felt sort of pinned down or something. Like there was like a big rock sitting on my back, and just to do anything felt hard. (Shane)

Alex described his own challenges with his mood disorder, its sometimes debilitating effects, and his efforts to overcome them each time he is revisited by his mood disorder:

> One day, I'll just be totally fine. You know what I mean? "Whatever."
>
> And then the next morning, I'll wake up—and nothing will have happened—but I'll just feel, just like, "Fuck this." Like, "I'm not getting out of bed today."
>
> And I feel like there's just this anvil sitting on my chest. So you just— And like I know, I know that feeling now.
>
> Before I just was like, "This is shitty."
>
> But now I know what it is. So it's easier to cope with it. You know what I mean?
>
> You can kind of pump yourself up a little like, "Alex, get out of bed. Go outside. Go outside." (Alex)

Alex explained "If you have a mood disorder, depression, anxiety or whatever, it just amplifies everything. It makes that little noise a lot louder in your head, and you can't help but listen to it because its so loud." Alex has been developing coping mechanisms and strives to manage his disorders to the best of his ability, but admits that some aspects of the disorders and their impact on him are out of control, and can even take him by surprise. The fact that Alex's mood disorder can still surprise him after all the time he has spent dealing with it further establishes that disclosure is an ongoing process.

When a person learns something new or notices something different about their own mood disorder, they are in effect experiencing an internal disclosure, and may externally disclose new information and insights to others. Alex's explanation of not being able to help but listen to the "noise" in your head demonstrates that mood disorders and their effects cannot be effectively ignored by those who live with them, even if they have been present in someone's life for a considerable amount of time. A person may tire of dealing with their mood disorder, or feel helpless to deal with it's weight, but mood disorders do not simply just go away.

These descriptions give a visceral image of mood disorders as being something outside oneself and also that something one must carry. Mood disorders and their effects are heavy and

can prevent a person from carrying out necessary functions within their lives. Mood disorders can impede someone's ability to enjoy aspects of life that people who are not affected by mood disorders may take for granted. Increased awareness and education around mood disorders can enable audiences of disclosure to better empathize with the difficulty of disclosure and appreciate the strength it requires.

Stigma, Disclosure and Image Management

Stigma is a social issue that shapes individual experiences, including a person's ability to accept characteristics about themselves that perhaps they can only manage and never change or eradicate. The ability to reach your full potential and be your authentic self are related to the concept of positive peace (Galtung 1969, 168). Intimate relationships are spaces in which people ought to be able to be their authentic selves and feel encouraged to reach their full potential. Intimate relationships are characterized by acts of self-disclosure occurring on a "regular and predictable basis" (Prager 1995, 23). First you may have to come to terms with aspects of yourself on your own,

> Once I really, accepted it I guess, I don't even know if that's the right word, but I was like "okay like its not like something that's wrong with me, its just something that I have"
>
> You gotta just, its gonna be there forever and so you just deal with it, right?
>
> I learned how to cope with it and like once you let go of a lot of like that shit that you've been fighting your entire life, you know what I mean you're just like (sigh).
>
> And you feel like you can breathe, you know what I mean, and you can just kinda let life do its thing and its easier to deal with it
>
> I've just learned to cope with it better, and accept it. And then ultimately I think it gets easier. The power of the attack or the episode, it becomes less and less every time.
>
> In terms of any sort of mental illness or disorder, the self-acceptance is a big part of it for yourself because that's were you gotta start. Right? Start with yourself. And just one day at a time with it.
>
> It doesn't define who I am as a person. It's just something that I've had to deal with. (Alex)

Alex's discussion of self-acceptance illustrates that some of the work one has to do with respect to their mood disorder is work they have to do alone, while others may provide support self-acceptance is something that comes from within.

Brad, when speaking specifically about figuring out when to disclose a mood disorder, said "some of it is to do with your own acceptance of a mental health issue," and Andrew stated "I've sort of come to terms that I think its gonna be a factor in my personality forever. I think it just is." John reflected on his experience of being diagnosed and finding a treatment regimen that was right for him, stating:

> One of the things I took away from it was you can only really help yourself. You cannot expect others to help you for you. Throughout the entirety, I felt it was sort of a self-actualization process. (John)

Although John recognizes that some of the work associated with managing his mood disorder is work he has to do alone, he also remarked that it has benefited his overall health and continues to strengthen his marriage. He has been focused on his career as well as his physical health, and now is concentrating on the emotional health of his relationship with his wife.

Like disclosure, coming to terms with one's mood disorder is a process rather than an event. It may involve several steps, including the recognition or awareness that one is having difficulty related to their mood, seeking and receiving treatment. Andrew acknowledged that while a healthy relationship can contribute to positive outcomes for a mood disorder, some of the work has to be done individually:

> Some of your happiness has to stem from within yourself. Right?
> Even in the healthiest relationships, you know, you hear all this fluffy stuff about two souls becoming one. And it's like, "No. That's just shit you say at weddings." Right? You are two different people, and you need to bring the best version of yourself.
> Your partner deserves that best version of yourself, and that could involve just like independence. (Andrew)

Self-acceptance and the realization that a mood disorder is part of one's identity, but does not define a person, is critical and fulfilling. Some of the men discussed image management with respect to their mood disorders.

The men's discussions of image management reveal the amount of effort and energy that are dedicated to managing how visible their disorders are to others:

> You become so absorbed and involved in making sure that your outward appearance is what you think people to want it to be.
>
> You just start to get wrapped up in your own head, and it becomes this perpetual cycle and its so hard to break it. (Alex)

The goals of image management with respect to a mood disorder could be projecting the image of person with a mood disorder who is managing it well, is not managing it well, or a person who appears not to have a mood disorder. In each of these situations, it would be challenging to find surplus energy to dedicate to building intimacy in a relationship with another person. Reflecting on the amount of energy that the men report having dedicated to their own image management prompted me to consider whether it can be potentially detrimental to one's health if it begins to become a priority over other coping mechanisms.

Shane reflected on his efforts to only project what he thought women, including his wife, liked best about him, and spoke about choosing what to share with his wife as a means of image management within his marriage. He said this was a practice he continued after they had lived together and even after they were married:

> I tried to like, charm, charm, and also like keep her interested for a few years. I would only tell her things that I thought were interesting.
>
> I think probably I would have figured out real quick, "Oh, my wife likes this about me, and she likes this and this and this, but she doesn't like this and this and this, so I will only talk about those things. (Shane)

Shane's assessment and inventory of his own personal traits into categories of traits he perceived that his wife does like and those she does not are part of his image management processes which for a time influenced his decision not to disclose his mood disorder.

Disclosure and Relationship Circumstances

Something I had not considered before beginning this research was how the context of a specific relationship, and the circumstances of the people involved can significantly influence whether or not a man discloses his mood disorder. This was true of Shane, who disclosed his mood disorder to his wife after seeing his physician and receiving a diagnosis of depression and medication to treat it. Shane's wife responded positively to his disclosure, and he described how "it did get easier for a while to talk about that, and be honest about it and, explain how the medication was helping me, and ways it wasn't either, like there was a lot of like shitty side effects. But yeah, I was pretty honest about it and transparent and it was a topic of conversation, too. But, not so much anymore." I asked Shane if he could account for this change:

> I think when I feel shitty, I often want to talk to somebody, but I will stop myself.
>
> I have a lot of people in my life that will listen to me, you know, but, I will not, for reasons that like—we're sticking with my wife—I won't tell her.
>
> Even like the last maybe week or two or so, I felt really shitty and she sort of cornered me a bit. And I said to her, "I don't want to talk about this. I don't feel like it's helpful to talk to you about it. And I don't feel like you can help me."
>
> And I also said, which is kind of mean, but, "I don't trust you to like—."
>
> Because I think I feel for my wife, specifically, that it's unfair to talk to her about it. Because she has a couple significant relationships with women friends, who basically use her as a psychiatrist, talk to her, tell her shit. I don't wanna jump onto that. (Shane)

Shane cannot control what his wife's friends share with her, or how their sharing affects her, but he recognizes he can control what he tells her and has made a conscious decision not to contribute to what he feels is already too great of a burden on her. He appreciates and

acknowledges the support she provides but also does not want to cause her any additional distress,

> There's a protective thing with why I won't say anything either because I can remember one time in particular where I was very honest and she was very, very supportive.
>
> And I was like, "Fuck, if somebody talked to me about this, a lot, like it would fuckin' hurt."
>
> I don't want to talk about it. I just feel like if I tell her what's going on I'm just taking years off her life 'cause it would hurt. (Shane)

Shane's choice to refrain from sharing what he feels is too much detail about his mood disorder reflects that he is concerned for his wife's well being and recognizes the impact his disclosure may have on her. Shane does not want to burden his wife with information he feels would be hurtful, and he is concerned about her capacity to deal with not just the quality of information that he shares, but also the volume of information or the frequency of which he shares it, since he is aware of others who discuss similar issues with her. Living with a mood disorder and its symptoms can be stressful enough for a person without the added stress of having to be concerned with how disclosing certain details may affect one's spouse, or other people in one's life.

Ultimately, personal health information is personal; each individual person will have a different opinion on what they wish to share with their partner and what they feel they are most or solely comfortable discussing with a health care provider. In addition to adjusting the depth of his disclosure to protect his wife, Shane is also concerned with protecting himself. Intimate relationships, like any relationships, will have unique power dynamics. His concern about losing agency in his relationship has motivated him to share less with his wife about his mood disorder,

> Maybe I'm projecting a little bit. I mean maybe I'm projecting completely, but like I think there's a weird— like maybe in marriage or maybe it's just in my marriage specifically—but there is a weird, sort of control thing.
>
> If somebody's sick, or like feeling sick, then the other person sort of has,

> not the advantage, but, can sort of override you and say like, "No, you're thinking unclearly."
>
> I guess there's just a thing where I don't really trust my wife. I don't trust her all the way. And so I don't feel safe talking about it. I felt safe disclosing how I have like a fucked up head sometimes. But I don't feel like going back to her for it.
>
> Just because I'm depressed doesn't mean I'm a fucking idiot. (Shane)

Each one of Shane's reasons for adjusting the depth of his disclosure, his desire to protect his wife from being hurt by his disclosure, his decision not to add to the disclosures she already deals with from friends, and finally his desire to protect himself and sustain his own agency within the relationship, relate to boundary setting. Boundary setting is an important component of intimacy (Lerner 1989, 3). Boundaries are created and adjusted and may be used to protect one or more partners in a relationship.

Shane and I discussed power balances – and imbalances – that can exist in intimate relationships for a variety of reasons. They can be temporary or permanent, related to a change in a partner's health, or employment status. If one partner is already feeling vulnerable due to their mood disorder, their partner's attempts to deal with it could be construed as helpful or supportive. They could also be construed as representing that the "helping" partner does not feel that the partner who is currently struggling is incapable of dealing with their mood disorder and even incapable of other tasks outside of it.

Disclosure and Trust

Trust was a significant recurring topic throughout all the discussions with the men I spoke to. Brad spoke about establishing trust in a relationship through disclosure, and the ramifications for relationships as a whole if someone does not disclose significant information, whether its related to a mood disorder, or something else. Brad explained:

> It's more important to be up front and disclose those things with people because I just think its important for the relationship.
>
> It should be based on honesty and trust. And if you can't be honest about your health, whether it be physical, mental, spiritual, whatever, I mean, then you really have nothing. You're lying to the person and it's doomed to fail.
>
> I don't think [disclosure's] necessary for the first little bit. You build some trust and you get to know the person. And things progress the way they should
>
> Then I think its important that you become up front at that point when you think it's going to be serious. (Brad)

This trajectory of trust and intimacy preceding disclosure make sense; if trust and intimacy are not established in a relationship, it would not make sense for the relationship to continue, nor would it be reasonable for one or both parties to engage in disclosing personal information.

Andrew described a relationship in which the trust between him and his partner was damaged. She confessed that she had slept with another man after she and Andrew became involved, and after hearing her confession, Andrew experienced a bout of depression that eventually lead him to seek counselling for the first time. He spoke to his girlfriend about the depressive symptoms he was having and that he was considering seeking treatment, and she was supportive. Andrew's girlfriend asked if she could accompany him to his counselling sessions, and realized that while he appreciated her support, he did not feel comfortable having her involved in his treatment:

> I talked to her about it 'cause she sort of encouraged me. I was like, "I think I need to get some help, you know,' cause I'm like self-destructing here."
>
> She was very supportive, too, and was wanting to be involved to whatever extent I was comfortable with. But I wasn't at that point. I eventually came to the conclusion that I never would be because I just didn't trust this person anymore. (Andrew)

Andrew and his girlfriend had been working to move past her indiscretion and trying to stay together. When he realized he was not willing to receive the support she was offering, it was clear to him that what he was feeling was a symptom of the overall health of their relationship. He recalled, "I mean how healthy can your relationship be when you're telling your partner like,

'I'm borderline suicidal, and no, I don't want you to help me.'" The breach of trust in Andrew's relationship, though unrelated to his mood disorder, affected the depth of disclosure he was willing to engage in regarding his mood disorder.

Andrew was also faced with the reality that their relationship was affecting him to the point that it was impacting the positive effects of his counselling treatments, which he realized based on how he felt when he returned home to his girlfriend after being at a counselling session:

> The time immediately after our sessions was definitely when I felt the healthiest. I always left his office feeling really good about everything. And then it was sort of like that was a diminishing emotion or feeling. (Andrew)

Andrew's relationship had come to constitute a sort of negative environment that he was striving to change while also dealing with symptoms of his mood disorder, and ultimately the environment was impeding his ability to fully reap the benefits of the treatment he was receiving at counselling.

The circumstances of Andrew's relationship, though different than Shane's, resulted in the level of trust prompting a re-evaluation of the boundary setting with respect to Andrew's mood disorder, and the depth of disclosure he was willing to engage in with his girlfriend. John spoke about the trust he has in his partner, how she is his "first and primary point of contact" and an "authority figure," in his life, which is largely why he went to her first when he needed help, even though he was, as he put it, answer seeking rather than support seeking. I asked him what he thought may have happened differently if he had not had his wife to speak to when he was initially trying to identify what he was experiencing, and he said, "by myself, I'm a very egotistical person, I would have just thought everyone else was weird and not myself." John's statement prompted me to consider that in circumstances where intimacy is established before a person recognizes signs of a mood disorder within themselves, or even just that something is

different about them, being close to someone that knows you might help you recognize an issue more quickly than if you are alone.

Trust means so many things in the context of men disclosing their mood disorders to intimate partners. It is also important to note, as I learned from the discussions I had, that it is not static, it can be strengthened or broken, and when the nature of trust in a relationship changes, so will quality of the intimacy in the relationship. Trust means trusting someone not to treat you differently or see you as having less agency or power with respect to knowing what is best for you. You might have the expectation that you can trust someone not to share the information you tell them with others. In the context of an intimate relationship, it is reasonable that partners trust each other to be there for one another and have each other's best interests in mind. You might also trust your partner to respect your privacy and boundaries and not put undue pressure on you to share more than you feel comfortable with.

Intimacy and Partners Who Also Have Mood Disorders

Unique insights were provided by both Alex and Andrew, who spoke of their respective experiences with dating women who had mood disorders themselves. Both Andrew and Alex gained empathy through their own experiences with mood disorders, which enabled them to be more understanding partners to these women. Alex spoke about the dissolution of a relationship he had with a woman who also had a mood disorder. After they broke up, Alex was faced with a tough decision when his former partner reached out to him, and he recognized that she was in a crisis:

> I was really sad 'cause I really loved her a lot. And I was super upset.
> And she called me and asked me to come help her.
> I said no because I'd finally started feeling better, like not so depressed, and then she called me and she said she cut herself.

> So I was like, "Fuck." And I was right over there 'cause I was like, "It's one step away from—. You know what I mean?
>
> And I got there, and sure enough she's had fuckin' blood all over her arms and shit. So I sat there with her and stayed with her and talked to her and helped her clean up. And I stayed the night.
>
> I've never done anything like that myself. I've never attempted suicide. I've never self-harmed or anything like that.
>
> But I can definitely see. I can understand. I can feel compassionate towards people that take it to that place because, I mean, I've come pretty close. Like I've felt some serious demons. (Alex)

Although Alex's experience with his mood disorders had been different than what his former partner was experiencing, he recognized that she needed help, and at the risk of potentially damaging the progress he had made personally in getting over their breakup, was able to be there for her. Alex and this woman are still in contact to this day and remain friends.

Andrew described a bond forged between himself and Leah, a woman with a mood disorder, that is unlike anything else he has ever experienced. Andrew attributes the close connection they share in part to the fact that they both have experience with mood issues. Andrew described that he can be his authentic self around this woman and she appreciates his sense of humor, especially with respect to mood disorders:

> I find that like she sees the humor in that. And I think it might come back to our own mental health issues. With subjects like that like you might as well laugh 'cause if you don't cry—. You know? So she just sort of gets my jokes which allows me to really be myself around her and creates a lot of comfort.
>
> So that's probably the healthiest dialogue regarding mental health that I've had with any partner. And its probably because its very much a two-way street. She's dealing with issues of her own. So it kind of comes back to that openness. (Andrew)

Andrew and Leah both understand what it is like to live with a mood disorder and both see the value in using humor to cope with it. Andrew and Leah were not exclusively involved at the time of our conversation, and he does not know what the future holds for them, but he expressed doubt that he will ever find anyone with which he shares such a strong connection or with whom he can be as open with his mood disorder.

Additional Experiences with Disclosure

Two of the men I spoke with discussed challenges with disclosing information other than their mood disorders: Brad discussed his challenges with disclosing his sexual orientation to family and friends, an experience that predates his awareness of his mood disorder, while Andrew reflected on the challenges he has faced since being diagnosed with a viral sexually transmitted infection, which occurred after he was aware of his mood disorder. Both Brad and Andrew compared their respective experiences to their experiences with disclosing their mood disorders and identified the risks associated with these disclosures. Sexual orientation and a sexually transmitted infection are similar to a mood disorder insofar as while they have stigma attached to them, they are attributes or aspects of one's identity that may not be readily visible to other people.

The process of coming to terms with and coming out about one's sexuality has been associated with decreases in self esteem as well as increases in psychological distress (Rosario et al. 2001, 134). Brad's internal disclosure about his sexuality happened when he was twenty-one. He remembers struggled with figuring out who to externally disclose to at the time. Brad confided in a close friend who was very supportive and accepting, "he was an outcast from my core group of friends, who, again, I didn't feel I could trust, and because I didn't disclose with them, they had questions I didn't answer." Brad externally disclosed to this particular friend based on the trust he felt, but his decision not to answer other people's questions about his sexuality lead to the conversation happening without him. The resulting stress from knowing his friends were talking about him behind his back was something he states he did not always deal with in "healthy ways."

Eventually Brad arranged to speak with a counselor, who encouraged him to bring his parents to a counselling session so that he could come out to them. Many people who are contemplating disclosing their sexual orientation to their families are apprehensive because of the perceived potential for rejection and also because they do not want to disrupt their family dynamic (Mosher 2001, 168). Brad was fearful of how his parents and brother would react to his coming out:

> My conception of them was that they're very conservative. Right-wing. You know? Born on the farm. Kind of redneck-ish.
>
> I didn't want to risk getting kicked out of my house, beaten by father, disowned by my mother, and my brother, for that matter. I didn't want to risk losing that with my family. (Brad)

Brad also recalls a lack of resources and support where he grew up, and describes how, unlike in larger cities at the time, his hometown did not have as much of a gay community.

Brad waited until he had left home, finished school and was able to support himself before coming out to his parents and brother. Looking back at the situation, Brad wishes he had spoken to his parents about his sexual orientation sooner. I asked Brad if his experiences with disclosing his sexual orientation had any bearing on how he felt about disclosing his mood disorder:

> If I had dealt with the homosexual thing, the depression probably may not have been an issue to this day.
>
> I think that's with anything, too. I think if you deal with whatever the problem, or, you know, as opposed to the vague symptoms that you're having, you would have better outcomes overall as far as your mental health, or being able to treat it better—if in fact it is a problem. Or is it something that needs to be medicated? Or is it something that you can just go talk to somebody about? (Brad)

Disclosure involves the exchange of information and therefore in some circumstances, power. Ideally, individuals should have the power to decide how, when and to whom they disclose

personal information. In Brad's case, when he did not disclose or confirm the suspicions his friends had about his sexuality, the conversation continued without him.

Brad's experience illustrates that in circumstances where disclosure is not solely at the discretion of the person to whom the information pertains, the resulting experience can be disempowering for the owner of the information. When a person's ability to speak for themselves, about themselves is taken away, so is their agency. This is especially important to recognize, because at times mood disorders may make a person feel as though they are out of control, or lack control over their symptoms, treatment, or other aspects of their disorder. Taking control away from someone with respect to their disclosure constitutes a sort of violence against that person.

Not long before our discussion, Andrew was diagnosed with HPV, human papilloma virus, which is a viral sexually transmitted infection that can cause cancer and genital warts. He experienced an internal disclosure when he noticed physical symptoms, which he brought to the attention of a doctor. The doctor dismissed Andrew's concerns and advised him he had skin tags, but later Andrew saw a different doctor when he was required to get a full physical for work. This doctor confirmed that he did in fact have genital warts. Andrew spoke about how his diagnosis has "definitely made dating more difficult," but despite this difficulty, he has engaged in external disclosure regarding his diagnosis with potential partners. Unfortunately, he has experienced some stigma as a result, "In my mind, sharing that prior to any intimate encounter demonstrates a level of honesty that I think should foster a healthy experience," he explained.

Andrew's honesty has not shielded him from feeling the negative impacts of the stigma associated with sexually transmitted infections. "It definitely compromises your self-worth, because it, you wonder like how am I ever going to find someone who wants to be with me?" He

has experienced uncertainty with regard to wondering how this diagnosis is going to affect his love life. He has also experienced uncertainty due to the difficulty he has had in gauging the reactions to his disclosure about his physical health:

> I haven't been in a relationship since finding out. So I mean I guess it remains to be seen. But at the same time it doesn't really hold me back.
>
> There's been a couple girls where I've been like, "We should get together." And I told them about it, and they were still down.
>
> But then like it also hasn't happened though. So it's kind of like it's easy to be like, "Oh no, it doesn't matter." But then at the end of that conversation be like, "For sure not sleeping with that guy." (Andrew)

The uncertainty that Andrew has experienced after disclosing his physical medical condition is a stark contrast to the positive reactions he received after disclosing his mood disorder. We spoke about the differences between mental and physical illnesses, and how these differences impact a person's obligations with respect to when to disclose each type of illness to a current or potential partner:

> Lots of first dates result in being in the sheets, but its more of a deal breaker because it's something that your partner can catch, too.
>
> You can't catch depression, whereas if you're going to sleep with someone who has disclosed some sort of viral illness, you kind of have to be at a comfort where you think it's likely that they'll be the last person you sleep with.
>
> If you catch that from someone and then you split up, that could compromise your ability to meet someone else later.
>
> I think that's where society's apprehension comes from. it all comes back to a stigma (Andrew)

In a situation where failure to disclose an illness to a partner constitutes a potentially direct consequence to that person's physical health, a decision to disclose may stem from a broader social or societal obligation rather than a genuine feeling of safety or security within the situation.

Andrew's discussion of the circumstances that make disclosure of a mood disorder different from that of an STI illustrate sort of a paradox: a mood disorder is something you

disclose to someone when you perceive the relationship is going to be serious and involve more than just sexual intimacy. An STI is something you are morally and ethically obligated to disclose to someone before you have decided whether the relationship is going to be more than physical. A study which explored factors influencing disclosure of HPV identified morality, the importance of honesty in relationships, and concerns about a partner's health as the most prominent factors influencing peoples' decisions to disclose that they have HPV (Keller et al. 2000, 292). Factors influencing peoples' decision not to disclose that they have HPV include fear of rejection and embarrassment, and several reported not disclosing because they had not had intercourse following their diagnosis (Keller et al. 2000, 292). Another study which examined specifically men's disclosure of HPV to women found that the duration and closeness in relationships influenced men's decisions to disclose their HPV diagnosis, while the perceived potential for embarrassment was reported as a reason not to disclose (Arima et al. 2012, 584). The quality and duration of a relationship as well as the perceived importance of trust and openness are factors that influence the disclosure of HPV as well as mood disorders as evidenced by the conversations I conducted.

Despite the new challenges he has faced with respect to sex and dating since receiving this diagnosis, Andrew remains optimistic that when he finds the right person, health concerns, whether physical or mental, will not be a determining factor in the success of his romantic life:

> In a way it's kinda like whoever's left after you disclose that, they're the pick of the litter. So its kind of constructive in that way.
>
> Or that's how I'm choosing to look at it anyways. 'Cause why not? Right? You might as well try to remain optimistic.
>
> I think that the type of person that'll end up with, with that forever and always type relationship, won't care about that issue, whether its mental health or sexual health. (Andrew)

So far Andrew has not received as overtly positive reactions to disclosing his physical illness as he reported receiving when he diagnosed his mood disorder. He remains positive and recognizes that neither of his illnesses define him as a person, nor will they be of major concern to the right person.

Brad and Andrew's experiences with disclosing personal information other than their mood disorders contribute to a broader discussion of disclosure which illuminates both the challenges and rewards of sharing personal information in interpersonal relationships. As Andrew's experience illustrates, when one must disclose an illness that is transmittable, it can be more difficult, and at the same time, more crucial, for a person to be honest about their diagnosis. In Brad's situation, he feared that disclosing his sexuality would cause changes or even the loss of his relationships with his family, and thus it is understandable why this disclosure was particularly difficult for him, and took considerable time to work up to.

With respect to Andrew's HPV diagnosis, he must sacrifice some of his own personal comfort in order to avoid compromising the physical safety of potential sexual partners. He has a responsibility to ensure that women are fully informed of any potential risks before engaging in sex with him and can only effectively achieve this by engaging in external disclosure regarding his diagnosis. Brad's decision to wait until he was self-sufficient before externally disclosing his sexual orientation was made in order to protect his relationship with his family from being destroyed. The analysis of the data allowed me to identify themes that constitute factors which affect men's decisions regarding whether to disclose their mood disorders in their intimate relationships. Initially these were categorized as barriers and facilitators, but upon further reflection, most of the factors can actually be both, depending on the circumstances. For example, trust is a crucial ingredient of intimacy which is very obviously something that can

either facilitate or be a barrier to disclosure depending on how strong it is or whether it exists at all in a relationship. Stigma on the other hand is a factor that at first appears to be exclusively a barrier, however, my conversation with Alex revealed that he continues to strive to be open about his mood disorder despite the stigma he still occasionally feels, as he recognizes the overall benefits of his openness for himself as well as others living with mood disorders and people who do not have mood disorders themselves but can benefit from learning more about them.

Conclusion

The conversations with the consultants confirm that for some men, gender identity does factor into decision making processes involving the disclosure of mood disorders to intimate partners. By engaging in external disclosure, men are combating the stigma around mood disorders and mental illnesses, and also building meaningful intimacy and connection with their intimate partners. This study confirms that intimate relationships are a place in which meaningful and significant peacebuilding can and should occur. Making room in intimate relationships for different expressions of masculinity, particularly with respect to disclosure, are ways in which hegemonic masculinity can be challenged. This is an important step toward broader goals of gender equality, social justice and ultimately positive peace.

The men interviewed for this study were all of a similar demographic insofar as they all had post-secondary education, all had accessed professional treatment for their mood disorders, and they were between the ages of 27 and 45 at the time of the study. The study could be expanded to include experiences of men with different backgrounds and ages. The age of a man when he experiences internal disclosure as well as the time that he lives in will both influence

not only his ability to recognize what he is experiencing as a mood disorder but also his feelings about help seeking and disclosure. A larger study could yield greater insights by including men of different cultural backgrounds and socioeconomic status, as these factors might influence not only their understanding and experience of gender, but also their experience of mood disorders and ability to access resources for mood disorders.

CONCLUSION

This study was conducted using a phenomenological approach. The information discovered in the conversations with the men with mood disorders about their individual experiences demonstrates how the experiences of mood disorders and disclosure may be different due to a person's gender and how they feel they are expected to perform it. When men engage in emotion work by sharing their emotions and disclosing personal information, including having mood disorders, they are strengthening the intimacy they share with their partners. They are also creating new ways to perform their masculinity. By strengthening their interpersonal relationships, having the courage to engage in disclosure and developing into their authentic selves, men are actively engaging in peacebuilding.

This study provides a collection of real life examples of how men have dealt with both disclosing and not disclosing their mood disorders, and acknowledges the challenges men have faced and overcome. Each of the men who spoke to me has had to grapple with the challenges of managing a mood disorder and being a partner, while simultaneously holding down jobs, going to school, maintaining relationships with friends and family, and addressing other health concerns. The insights they have shared can be used to help others in similar situations, whether a person has a mood disorder themselves or is in a relationship with someone who has a mood disorder.

The impact of previous disclosures on future ones is significant. It seemed obvious prior to the interviews that a positive or negative reaction to a man's disclosure of his mood disorder would in some way influence future disclosures. This appeared to be the case for Shane, who was silenced in his first attempt to share how he was feeling with a then former girlfriend did not appear to encourage him to try to disclose overtly to anyone else. Alex acknowledged how

rejected a person would feel if they did not get the positive reaction that they would have to be expecting in order to even consider disclosure. Brad felt that disclosing his mood disorder, while challenging, was important to do as soon as possible, partially because he had struggled with disclosing his sexual orientation previously. Andrew had only positive experiences with disclosing his mood disorder, but then experienced with a jarring contrast when faced with disclosing his diagnosis of an STI.

An important insight with regard to how experience with disclosure may have a bearing on future consideration about whether or not to disclose is that those who are the audience to a disclosure need to recognise the strength required to undertake it, and be respectful of what they are hearing. Those engaging in disclosure must realise that the information they share may deeply affect the person they are sharing it with. Both parties need to be patient with one another throughout the process.

A key finding of the study was that most of the men acknowledged that disclosing their mood disorder required significant consideration and was not something they rushed into. Instead the men in the study stated that they were more apt to disclose to someone that they saw some a potential future with. Even those men who report being more open about their mood disorders would not disclose to a partner early on in a relationship. Most of the men also spoke about why this was the case, and acknowledged that disclosing too early could have negative consequences.

An unexpected and significant finding was the distinction between internal and external disclosure. This was a concept that I put together as I was doing the transcribing. A continuation of this study would be enriched by discussing in more detail not only men's external disclosures but their internal ones. This could further our understanding of how internal disclosures may

influence external ones and also how internal disclosures are shaped by a person's identity or circumstances.

Future studies could expand on this topic by exploring how a persons' gender shapes their reactions to disclosure. We have seen in the literature review that often women are conditioned to push boundaries in relationships in order to increase sharing and intimacy. A study that explores people's reactions to their partner's disclosures of mood disorders could teach us more about gender roles in intimate relationships as well as gendered experiences of mood disorders.

The processes of maintaining an intimate relationships and deciding whether or not to disclose to one's partner that they have a mood disorder should be recognized simply for what they are: a lot of hard emotional work. For disclosers, making a decision to share something so deeply personal while considering the implications of your decision for the relationship, as well as your own personal mental health for which you are primarily responsible, is daunting to say the least. Being vulnerable, even in a strong relationship where you feel safe, is not easy. The image management required if you choose not to disclose, and the boundary setting that you may have to engage in if you do disclose with respect to how much you share and how often, are not easy tasks either. These considerations, of course, will be made if and when you are able to put what you are experiencing into words you feel comfortable using.

Listening and providing support are forms of emotion work which deserve to be recognized for the effort they entail as contributions to the health of intimate relationships. Partners of people with mood disorders and the effort they put into supporting their partners need to be recognized as well. While disclosure and sharing can be indicators that a relationship has been built on a lot of trust, partners may share things that cause the listening partner to feel

worry, concern or grief. The partner hearing the disclosure has to balance providing support with ensuring they are tending to their own emotional needs. Partners who hear a disclosure must understand that their partner's willingness to share may change over time.

The men who shared their stories revealed that mood disorders, when unmanaged, can take a toll not just on the individuals afflicted with them but on the relationship as a whole. A step towards developing healthy relationship practices in instances where one or both parties is living with a mood disorder could involve engaging in emotion work to establish boundaries through clear and honest communication and also setting boundaries by being clear about the kinds of support a partner can provide, and the kinds of support best provided by professionals. Partners should not be a person's sole source of support with respect to managing a mood disorder, and both parties should be comfortable with the level of support provided. The quality of support a partner can provide may change based on their own personal circumstances and obligations outside the relationship, as well as based on the amount of support required.

People with mood disorders, including men, can help their partners be of support to them by being up front about their needs and about the kinds of support that work best for them. If a partner cannot provide a specific type of support themselves, they should be able to remind their partner how and where to access it, whether it is taking medication, making an appointment to speak to a professional, eating healthy, or engaging in exercise. Partners of people with mood disorders need to be comfortable explaining the limits of their ability to help without shutting down conversations or silencing someone who might be reaching out to them.

The willingness of these five men to speak to me about deeply personal and at times difficult experiences in their lives has yielded a wealth of information and insight. These insights hold value to people in a variety of circumstances; whether they are tasked with disclosing their

mood disorders or other deeply personal topics. Beyond mood disorders there are other stigmatized or marginalizing parts of people's lives that they are tasked with managing while in intimate relationships, most of which they will have to consider disclosing at some point.

This study is of significance to the field of Peace and Conflict studies because it draws our attention to the individual level. We know that an individual is shaped by their identity, and that identities are socially constructed. This study shows us how and individuals identity shapes their own views of themselves, and how their views influence their behaviour in their intimate relationships with regard to their disclosure practices. Gender influences much of our own behaviour as well as how we expect others to behave. If we can encourage and support others to take a risk by acting in a way that is not prescribed by dominant gender norms, we can start to build better relationships. In doing so, we are contributing to the development of positive peace.

Because of my own personal experience with living with a mood disorder and disclosing it to intimate partners, I felt in a sense qualified to conduct this study. There was of course a risk of my own personal bias creeping into the study, and in an effort to minimize this, I chose to study men exclusively. This is because how I feel about having a mood disorder and how I feel as an intimate partner are heavily influenced by my gender identity. In particular, the concerns I have about losing agency in relationships by being perceived as hyper emotional or irrational and the concerns I have had about losing relationships because my mood disorder will be seen as some sort of defect are both deeply rooted in my gender identity and beliefs that I have held that say women are already too emotional and that if you are a woman, finding and keeping a partner is a priority. My own experiences influenced my expectations regarding what I would find in the course of the study. As anticipated, the men I spoke to had different gendered concerns about their mood disorders, for example Alex wanting to appear strong and Shane wanting to appear

fun and confident. I had to be careful not to assume that others who responded to the study would have the same concerns about disclosure and mood disorders as I do, and I was glad to be contacted by consultants who are more open about their mood disorders than I am.

The most significant finding in the study is that intimate relationships and in fact other types of interpersonal relationships (between friends or family for example) are spaces in which meaningful peacebuilding can occur in a number of ways. The kind of peacebuilding we can do in these kinds of spaces is therefore in some ways accessible peacebuilding insofar as most people participate in interpersonal relationships over the course of their lifetimes. In these relationships we can practice supporting others by practicing tolerance and acceptance. We can also reflect on and when applicable challenge our conceptions of our gender roles as well as our gendered expectations of others. We can create and foster environments of trust where people can be their authentic selves. These behaviours will help us contribute to larger goals of social justice and positive peace.

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APPENDICES

Post used on my personal social media accounts (Facebook and Instagram):

Are you someone over 18, who identifies as male and has a mood disorder (depression, anxiety or bipolar disorder)?

I am looking to interview people for my MA thesis (I'm pursuing an MA in Peace and Conflict Studies). Specifically, I want to learn more about how men with mood disorders think and feel about disclosing their mood disorders to intimate partners (someone you have a serious or casual sexual or romantic relationship with).

If you would like to sit down and talk, the interviews will last approximately 60-90 minutes.

If you are interested, please send an email to [redacted] or direct message me, and I'll be happy to answer any questions you have.

This research has been approved by the Joint-Faculty Research Ethics Board at the University of Manitoba and you can contact the Human Ethics Coordinator at humanethics@umanitoba.ca or 204-474-7122.

FEEL FREE TO RE-POST

Thanks!

Interview Guide

1. Did you grow up in Winnipeg? What do you like about living here?
2. Are you in school/currently working? What do you like to do for fun?
3. Do you consider yourself a private person?
4. Is your mental health something you consider "private"?
5. Do your friends or family know about your mood disorder? If so, did you disclose it to them or did they find out through other means?
6. Are you currently in an intimate relationship?
7. Does your current partner know that you have a mood disorder?
8. If so, how did you decide to tell them? If not, do you have plans to tell them?
9. Have you disclosed to previous partners? How do you feel when you think about that process? Did it go as expected?
10. If you have disclosed to your current or a previous partner, what was their reaction? How did it make you feel about yourself? About your partner?
11. Is it important to you to be able to disclose to your intimate partners?

UNIVERSITY OF MANITOBA | Research Ethics and Compliance

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PROTOCOL APPROVAL

TO: **Krystan McCaig** **(Advisor: Jessica Senehi)**
Principal Investigator

FROM: **Kevin Russell, Chair**
Joint-Faculty Research Ethics Board (JFREB)

[redacted]

Re: **Protocol J2017:073 (HS21015)**
"Men, Mood Disorders, Intimacy and Disclosure"

Effective: July 26, 2017 **Expiry:** July 26, 2018

Joint-Faculty Research Ethics Board (JFREB) has reviewed and approved the above research. JFREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This approval is subject to the following conditions:

1. Approval is granted only for the research and purposes described in the application.
2. Any modification to the research must be submitted to JFREB for approval before implementation.
3. Any deviations to the research or adverse events must be submitted to JFREB as soon as possible.
4. This approval is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.
5. A Study Closure form must be submitted to JFREB when the research is complete or terminated.
6. The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

Funded Protocols:
- **Please mail/e-mail a copy of this Approval, identifying the related UM Project Number, to the Research Grants Officer in ORS.**