Invisible Wounds: Trauma, Gender, and the Lived Experience of Sri Lankan Tamil Refugee Men

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Abstract

This thesis focuses broadly on three distinct yet inter-related areas: men's mental health, refugee mental health, and the effect of trauma on psychological/emotional functioning. I have a number of specific aims. My first aim is to introduce the reader to the field of men's mental health. This is an emerging field of research, which has only begun to gain attention in the psychiatric mainstream. My second aim is to explore and document the myriad ways that emotionally and psychologically vulnerable men, and specifically refugee men, are rendered invisible in the field of mental health research, policy, and practice. This is the focus of chapters 1, 2, 3, 4. My third aim is to highlight previously unexplored ethical issues in traumatic stress research. This is the focus of chapters 4 and 5. My fourth and final aim is to better understand how gender, specifically masculinity, insects with culture in the war-trauma and resettlement experience of refugee men. This is the aim of the 6th and final chapter. By fulfilling these three aims, this thesis contributes to the fields of cultural psychiatry, mental health ethics, global mental health, and men's mental health research.

Cette thèse se focalise sur trois domaines distincts mais liés : la santé mentale des réfugiés, la santé mentale des hommes et l'effet des traumas sur le fonctionnement psychologique et émotionnel. Cette thèse aura pour but d'atteindre plusieurs objectifs spécifiques. Le premier est de familiariser le lecteur avec le thème de la santé mentale des hommes. Ce domaine, qui est émergent dans la recherche, a seulement récemment suscité l'attention de la psychiatrie générale. Mon second objectif est d'explorer et de documenter les nombreuses façons par lesquelles les hommes psychologiquement et émotionnellement vulnérables, plus particulièrement les hommes réfugiés, sont devenus invisibles dans le domaine de la santé mentale, que ce soit en recherche ainsi qu'en pratique. Cet objectif sera la focalisation des chapitres 1, 2, 3, et 4. Mon troisième objectif concerne les problèmes éthiques dans la recherche des stress traumatiques, un domaine auparavant non exploré. Les chapitres 4 et 5 porteront sur ce sujet. Mon quatrième et dernier objectif est de mieux comprendre comment le genre, spécifiquement la masculinité, interagit avec la culture des hommes réfugiés qui souffrent de traumatismes de guerre et/ou de l'expérience de réinsertion. Cette idée sera l'objet du 6ème chapitre. En répondant à ces objectifs, cette thèse s'inscrit aux domaines de la psychiatrie culturelle, des responsabilités éthiques dans la santé mentale, et à la recherche et pratique clinique dans la sphère de la santé mentale des hommes.

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Thesis Introduction

Like many men's health issues, mental health and illness are deeply gendered. For example, depression can emerge as a by-product of unemployment or relationship breakdown, dislocating men from the provider and protector roles and the breadwinner identity (Oliffe & Philips, 2008). Men's depression-related reactions are also influenced by masculine norms that prescribe stoicism and restrict help-seeking. For example, reluctance to seek help for mental illness is especially common in men because it signals vulnerability, attracts significant stigma, and directly contradicts the strength and power synonymous with masculine ideals (Courtney, 2000). Solitary discourses around masculinity can leave men emotionally inexpressive and socially isolated- known risk factors for suicide (Chagron, Houle & Mishara, 2008; Murphy, 1998). Suicide has been linked to masculine ideals of autonomy, self-reliance and control (Capaldi, Kerr, Owen & Pears, 2008; Hawton, 2000). Men are more likely to engage in maladaptive coping strategies, including alcohol and drug-misuse (Moller-Leimkuhler, 2003), which are also known risk factors for suicide (Groves & Sher, 2005).

Over the past decade, increased attention has been paid to men's mental health in psychiatric research. However, significant gaps in the knowledge remain. Nowhere is this more obvious than in humanitarian and refugee research. Beyond a handful of studies that have addressed male sexual abuse and gender-based violence, little is known about the war trauma and resettlement experience of refugee men. Most of the information is gleaned from studies comparing their experience to that of women. Very few studies have examined refugee men's experience in their own right. The aim of this thesis is to help fill this gap.

When I first met my supervisor, Dr. Duncan Pedersen, he explained that every good study makes a theoretical, methodological and empirical contribution. In this thesis I have

striven to fulfill this requirement. I have also sought to make original contributions to three separate fields related to my topic of research: men's mental health, traumatic stress research, and transcultural psychiatry.

Conceptually, this thesis can be divided into two main sections. The first, which is comprised of chapter 1-3, makes a theoretical contribution. The second, comprised on chapters 4-6 makes an empirical contribution.

The outline of this thesis is as follows: In chapter one, I briefly introduce the reader to the field of men's mental health, and discuss a number of social determinants that often go unacknowledged by researchers and clinicians. I wrote this chapter with my supervisor, Rob Whitley, and the manuscript has been submitted to the *Canadian Journal of Psychiatry.*

In chapter two, I discuss how social gender norms, reinforced by institutional guidelines, can result in the vulnerabilities of male survivors of trauma being overlooked. I also offer strategies that researchers can use to help mitigate some of these vulnerabilities. I co-wrote this chapter with my colleague Eric Racine. A manuscript based on this chapter has been submitted to the journal *Accountability in Research.*

Chapter three also makes a theoretical contribution. In this chapter, I outline how researchers are misunderstanding and misapplying ethical guidelines as they relate to traumatic stress research. This misunderstanding has resulted in questionable risk assessments of traumatic stress studies. I offer a method of risk assessment, labelled "Content analysis" that investigators can use to more accurately assess risks to participants. I am the sole author of this chapter. A manuscript based on this study has just been published in the journal *Accountability in Research*.

Having broadly introduced the field of men's mental health and traumatic stress studies, in the second, empirical section of this thesis I focus in on refugee men. In chapter 4, I quantify the extent to which refugee men are overlooked in gender-focused refugee research, and offer some possible explanations for why this gap is so substantial. I co-wrote this chapter with Ann Salvaduri, a nursing student who I met while doing my field research in Sri Lanka, and Lindsey Sikora, a research librarian at the University of Ottawa. A manuscript based on this chapter has been accepted in the journal *Intervention.*

Using a similar systematic review, in Chapter 5, I document how gender and gender-relations are represented in gender-focused refugee research, and discuss how these patterns of representation isolate and demonize refugee men. I also situate these gendered representational strategies in the history of European colonialism, demonstrating how they perpetuate larger discourses of dominance and control. I co-authored this chapter with my student Jonathan Abres, and my colleague Lindsey Sikora. A manuscript based on this chapter is currently under revision with the journal *Transcultural Psychiatry*.

Lastly, in the sixth and final chapter, I present an empirical study, conducted in Sri Lanka and in Canada, that explores the psycho-social experience of Sri Lanka Tamil refugee men. The goal of this study was to empirically examine the inter-relationship between war-trauma, migration, resettlement, concepts of masculinity and mental health. I co-authored this chapter with my colleagues Umaharan Thamotharampillai and Judy Jeyakumar from Sri Lanka, and my supervisor Rob Whitley. A manuscript based on this study is currently under review in the journal *Social Science and Medicine.*

Chapter 1: The Social Determinants of Men's Mental Health

As mentioned in the introduction, over the past decade, men's mental health has gained increased attention in psychiatric research. Males outnumber females in a number of developmental disorders, substance abuse disorders, and suicide. Research has also begun to question commonly-held epidemiological estimates that rates of common disorders such as depression and anxiety are higher in women than men. The central explanation for men's mental health remains gender socialization. It is believed that the desire to act congruently with traditional gender ideals, and fears of appearing un-masculine leads men to avoid mental health services and attempt to self-medicate through drugs and alcohol. However, there are a number of factors external to the individual that are also implicated in both the development of mental health issues in men, and men's avoidance of mental health services. Awareness of these factors can have significant implications for mental health policy and clinical practice. In this chapter I first review epidemiological literature on mental disorders with high incidence and prevalence rates in men. Second, I examine the evidenced- based, but often-overlooked, risk factors that help to explain the disproportionate number of men in certain illness categories, and the lack of men in mental health services. The chapter argues that a new public-health oriented approach is needed that documents and addresses the social determinants of men's mental health, and critically examines conventional mental health services offered to men.

Introduction

Researchers have long-been interested in the impact of sex and gender on mental health. This interest has led to the development of two somewhat distinct but overlapping fields: the field of 'women's mental health' and the field of 'men's mental health'.

Interest in men's mental health has increased dramatically in recent years due to a variety of factors. First, studies in psychiatric epidemiology consistently indicate that men experience much higher rates of certain mental health outcomes than women (Seedat et al., 2009). Second, wider social science research suggests that broad socio-economic change is leading to the marginalization of certain sub-groups of men (Farrell, 1993; Sommers, 2013) Third, activists and scholars from related domains including criminology, education and psychology have successfully agitated for more attention to men's issues and well-being

(Klienfeld, 2009; Sax, 2009). All of this has legitimized the development of the field of men's mental health, which now has common themes and interest.

Indeed, interest in men's mental health tends to revolve around a number of related issues, which will be discussed separately throughout this paper. First, I will discuss the basic epidemiology of mental disorders with high incidence and prevalence rates in men. This will include critical discussion of possible measurement and reporting biases. Second, I will explore common risk factors that may explain higher rates of certain mental health outcomes in men. Third, I will examine low rates of mental health service utilization in men, and possible reasons to explain low service usage.

The Epidemiological Background

There are certain mental health outcomes which have a much higher prevalence in men. Suicide and Substance Use Disorder (SUD) are both outcomes where approximately 75% of all cases are men. The most recent report from Statistics Canada indicate that there were 3 890 suicides in 2009, of which 2 989 were men (77%) (Navaneelan, 2009). Gender interacts with ethnicity to produce extremely high rates of suicide in some men. Amongst the Canadian Inuit, for example, the ratio of suicide amongst men and women is 6:1, compared to 3:1 in the general Canadian population (Chachimovich, 2015). These findings correspond with those from the US. The ratio of suicide amongst African-American men and women is 6:1, compared to 4:1 among the general US population (Griffin-Fennel & Wiliams, 2009).

Men are much more likely to develop a substance abuse disorder (SUD) than women. In 2012, 6.4% of Canadian males met the threshold for at least one reported SUD compared to 2.5% of Canadian females. Rates of non-cannabis drug abuse are similar between

men and women (0.2%). However, approximately 1.9% of Canadian males met the criteria for cannabis dependence and abuse, compared to 0.7% of females. Likewise, 4.7% of Canadian males met the criteria for alcohol abuse or dependence compared to 1.7% of females (Ali, Janz & Pearson, 2012). Recently, the epidemiological profile that women and men have similar rates of illicit non-cannabis drug abuse has been challenged by research which found that 80% of deaths in the recent Canadian fentynol crisis are men (British Columbia Coroners Service., 2017).

Males also have significantly higher rates of mental disorders listed in DSM-5 as 'neurodevelopmental disorders'. In Canada, boys are three times more likely to be diagnosed with ADHD than girls (Statscan, 2012). These rates are similar to those found in other countries. Between 2012-2014, 14.1% of American boys were diagnosed with ADHD, compared to 6.2% of American girls (US Center for Disease Control and Prevention, 2016). Boys are also much more likely to be diagnosed with Autism Spectrum Disorder (ASD). In Canada, the male to female ratio for ASD is 4:1 (Fombonne, 2009). These findings are consistent with other developed countries. In the UK, the prevalence rate of ASD in men is 1.8% compared to 0.2% for women (Brugha, McCanus, Meltzer, et al., 2009).

Males also have significantly higher rates of disruptive and impulse control disorders. Worldwide, the male to female ratio for such disorders as Intermittent Explosive Disorder and Oppositional Defiant Disorder is 8:1. For conduct disorders, the male to female ratio is 5:1 (Seedat et al., 2009). These differences are presented in Table One.

Table 1: Gender prevalence of common mental disorders.

MENTAL DISORDERS	MALE TO FEMALE PREVALENCE RATIO	RISK FACTORS	SUB-GROUPS

DEPRESSION	1:3 (Wang et al., 2012; Patten et al., 2015)	Low job (Wang et al., 2012) Unemployment (Whooley et al., 2002) Educational gap Divorce (Rotermann, 2007)	Homosexual and bisexual men (Puckett et al., 2016) Veterans (Koo et al., 2015) Ethnic Minorities (Steenbeek et al., 2016)
ANXIETY	1:3 (Watterson et al., 2017)	Unemployment (Whooley et al., 2002) Educational gap (Stats Can., 2014)	Homosexual and bisexual men (Pitoňák, 2017)
SUBSTANCE USE DISORDER	3:1 (Pearson et al., 2015)	Loss of child custody (Felix et al., 2013)	Homosexual and bisexual men (Hughes et al., 2010) Veterans (Benda, 2005)
SUICIDE	3.5:1 (Navaneelan, 2017)	Unemployment (Whooley et al., 2002) Male occupations (Roberts et al., 2013) Outsourcing and technological advances (Autor and Wasserman, 2013) Educational gap (Stats Can., 2014) Loss of child custody (Felix et al., 2013) Divorce (Rotermann et al., 2007)	Ethnic Minorities (Chachamovich et al., 2015; Griffin-Fennell and Williams, 2006)
ADHD	3:1 (Stats Can., 2015)		Adult prison inmates (Cahill et al., 2012)
AUTISM SPECTRUM DISORDER	4.2:1 (Fombonne, 2009)		
CONDUCT DISORDER, IED AND ODD	8:1 (Seedat et al., 2009)	Low SES (Boden et al., 2010) Childhood abuse (Boden et al., 2010) Adverse parenting styles (Lytton, 1990)	

Common mental disorders: real differences or artefactual differences?

Psychiatric surveys routinely indicate that men have significantly lower prevalence than women of certain mental disorders, namely anxiety and depression, which they experience at a rate of approximately 1:3 (Patten, et al., 2015; Watterson et al., 2017). However, some research indicates that these differences may be exaggerated due to measurement and reporting bias.

For example, research has found that men are much less likely to acknowledge and report possible symptoms of mental illness, and judge their symptoms less severe in comparison to women. Nolen-Hoeksema et al. (1994) argue that women 'amplify' and men 'blunt' reporting of possible symptoms of mental illness (11, pg. 428). Considering that most psychiatric epidemiological measures include self-reported severity-based measures, these gendered differences in expression may influence both reported incidence and prevalence rates (Fletcher, Parker & Paterson, 2011).

Furthermore, some researchers have gone so far as to suggest that there is a distinct and unrecognized "male depressive syndrome" (Rutz & Waliner, 2001) that correlates with the notion of 'masked depression' (Real, 1997). This is based on data suggesting that women tend to 'act in' when faced with psychosocial suffering, while men 'act out'. This 'acting out' often involves high levels of alcohol and drug misuse, increased risk-taking, poor impulse control, and increased anger and irritability. Some have stated that these are 'depressive equivalents' (Cochran & Rabinowitz, 2000) masking an underlying sadness, loneliness and alienation reaching pathological levels in the afflicted men.

These differences in symptomatology present a number of challenges to psychiatric epidemiology. First, 'acting out' symptoms are not included in standardized diagnostic or measurement criteria of depression and anxiety. This may result in inaccurately low prevalence rates, as well as a preponderance of male false negatives in the clinic. This may help explain the comparatively low rates of common mental disorders and high rates of substance abuse and anti-social personality disorders in men.

This danger of miscategorisation may be compounded by issues of comorbidity, which is common between psychiatric conditions (Brooner, Kidorf & King, 2011). Indeed,

research has found that comorbidity between depression/anxiety and SUD are significantly more common in men than women (Bolton, Robinson, & Sareen, 2009). Likewise, in communities where alcohol and drug use are culturally prohibited, the disparity between men's and women's reporting of depressive symptoms narrows (Egeland & Hostetter, 1992, 1995). In fact, studies which include 'acting out' symptoms in depression measures suggest that men and women meet the criteria for depression in equal proportions (Griffith, Martin & Neighbors, 2013).

Perhaps the most compelling evidence that epidemiological and diagnostic measures are faulty is the large discrepancy between men's low rates of depression and high rate of suicide. Depression is heavily implicated in suicide, underlying approximately half of completed suicides (Moller-Leimkuhler, 2003). Nevertheless, despite experiencing significantly lower rates of depression than women, men kill themselves at a much higher rate. The hidden nature of men's mental health symptoms, and the disconnect between low rates of diagnosis and high rates of suicide has led some scholars to suggest a "silent crisis" in men's mental health that is not being sufficiently addressed (Bilsker & White, 2011).

Common Risk Factors: Employment

Epidemiological research on suicide, substance abuse and depression in men indicates numerous common risk factors. One of the key factors is employment and occupational issues. Research indicates that unemployment can be a chronic stressor, while being made unemployed can be an acute stressor. Numerous studies have found that unemployment has a greater impact on the mental health of men than women (Heponiemi et al., 2007; Whooley et al., 2002).

For example, a recent meta-analysis found that the effect of unemployment on mental health was significantly stronger for men than for women (Moser & Paul, 2009). Likewise, Arttazcoz, Benach, Borrel & Cortes (2004) found that unemployment had nearly twice as severe an effect on the self-reported mental health of men than women.

This difference between may be because work has traditionally been the domain from which a man derives his self-identity, self-esteem and self-worth. Work also provides status, income and resources which can be used to support men and their families. As such, rupture and discontinuity in the work domain can lead to significant psychosocial stress, not to mention severe financial strain.

Indeed, Wang et al. (2012) found that low job security and conflict resulting from competing family and work responsibilities were predictive of depression. Contrariwise, moderate levels of job strain were in fact found to be protective factors in the development of depression in men (Currie, Patten & Wang, 2014).

Another factor affecting men's mental health may be uncertainty of employment, as well as levels of danger within the workplace. For example, recent research has found that male-dominated industries in economic precarity such as coal mining, commercial fishing, and labouring have high rates of suicide. These industries have also seen the greatest increase in suicide over the past 30 years. In contrast, more gender-balanced growth industries such as white collar and non-manual occupations have the lowest suicide rate, and have had the greatest decrease in suicide over the past 30 years (Roberts et al., 2013).

These trends in men's mental health are likely linked to macro socio-economic forces. The past several decades have seen profound restructuring of western economies with a transition from a manufacturing to a service-based knowledge economy. This has led to a

decline in male-oriented industries with the closure of factories, coal-mines, mills and other manual industries which often gave men (especially rural less educated men) a job for life and a meaningful place in their local communities (Autor & Wasserman, 2013). Indeed, recent research suggests that the highest suicide rates in Canada are in rural areas with high rates of unemployment (Auger, Barry, Burrows & Tamamban, 2013).

Statistics also indicate that increasing proportions of men are taking on low-wage and low-skilled jobs. For the past 30 years, average male earnings have been steadily declining throughout many Western countries, while women's earnings have been steadily increasing. In fact, women under 40 are now out-earning their male peers, with many young men struggling to find a place within the new economy (Autor & Wasserman, 2013).

Trends in education are likely implicated in these patterns. Boys have much higher rates of drop-put than girls, and this rate is increasing. In 1990, 58.3% of high-school dropouts were men. By 2005, the rate had increased to 63.7% (StatsCan, 2010). Male dropout is highest in Quebec. In 2005, 70% of high-school dropouts were young men (Statscan, 2010). Young men also receive a significantly fewer number of university degrees. In Canada in 2014, men received roughly 40% of both undergraduate and graduate degrees. These findings are consistent with other developed countries (US Department of Education, 2016).

Common Risk Factors: Family Issues

Family is another life domain by which men garner significant purpose and meaning in life. Evidence suggests that divorce and romantic break-up are strong risk factors for mental illness and suicide (Grove, 2012). One study found that the incidence of depression is nearly four times higher amongst individuals who are separated, divorced, or single

compared to those in relationships (Rotterman, 2007). Furthermore, research indicates that men have worse mental health outcomes following divorce than women. One study indicates that divorced men are roughly twice as likely to report depressive episodes in the 2 years following a divorce than divorced women (Rotterman, 2007).

The negative influence of divorce on men's mental health has been attributed to numerous factors. A key factor is the loss of social support and emotional connectivity. For example, one study indicated that 19% of men who were no longer with their spouse reported a drop in social support, compared to 11% for women (Rotterman, 2007). This is consistent with sociological research indicating that women tend to have larger circles of family and friends who they can rely upon after a divorce, whereas men tend to rely largely on their partner and immediate family for emotional support. Thus the loss of a partner can be felt particularly hard, as can the loss of any children deriving from the relationship.

Indeed, figures from Justice Canada show that close to 80 percent (79.3%) of divorce fathers lose custody of their children following a divorce (Justcan, 2015), and only 15% of fathers will have their children live with them (Statscan, 2015). Evidence suggests that loss of custody and negative experience in family court is one of the most stressful aspects of post-divorce for men and has been implicated in both substance abuse and suicide (Felix, Jarzynka & Robinson, 2013). Like the loss of employment, this can leave a man bereft of purpose and meaning in life, leaving him financially and emotionally drained.

Indeed, rising divorce rates have been linked to rising suicide rates. During the 1950s, both divorce and suicide rates in Canada were fairly stable, but began to rise in unison during the 1960s. Dramatic increases in both rates followed the passing of the Divorce Act in 1968. In the twenty years following, the number of divorces spiked from less than 50 per

100,000 to 350 per 100,000. In parallel, suicides in Canada spiked from 2 per 100,000 in 1968 to 15 per 100,000 in the mid 1980s (Navaneelan, 2007).

Common Risk Factors: Adverse Childhood Experience

Adverse childhood experiences are common factors in long-term psychological and physical health consequences (Akman, Beitchman, daCosta, Hood & Zucker, 1991). Childhood abuse is common amongst boys and girls, however, some types of abuse are more prevalent in girls than boys and vice-versa. While sexual abuse tends to be more prevalent in females, physical abuse (Desai, Kingree & Thomson, 2004) and emotional abuse tend to be higher in males.

There is ample research evidence to show that a history of child abuse and maltreatment constitutes a risk factor for adverse outcomes among children and adolescents of both genders (Beitchman, Zucker, Hood, 1992). However, for a number of reasons, it is more likely that abuse amongst boys will be overlooked. First, abused children tend to exhibit gender specific symptoms: females are more likely to engage in internalizing behaviours and males are more likely to exhibit externalizing behaviours (Blum, Chandy & Resnick, 1996). Thus, while abused girls are at a higher risk of more traditional mental health symptoms such as suicidal ideation, depression, and disordered eating, abused males are likely to act up in school, have poor school performance, participate in delinquent activities, binge-drink, use drugs, and undertake sexual risky behaviour (Blum, Chandy & Resnick 1996). Such 'externalizing' behaviours are often not included in the official nosology of mental health symptoms. It can also be difficult to differentiate externalizing symptoms from normal boy behaviour. Research has shown that there is a high degree of symptom overlap and co-morbidity between ADHD

and SAC (sexually abused children) (Bender, Halldorsdottir & Sigurdardottir, 2012). This can result in a greater risk of childhood abuse in boys being misdiagnosis as ADHD, and, in turn, further overlooked in clinical practice.

Common Risk Factors: Life-Transitions

Periods of major life change are well recognized to be risk factors in mental health for men. One such change is the transition to parenthood. The existence of paternal post-partum depression (PPD) is now well established. Meta-analyses have found that PPD affects 10.4% of fathers (Bazemore & Paulson, 2010). This is more than double the 4.8% rate of depression typically found in male populations (Berglund, Demler, et al. & Kessler, 2003). PPD is especially prevalent in new fathers, and while it can be seen as early as the first trimester, is highest in the 3-6 month postpartum period (Bazemore & Paulson, 2010). Besides affecting the individual, PPD has been shown to exacerbate maternal postpartum depression (Goodman, 2004), and negatively affect the emotional, behavioural, and development outcomes of children (Keefe, Leiferman & Paulson, 2009; Evens, Heron, Murray, O'Connor, Ramchandani & Stein, 2008). Despite representing a significant public health concern, little attention is paid to PPD in research or mental health promotion (Ramchandani et al., 2005). Unlike maternal post-partum depression, it is not included in the DSM-V.

Help-Seeking

Much research from across the Western world indicates that men under-utilize mental health services in comparison to women. In Australia, for example, men are 11% less likely than women to see a psychiatrist (7.5% vs. 8.3%) and 18% less likely to see other mental

health professionals (6.9% vs 8.4%) (Australian Bureau of Statistics, 2008). Similar findings have been found in other developed countries (Dezetter et al, 2013; Gagne et al., 2014; Wang et al, 2005).

The most common interpretation for men's low rates of service utilization surround masculine gender socialization (Möller-Leimkühler, 2002). It is hypothesized that men are socialized to be strong, stubborn, stoic and self-reliant in the face of adversity. As such, seeking professional help for mental health issues can contradict these deeply held notions of masculinity which make up a core part of many men's identity (Courtney, 2000). In other words, men make the decision not to use mental health services because it could be perceived (by themselves and others) as 'unmanly' and a sign of weakness.

To this end, a number of initiatives have attempted to counter men's supposed negative attitude to seeking help. This includes Canada's Man-UP Against Suicide program (manupagainstsuicide.ca), and Australia's *Beyondblue* initiative (beyondblue.org.au). Such programs may account, at least in part, for modest increases in the use of mental health services amongst men in recent years (Harris et al., 2015). However, the common interpretation that men's lack of service engagement is due to men's stubbornness is only part of a much more complex picture; and also can reasonably be construed as victim blaming.

Men's perspectives on mental health and help seeking are not developed in isolation; they are informed by broader societal discourse that informs experiences and decisions. In Western society, and indeed throughout the world, notions of masculinity and femininity colours the definition and experience of vulnerability, emotional distress, and "mental illness" (Inckle, 2009).

This can be seen in popular culture and media reports, which often perpetuate notions that men are somehow to blame for their own mental health issues, thus contributing to an unsympathetic social environment. For example, a content analysis of Canadian media reports found that women with mental illness are treated more sympathetically than men with mental illness in the media (Adoponle, Miller & Whitley, 2015). A similar analysis of newspaper stories found that the media tended to berate men for being silent about their depression and their feelings and reluctance to seek help (Bengs et al., 2008).

The link between social gender norms and men's mental health behaviour are well-established (Galdas, Johnson, Kelly, Ogrodniczuk & Oliffe, 2011; Gough, 2006). However, much less attention has been paid to the impact that these social norms have on healthcare providers.

Inevitably, policy-makers and health professionals will be influenced by gender norms . Some sociologists argue that traditional notions of masculinity are institutionalized in the medical system (Moynihan, 2002). Indeed qualitative research has found that health care providers often encourage 'stoical masculinity' amongst male patients (Broom, 2005). For example, research shows that men receive significantly less of a doctor's time in medical encounters than women, and men are provided with fewer and briefer explanations- both simple and technical (Brooks, 2001).

In mental health specifically, social gender norms may result in professionals being less likely to look for emotional and/or psychological vulnerability in men (Courtenay, 2000; Moller-Leimkuhler, 2002). Indeed, studies have found that healthcare providers are both less likely to diagnose mental illness in men than women, and are less likely to act upon mental illness in men once it is detected (Borowsky, Meredith, et al. & Rubenstein, 2000).

Evidence also suggests that healthcare providers are less sympathetic or accepting of mental health issues in men. A qualitative study from Toronto found that dismissive and intolerant attitudes of healthcare providers were implicated in suicidal men's decision to use alcohol, drugs, and sex as alternatives to taking up mental health services (Bergmans, Links, Rhodes & Stike, 2006).

Gendered attitudes of healthcare providers, either implicitly or explicitly communicated, may reinforce some men's beliefs that mental health services are not appropriate for males. They may also exacerbate men's tendency to downplay or minimize the severity of mental health symptoms in the clinical encounter (Oliffe & Philips, 2010).

All of the above has led some scholars to suggest that that the dominant modality of healing within clinical psychology and allied professions is 'feminized' (Sommers, 2015). Indeed, in the United States, 75% of psychologists, 80% of social workers, and 88% of psychiatric nurses are women (US Dept of Labor, 2016). Although some men may prefer consultation with female health professionals, it has been suggested that some men may feel especially self-conscious about disclosing their emotional problems to women (Banks, 2001). This raises the issue of gender matching of client and clinician, which has received surprisingly little attention in comparison to ethnic matching (Klimidis, Lewis, Stuart & Ziguras, 2003).

It has also been suggested that men can be dissuaded by the physical environment of mental health services. Banks (2001), for example, describes mental health services as "male unfriendly spaces", arguing that waiting-rooms are commonly designed for women, displaying much material about women's and children's health but little for men, with the exception of sexual health literature which may sometimes have a judgemental tone.

Research into men's treatment preferences is mixed. While some studies have found that men prefer psychotherapy to medication (Hernandez, Joyce et al. & Oliffe, 2014), others have found that some men can find the traditional model of psychotherapy uncomfortable and even emotionally threatening (Doka & Martin, 2011).

In contrast, therapies that are framed in a non-clinical ethos, such as activity-based or music/arts therapy have been shown to be effective in attracting and treating men (Kemple & Wilkins, 2011). Evidence also suggests that anonymous or 'arms-length' approaches, such as online or telephone therapies can be helpful in engaging men, though more research is needed to determine their precise effectiveness (Robertson et al., 2015).

Conclusion

Traditionally, men's mental health problems have been explained through deficit-based models, some of which have an air of blaming or berating men for bringing mental health issues upon themselves. But as this paper outlines, social determinants are intricately implicated in men's mental health, but have been overlooked in favour of individual-level explanations. Men's mental health was for many decades a marginal aspect of psychiatry, but has been increasing in importance in recent years. The evidence suggests that individual men may need to change, but more importantly, health service providers and society as a whole may also need to change. This can go some way to allaying what some have called 'the crisis in men's mental health'.

Chapter 2: The Overlooked Vulnerabilities of Male Survivors of Trauma

A substantial amount of empirical research has explored ethical issues in traumatic stress research. However, studies have either focused on women's experience of research participation, or have not accounted for sex differences in their analysis. Men have a unique mental health experience, expression, and pattern of help-seeking that have implications for ethical analysis. However, men's vulnerability often goes overlooked in mental health research. This neglect may have been replicated by institutional guidelines that define vulnerability through the membership to a specific group. Drawing from a more-evidence informed integrative-functional account of vulnerability, this chapter outlines a number of ethical issues that should be considered when working with male survivors of trauma. It concludes with some suggestions for good practice, although the aim is to initiate discussion rather than establish prescriptive guidelines.

Introduction

Traumatic stress, in its different forms, has become an acknowledged clinical reality in the past decades. Epidemiological surveys have found that 80% to 90% of individuals are exposed to traumatic event in their lifetime (Brunet, Caron, Lonergan & Monson, 2015; Mills et al., 2011). PTSD has a lifetime prevalence of approximately 6-8% in the general population, and 80% of affected individuals have one or more co-occurring psychiatric disorders, most notably depression and substance abuse (Cohen, Foa, Friedman & Ieane, 2009). In response, research on traumatic stress has tackled its psychological mechanisms, its treatment, and its economic and policy implications (McFarlane, Van der Kolk & Weisaeth, 2012). A significant amount of empirical work has also explored ethical issues that result from participation in traumatic stress research, including risks and benefits (Kaloupek & Newman, 2004) and issues surrounding informed consent (Geflan, Newman & Walker, 1999). To date, however, these studies have either explored the experiences of female participants (Decker et al., 2011; Goff & Schwerdtfeger, 2008; Walker et al., 1997) or have not accounted for sex

differences in their analysis (Cook et al., 2011; DePrince and Freyd, 2006). As a result, ethical issues, as they pertain to men's experience of trauma-research participation, have largely been unexamined. After briefly exploring why men's vulnerabilities are overlooked in mental health research and research ethics, this article details a number of vulnerabilities that researchers, REB members, and other relevant actors should consider when conducting research on male survivors of trauma. We offer suggestions to help investigators address and mitigate these challenges.

Before detailing these vulnerabilities, it is worth adding a few broad caveats. First, in line with the suggestion of Deaux (1985) it is important to distinguish between sex and gender. Sex refers to the physical anatomy, whereas gender refers to an individual's social identity. This article focuses on men's gendered vulnerabilities, i.e. as they are socialised based upon gender norms and behaviours. Second, the aim of this article is to outline some general ethical issues that can arise when studying male survivors of trauma. This necessitates a generalized discussion of gender although gender is not a fixed disposition, but rather exists along a continuum (Wilchins, 2011). Gender is also a social construct, and how it is experienced and expressed will differ across age, race, class, culture and religion (Connell, 1995). The reader should keep in mind that there are many shades of grey within the category of "men" and caution should be taken when applying these themes to individual experience.

Overlooking Men's Vulnerability in Mental Health Research and Research Ethics

It is widely recognized that men's vulnerabilities are often overlooked in mental health research and practice (Addis & Cohane, 2005; Kempner, 2006; Riska, 2009), which we find to have repercussions in research ethics. To understand this oversight, it is important to step back and examine the features of the broader context that could distort the understanding

of the vulnerabilities of men in mental health and mental health research more broadly given the tight coupling between both topics.

Overlooking Men's Vulnerability in Mental Health Research

There are likely many causes explaining why men's vulnerability are overlooked in mental health research but it may be the result of over-arching normative gender structures that continue to define vulnerability and psychological/emotional distress through the lens of traditional masculinity and femininity (Inckle, 2014). These structures can be clearly witnessed in both the historical and contemporary explanations of mental illness. Historically, for example, females were considered more vulnerable to mental health issues on account of their biology, specifically their reproductive functions and hormonal cycles (Ussher, 1991). In fact, some of the earliest mental illnesses were defined purely in terms of female reproductive biology. Hysteria, for example, which originates from *hystera* the Greek word for uterus, was thought to result from the womb having become dislodged within the body and wandering into a woman's brain, making her insane (Ussher, 1991).

While such straightforward associations between female biology and mental illness have been discredited, they have been replaced with some social explanations that can be equally essentialist. For example, one explanation holds that girls and women are more vulnerable to mental illness due to societal gender norms that restrict the outward expression of negative emotions, which forces girls and women to turn these negative feelings inward upon themselves, causing mental illness (McAlpine, Rosenfield & Vertefuille,2000). A similar explanation for women's increased vulnerability holds that mental illness is a response to experiences of powerlessness, abuse, lack of autonomy, or control over one's life. Because

these experiences are more likely to be endured by women and girls – who remain disempowered and sexually objectified in society and are less likely to have either the freedom or the means to challenge and confront these experiences – girls and women are more vulnerable to mental illness (WHO, 2000).

While these explanations may seem plausible, just like the biological explanations, they are defied by evidence. For example, research has found that boys and men are equally, if not more, socially restricted from expressing their emotional pain and suffering than women (Evans and Wallace, 2007). Likewise, while gender norms structure male and female vulnerability differently, this difference is not necessarily quantifiable. In other words, at least in the developed world, girls and women do not experience disproportionately high negative life events. For example, while girls are more likely than boys to be sexually abused, in the United States, boys are more likely to be physically assaulted (Pinheiro, 2006), bullied at school (Kim & Leventhal, 2008), and emotionally abused or neglected at home (Scher et al., 2004). Similarly, in Canada, while women tend to face higher levels of sexual harassment and gender discrimination, men are more likely to be uneducated (Scher et al. 2004) and unemployed (Statistics Canada, 2007) than women and are more likely to be homeless and live in extreme poverty (Gaetz, Gulliver & Richter, 2014; Gaetz & O'Grady, 2004). Men also experience a greater number of traumatic events than women (Breslau et al., 1997; Ditlevsen & Elklit, 2012) and are much more likely to be victims of serious violent crime and assault (Vaillancourt, 2010). However, this trauma has only gained attention in the last years as a major health concern. For example, the massive trauma suffered by second world were veterans is only beginning to be understood as well as its subsequent impact on domestic violence, homelessness, alcoholism, and suicide (Dallaire, 2016).

The discussion is in no way meant to downplay the suffering of girls and women, deny the ill effects of sexism, or detract from the importance of studying trauma as it relates to women's mental health. Rather, the intent is simply to highlight the impact that social gender norms have on the conceptualisation of vulnerability. The fact that problematic explanations about women's particular vulnerability to mental illness remain in the face of this counter-evidence suggests that they are partly rooted in larger social meta-narratives surrounding gender and psychological and emotional vulnerability, rather than critical analysis of evidence.

Overlooking Men's Vulnerability in Research Ethics

In the context of mental health research, the tendency to overlook men's vulnerability may be perpetuated in concepts and guidelines used in ethical analysis. Take for example, vulnerability, a key concept within research ethics. The category of "vulnerable population" has existed since the introduction of the guidelines formulated in the Belmont Report in 1979 (Resea & Ryan, 1979). The concept is used to identify, and give special considerations to those who are less able to safeguard their interests in research and has been deemed important in the context of mental health research (Brooks & Holian, 2004; EU Commission, 2014; Tri-council Policy, 2014). This, of course, is understandable: certain individuals are more susceptible to harms and of being taken advantage of than others and it is morally incumbent upon investigators and IRBs to protect the interests of these participants. However, the way in which the concept of vulnerability is operationalized in the research ethics process is problematic, particularly in the context of research on men's mental health.

The predominant approach to determining vulnerability is known as the categorical or sub-population approach (Luna, 2009). This approach begins from the position

that there is a default baseline 'normal' research participant who is mature, clear-thinking, well-educated, socially privileged, and economically self-supporting. 'Vulnerable' populations are identified in opposition to this norm (Luna, 2009). The result is a type of binary essentialism in which populations are seen as either "vulnerable" or "not vulnerable" based on their membership in a specific group. Because of men's social and economic advantage, they are typically categorized as "not vulnerable" as a group unless they belong to a specific and ptre-identified group (e.g., homeless, prisoner). Like all theoretical lenses, research guidelines exert an influence on how problems are conceptualized and, consequently, sideline examples that do not fit within their frame. The result of the binary essentialism is that the vulnerabilities of those deemed 'not vulnerable', such as male research participants, but also women who do not fit squarely within the parameters of the sub-population approach, can easily be overlooked (Luna, 2009). This danger is further compounded because the subpopulation approach fails to recognize intersectionality and context. As a result, men who do not belong to a vulnerable group such as homeless, prisoners, or people living in poverty may not be considered to be vulnerable following the sub-population approach. Likewise, context-specific vulnerabilities, can also be overlooked.

In contrast to the sub-population approach, but consistent with Luna's proposal to consider different "layers of vulnerability", [Bracken-Roche & Racine, in press] have put forward the "functional Integrative" account of vulnerability, which provides a practical approach to uncovering and meaningfully addressing vulnerabilities of research participants. Inspired by philosophical pragmatism, this model defines vulnerability as "a situation in which a research participant has an identifiably increased likelihood of incurring additional or greater harm or wrong because of relational asymmetry in the research context (i.e. between participant

and researcher, research environment, research institution)" (Bracken-Roche & Racine, in press). Accordingly, research participants are not intrinsically considered vulnerable, but are vulnerable in certain situations or circumstances. The benefit of the integrative-functional account is that it facilitates a finer-grained analysis of the potential vulnerability of participants in a specific research context and provides the framework to test a potential vulnerability in light of evidence It is not intended to generate summative conclusions regarding the overall vulnerability (or not) of a specific group, but rather to bring rigour and thoroughness to what otherwise may be unchecked assumptions about the vulnerability of subpopulations of participants, including those already considered vulnerable and those not suspected of being vulnerable.

The application of the integrative functional account is operationalized according to seven *dimensions* of vulnerability (Kipnis, 2001). These include: *cognitive vulnerability*, lack of capacity to deliberate and make participation decisions about a given study; *juridic vulnerability*, liability to the authority and influence of others who may have an independent interest in that participation; *deferential vulnerability*, custom to deferential behaviour that may make participation refusal difficult; *medical vulnerability*, participant selection based on a serious health condition for which no other satisfactory treatment exists; *allocational vulnerability*, research participation will provide access to benefits participants could not otherwise access; *infrastructural vulnerability*, a political, organization, economic, and social research context that does not possess the integrity and resources needed to adequately manage the study; and *social vulnerability*, participant as a member of a group whose rights and interests have been socially disvalued (Kipnis, 2001). To assess the ethical nature of a research project, these dimensions are then evaluated with respect to six research ethics criteria

commonly used to assess the ethical nature of clinical research (i.e. value, scientific validity, favourable risk-benefit ratio, independent review, informed consent, respect for potential and enrolled subjects) (Emanuel, Grady & Wendler, 2000).

Applying the integrative-functional account of vulnerability begins with a heuristic-like initial review of the seven dimensions of vulnerability to consider which may be relevant and to ascertain the relevant dimensions of vulnerability at stake in a research protocol (Bracken-Roche & Racine, in press). When the case of male participants in traumatic stress research is considered c, three of the six criteria are relevant: favourable risk-benefit ratio, respect for potential and enrolled subjects, and informed consent, which intersect with four dimensions of vulnerability: clinical, social, juridic, and deferential.

Table 1: The overlooked vulnerabilities of men participating to trauma research: An analysis guided by the integrative-functional account of vulnerability (blinded, under review)

Criteria for Ethical Research	Relevant dimensions of vulnerability	Concern	Possible implications
Favourable risk-benefit ratio: within the context of standard clinical practice and the research protocol, risks must be minimized, potential benefits enhanced, and the potential benefits to individual and knowledge gained for society must outweigh the risks.	Clinical Social	Risk-benefit analysis for male participants has not been adequately studied. Evidence suggests that male participants may have a less-favourable risk-benefit analysis than female participants	Understandings of risk-benefit analysis may not be relevant for male participants.

Informed Consent: individuals should be informed about the research and provide their voluntary consent.	Juridic Deferential	Male participants can be unduly pressured to participate in research (e.g., by family members).	Voluntary consent of male participants may be compromised.
Respect for potential and enrolled subjects: subjects should have their privacy protected, the opportunity to withdraw, and their well-being monitored.	Juridic Deferential	Male participants may feel unable to withdraw from the research out of a sense of gender role and masculine obligation. Tools to monitor the emotional/psychological distress of male participants are not commonly used in trauma research. Researchers may be unfamiliar with a male participant's expression of emotional/psychological distress.	The ability of male participants to voluntarily withdraw from the research may be compromised. Researchers may be unable to adequately monitor the psychological and emotional wellbeing of male participants.

* Based on Christine Grady, David Wendler, Emanuel & Ezekiel J's "What Makes Clinical Research Ethical?" JAMA 283, no. 20 (2000), 2701. doi:10.1001/jama.283.20.2701.
** Based on Kipnis, K. Vulnerability in research subjects: A bioethical taxonomy. National Bioethics Advisory Commission, editor. Ethical and policy issues in research involving human participants. Bethesda: National Bioethics Advisory Commission p. G1–13.32, 2001.

Exploring Men's Vulnerability in Research Ethics

Like any ethical issues that arise in research (Brendel & Miller, 2008), vulnerability is contextual. That is, it can vary depending upon the population under study, the focus of the research, and related conditions for participation. Importantly, research on trauma in men suggests that male participants have characteristics that should be considered when

examining their potential vulnerability. In the discussion that follows, these vulnerabilities are outlined using Kipnis' (2001) types of vulnerabilities, reframed as dimensions of vulnerability within the functional-integrative account. For conceptual purposes, the discussion is divided into three different relevant research ethics criteria (Emanuel, Grady & Wendler, 2000): risk assessment, respect for participants, and informed consent. While each of these criteria is discussed separately, they often overlap. In other words, issues and concerns that arise regarding the criterion of risk assessment have implications for informed consent and respect for participants, and vice-versa.

Favourable risk-benefit ratio

Risk of increased exposure to harm is one of the central components of vulnerability (Hurst, 2015). Both ethics codes and government regulations require researchers to identify all pertinent risks in research to ensure that participants are not exposed to unnecessary or disproportionate likelihood of harm (Tri-council policy, 2014; USHHS, 2014). In research, risk is determined through two different methods, depending upon the nature of the research (or more accurately, the procedures found within the research protocol) (Weijer, 2000). For clinical research, (i.e. that pursues aims related to the health condition of the participant), a risk-benefit analysis is used, whereby the risks of participation are weighed against the benefits available to the individual for participating. For non-clinical research (i.e. that does not pursue aims related to the health condition of the participant) risks must be weighed against the importance of the knowledge that the study is likely to produce (Weijer, 2000).

To determine the level of risk in traumatic stress research, investigators have applied different methods of risk-benefit analysis (Willebrand, 2008), the minimal risk

approach (Yeater et al., 2012), and often a combination of the two (Cook et al., 2011). Generally, the level of risk has been found to be tolerable: benefits of participation outweigh the risks, and traumatic stress research poses no more than minimal risk (Kaloupek & Newman, 2004). However, this research is limited since the studies that have explored the experience of traumatic stress research participation have either used all female samples (DiLillo et al., 2006; Goff & Schwerdtfeger, 2008; Walker et al., 1997) or have not accounted for sex differences in their analysis (Cook et al., 2011; DePrince & Freyd, 2006). As a result, ethical issues specific to male participants could have been overlooked. A large body of evidence suggests that this risk assessment may be more complicated when studying male survivors of trauma. This stems from two overlapping issues: men's higher susceptibility to distress as a result of talking in-depth about their experience, and difficulty that outsiders, including researchers, have in detecting men's emotional and psychological distress.

Gendered Risk Benefit Analysis of In-depth Discussion About Distress

Emotional distress as a result of discussing traumatic experience is the primary risk in trauma-focused research (Kaloupek & Newman, 2004). Research suggests that on the whole, men may experience greater levels of risk, and lower levels of benefits from speaking about their traumatic experience than women. Clear evidence for this comes the work of Doka & Martin (2000, 2011) who, working within the field of bereavement, distinguished between the *intuitive* pattern of grief processing, which tends towards an outward and affective expression, and the *instrumental* pattern, which tends towards a more intellectual, inexpressive style of grief processing. Here, grief is considered to be one kind of trauma. *Intuitive* grievers gain strength and solace from openly sharing and speaking at length about their experience, and

will often seek out opportunities to share their experience with others (therapists, support groups). In contrast *instrumental* grievers desire to master their feelings, gain strength through the completion of practical task-oriented activities, and tend to avoid speaking openly about their experience. Unlike intuitive grievers, instrumental grievers often find speaking about their experience highly stressful and emotionally threatening, do not enjoy talking about their trauma, and do not have access to many of the benefits associated with talking through their experience (Doka & Martin, 2011).

The differences in grieving patterns are highly correlated with gender. There are important exceptions that need to be considered. However, in general, intuitive grievers tend to be women whereas instrumental grievers tend to be men (Doka & Martin, 2000). The roots of this distribution are believed to lie in gender socialization. Beginning in early childhood girls and women are socialized to share confidences, draw support from one another, and develop more emotion-focused ways of coping. Boys and men, on the other hand, are socialized to control their emotions, learn active and problem-focused solutions of coping with emotional distress, and value self-reliance. Solving one's problems and facing one's difficulties alone have long been defined as hallmarks of manhood (Bordo, 1999).

The distinction between intuitive and instrumental grievers has obvious implications for risk assessment of traumatic stress studies. As predominantly instrumental grievers, it is likely that male participants will experience greater levels of emotional and/or psychological distress from participating in in-depth interviews or survey research about their experience. Likewise, they are less likely to have access to benefits, such as enjoyment of the research process and cathartic release from discussing their experience, commonly used to offset risk in trauma-focused research (Kaloupek & Newman, 2004). Research on risks and

benefits of trauma research have largely relied upon studies exploring women's experience; that men might have different risk-benefit experiences raises questions about the limitations of this research.

This analysis also has implications for the determination of minimal risk. Both because of the instrumental grief pattern, and because of gender norms around emotional expression, men are much less likely to talk in depth about their experience (Doka & Martin, 2011). They are also much more likely to avoid situations in which they will be obliged to directly confront their experience, including seeking out professional mental health services (Doka & Martin, 2011). Thus, it is likely that the level of distress and discomfort that accompanies participation in trauma research will be significantly higher than that experienced in every-day life or in routine medical examinations or tests, which could therefore affect the determination of minimal risk.

Informed consent

The discussion of men's unique risk-benefit profile is also relevant to informed consent. Beyond risk assessment, both ethics codes and government regulations require researchers to identify all pertinent risks and benefits so that potential subjects are able to make informed judgements about research participation. Considering Doka & Martin's (2000, 2011) work, men, who are typically instrumental grievers, experience greater distress and lower levels of comfort from discussing their experience, it is probable that the evaluation of risk and benefits of trauma research participation will be different for male research subjects. Without accurate, gender-specific information on risks and benefits, a male participant's decision to participate in trauma research may be compromised.

In terms of informed consent, it is not just the analysis of risk-benefit ratios that needs to be considered. One of the central requirements in research ethics is that the decision to participate be voluntary. Individuals cannot be coerced to participate by outside parties, regardless of motivation. Coercion can come from a number of sources, including financial and medical incentives and power inequalities between the researcher and participant. Family members can also be a source of undue influence. This was recognized by the Belmont Report, which states that: "undue influence includes actions such as manipulating a person's choice through the controlling influence of close relatives and threatening to withdraw health services to which an individual would otherwise be entitled." (Resea & Ryan, 1978, p. 8). In the case of male survivors of trauma, the pressure to participate in research may not come from "controlling" relatives but rather from loved ones who are concerned about a man's emotional and psychological wellbeing. Influenced by the cultural ethos that links psychological healing to verbal expression, loved ones often worry that because a man is not openly talking about his trauma, he is not 'properly' dealing with his experience (Walter, 1999). Out of this concern, and a desire for reassurance, there is a danger that loved ones will pressure a man to speak to a trauma 'expert', even if they are only a researcher. Rosenblatt (1995, p. 143) describes such a scenario:

> They [participants] would not have said yes had they not been pressured by a family member… One example of what I considered coercion by a family member began when a woman who I was going to interview told another woman about the study. The latter women and her husband had lost a child in a farm accident a few years before. This woman called me while I was interviewing her neighbours and asked me to visit…she told me that he (husband) had never talked about the accident. I came to her farm as soon as I was free, and followed the husband from cow to cow, telling him the things stated in the advertisement for the study. He was obviously hurting as we talked, using jokes and laughter to hold back tears, but he eventually said he would do it.

While Rosenblatt is convinced that in the end, the experience of talking through his grief was helpful, he concedes "[t]his man would not have participated if he had not been so pressured by his wife" (Rosenblatt, 1995, p. 143). In other words, challenges to the voluntary nature of consent could occur because, in this case, of the neglect about a common way of experiencing trauma in men (lack of professional attention to men's mental health issues).

Respect for potential and enrolled subjects

There is a danger that the emotional/psychological distress of male participants will be overlooked in the research context. This is a result of at least three separate yet interconnected issues: a) men's health and illness behaviours; b) men's mental health symptomatology; and c) the tendency amongst health-workers, including researchers, to be less attentive to emotional and psychological distress in men.

Men's health and illness behaviours

Many men embody distinct health and illness behaviours. Specifically, men are known to risk rather than promote their health, rely on performance-based models to confirm health, self-monitor and treat symptoms, and deny or downplay illness (Addis & Mahalik, 2003; Courtenay, 2000). Like other aspects of their experience, men's health behaviour is linked to gender socialization. Beginning in early childhood, boys are taught to identify with culturally dominant ideals of masculinity, which teach them that the expression of vulnerability is inappropriate, that only 'weak' or 'feminine' men respond to stress, and that it is 'manly' to ignore symptoms of ill health (Hart, Hunt & O'Brien, 2005). This results in the widespread denial of suffering and the suppression of affect, especially surrounding emotional and psychological issues, the expression of which directly contradicts the strength and power

synonymous with masculine ideals (Oliffe & Phillips, 2008). Within the context of traumatic stress research, men's health behaviour can result in male subjects supressing, denying, or dismissing any emotional and psychological stress that results from research participation. Male participants may also be less likely to stop the interview or choose not to answer certain questions out of a fear that they will be deemed 'unmasculine' for doing so (Schwalbe & Wolkomir, 2003). Such behaviours can make it difficult for investigators to recognize when a male participant is experiencing distress, and, in so doing, fail to take appropriate actions.

Men's mental health symptomatology

Another reason why men's distress and vulnerability may be overlooked in the research ethics context – and in ways relevant to potential and enrolled research subjects – surrounds the way that their distress is expressed. It is now well established that there are distinctly gendered patterns of mental health symptomatology. Like other aspects of their experience, this too is believed to be linked to gender socialization. Girls and women, for example, are socialized to 'act in', and tend to present an internalized pattern of emotional distress. This includes low-mood and increased self-criticism (Griffith, Martin & Neighbors, 2013). Men on the other hand, tend to present an opposite "acting-out" symptomatology, which can include increased anger attacks, impulse control difficulties, anxiety and gender-role discord, irritability, aggression, substance abuse, increased risk taking behaviours (e.g. drunk driving, binge drinking), and escaping behaviours (e.g. over-involvement in work and/or sports, illicit affairs, etc.) (Angst et al., 2002). Without an adequate understanding of this 'masculine-specific' symptomatology, outside observers, including mental health professionals, are likely to overlook men's distress or simply dismiss symptoms as rudeness or otherwise inappropriate

behaviour (Oliffe & Phillips, 2008). This danger is exacerbated by the fact that men who experience emotional distress can exhibit emotional numbness, and often present with an inability to express emotions (alexithymia) (Levant et al., 2006).

Compounding challenges associated with identifying men's vulnerabilities in the context of trauma research, generic screening tools commonly used to diagnose common mental disorders are often not sensitive to men's symptom patterns. For example, the diagnostic criteria for major depression emphasize expression of feelings and internal judgements of one's own inadequacies. This represents a pattern of behaviour with limited applicability to men. Similarly, generic depression scales do not measure anger and rage, a common symptom that depressed men experience at a rate of 3 times that of women (Kasper, Pjrek & Winkler, 2005). This lack of gender sensitivity of current diagnostic tools may be evidenced by the discordant relationship in which men are diagnosed with common mental health disorders (e.g. depression, PTSD) at half the rate of women, but complete suicide at 4-5 times the rate (Oliffe & Phillips, 2008).

Lack of professional attention to men's mental health issues

Lastly, the lack of recognition of men's distress and vulnerability in the research context may be affected by the attitudes of researchers. Across a variety of illness categories, health care professionals have been found to be less sensitive to mental health issues in men (Borowsky et al., 2000). It has been suggested that health professionals may be influenced by gendered epidemiological profiles, which state that women experience common mental disorders at twice the rate of men (Oliffe & Phillips, 2008). However, it is also likely that health professionals are influenced by dominant gender constructs that make them less

sensitive to emotional and psychological issues in men, and more critical of men who exhibit emotional vulnerability (Inckle, 2014). This is evidenced, at least in part, by studies that have found that healthcare workers present critical and dismissive attitudes towards men's mental health (Watson, 2000), and are less likely to act on men's mental illness once it is detected (Borowsky et al., 2000).

Overcoming vulnerabilities

Having identified some of the vulnerabilities faced by male participants in traumatic stress research (Table 1), there are a number of steps through which they can be addressed. For example, before data-collection, investigators working with male survivors of trauma could take the time to adequately understand the nuance and complexity of men's mental health experience, expression, and help-seeking behaviour. This would allow researchers to better recognize any discomfort and emotional distress that arises as a result of participation and take appropriate actions. To further monitor wellbeing, investigators could also consider using male-specific screening instruments, such as the Gotland Scale of Male Depression, which are specifically designed to assess men's mental health behaviours such as aggressiveness and self-control, as well as self-medicating techniques such as alcohol, excessive work, and physical activity (Zierau, 2002). Considering the distress that some men have when talking in-depth about their experience, investigators could consider moving beyond in-depth interviews to research methods that incorporate other modes of emotional expression (Affleck, Glass & Macdonald, 2012). Lastly, researchers and REB members should be aware of the effect that gender role, gendered expectation, and the influence of loved ones (no matter

how benevolent) can have on the voluntariness of participant's consent and ability to withdraw from research.

In terms of future research, studies should examine gender differences in the experience of trauma-focused research participation, focusing particularly on issues of intuitive vs. instrumental processing. In this way, a more accurate understanding of risks and benefits can be gained, which can be applied to ethical analysis to help minimize risk and inform men's decision to participate in trauma research.

Future directions

The intention of this paper is to initiate the discussion of ethical issues that can arise when studying male survivors of trauma, not to establish formal guidelines. With this in mind, there are important caveats that need to be made. First, while there are clear relation between gender and grieving patterns, this link is not deterministic. Women may express traits of instrumental grievers and men may express traits of intuitive grievers (Doka & Martin, 2010). Second, as outlined in the introduction, gender exists along a spectrum and intersects with age, culture, class, religion, abilities, etc. Future ethics research is needed to explore men's experience of traumatic stress research participation. Within this research, particular attention should be paid to the experience of men from different intersectional positions and identities.

Conclusion

Protecting participants is a central function of research ethics. However, in practice, the ability to identify, and therefore respond to potential vulnerability of participants may be impeded by pre-conceived assumptions, as well as conceptual gaps in ethics policies

and guidelines. The integrative-functional account of vulnerability helps to bring rigour and thoroughness to unchecked assumptions about the vulnerability in response to the limitations of the subpopulation approach which relies on scant evidence and leaves aside many groups. Using this approach, this paper highlighted a number of ethical issues in the domains of informed consent, respect for participants, and risk-benefit analysis for male participants in traumatic stress research that had previously been overlooked. Having outlined these vulnerabilities, there are a number of steps that investigators working with male survivors of trauma can take to help mitigate them.

Chapter 3: The Inappropriate Use of Risk-Benefit Analysis in the Risk Assessment of Experimental Trauma-Focused Research

A large body of research has explored the impact of questioning participants about traumatic experiences. To determine the level of risk, these studies have relied, to various degrees, upon a risk-benefit calculus, whereby risks are weighed against the benefits that an individual can receive from participating. In the case of trauma-focused studies this approach is erroneous. The procedures involved in trauma-focused studies do not meet the criteria to be considered therapeutic, and the benefits associated with these procedures do not carry the moral weight to offset risk. Applying the risk-benefit calculus to non-therapeutic procedures leads to inaccurate risk assessments and ethically problematic claims, examples of which can be found throughout traumatic stress literature. This chapter outlines how the standard approach to risk assessment in trauma-focused studies is fallacious, and presents an established alternative model that researchers can use to accurately assess the risks of asking participants about their traumatic experiences.

Introduction

Over the past two decades, myriad empirical studies have been undertaken to evaluate the risks of research that asks participants about their traumatic experiences. These studies have largely been conducted in response to the concern shared by many Institutional Review Boards (IRBs) that questioning participants about their experience will "retraumatize" or otherwise cause them psychological harm. To determine the level of risk, the researchers who have undertaken these studies have, either alone or in conjunction with other risk assessment techniques, relied upon a risk-benefit analysis in which risks are weighted against the potential benefits that individuals can accrue from participating in the research. The rationale for using this risk-benefit analysis is found in the *Common Rule*, a comprehensive framework that governs research with human subjects, which states that "risks to subjects are [to be] minimized" and "risks to subjects are [to be] reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that is reasonably expected to result" (45 CFR 46.111 (a)(1,2)).

Upon a review of the most frequently cited studies that examine the risks of asking research participants about their traumatic experience (See table 1), a pattern emerged. Interpretting the Common Rule, ethics researchers first ask participants about the benefits they obtain from participating in trauma research, which can include general enjoyment of the research process, willingness to participate again, pride in helping future trauma survivors, deeper insight from thinking systematically about the traumatic event, and cathartic release from discussing their experience. Then, using the risk-benefit analysis, these benefits are weighted against the risks to determine if the level of risk to participants are justified. This approach was outlined by O'Mathuna (2010) in a review of research ethics in the aftermath of disaters:

> Getting invovled in a research project can help people to start to make sense of the events and see how they can find meaning in the midst of their difficulties. Such evidence-based benefits from research participation can then be included in the risk-benefit analysis of other, related research (p. 69).

This approach to risk assessment has been widely applied in trauma-focused studies over the past 15 years (Dyregrov & Dyregrov, 2000; Pienaar, Seedat, Stein & Williams, 2004; Becker-Blease, Binder, Cromer, Deprince & Freyd, 2006; Buckle, Dwyer, & Jackson, 2009; Brabin & Bereh, 2010; Anthony, Cook, Darnell, Enkhtor, & Hipp, Tusher, Zimmerman, 2011). It also underpins a research questionnaire that is commonly used to determine the risks and benefits of trauma-focused research in specific participant groups (Kaloupek & Newman, 1996; Kaloupek, Newman, Sinclair & Willard, 2008).

Considering the instructions in the Common Rule, this approach to risk assessment may seem intuitive; however, in the case of traumatic stress research, it is incorrect. The problem lies in these researchers' interpretation of the Common Rule, which fails to recognize

and separate therapeutic and non-therapeutic research procedures, and the corresponding application the incorrect risk assessment technique to their research.

Therapeutic vs. Non-Therapeutic Research Procedures

The separation of therapeutic and non-therapeutic research procedures is a fundamental principle of risk assessment, and has a long history in research ethics. It was first introduced in several National Commission reports, including *Institutional Review Boards* (1978) and *The Belmont Report* (1978), which subsequently informed the Common Rule and the Canadian Tri-Council Policy. The moral rationale for this separation is built on the understanding that research procedures are administered with different purposes. Some research procedures, for example, are administered with therapeutic warrant; that is, they are administered on the basis of evidence that they may benefit research subjects, while other procedures are not used in clinical practice and are administered solely as a means of answering the scientific question at hand. This distinction is morally and practically relevant. Because therapeutic procedures are intended meet participants' health needs they must be of a high enough standard to be offered as treatment. This standard is known in medical research ethics as *clinical equipoise.* Clinical equipoise dictates that a procedure offered in a research context must be consistent with current and competent medical practice (Freedman, 1987). In other words, a therapeutic procedure must be "considered precisely as it is in the practice of clinical medicine" (Levine, 1988, p. 37).

Risk assessment of therapeutic procedures

Therapeutic procedures and non-therapeutic procedures are fundamentally different, and as such, they require separate moral justifications. Because the risks associated with therapeutic research procedures correspond to what the individual would face in the clinical setting, there is, in fact, no limit to the amount of risk that a participant can be subjected to, as long as the research offers a greater amount of benefit to the individual. That is, the procedures must be "reasonable in relation to anticipated benefits, if any, to the participant" (45 CRF 46.111 (a) (1). The reasonableness of risk in therapeutic researchers procedures is determined by using a risk-benefit calculus that weights risks against the benefits to the individual. However, just as in the clinical setting, risks to participants can only be offset by benefits that are directly related to the specific procedure (i.e. not a secondary consequence of the procedure) and are of a high enough moral standard to be offered as clinical treatment (i.e. meet clinical equipoise). These are known as *direct benefits*. Benefits that are not directly related to the procedure or result from procedures that do not meet clinical equipoise are known as *collateral benefits*. These benefits do not hold the moral weight to be offered in the clinical setting, and using them to offset participant risk (a.k.a. in risk-benefit analysis) is erroneous and will lead to problematic outcomes. An extreme example will help illustrate this point: If a study involves removing a patient's leg, the risk of doing so is only acceptable if this procedure was already part of her regular course of care (say, if for medical reasons the leg had to be amputated) and if removing the leg would lead to a better quality of life (a direct benefit of participation). If the patient did not have a medical condition serious enough to remove the leg, then no amount of collateral benefits (such as cash compensation or nutritious hospital food, which are not directly related to the procedure) can justify the risk of doing so. Likewise, if the patient's condition requires specific medication and regular follow up by a specialist, then

collateral benefits that do not meet clinical equipoise (such as over-the-counter medication or positive attention from nursing staff) cannot be used to justify the level of risk that she would face.

Risk assessment of non-therapeutic procedures

Unlike therapeutic procedures, non-therapeutic procedures are either not intended to meet participants' health needs, or are not of a high enough caliber to be offered in the clinical setting (clinical equipoise). As the benefits associated with these procedures are collateral, they do not hold the moral weight to offset risk. To properly analyze the risks of non-therapeutic procedures, two separate ethical standards must be met. First, that the risks to the participant be minimized according to sound scientific design. Second, risks must be weighted against the scientific value that is expected to result from the research. In other words, risks must be deemed "reasonable in relation to the importance of the knowledge that is reasonably expected to result" (45 CFR 46.111 (a)(2)). Thus, for non-therapeutic procedures, a different type of risk-benefit calculus must be used, one that weights risks against scientific benefits of the research. Benefits to the individual play no role in the risk assessment of non-therapeutic procedures.

If the research involves a vulnerable population as determined in the Common Rule (45 CFR 46, Subparts A-D), additional protections may be required. In these cases, a threshold may be invoked that limits the non-therapeutic risks to which vulnerable subjects may be exposed. In the case of children, for example, risks are limited to the standard of a "minor increase over *minimal risk* [emphasis added]," which is defined by the common rule as "those risks ordinarily encountered in daily life" (45 CFR 46. 406 (a)).

Are the procedures found in qualitative traumatic stress studies therapeutic? Given the moral and practical differences in risk assessment within therapeutic and non-therapeutic research, it is important to determine which type of research a given procedure falls under. If the specific procedures found in experimental traumatic stress research are carefully examined, it becomes clear that the majority do not meet the therapeutic standard. First, they do not meet clinical equipoise. There are several clinical approaches that are common in the treatment of traumatic stress, including Extinction-Based Cognitive Behaviour Therapy (CBT), Exposure Therapy, and the prescription of various antidepressants. Although these treatments are diverse, there are several fundamental characteristics that they share, which are not available in the research context.

For example, therapeutic procedures are explicitly designed and validated to help the patients. This is not the case with research interviews. The surveys, questionnaires, and interviews that are used in qualitative traumatic stress studies have a structure that is dictated by the study's validity, not the health needs of the patient. As Levine (1988) states, "There is no such thing as a systematic collection of data or observations…[that is] designed to improve the health condition of a research subject…[and] that departs from standard medical practice" (Belmont Report, supra note 7 at 298).

Next, in a therapeutic context, all of these approaches require the involvement of a trained clinician. Clinicians will tailor care by recommending treatment programs based on their clinical training, previous experience, expertise with a subgroup of patients, and the patient's own past treatment experience. Additionally, they will monitor the plan's effectiveness and adapt the treatment schedule to meet the ongoing needs of the patient. In much traumatic stress research, as in many other areas of the social health sciences,

investigators are often not trained clinicians, and neither have the same level of clinical expertise, nor access to the patients' medical history as clinicians do. Due to the structure and nature of research, investigators also do not have the ability to adapt or modify the treatment schedule to meet the patient's needs or progress.

Finally, unlike in a clinical setting, where treatment outcomes have been extensively tested and verified for both short-term and long-term efficacy, the individual outcomes of research remain unmeasured. Qualitative traumatic stress researchers themselves have acknowledged this gap: According to Dyregrov, Dyregrov, and Raudalen (2000), for example, "the extent that this effect [of participation on participants] may be therapeutic is impossible to state, because the term refers to stable changes in attitudes, emotions, and behaviour" (p. 25).

Along with not meeting clinical equipoise, the beneficial outcomes that participants accrue from research participation are not a direct consequence of any specific research procedures, but arise simply by virtue of participating in the study. The insights and cathartic moments that the participants cite, for example, could result from an in-depth discussion with any engaged listener, not just with the researcher. Likewise, because these studies are not designed to increase feelings of pride and altruism, when these feelings do arise, they are a secondary consequence and not the primary intention of the research.

Problematic risk assessments

In traumatic stress research there is often a small and largely undetermined amount of risk, and a high number of collateral benefits (feelings of pride, joy of talking, kind-treatment from research staff, etc.). Thus, inappropriately using these collateral benefits in the

risk-benefit analysis in order to examine risk will inevitably lead to skewed risk assessments, an underestimation of risk, and, problematic assertions about participant distress and vulnerability. When accepted and oft-cited analyses of risks and benefits are examined closely, this become apparent. For example, in a study examining the effects of trauma-focused research on pregnant women, Goof, Nelson and Schwerdtfeger (2008) concluded that:

> A majority of participants indicated experiencing personal benefits, including insight and meaning as a direct result of research participaiton. These findings support the claim that pregnant women participating in trauma-focused research are at a low risk of distress or harm (p. 64).

Similarily, in a often-cited review of the risks and benefits of traumtic stress research participation, Kaloupek and Newman (2009) assert that:

> Individuals who have experienced trauma or PTSD do not appear to constitute a vulnerable group…although distress may be experienced during research participation in traumatic stress studies, the overall cost-benefit balance seems favourable. Even when participants endorse unexpected upset during the study, most signify willingness to repeat the experience or otherwise indicate no regret about participation (p. 600).

When examined closely, we can see that the use of risk-benefit analysis with collateral benefits has resulted in a number of ethically suspect assertions: 1) Various collateral benefits of exploring trauma research justify the research; 2) subjective harm-benefit assessments justify the risks of research participation; 3) because of the cited collateral benefits, people who participate in such studies should not be considered vulnerable, and their distress can be minimized.

Towards a more comprehensive approach

The interpretation of the Common Rule that led to the use of risk-benefit analysis for non-therapeutic procedures in traumatic stress studies, is problematic. However, it is not

unexpected. The Common Rule guidelines are vague and often raise more questions than they answer: For example, which risks to subjects must be minimized? To what extent must they be minimized? Which risks and which potential benefits are to be considered in the determination of reasonability?

Difficulty arises because the rules guiding risk assessment, including those outlined in the Common Rule, are not self-interpreting. In order to be fully understood, the guidelines must be viewed within the historical development of research ethics and situated within the larger moral context that underpins risk assessment. In light of this, Weijer's (2000) Component Analysis framework has been developed to help guide researchers and IRBs to understand and analyze risk. Component Analysis has been endorsed by all major ethical agencies, including the National Bioethics Advisory Commission (NBAC), The Canadian Tri-Council, and the American Medical Association (AMA).

The strength of the Component Analysis framework lies in the recognition that within a research protocol there is often a combination of therapeutic and non-therapeutic procedures, which require separate risk assessment. Component Analysis separates these individual procedures, which are then analyzed independently depending upon their intent. Those procedures that are administered with therapeutic intent are subjected to clinical equipoise to determine if they qualify as therapeutic. For those that do, a risk-benefit calculus using individual benefits is used to determine if the risks associated with the procedure are acceptable.

For those procedures that do not meet the therapeutic standard, either because they are not administered with therapeutic warrant, and/or do not meet clinical equipoise, risks are first minimized, and then deemed reasonable in relation to the importance of the knowledge

that will be gained from the study. If the study deals with a population that is deemed vulnerable according to the Common Rule [45 CFR 46, Subparts A-D], such as prisoners, pregnant woman, and children, a standard of *minimal risk* is applied. A research program passes ethical review only when the tests for both therapeutic and non-therapeutic procedures have been successfully met.

Conclusion

Determining risks and benefits of research participation is a central component of the ethical review process; however, the method that ethics researchers have used to determine the risks in traumatic stress research is faulty. Following a misinterpretation of the Common Rule, these researchers have failed to distinguish between therapeutic and non-therapeutic research procedures, and as a result weighed risks against collateral or indirect benefits of participating in trauma related research. While this method may seem intuitive, these benefits do not hold the moral weight to offset risk. This error will inevitably result in flawed risk assessments and an inaccurate conclusion about the acceptability of risk. Given that the high number the studies examining the risks of participating in trauma-related research over the past 20 years have used this method of assessment, either alone or in combination with other techniques of assessment (such determination of minimal risk), I suggest that the risks associated with asking research participants about their traumatic experiences be revisited using the Component Analysis Framework (Millar & Weijer, 2000; Weijer, 2000). This approach was specifically designed to facilitate a clearer interpretation of the ethical guidelines and help investigators and IRB members more accurately analyze the risks of participating in health research.

Chapter 4: Underrepresentation of Men in Gender-Based Humanitarian and Refugee Trauma Research: A Scoping Review

Sex and gender are important considerations within refugee studies. Risks to health and wellbeing may manifest differently for refugee women and men, as may their use of health and social services and responses to interventions. Since the 1980's, increased attention has been paid to the experience of girls and women in refugee and humanitarian research. However, much less attention has been paid to boys and men. This chapter presents a systematic scoping review that was undertaken to investigate whether there is a gender bias in refugee and humanitarian research on refugee trauma. Findings demonstrate that since 1988, fully 95% of gender-focused research addressed women's issues, while only 5% addressed the experience of refugee men. This article offers possible explanations for this gap and discusses its ramification for both research and clinical practice.

Introduction

Sex and gender play a central role in all human experience. For refugees and displaced populations, risks to health and wellbeing may manifest themselves differently for women and men, as may the use of health and social services and responses to interventions (Gururaja, 2000). For example, the events that refugee women find the most stressful tend to surround issues of physical and social vulnerability (Mezey & Tachhil, 2010). For male refugees, on the other hand, stressors tend to surround the inability to fulfil masculine gender norms and roles (Ryde & Vitale, 2016).

The effect that various stressors have on the mental health and wellbeing can also differ between refugee men and women. For example, studies have found that issues of underemployment and lack of social standing, which are common amongst all refugees, can be especially difficult for refugee men as they can contradict men's sense of identity and self-worth (Colic-Peisker, 2007). Refugee men also feel disproportionately excluded from economically and socially valuable activities, community support, and social services, which

can negatively impact their mental health and wellbeing (Correa-Velez, Spaaij, & Upham, 2013).

Differences can also be seen in the clinical setting. Refugee men have been found to be suspicious of mental health practitioners, more fearful of being re-traumatised by the clinical encounter than women, and distrustful of psychotropic medications used to treat mental health problems (Mezey & Thachil, 2010; Ryde & Vitale, 2016). Throughout the world, refugee men are also far less likely than refugee women to seek help for emotional issues or visit psychosocial services (Weiss, 2011). Understanding the various ways that sex and gender intersect with refugee mental health is essential in designing effective services (Chan & Young, 2015).

Like many other areas of health and social science, historically the field of refugee studies relied primarily on male research subjects, ignoring the specific realities of refugee girls and women (Barakat, 1973; Mezey, 1960). During the 1980s and 1990s, research on refugee women gained increased attention. This was largely the result of two factors: increased awareness of the lack of women in health and social science research (LaRosa & Pinn, 1993; Woods, 1994.) and Western mass media reports of ethnic cleaning and rape camps during the Yugoslavian civil war (Bartolomei & Pittaway, 2001). Since then, research focusing on refugee girls and women has become a priority for funding agencies and refugee support organisations at every level (Ticktin, 2011). In recent years, however, concern about gender bias in refugee studies has begun to shift in a different direction. Researchers are increasingly calling attention to the underrepresentation of men in refugee research, particularly as it relates to trauma and mental health (Correa-Velez et al., 2013; Ketting, Oosterhoff & Zwanikken, 2004).

Purpose

The purpose of this study is to investigate whether there is a gender bias in gender-focused refugee mental health research. The general hypothesis guiding this inquiry, derived from seven years of studying refugee men's experience, is that there is a disproportionately high number of studies that focus on refugee women to the exclusion of studies that focus on refugee men.

In this article we use the term "gender bias" rather than "sex bias." Unlike sex, which is biologically determined, gender is a social construction, encompassing expectations and norms about behaviour, choices, roles, and interests (Scott, 1987). It is also a relational system of stratification that structures relationships and interactions between and among men and women, shapes access to resources and status, and signifies power (Butler, 1990; Connell, 1987). Various social scientific theoretical traditions have emerged to explain gender (Risman, 2004). Most interpret gender as the result of social interaction and accountability to others' expectations. Lorber (1994, p. 2) for example, views gender (like culture) as a "human production that depends on everyone 'doing gender'". Lorber argues that everyone 'does gender' without thinking about it. If the men and women are not proportionally represented in gender-focused refugee mental health literature, the bias may well reflect societal forces that influence the various parties involved in research such as participants, researchers, funding agencies, etc.

Methods

Data for the investigation of the hypothesis were collected from the following databases: Cochrane Database of Systematic Reviews, DARE (Database of Abstracts of Reviews of Effects), Cochrane Central Register of Controlled Trials (CENTRAL), Medline and Medline in Process (via OVID), Embase (via OVID), PsycINFO (via OVID), and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). A search strategy was developed to define keywords for all searches (see Appendix 1 for the Medline search). The Cochrane Library was searched with Medical Subject Headings (MeSH) and keywords included from the Medline strategy. There were no date restrictions, with the search ending in February of 2017. For feasibility purposes, only articles in English and French were retrieved. All references were entered into an Endnote file for processing (n = 6076). After duplicates were removed, the search yielded 2427 studies.

Analysis

Two authors (AS & WA) independently coded the articles, selecting only those that fit the following inclusion and exclusion criteria: (a) were empirical (quantitative, qualitative, mixed-methods); (b) had *women* or *men* in the title, keywords, or abstract (or a corresponding designation; e.g. *mother, father, grandfather, grandmother, aunt, uncle*, etc.); (c) had *refugee* in the title or abstract (or a corresponding designation; e.g. *displaced persons, internally displaced, asylum seeker*, but not *immigrant, migrant,* etc.); and (d) focused on psychological trauma as it relates to the refugee experience such as *war, sexual assault, rape, gender-based violence, displacement, political violence*, and *natural disaster* (not *motor vehicle accidents, childhood bullying,* etc.). Among the initial sample of 2427 articles, 379 met the inclusion criteria. The two authors agreed on 375 of the studies. There were 4 studies upon

which the coders did not agree. Upon further discussion, these studies were excluded from the final sample because they only made passing reference to refugee women, but did not focus on refugee women directly. Articles were then divided into two binary categories based upon the primary focus of the research: "women studies", which focused on refugee women, and "men studies" which focused on refugee men. Categories were mutually exclusive. In other words, studies were classified as either women studies or men studies. They could not be classified as both. There were a small number (6) studies that focused upon the experience of both men and women. These studies were excluded from the final sample. Although they would be valuable for understanding how the refugee experience is gendered, they were not relevant to the primary research question of whether there is gender bias in the overall gender-focused refugee literature.

Results

The collected results support the hypothesis: the retrieved articles showed a significant underrepresentation of studies examining men's experience. Of the 373 articles that met the inclusion/exclusion criteria, 94.5% (n=352) of the studies focused on women, while only 5.5% (n=21) studies focused on men. There were also surprisingly few male refugee researchers examining issues of gender. Of the 373 studies identified, only 36 (9.5%) had male first authors, while 337 (90.5%) had female first authors. Of the 352 studies that focused on women, 326 (92.5%) had female first authors, and 202 (56%) had all female authors. Of the 21 studies focusing on men, 14 (66%) had male first authors, and six (28%) had all male authors.

Discussion

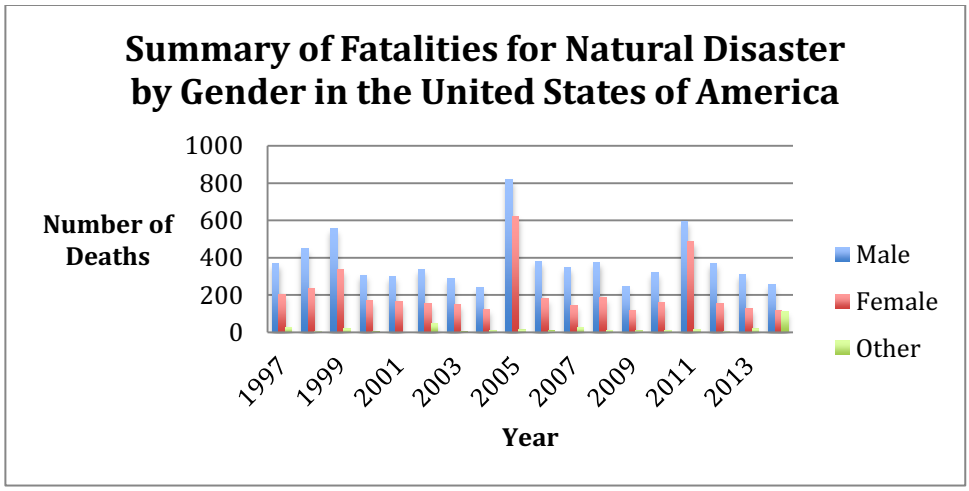
The lack of attention paid to men's issues in specifically gender-focused refugee mental health research is not surprising. In research and policy practices, the notion of "gender and health" is often conflated with "women's health" (Carroll & Richardson, 2009; Robertson & Smith, 2008; Savoye & Wilkins, 2009). In light of this historical disadvantage, the wealth of female-oriented studies over the past 30 years is understandable. However, earlier refugee studies did not examine gender as a topic of study, and as such, did not address men's gender experience. The United Nations High Commissioner for Refugees (UNHCR) and its Executive Committee have long stressed that situations of flight and displacement affect men and women differently and effective programs must recognize these differences (UNHCR, 1980). This relies upon understanding how the experience of disaster is gendered for both women and men. In light of this need, the scale of underrepresentation of men's issues in disaster research is startling and deserves further consideration.

The most prominent reason given by researchers for their focus on women is the contention that women are more vulnerable during and after periods of mass catastrophe than men. This is, of course, an understandable position: there are clear social and political inequalities that affect the lives of women and girls throughout the world and increase their vulnerability. Research also indicates that the life-expectancy gap between men and women (which tends to favour women) narrows after both wars and natural disasters, suggesting that more women than men die as a result of mass catastrophes (Neumayer & Plumper, 2007). This claim is not unproblematic, however. Natural disasters provide one of the primary sources of population displacement (Campbell & Nair, 2014). Although few countries report deaths from natural disasters by gender, those that do track this distinction report higher numbers of male than female fatality in the wake of such disasters. In the United States, for example, between

2000 and 2015, almost twice as many men were killed in weather-related disasters than women, on average (see Table 1). This pattern holds for most types of natural disaster except earthquakes (where mortality rates tend to be higher amongst women).

Researchers attribute these differences to gender roles, which tend to keep men outdoors and women indoors. During an earthquake, it is particularly dangerous to be indoors, but covered shelter may provide protection during other types of weather-related catastrophes, including hurricanes, cyclones, and floods (Fothergill, 1996). Similarly, gender roles tend to dictate that men, as 'protectors', are exposed to significantly higher risks both during and after disaster (Mishra, 2009). For example, the vast majority of the 800,000-plus 'liquidators', civilians who helped clean up the Chernobyl site over several years and received the highest exposure to radiation, were men (WHO, 2004).

In the case of war and human conflicts, another leading cause of population displacement (Campbell & Nair, 2014), mortality rates tend to be significantly higher amongst civilian men than amongst women: men are more often forced to engage in active combat, are detained and killed at higher rates out of suspicion that they are secret combatants, and are usually the last to be evacuated from war zones (King, Krug, Lopez, Murray & Tomijima, 2001; Krug, Mercy & Reza, 2001; Li & Wen, 2005; Salama & Spiegel, 2000).



U.S. National Weather Service, Office of Climate, Water, and Weather Services, 2016.

Many researchers who focus on refugee women's experience also argue that women experience the majority of suffering in the aftermath of war and natural disaster (Chew & Ramdas, 2005). This, too, is an understandable position: refugee women tend to shoulder the burden of responsibility for long-term caregiving of children and the elderly family members; In the aftermath of disaster, female-headed households can be excluded from redevelopment programs that privilege men as 'heads of households' (Enarson, 2012); refugee women lack full access to public affairs and can be excluded from the post-disaster decision-making process (Fothergill, 1996); displaced women are more likely to have their land confiscated after war and natural disaster (Chew & Ramdas, 2005); refugee women are disproportionately vulnerable to domestic violence and sexual assault (Ryde & Vitale, 2016); lastly, a greater proportion of refugee women/girls report suffering from emotional disorders and distress than refugee boys/men (Blight, Ekberg, Ekblad & Persson, 2006).

However, the gender-specific suffering of refugee women finds its counterpart in the experience of refugee men. Men suffer from their own vulnerabilities, which occur in different situations and for different reasons from those of women. For example, in times of war, men are subjected in greater numbers and with greater intensity to potentially traumatic

events such as assault, combat, injury, and witnessing violent injury and death (Foa & Tolin, 2006; Mills et al., 2011). Men are also subjected to more torture and imprisonment, and are detained for longer periods than women (Spiric et al., 2010). Male refugees are also more likely than women to be persecuted in their own country in order to eliminate their ethno-cultural group (Carpenter, 2006). Like women, men are also subjected to sexual violence and sexual torture during war, often at shockingly high rates. An extensive study of 434 male political prisoners in El Salvador, for example, found that 76% reported at least one form of sexual torture (Agger, 1989), while a study of 184 Sri Lankan Tamil men seeking asylum in London found that 21% had been sexually abused (Peel, 2000). However, sexual abuse in men often goes unrecognized, both because men are less likely to report the abuse due to shame and stigma, and because medical professionals and aid workers are less likely to look for sexual abuse in male refugees or recognize symptoms of sexual trauma in men (Ketting, Oosterhof & Zwanikken, 2004).

There are also a number of vulnerabilities in the refugee experience that are unique to men; the loss of the 'provider and protector' role, the stigma of being dependent on relief agencies after a disaster, and the lack of self-determination that accompanies the refugee experience separate men from their traditional masculine identities, roles, and relations. When these experiences lead to feelings of inadequacy and failure, they may trigger or accentuate mental health issues in refugee men (Jaji, 2009), as evidenced by the high correlation between mental health symptoms and unemployment that exists for refugee men but not refugee women (Blight et al., 2006). There is a particularly significant danger that older men, who tend to lack the social connections of elderly women, will become socially isolated after a disaster and be

left unsupported, leading to higher rates of depression and exacerbating pre-existing PTSD (Sollund, 2010).

It has been suggested that the loss of way of life that often follows a disaster can be especially acute for refugee men. Unlike women's gender roles, such as child rearing and cooking, men's roles, which are often tied to local geography (farms, businesses, fishing, etc.), are likely to be lost in times of disaster and resettlement or replaced by aid organisations (Maffia, 2006). Finally, men can face discrimination from medical practitioners and aid workers during post-disaster reconstruction. The dominant discourse within NGO and international aid communities constructs women as extremely vulnerable; as a result, programs tend to be designed to assist mostly (or only) women, causing men to feel neglected and emasculated (Kabachnik et al., 2012; Lwambo, 2013).

Male refugees also face a number of institutional challenges. For example, they are often met with greater levels of suspicion by immigration officials than women (Deuchar, 2011) and endure harassment and arbitrary attacks from police and security guards (Jaji, 2009). Men are less likely to be granted asylum than women, and are more frequently deported by resettlement countries. During the recent Syrian refugee crisis, single men were explicitly excluded from the refugee populations accepted by many resettlement countries, including Canada (Aziz, 2015). The suspicion with which refugee men are viewed by citizens of the host country can make it harder for them to 'break into' the resettlement culture (Hart, 2008).

The discussion of mortality statistics and examples of men's vulnerabilities presented in this section are in no way meant to downplay the suffering of refugee women, deny the ill effects of sexism, or detract from the importance of examining refugee women's experience. Nor is the authors' intent to participate in what Hancock (2011) termed "the

oppression Olympics", whereby different special interest groups compete to prove their vulnerability. Particularly in the case of refugees and displaced populations, such us-versus-them, my-pain-is-worse-than-your-pain rhetoric can lead only to unfruitful battles between the sexes (White, 1997). Rather, our intention is simply to highlight a broad and crucial question: given that an equal (or even slightly higher) number of men die in disasters than women, and given that men have their own biologically and socially determined vulnerabilities, why are men so underrepresented in gender and disaster research?

Possible explanations

The most likely explanation for the predominant focus on women in disaster research is that refugee and humanitarian researchers themselves are making this choice. Why might this be so? First, there may be an on-going desire among researchers to redress discrimination by prior generations of refugee researchers who paid exclusive attention to the male experience, generalizing "human" (a.k.a. men's) experience to all persons (Annendale & Hunt, 2000). The early, long-lasting failure of scientific research to incorporate women's perspectives certainly sparked a shift in focus beginning in the 1980s; the overwhelming focus on refugee women's experience may therefore constitute an attempt by researchers, either consciously or unconsciously, to rebalance the knowledge base by focusing on refugee women.

Second, logistical factors may account for some of the bias. It is widely recognized that it is more difficult to study men than women, particularly in qualitative research. Men are more reluctant than women to participate in health studies (Oliffe & Thorne, 2007), and a number of problems can arise during data collection — especially for studies addressing highly personal or emotionally complex topics — including minimized responses,

subdued emotional expression, and non-disclosure. These issues can add a great deal of stress for researchers and affect the quality of the data (Affleck, Glass, & Macdonald, 2012; Schwalb & Wolkomir, 2012).

Third, it is possible, as suggested by Polit and Beck in the context of nursing research (2008, 2013), that the gender of the researchers themselves is influencing their choice of topic. Like culture, gender is a social construction, which encompasses expectations and norms about behaviour, choices, roles, and interests. Lorber (1994) argues that everyone "does gender" without thinking about it. 94.5% of the researchers in our sample were female. Researchers may simply be drawn to issues facing other women. Conversely, because men's experiences of disaster do not align with these interests or sympathies, their experience may be overlooked. Again, a proper examination of this possibility is beyond the scope of this paper. However, the fact that there were a higher number of studies that focused on refugee men when some of the researchers were male gives tentative support to this explanation.

Fourth, researchers may be overlooking, or otherwise failing to recognize, men's vulnerability in the aftermath of disaster. There are several possible reasons why this situation might arise. First, men's own behaviour may fail to communicate or acknowledge their vulnerability. Hegemonic masculinity refers to the dominant ideal of masculinity within any specific culture (Connell, 1987). Though social constructed and variable across time and place, throughout the world, hegemonic masculinity stresses toughness and emotional control, and emphasises rationality over emotionality. As a result, men tend to censor outward expressions of vulnerability, indulging these expressions in private, or masking them behind a façade of stoicism (Connell, 1987). Hegemonic ideals of masculinity also affect men's help-seeking

behaviour (Courtney, 2000), especially in relation to emotionally vulnerable topics such as torture, sexual assault, bereavement, and mental health problems (Oliffe & Philips, 2010).

Men also have a different style of distress expression, which may contribute to their vulnerability being overlooked within mainstream trauma research. In contrast to women, who are inclined to direct their emotional/psychological distress inward, men tend to 'act-out'. Thus, where women become quieter, cry more, or seem down or withdrawn when distressed, men consume more drugs and alcohol, take greater risks, and become more hostile or otherwise aggressive (Rutz & Walinder, 2001). This behaviour may make it difficult for outside observers, such as researchers, to recognize men's emotional vulnerability. Without knowledge of mental health, it may be difficult for researchers to distinguish men's mental health symptomatology from every-day masculine behaviours, especially in different cultural groups. The morally objectionable and destructive nature of men's distress-response behaviour can also evoke feelings of blame and condemnation in observers rather than sympathy, particularly when it is directed towards other vulnerable populations, such as women and children. Compounding this difficulty, these male-specific symptoms are not included in generic screening tools for many common mental disorders, including depression and anxiety disorder (Oliffe & Philips, 2010).

It is also possible that the conceptual framework used by gender-and-development commentators may contribute to the lack of focus on men's vulnerability. The conceptual framework currently in vogue relies on the feminist model of patriarchy, which holds that women are more vulnerable than men within any given group, due to socially gendered power relations and women's structural disprivilege. Humanitarian disaster researchers have relied heavily on this framework to view issues of gender and disaster. As Juran (2012) explains:

> The post disaster period is merely an alternative sphere in which pre-existing gender inequalities are maintained and regenerated, if not magnified. Thus, while the post-disaster arena varies greatly from the 'normal time', the overarching parallel is that disparities that existed before the disaster are perpetuated and exacerbated both during and after disasters (p. 2).

Like all conceptual lenses, this framework, while valuable, risks side-lining evidence that does not fit within its frame. When women are assumed to be socially more vulnerable than men, their suffering automatically becomes the focus of attention. Similarly, the relative privilege of men, as a group, leads to their vulnerability being overlooked.

In the specific case of disaster, the use of the patriarchy framework may be particularly problematic. In the aftermath of mass catastrophes, vulnerability is seldom clearly distributed along gender lines. Despite men's general position of privilege, marginalized groups of men — including the mentally ill, the homeless, and those without jobs or money — are excluded from traditional positions of power and privilege. Not only do such disadvantaged men suffer disproportionately from disasters, but with the terrible loss of property, wealth, and health that accompanies disaster, the number of these men is likely to increase dramatically. Additionally, the patriarchy framework tends to overlook the role that humanitarian aid organisations play in the post-disaster context. As anthropologist Miriam Ticktin observes, in modern times, both NGOs and INGOs, tend to come to effectively "*govern*" disaster zones (Ticktin, 2011, p. 255). Virtually all of these organisations have a stated mandate to prioritize the protection of women and children (Buse & Hawkes, 2013). The starting point of the patriarchy framework, therefore — i.e., that women are more vulnerable than men because of socially structured disprivilege — discounts the central role that these organisations play in disaster relief and recovery, and the effect that these organisations have on pre-existing gender relations and patriarchal structures. As Turner (1999) explains:

> The UNHCR's ideology and practice of equality together with the nature of living in a refugee camp has seriously challenged notions of structures of authority… Old values and norms about essential issues such as relationships between husbands and wives, between parents and children, and between rich and poor are being challenged in the camp regime. Old authorities are losing their grip and a new authority- represented most strongly by the UNHCR- is in control of resources, livelihoods and ideological formations (e.g. the ideology of equality between men and women" (Turner, 1999, p. 6).

The "women-and-children first" approach of relief agencies can dramatically affect gendered access to resources. For example, although aid organisations give food and aid on an equitable basis, this policy of equality is supplemented by special programmes for women and other disadvantaged groups. Since aid is distributed on the basis of perceived necessity, the needs of men often takes second place to those of women (Lwambo, 2013). As Jaji (2009) explains "While masculinity entails privilege in 'normal' situations, in exile it becomes an albatross around a refugee man's neck" (Jaji, 2009, p.13).

Lastly, the political discourse surrounding aid and humanitarian assistance may also contribute to the lack of attention to men (Cornwall, Harrison, & Whitehead, 2007). Advocacy of women's rights sits high on Western political agendas. Western donor countries and private foundations that fund most humanitarian research rely on masculine stereotypes to uphold and advance their political agendas (Del Zotto & Jones, 2002). Consciously or unconsciously, government and private bodies seek to position themselves as protectors of women, which is echoed in the direction of their funding (Apperley, 2015). Like all other development players, refugee researchers depend upon these countries and private foundations to fund their projects. As such, they may be pressured to focus on refugee women and overlook refugee men (Apperley, 2015).

Implications

Regardless of the explanation for men's underrepresentation in the humanitarian and refugee disaster literature, this oversight has serious implications. First, it is scientifically problematic. The omission of one sex or the other implies an untenable assumption of gender and sex neutrality or universality of the disaster experience — yet there is ample evidence that males and females differ in their experiences, needs, and responses to interventions (Bottorff, Hoyak, Johnson, Ogrodniczuk & Oliffe, 2012; Greaves, Johnson & Repta, 2009). To exclude the disaster experience of men undermines the evidence base on which health realities are understood and future support decisions are made. As Klinge and Nieuwenhoven (2010) put it, "it is plainly unscientific to leave out half the population" (p. 314), whether they be women or men.

There are also clinical implications of the neglect of research on men's issues. There is already a widespread concern that men's mental health issues are overlooked in clinical practice (Oliffe and Philips, 2010), and that traumatic stress interventions do not adequately consider the needs of men (Forbes, Hetrick, Kartal, O'Donnell, Varker & Wade, 2016). The exclusion of men from the humanitarian and refugee disaster literature limits the evidence base from which health workers and humanitarian aid workers can develop viable practice.

The argument for increasing research attention to men's disaster experience is also a practical one. Families and communities are better served when service providers are more attuned to the mental health needs of men following disasters. Men are rarely, if ever, completely absent from the nexus of social relationships in which women, children, and families exist. Research has consistently shown that in the aftermath of disasters, the mental health and wellbeing of one family member can affect the mental health and wellbeing of the

family as a whole, including refugee women and children (Brooks, Bryant, Nickerson, Silove & Steel, 2011; Cowell, Fox, & Johnson, 2004). This may be especially true when a male family member is suffering from mental illness. As discussed earlier, masculine-specific expressions of emotional and psychological distress tend to include increased use of alcohol and recreational drugs, financial mismanagement, as well as increased anger, irritation, and propensity for interpersonal conflict. These behaviours can substantially increase stress for families and communities that are already struggling to rebuild their lives after a disaster. The impact that a male family member suffering from psycho-social stress can have on the family may be especially significant in traditional societies where there is high gender inequality, where divorce is not culturally acceptable, and where there are limited work opportunities for women (Pedersen, 2002).

Failing to examine men's disaster experience may also unintentionally reinforce false social attitudes and beliefs surrounding men's vulnerability that contribute to the underrepresentation of men in post-disaster mental health interventions. These include the belief (which exists in many cultures) that mental illness is predominantly a women's affliction for which only they can legitimately seek help (Riska, 2009), or that men are naturally less susceptible to mental illness and better able to cope with their trauma experience than women (See this Chapter 6, this thesis). Without more research on men's experience, these beliefs may continue to go unchallenged.

Finally, including men in humanitarian and refugee disaster research is a matter of justice. The medical community in the 1970s and '80s was criticized for its exclusion of women in research, based on the contention that this exclusion represented a type of discrimination. The present gender bias in the humanitarian and refugee disaster

literature represents a similar type of discrimination; it is not only professionally unbecoming, it also interferes with the right to health guaranteed by the Universal Declaration of Human Rights (United Nations [UN], 1948).

Limitations

There were several limitations of this study. Firstly, the search strategy focused broadly on trauma and PTSD, not specifying the various types of trauma that refugees can experience such as torture, rape, and Sexual and Gender Based Violence (SGBV). Many of the specific types of trauma may have been captured by the subject headings and search terms included in the search strategies, but this cannot be guaranteed as they were not specifically incorporated. Secondly, search terms such as gender and masculinity were not used on purpose, in order to keep the search broad and encompass both genders. It is unclear to what extent these limitations may have biased or limited the results. It should be noted that many studies addressing specific types of trauma such as rape, torture, and so on, for both genders were included in the results. As well, it is likely that studies that addressed gender and masculinity would have included "women", "men" or term equivalents such as "male, female, grandmother, grandfather, mother, father, uncle, aunt" in the title or abstract. Lastly, in global health research and policy practices, gender and gender and health are often conflated with women and women's health (Hankivsky, 2012). It is likely that the inclusion of gender as a specific search term would have contributed to rather than decreased the gender-gap outlined by this study. As such, it would not have impacted the central finding that men are under-represented in gender focused refugee research.

Conclusion

Gender bias in the refugee and disaster gender literature is pervasive and widespread. Of the 373 articles that met the inclusion/exclusion criteria of this study, 94.5% (n=352) examined women's experience of trauma, while only 6% (n=21) looked at men's experience. We also found a large underrepresentation of male researchers examining issues of gender and trauma. Only 36 studies (9.5%) had male first authors, while 343 studies (90.5%) had female first authors.

Considering the uniqueness of women's experience and vulnerabilities in the aftermath of disaster and the disregard for gender that has historically existed in disaster studies, the desire to focus on women in research is laudable. However, failing to also examine men's experience of disaster is both ethically and practically problematic. In a 2002 report, *Gender and Disaster*, the World Health Organisation (WHO) outlined a "general lack of research on sex and gender differences in vulnerability to the impact of disaster" and noted an "urgent need for international data sets to provide sex-disaggregated data on disaster-related mortality, morbidity and long term health consequences" (WHO, 2002, p. 4). More recently, this call was reiterated by Benelli, Mazurana and Walker (2013), who — recognizing the anecdotal evidence upon which humanitarian aid policy relies and the problems this can cause for critical decision-making in humanitarian response to emergencies — called for increased sex- and age-disaggregated data, as well as gender and generational analysis. The findings of the present study underline the importance of these recommendations. Sex data and gender analysis need to be incorporated into evidence-based practice for those wishing to aid civilian survivors of disaster, and this requires that research on the health and social issues of both females and males be equitably pursued. Finally, considering the potential impact that the

gender of the researcher has on choice of research topic, we also echo Beck and Polit's (2008; 2013) recommendation that measures be taken to increase the number of male investigators pursuing issues of gender in health research.

Chapter 5: Missing Men and Gender Stereotypes: A Critical Analysis of How Sex, Gender and Gender relations are represented in Gender-focused Refugee Disaster Literature

The way in which the Other is represented is of central concern for cross-cultural research, as it significantly impacts how clinicians, policy makers and other relevant actors conceptualize and, in turn, respond to issues. As the last chapter outlined, little attention has been paid to how sex and gender are represented in refugee research. In this chapter, I examine how gender is represented in gender focused refugee literature. Through a systematic literature review, I identify two representational techniques: a. the "missing man phenomenon" in which men, particularly family men, are excluded from discussions of refugee women's experience, and b. the use of gender stereotypes, in which women are depicted as deserving victims and men as selfish perpetrators. Relying upon post-colonial theory, I argue that the use of these techniques has more to do with the self-identity and motivations of the representer than any pre-existing reality. This chapter concludes by outlining specific dangers that can result when these techniques are employed in refugee research.

Introduction

Representation of the 'other' is a central issue in cross-cultural research, as it is through such representations that reality of the 'other' is understood and responded to (Donnelly, 2002). Researchers must be constantly aware not only with the representations they use, but also of the social meaning given to representations, and the effect that representations have on their audience (Hall, 1997). The use of stereotypes in cross cultural research can be particularly problematic. Stereotypes can lead to superficial or skewed understandings of the problems and populations being studied, can damage the social standing of marginalized groups, and can deflect attention from legitimate health priorities. In the field of development, gender stereotypes in particular have been found to affect the quality of health service delivery (Howerton, Szymansk & Travis, 2013) and the outcomes of humanitarian initiatives (Cornwall, Harrison & Whitehead, 2007). Traditionally, scholarship has focused upon the use of gender stereotypes in relation to women's health and development research (Wilson, 2011). Recently, however, attention has begun to be paid to stereotypes of men (Buse & Hawkes, 2013; Cornell

& Myer, 2013). The purpose of this article is to explore how women, men, and gender relations are represented in gender-focused disaster research, and to assess the extent to which gender stereotypes appear in this literature.

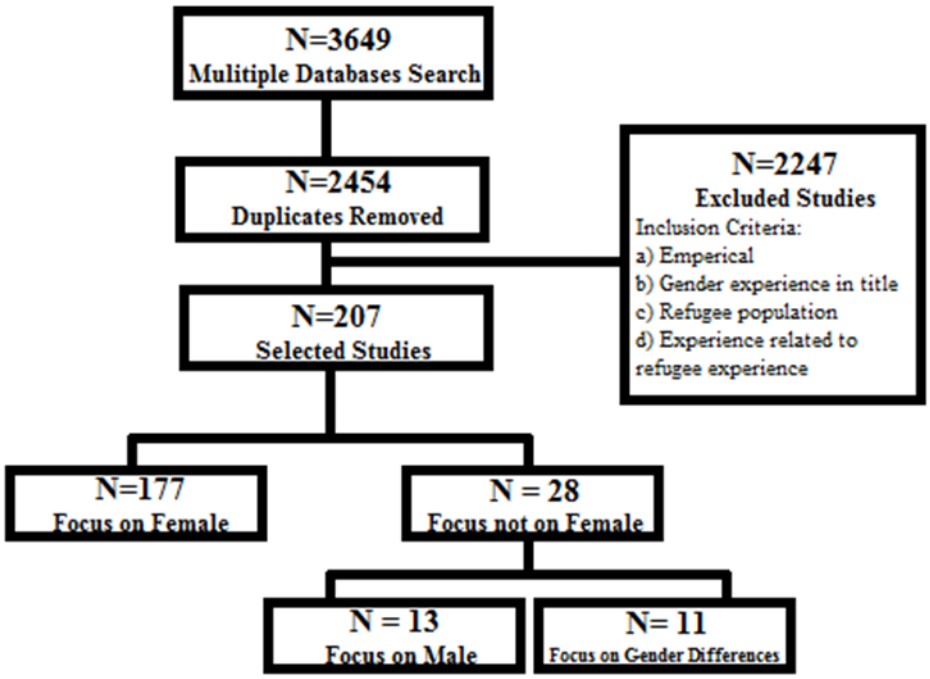
Methods

The search strategy was created by the third author (L.S.), a health science librarian. Articles for this review were collected from the following databases: Cochrane Database of Systematic Reviews, DARE (Database of Abstracts of Reviews of Effects), Cochrane Central Register of Controlled Trials (CENTRAL), Medline and Medline in Process (via OVID), Embase (via OVID), PsycINFO (via OVID), and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). A search strategy was developed to define keywords for all searches (see Appendix 1 for the Medline search). The Cochrane Library was searched with keywords included from the Medline strategy. All references were entered into an Endnote file for processing (N=3649). After duplicates were removed, the search yielded 2454 studies.

Two authors (JA & WA) identified the articles, selecting only those that fit the following inclusion criteria: (a) were empirical; (b) had "women's experience" or "men's experience" in the title or abstract (or a corresponding designation: mother, father, grandfather, grandmother, aunt, uncle, etc.); (c) had "refugee" in the title or abstract (or an equivalent designation: displaced persons, internally displaced, asylum seeker, etc.; articles that focused on the experience of "immigrants," "migrants," etc. were excluded); and (d) focused on experiences of trauma directly related to the refugee experience, such as trauma arising through war, displacement, political violence, and natural disaster (not motor vehicle accidents,

childhood bullying, etc.). Of the initial sample of 2454 articles, 216 met the inclusion criteria. Of these articles, 177 focused on women's experience of disaster, 13 focused on men's experience, and 11 focused on gender differences in the experience of disaster.

For conceptual and comparative purposes, articles were divided into three binary categories based upon the primary focus of the research: "women studies", which focused on refugee women, "men studies" which focused on refugee men, and "mixed gender studies", which focused on issues of both men and women. Categories were mutually exclusive. In other words, studies were classified as women studies, men studies, or mixed gender studies. They could not be classified in multiple categories. Analysis followed a Qualitative Content Analysis Approach (Hsieh & Shannon, 2005). First, a "focused reading" of the articles was conducted to identify relevant "meaning units" (i.e. sentences and paragraphs that discussed men, women, and gender relations between men and women). Articles that only made passing or incidental mention of women, men, or gender, were excluded. Next, inductive thematic analysis of these meaning units was undertaken to better understand the context in which sex, gender, and gender relations were discussed. The final step of the analysis involved a comparison of how women, men, and gender relations were represented in the three categories of studies (focusing on refugee women's experience of trauma, refugee men's experience of trauma, and those examining gender differences in refugee trauma).



Findings

There were two main findings from the review. First, there was a significant lack of attention paid to male-female gender-relations. This finding was reflected in the high number of studies in which there was no mention of the opposite sex. In nearly three quarters (n=113) of the studies examining women's experience, there was no meaningful mention of men, be they fathers, husbands, sons, or men outside the immediate family. We term this lack of attention to gender relations in the studies examining women's experience the *missing man phenomenon*. This lack of regard for gender-relations did not appear in the studies that focused on men. 93% (n= 12) of these studies discussed the role of wives and partners in the men's experience, often in detail.

Second, the review found a high number of gender stereotypes, particularly in the studies that focused on women. These stereotypes tended to follow a trend that we term *moral*

female victim and immoral male villain. For example, of the 40 articles that discussed family men, such as husbands and fathers, 21 described them as physically and/or sexually abusive; 15 depicted them as authoritarian tyrants; and 4 described them as irresponsible (a.k.a deadbeat father/abandoner of the family). Similarly, of the 14 articles that discussed men outside of the immediate family (i.e. soldiers, border guards, politicians), men were depicted as physically/sexually abusive or coercive. In the total sample of 177 articles that focused on women, not a single study depicted men positively, for example, as a source or recipient of emotional or material support or protection.

Stereotypes of women, on the other hand, displayed the opposite traits. Of the 64 studies that discussed family women, such as mothers, grandmothers, sisters, and daughters, over 90% (n=58) used a female stereotype that aligned with the category of *moral female victim* (i.e. victim of rape or domestic violence, victim of patriarchal oppression). Within the 177 articles, fewer than 5% (n=6) of studies depicted women as empowered (i.e. as activists or having control over their environments). Of the 177 articles that focused on women's experience of trauma, there were no cases in which women were represented negatively, for example as selfish, unjust, coercive, or dishonest.

There were substantially fewer gender stereotypes in studies looking at refugee men's experience of trauma. Male villain stereotypes were found in only 2 of the 13 articles, both of which depicted men as violent and sexually abusive. Female victim stereotypes were found in 3 studies, where women were depicted as heroic, stalwart survivors of sexual abuse. None of the studies comparing gender differences included gender stereotypes. In all of the studies in gender differences categories, women were depicted positively. Only 15% (n=2) of the studies depicted men negatively (i.e. as villains or sexual abusers).

Discussion

The two main findings reported above — the "missing man" phenomenon and the prevalence of gender stereotypes in studies of refugees' experiences — are not surprising. The use of both these discursive strategies has been well documented in development discourse for decades (Cornwall, 2000). However, the sheer pervasiveness of such rhetorical strategies — and the fact that they appear in peer-reviewed academic research — is worrisome and deserves further consideration.

One possible explanation is that representations of women, men, and gender relations in fact reflect the on the ground reality as it is outlined by research participants. Indeed, higher rates of domestic violence and sexual abuse are found in refugee and displaced populations (Watts & Zimmerman, 2002). There are situations in which female refugees can be discriminated against or otherwise mistreated by men in authority (Bartolomei & Pittaway, 2001). However, the fact that studies that focused on women often made no mention of fathers, brothers, or sons, and did not include any positive representations of men or negative representations of women suggest that this is not the case. Members of the opposite gender play a fundamental role in an individual's social and familial experience, and it is unlikely that women participants neglected to mention men completely, or only represented them negatively. If indeed the gender representations accurately do reflect the research data, it would suggest a type of bias, in which research is designed and/or analysed in such a way as to not consider gender relations, or to only illicit negative depictions of males and/or positive depictions of females.

We posit that the roots of both the "missing man" phenomenon and the use of gender stereotypes (the moral, deserving, helpless woman and the corrupt, abusive, selfish

man) lie in a representational strategy known as *feminization* (Kelleher, 1997). There are three primary methods through which feminization is accomplished. The first is through an overwhelming focus on images of suffering women, and particularly suffering mothers and girls. The second is a rhetorical technique, commonly referred to as *demasculation* (Dogra, 2011), in which men — especially family men, such as sons, fathers, and husbands — are omitted from representation. The third is a technique Kelleher (1997) refers to as *articulation of virtue through gender* (Kelleher, 1997, p. 78), in which all things deserving and good, such as love, pragmatism, hard work, and selflessness, are simplistically reduced to and personified in female characters, while male characters personify the opposite characteristics: selfish, drunk, irresponsible, and abusive.

Scholars have suggested that the roots of feminization lie in the emotional effect inherent in the image of the suffering woman. In the archetype of the human imagination, women represent home, family, and human connectivity; as a result, representations of suffering women naturally carry a powerful affective dimension and elicit strong feelings of empathy and a desire to protect. Scholars believe that the power of the "suffering woman" image is related to our evolutionary psychology. As Maude Ellmann (1993) explains, "the spectacle of the mother appeals to our forgotten past, to the famished and abandoned infant in ourselves" (p. 52). Similarly, Kelleher (1997) suggests that "women's suffering is an expression of the unthinkable, representing the breakdown of our very humanness" (p. 7).

The three methods of feminization described above all rely upon the power of this "suffering woman" image. Focusing on women's deprivation and misery, and especially on the misery of mothers and girls, draws emotional power directly from the feminization trope; likewise, representing women as innocent, hardworking, and honest adds another layer of

emotional outrage and sense of injustice to their suffering. By diminishing the positive role of men in the lives of their families, demasculation and the articulation of virtue through gender also rely on the emotional power of the suffering woman image. Just as women are symbolic of home, family, and human connectivity in the archetypal human imagination, men are symbolic of the protection of and provision for that home. Thus, erasing men's presence from the depiction of trauma (demasculation) or focusing that depiction on "bad" men who contribute to, rather than alleviating, women's suffering, accentuates the vulnerability and deprivation of the suffering woman, and, in so doing, magnifies the emotional engagement of the audience.

Feminization in disaster literature

Feminization has a long history in disaster literature. As far back as Ovid, depictions of disaster — whether through war, natural disaster, or famine — have capitalized on images of suffering women, with men either excluded from the story or relegated to the position of the "bad man" (Kelleher, 1997). Interestingly, in the 18th century, two additional stereotypical gendered characters began to appear in disaster literature. The first of these is the ruthless, pitiless patriarch (usually a policeman, landlord, or politician), who not only fails to protect women and children in times of need, but also goes out of his way to make their lives more difficult. The second new stereotype is the foreign (read: European) female, upper-class activist/advocate, who is usually white, wealthy, educated, and socially well-positioned. As Kelleher (1997) explains, this character (whom she labels the *ministering angel*) works tirelessly at the site of the disaster to protect the less fortunate "native" women from the various injustices inflicted upon them by their male oppressors (patriarchs and husbands/fathers). Interestingly, these latter characters of the corrupt patriarch and ministering angel appear most often in disaster literature written by European women (Kelleher, 1997).

Feminization is also widely found in contemporary disaster discourse. It is especially noticeable in fundraising messages for humanitarian disaster relief. These appeals tend to narrow in on the plight of suffering women — particularly suffering mothers who are unable to properly care for their children — and omit images of family men such as husbands and fathers. When men do appear in development literature, it is overwhelmingly in the guise of the bad man: either the abusive family man, or the dangerous, threatening, or manipulative stranger (Dogra, 2007; Hawkins & Valencia-Fourcans, 2015).

Advantages of feminization

In order to understand feminization in both the development discourse and the historical and contemporary disaster literature, it is important to recognize the many advantages available to commentators who employ this strategy. First, feminization helps to emotionally engage one's audience with the trauma in question. A feminized message can be particularly effective at bringing attention to a crisis, increasing sympathy for one's cause, and gaining support for intervention. As White (2000) has said of feminization, when practitioners "win hearts [they] access pockets" (White, 37).

There are also representational advantages that accompany feminization. One of the key struggles for any writer or commentator on mass tragedy or disaster, especially those who seek to write factually about the event, is how to sufficiently convey the depth of human suffering in a way that does not make it appear overly trite or simplistic, or in a way that does not obscure the complexities of the event. There is also a danger that writing factually about human catastrophe may lessen or otherwise trivialize the horror. One of the ways around these challenges is to dramatize the event. As Veena Das points out, some realities are so devastating

that they need to be "fictionalized before they can be comprehended" (Das, 2000, p. 69). By depicting disaster through the suffering of women, commentators are able to capitalize on innate human sympathies in order to convey a sense of the unspeakable and to individualize the crisis. As the literary critic John Banville (1987, p. 143) writes, the image of the suffering woman is used "so that tears might be shed and the inexpressible expressed"

Neutrality

Feminization also allows commentators to retain a semblance of neutrality. Traditionally, the female realm is that of children, the family, home, and nature: concepts that stand in contrast to the political, economic, and corrupt military realm of men. Focusing on women and children, the more-or-less universally recognized real "victims" of tragedy (Lewis, 1996), allows authors to distinguish the human, victim element of tragedy from its political, economic, "man-made" causes. It also allows commentators to remain at a safe distance from the more sensitive and volatile political discourse that often surrounds traumatic events. This position of neutrality is essential for anyone working in politically precarious situations, including journalists, aid workers, and development practitioners, as it grants them access to civilian populations while allowing them to eschew partisanship with one group or another and to avoid complications from potentially hostile political factions. This neutrality is often essential for accessing populations affected by war and other disasters.

Deserving and undeserving poor

Another advantage of feminization is that it allows commentators to separate the "deserving" from the "undeserving" poor. Humanitarian aid is a limited resource, which

inevitably leads to thorny questions of moral economy: *Who is the most in need of aid? Who is truly worthy of limited aid resources, and who may be simply manipulating their victim status for his or her own personal gain?* Focusing on images of suffering women, and depicting women as innocent and honest and men as manipulative, abusive, and selfish, offers a convenient and non-controversial way around such questions (Kelleher, 1997).

Personal and Professional Advantages

The strategic advantages of feminization discussed above are relatively straightforward. However, there are also a number of personal and professional advantages that are more subtle. These advantages are rooted in the rhetorical function of the Other and the role that representations of the Other play in the identity politics of the representer.

Binary function of the Other

Representations of the Other, including stereotypes, serve two separate but interrelated rhetorical functions. The first is binary: by representing the Other in one way, the representer can strategically position himself as the opposite. This is an important function in identity formation. By contrasting himself with the Other, the representer is able to define his own identity; by demonstrating what he is not, the representer is able to define what he is. In particular, this binary function of the Other allows the representer to validate his *values and worldview*. If the Other, who holds opposing values, is troubled or struggling, the values of the representer, who is thriving, must be superior. Through this conceptualization, the values of the representer are not only validated, but also offered up as the solution to the suffering experienced by the Other. If only the Other had access to the knowledge, values, and religion of

the representer, their suffering would cease and they too could have access to the same standard/quality of life (Neumann, 1999).

Narrative function of the Other

The second rhetorical function of representations of the suffering 'Other' is rooted in self-narrative. According to narrative identity theory, individuals form their self-identity by integrating their life experiences into an internalized, evolving narrative or story of the self (Ricoeur, 1984). In other words, our story provides the foundation of our self-identity. Representations of the Other play a key role in the establishment of this self-narrative by demonstrating the representer's position and function. In contrast to the suffering Other, for example, the representer's position in the narrative may be cast as positive. He becomes a saviour figure, the bringer of "correct" knowledge, values, and a worldview that will alleviate the suffering experienced by the Other (Taylor, Wetherell & Yates, 2001).

Rhetorical function of gender stereotypes

Gender stereotypes of the suffering/oppressed/hard-working woman and the abusive man are particularly well suited for both these rhetorical functions. First — as with any representation of the suffering Other — through the binary function, these stereotypes allow the representer to position himself in opposition: to validate his worldview and justify interventions that deliver the "correct" values of his culture to the suffering woman. Indeed, images of suffering women and their abusive male counterparts have been used in this way for centuries to justify interventions in the lives of the Other, whether through war, religious missions, or contemporary humanitarian aid campaigns (Das, 2000).

This use of feminization can also be clearly seen in the international feminist movement of the late 20th century. Western commentators from the so-called "second wave" of feminism made extensive use of images of the deserving-yet-oppressed (and ultimately helpless) "Third World Woman" to position themselves in opposition: as liberators whose worldview and value system (feminism, female liberation) was the needed salve for the plight of the downtrodden woman against her abusive male oppressors. This arguably manipulative use of gender stereotypes in the late 20th century led a number of scholars, particularly third-world feminists themselves, to draw parallels between the international feminist movement and the European colonialist project (Mohantry, 1987; Ogundipe-Leslie, 1994; Oyewumi, 2003; Spivack,1988).

Gender stereotypes and the narrative function of representation

Gender stereotypes dovetail well with the narrative function served by representation of the Other. In particular, a unique type of saviour role can be crafted through the use of gender stereotypes: by portraying the female Other as "innocent" and "deserving" and either excluding men completely or portraying them as "bad" and abusive, the representer is able to step into the role of provider and protector that the "missing," "inept," or "bad" man is failing to fulfill. Similarly, stereotypes of the male patriarch like the "corrupt politician" or "heartless landlord" allow the representer to step into either that missing leadership role or the role of the advocate or activist who works on behalf of oppressed women, giving a voice to the character who, through the imagery of gender stereotypes, is deemed voiceless (Mohantry, 1987).

In fact, some scholars have suggested that this narrative function in the identity politics of the representer was the instigation behind the emergence of the "corrupt and ruthless politician" and "foreign female saviour", characters that emerged in the mid-19th century in disaster literature written by women (Burton, 1994). The second half of the 19th century was a period of unprecedented colonial expansion, during which European women enjoyed increasing access to the Orient as travellers, authors, artists, journalists, and missionaries. Lewis (1996, p. 22) suggests that the new gender stereotypes arose as part of female commentators' attempt to carve a place for themselves within the colonialist discourse:

> Although women writers often expressed sympathy for native women or voiced criticism of colonial administration, it would be wrong to take this as a displaced feminist anger. Aside from personal conservatism of many women travellers, the proto-feminist concern for 'native' women was itself frequently structured by the same assumptions of white superiority and civilization (Indian women are oppressed by their backward menfolk and must be liberated by their more advanced white sisters) that drove imperial policy.

Professional advantages

Alongside the clear personal advantages that exist for commentators who make use of feminization (including articulation of one's own identity, validation of one's values and worldview, creation of a saviour role, and justification of one's presence in the lives of the Other), there are also a number of professional advantages, rooted in the identity politics, not of the individual, but of the audience. Through the rhetorical process of feminization, representations of the Other allow members of the in-group to articulate their collective identity and validate the identity politics of the in-group itself. Said (1978), writing about the colonialist discourse, labelled the advantages available to commentators who produced representations of the Other that aligned with this in-group status the *Imperial Spoils.* These could include increased recognition, appreciation, and support for the commentator's work, both within the

wider culture and the commentator's specific professional community (who relied on binary and narrative rhetorical representations of the Other to develop their own identity and mission).

Humanitarian Disaster Research in Context

Although the work of modern humanitarian trauma researchers is directed towards a different audience — namely the research community and policy makers — when carefully considered, we can see how many of the same struggles exist for this group as for other disaster commentators. For example, disaster researchers often work in politically precarious situations, where the appearance of neutrality is essential for gaining access to vulnerable populations affected by the crisis. Along with producing measurable data, health and social science researchers also aim to raise awareness and elicit a policy-level response; the effectiveness of this work often depends upon the investigator's ability to emotionally engage their audience. Furthermore, like other disaster commentators, researchers struggle with how to convey facts or details of mass catastrophe without losing sight of the human cost of the disaster or making real suffering appear simplistic or banal; focusing on women and using gender stereotypes of the innocent woman and the abusive man/corrupt politician helps researchers to "reify" the disaster for their audience and therefore justify their work, their proposed solution, and their presence in the lives of the Other. Finally, the high cost of research and a lack of available experts make research a limited resource, and feminization provides a convenient way around thorny issues such as who deserves research attention in the aftermath of disasters and who does not. On the cultural level, the overwhelming majority of humanitarian disaster research comes from the West and is funded by Western institutions and organizations (Summerfield, 2012); use of gender stereotypes can help researchers appeal to

both the wider identity politics of Western culture and to researcher's own professional community. All these factors suggest that present-day disaster researchers have access to the same advantages for using feminisation that Said (1978) described as the "Imperial Spoils" of colonialism. These include greater professional recognition, public acknowledgment of their work through media and advocacy groups, and increased funding opportunities from donors and funding agencies.

It may be argued that a clear boundary exists between scientific and non-fiction work on disaster and works of fiction. After all (so the argument might go), science, unlike fiction, emphasises the recording of observed facts and is therefore unaffected by the aesthetic requirements of artistic representation. However, such distinctions are not tenable. Starting with Said (1978), postcolonial theory has discredited the claim of neutral academic expertise and shown how Western knowledge and representations of the non-Western world are neither un-biased nor based on some factual reality (Reingold & Rothenberg, 1987). In the colonial period, works of scientific inquiry were as equally implicated in Europe's imperial expansion and quest for power as other forms of knowledge creation about the 'native' Other. In fact, it was science's mask of objectivity during the colonialist period that made its role in the perpetuation of stereotypes so insidious, since that mask obscured relations of inequality and domination. Regardless of the narrative framework, be it fictional or scientific, production of knowledge about the Other is necessarily mediated through the knowledge-maker's own culture. In other words, the construction, articulation, and affirmation of differences between the Self and Other cannot help but feed into the identity politics of the representer's in-group consumers and thus reflect both institutional and individual power (Said, 1978).

Representation in peer-reviewed literature vs. other forms of representation

The above discussion is in no way meant to dismiss the realities of sexism or the many serious challenges faced by women around the world. Nor is it to suggest that feminization is all bad. It could be argued that the harms associated with these discourse devices are outweighed by the benefits. After all, the use of such gender stereotypes help bring attention women's health and social issues, they stimulate support for gender interventions (financial or otherwise), and they help to unite various powerful actors in the cause of enacting change (Cornwall, Harrison & Whitehead, 2009). It could also be argued that focusing on the epistemological status of representations, or their relationship to truth or falsehood, is beside the point. Rather, the images, representations, and narratives of the Other used by development practitioners — including those predicated on feminization — are justified by the sense of purpose and moral conviction they provide: without these representations, development practitioners would be unable to sustain motivation in the face of near insurmountable obstacles associated with transforming conditions of misery and disadvantage (Hirschmann, 1967).

While such moral reasoning, in which the end justifies the means, is (perhaps) defensible in the context of development and public fundraising campaigns, it cannot apply to research. Using feminization tactics in research results in a number of negative outcomes. First, these techniques lead to a skewed interpretation of the post-disaster reality and the lived experience of disaster survivors. For example, men are seldom, if ever, completely absent from the nexus of social relationships in which women and families exist, yet their presence is almost entirely expunged from published research on refugee families. Failing to acknowledge gender relations between men and women ignores the fundamental role that men play in

women's social and familial experience. It also ignores the inter-connectedness of individual health and family health that exists in times of disaster (Catani et al., 2008).

Gender stereotypes offer a similarly distorted perception of reality. Not only do stereotypes paint a false representation of individuals as mere cardboard cut-outs without any real complexity, but they necessarily diminish variation. For example, when one chooses to depict men *in general* as abusers, one necessarily excludes from consideration the many examples of husbands, fathers, and sons who support, provide for, and protect women and children during and in the aftermath of disasters. Similarly, depicting men-in-general as privileged denies the experience of significant populations of adolescents, homosexuals, minorities, and the economically or socially disadvantaged, who do not have access to the traditional power ascribed to men in any given society.

The stereotypes of women found in humanitarian disaster literature also distort reality to negative effect. First, through the exclusion of difference, these stereotypes deny examples of not-so-moral women, such as wealthy older women who use "development" funds for their own projects, or women with social power who deny younger, poorer women access to development programs (see for example, Bulow, 1995). Even more importantly, the perpetuation of the "innocent victim" stereotype negates the existence of powerful or empowered women, self-determining women, or women who are both willing to and capable of standing up and coping with the hardships and injustice that they face. Stereotypes problematically reinforce traditional perceptions of women as objects of pity and helpless victims of circumstance, who lack internal agency and are wholly dependent upon outside intervention.

There are also clinical implications of the use of feminization in disaster research. As Das, Klienman & Lock (2000) point out, "how we represent something becomes our reality" (p. 7). There is thus is a danger that reliance on feminization can lead to the conclusion, either conscious or unconscious, that men, as a group, are not vulnerable in times of disaster — or worse, that they are not deserving of research attention at all. This may help to explain the findings of a recent systematic review that found only 6% of gender-focused refugee research focused on men (Affleck, et al., in press).

The use of gender stereotypes in research can also result in overly simplistic post-disaster interventions that are less effective than interventions based on more nuanced data. There are many examples of this phenomenon in the development sphere. Gender stereotypes have been implicated in a number of problematic and ineffective development interventions, including environmental initiatives (Leach, 2008) and poverty reduction programs (O'Laughlin, 2008).

Finally, and perhaps most importantly — as was so well demonstrated in the case of colonialism — the 'imagined reality' constructed through use of gender stereotypes and demasculation obscures and perpetuates power imbalances between the researcher and the researched. It is not just the Other that is misrepresented when stereotypes are used; rather, through the binary and narrative rhetorical functions, stereotypes of the Other can also misrepresent the representer, creating an image of pure benevolence and superiority that clouds deficiencies in the representer's values and character, and hides other less benevolent motivations, such as personal affirmation, professional advancement, and social recognition.

Conclusion

This review outlines how the use of demasculation and gender stereotypes is widespread in gender and disaster literature, particularly in research focusing on women. As Foucault (1926-1984) stated so succinctly, knowledge can never be free from power: constituting someone/thing as an object of knowledge is to assume power over it (Foucault, 1972). In the colonialist era, Orientalism, as a body of knowledge about the East produced for and by the West, came to bypass Eastern sources altogether in a self-referential process of legitimation that endlessly asserted the power of the West to know, speak for, and regulate the Orient "better than the Orient itself could" (Said, 1978). Through the binary and narrative functions of representation, which included demasculation and gender stereotypes, colonialized populations came to identify with this imagined reality until eventually they viewed the knowledge, culture, and values of Europeans as superior to their own.

A number of authors have drawn parallels between contemporary development and global health research and European colonial expansion (Benatar, 1998; Fernando, 1991; Summerfield, 2013). The use of representational strategy known as feminisation, which includes the use of gender stereotypes and demasculation, represent a specific mechanism through which the colonial relationship is perpetuated. Both global health researchers and their audience need to be aware of such discursive strategies, lest rhetoric once again be confused with reality.

Chapter 6: "If One Does Not Fulfil His Duties, He Must Not be a Man": Depleted Masculinity and Strategies of Resilience Amongst Sri Lankan Tamil Refugee Men in Canada.

Immigrant and refugee men face unique mental health stressors in the pre- and post-migratory periods. However, as the last several chapters have demonstrated, there has been little in-depth research on the mental health of refugee men in Canada. Given this situation, the overall aim of the study presented in this chapter is to explore the psycho-social experience of Sri Lankan Tamil refugee men in Canada. Particular objectives include better understanding any inter-relationship between war-trauma, migration, concepts of masculinity and mental health. The study employed a two-phase participatory action research design based on the grounded theory approach. Phase 1 involved an 8-month ethnography conducted in Sri Lanka. Phase 2 consisted of qualitative interviews with 33 Sri Lankan Tamil refugee men living in Canada. Consistent with grounded theory, analysis was conducted inductively and iteratively. Four specific themes emerged from the data (i) *gendered nature of war:* participants commonly reported ongoing negative rumination regarding experiences where they were unable to adequately protect loved ones from physical suffering or death; (ii) *reduced capacity:* participants frequently felt unable to fulfill culturally-sanctioned duties, such as supporting their family, due to ongoing pre- and post-migratory stress; (iii) *redundancy*: many participants felt that they were useless in Canada, as they could not fulfill typical masculine social roles (e.g. provider) due to factors such as unemployment and underemployment; (iv) *intimate criticism:* some participants reported that their spouses would often attempt to 'shame' them into greater achievement by constantly reminding them of their 'failures'. Many found this distressing. These various failures culminated in a state that we label "depleted masculinity", which participants linked to emotional and behavioural problems. Participants reported that they actively tried to rebuild their masculine identity, for example by adopting leadership roles in community organizations, which fostered resiliency. Results suggest a need to review and rebuild masculine identity to support the mental health of refugee men.

Introduction

The link between war trauma, resettlement stress and mental health problems in refugee populations is well established (Miller & Rasmussen, 2010). Mental health issues in refugee men can be particularly devastating to families and communities, as well as to the affected men themselves. Such issues can lead to increased anger and rage, drug and alcohol abuse, financial mismanagement and interpersonal violence (James, 2010; Kabachnik, et al., 2013).

Despite these heavy individual and social burdens, there are still gaps in the knowledge base regarding the mental health of refugee men. Indeed, refugee men remain significantly under-represented in mental health research (Affleck et al, in press, Azinkulure-Smith, 2012; Correa-Velez & Onsando, 2009).

That said, some research suggests that masculine identities and roles affect the mental health experience of refugee men. In times of war, for example, the inability to defend oneself and one's family can contradict common beliefs that men should stand and fight external threats or oppression (Jaji, 2009). The failure to protect family members from harm and death can disconnect a man from the socially valued masculine protector role (Chan & Young, 2009). Likewise, under or unemployment in a new host country can hinder a man's ability to provide for his family, leading to dependency upon others, which is inconsistent with common masculine ideals such as self-reliance. (Kliest, 2010).

Hegemonic masculinity is a notion referring to the dominant ideal of masculinity within any specific culture (Connell, 1987). The specific ways in which (hegemonic) masculinity can intersect with mental health can vary dramatically between cultures (Connell, 2005). As such, there is a pressing need to investigate notions of masculinity and its impact on mental health within immigrant groups and ethnic minorities (Chopra, Osella & Osella, 2004). Refugee men are a vulnerable and under-researched group in this regard.

Given this situation, the broad aim of this study is to explore the psycho-social experience of Sri Lankan Tamil refugee men currently living in Canada. Specific objectives include better understanding any inter-relationship between war-trauma, migration, resettlement, concepts of masculinity and mental health.

In order to contextualize the study, the following section gives a brief overview of relevant information including (a) the hegemonic conception of masculinity in Tamil Sri Lanka; (b) the Sri Lankan civil war; and (c) the Sri Lankan Tamil refugee population in Canada.

Background: Sri Lankan Tamil Masculinity

Many scholars have noted that Sri Lankan Tamil culture is highly patriarchal (De Alwis & Hyndman, 2003; Jeganathan, 1998). In general, greater respect is paid to males than to females. This can be witnessed at all levels of society. Within the family, for example, the birth of a son frequently evokes more pride for parents than the birth of a daughter. Likewise, male children are often afforded greater opportunities than female children, and men are generally considered to be the ultimate authority within the household (de Almeida-Gunerante & Pinto-Jayawardena, 2010; de Mel, Gomez & Peiris, 2013). Throughout Sri Lanka, (with important exceptions) men tend to occupy positions of power in the private and public sector. As Nagel (2005, p. 397) writes, men "organize, run, and 'man' the machinery of society".

Cultural beliefs about appropriate gender roles reflect Tamil society's reverence for masculinity and underpin a social structure that many consider patriarchal. It is widely believed, for example, that males, by their nature, are physically and psychologically stronger than females (Marecek, 1998). Men are also commonly believed to have greater moral character than women, and be more concerned for community well-being. Women, on the other hand, are often said to be morally 'selfish', caring only for themselves and their immediate families (Hewamanne, 2008).

The dominant or hegemonic conception of masculinity in Sri Lankan Tamil culture has been described as "hyper-masculine" (De Mel, 2007). It is based upon what Hellmann-Rajanayagam (2005) labeled the *Warrior-Hero* ideal. Attributes include physical and psychological strength, courage in the face of danger, leadership, sexual prowess, and self-reliance. In this sense, Tamil masculinity overlaps with the hegemonic ideals of masculinity found in many other cultures around the world (Connell & Messerschmidt, 2005).

Tamil masculinity also places much importance on what Gross (2008) labeled "altruistic self-sacrifice", referring to a willingness to sacrifice oneself in the name of the other, be it family, community, or the nation. This is seen as the paramount character trait of the warrior-hero, and with it the quintessential character trait of an ideal Tamil man. According to Gross (2008), the more of his own happiness and wellbeing a Tamil man is willing to sacrifice for others, the greater a man he is considered to be.

The warrior-hero ideal is deeply embedded in Sri Lankan Tamil culture. Tamil legends and myths are replete with paradigmatic warrior heroes, who embody the essence of Tamil masculinity (strength, courage, sexual virility, and altruistic self-sacrifice). Poems about these warrior exploits are read at cultural festivals, adapted into folk-songs and into children's stories such as *Mahabraratham* and *Ramaanam*. The Warrior-hero is also embedded in religious practice. Hindu deities such as *Murukan* and *Ayyappan* personify the warrior-hero ideals of virility, courage, and selflessness (Clothey, 1978; Gross, 2009).

This warrior-hero conception of masculinity remains popular, and can be seen in many elements of contemporary Tamil culture. Perhaps the clearest example is found in 'Tamil-wood' films. These films are widely viewed, both in private homes and in public spaces such as restaurants and retail establishments. The general plot of these films remains constant: a

hyper-masculine protagonist, who exemplifies the warrior hero ideal, who against all odds must rescue innocent women and children, usually his family, from a gang of 'bad' men. These adversaries represent the opposite of the warrior hero. They are skinny, boyish, undisciplined, selfish, and morally weak. Invariably, through herculean challenges and near super-human feats, the protagonist overcomes these multitudes of 'bad' men to ultimately save his family. The essence of Warrior-hero masculinity is presented in the protagonist's central line that consistently appears in most Tamil-wood films: "fight for your country, save your family, or die a hero" (Daiya, 2011).

Sri Lankan Civil Conflict

After Sri Lanka gained independence from Great Britain in 1948, latent hostilities between the county's Sinhalese majority and the Tamil minority became increasingly overt. The culmination was a devastating 26-year civil war (1983-2009) between the Sri Lankan Security Forces (SLF) and the Liberation Tigers of Tamil Eelam (LTTE) whose mission was to create their own Sri Lankan Tamil state, or *Eelam*, in the North and East of the country.

By the early 1990s, the LTTE had established a de facto Tamil state with its own media, police force, and judicial and financial systems. Though the quality of life was reported to be high, the LTTE ruled with authoritarian tactics. These included political murders, disappearances, and corporal punishment for those who questioned or opposed the leadership.

Tamil civilians bore the brunt of the violence. The war was marked by indiscriminate shelling of civilians, countless large-scale massacres, and widespread displacement of civilian populations. Throughout the war period there were also ongoing

abductions, torture, disappearances, and extrajudicial killings of Tamil civilians by both the LTTE and the SLF.

Both parties also established vast networks of checkpoints where civilians were subject to delays, humiliation, and harassment. In the end, as Somasundaram (2010, p. 27) describes, "Tamil civilians were caught between terror and counter-terror, the parallel authorities, and the violence of both the LTTE and the state". It is estimated that 40,000-60,000 Tamil civilians died during the conflict (UN, 2011).

From 1984-2012 Canada accepted 136,422 immigrants and 53,491 refugees from Sri Lanka, the majority of whom were Tamil (Amarasingam, 2013), though this figure does not include illegal immigrants. As such, community sources estimate that there are currently between 200,000 and 300,000 Tamil people living in Canada (Marasingam, 2013). The vast majority of these people live in the Greater Toronto Area (GTA), making Toronto home to the largest Tamil population in the world outside of South Asia (Beiser, 2014).

Methods

This study reports findings from a larger research project entitled "Invisible Wounds", which evolved from a desire to understand the wider relationship between masculinity and mental health in Sri Lankan Tamil refugee men. This study was divided into two phases, one in Sri Lanka, the second in Canada.

Phase one. The first involved an ethnographic field study in Sri Lanka itself, with the first author spending 8 months (2013-2014) in a small village in the East of Sri Lanka that was

heavily affected by the war. Much of this time was spent conducting observations and interviews at a local all-male psychiatric rehabilitation center.

Following best practice in cross-cultural research, this study used a participatory action research (PAR) design (Whyte, 1991). This approach involves working in close partnership with a coalition of local stakeholders who act as an advisory committee to assist throughout to ensure cultural appropriateness. Soon after his arrival in Sri Lanka, the first author assembled an advisory committee which consisted of a psychiatrist, a mental health nurse, a psycho-social researcher, and a local religious leader. The first author met regularly with committee members who helped to formulate and guide the data collection process in a culturally sensitive manner. Prior to the fieldwork, ethics approval was obtained by a major research institution in Canada. However, the committee also undertook further ethical analysis to ensure that any locally relevant ethical issues were considered and addressed.

The aim of this phase of the study was for the first author to better understand overall Sri Lankan Tamil culture, its conception of masculinity, and the experience of war by civilian Sri Lankan men. The first author utilized numerous qualitative methods to achieve this aim, including ethnographic observations, key informant interviews and shadowing. The first author kept daily field-notes, which were typed into a word document.

Phase Two. The second phase consisted of qualitative interviews with Sri Lankan Tamil refugee men in Toronto, Canada. The goal of Phase 2 was to better understand the impact of war, migration and resettlement on mental health, particularly with regards to cultural conceptions of masculinity. Phase 2 also used a participatory action research design. A local advisory board was established, which consisted of community representatives, members of an

elders' organization, and Tamil-speaking mental health professionals. As a group, this board further assessed locally relevant ethical concerns and gave feedback on the interview topic guide, which was integrated into the study.

Participants were recruited through a local community organisation who partnered in the research. Recruitment strategies included placing posters throughout the centre that highlighted the study. Convenience and snowball sampling were also used, in which participants were asked to inform friends and associates about the study. In total, 33 Sri Lankan Tamil refugee men were interviewed. Participants' age ranged from 20-60, and time spent in Canada ranged from 3 years to 27 years. Demographic details of the sample are given in Table One. The interview schedule included questions such as "Tell me about your life in Sri Lanka" and "How did your experiences impact you?" Interviews lasted between 1 and 3 hours. Interviews were conducted in Tamil by the second author (U. T.) a Toronto-based psychiatrist from Sri Lanka fluent in both Tamil and English. The second author then translated and transcribed the interviews into word documents.

Analysis. Collection and analysis of the data was guided by the grounded theory approach outlined in the various writings of Glaser and Strauss (Glaser, 1978, 1992; Glaser and Strauss, 1967). This primarily inductive method requires that analysts develop prominent themes and categories from the earliest stages of data-collection that are grounded in the lived experience of participants. Conditional themes are then tested as working hypotheses during new rounds of data collection for further confirmation or elimination. Grounded theory is thus perfectly suited for a multi-phase study utilizing numerous qualitative methods.

Grounded theory was followed throughout the four years of the project (2012-2016). During Phase 1, a thematic framework was created from observations and reflections in field notes and key informant interviews. This led to the development of the working hypothesis which was tested during phase 2. New and adapted themes were further extracted during the analysis of phase 2 data. Themes from both Phase 1 and 2 were compared and verified between authors, shared with the advisory board, and presented at academic conferences for expert feedback. Through consensus, the authors and committee members agreed upon a theory grounded in the data that we label as 'depleted masculinity', with various component parts. This theory is presented in more detail in the discussion below.

Table 1: demographic information

Age	*N*	%
20-29	3	9.1
30-39	8	24.2
40-49	11	33.3
50+	8	24.2
Marital Status		
Married	23	70.0
Engaged or Living Together	2	6.1
Unmarried	5	15.2
Employment		
Labourer/Factory/Retail	14	42.4
Cook/Restaurant	3	9.1
Unemployed	13	39.3
Time spent in Canada		
3-5 years	10	30.3
5-10 years	17	51.5
10+ years	6	18.2

Results

Analysis indicated four major threats to participants mental health related to war, masculinity and migration, namely: (i) *gendered nature of war:* participants commonly reported ongoing negative rumination regarding experiences where they were unable to adequately protect loved ones from physical suffering or death; (ii) *reduced capacity:* participants frequently felt unable to fulfill culturally-sanctioned duties in Canada, such as supporting their family, due to ongoing pre- and post-migratory mental stress; (iii) *redundancy*: many participants felt that they were useless in Canada, as they could not fulfill typical masculine social roles (e.g. provider) due to factors such as unemployment and underemployment; (iv) *intimate criticism:* some participants reported that their spouses would often attempt to 'shame' them into greater achievement by constantly reminding them of their 'failures'. Many found this distressing. The themes are discussed in more detail below.

The most striking finding of this study surrounded participants' interpretation of their experience: regardless of the specific type of trauma or daily stress, each had the same effect: they reinforced participants' feelings of inadequacy, helplessness, and failure. This resulted from the inability to live up to culturally prescribed standards of masculine behavior and achievement. In turn, this undermined participants' masculine self-concept and self-worth.

The cumulative effect of these stressors was an emotional and psychological state that we label '*depleted masculinity'.* In this state all of the attributes that the men associated with their masculine identity were depleted, sometimes to the point where they were lost completely. Participants linked this to a number of negative emotional and mental health problems.

1) Gendered nature of war. As members of the civilian population, men's lives were overturned by the chaos and violence created by the war. Interviews revealed that civilian men had their own gendered experience of the war. As linchpins of the social and economic realm, men comprised the overwhelming majority of business people, farmers, and fishermen in Sri Lanka. During the war it became impossible to carry out the daily activities necessary to pursue their livelihoods. Participants described how businesses were constantly devastated, farming was disrupted regularly by military attacks, fields and livestock were destroyed by shelling or abandoned during displacements. Fisherman were kept from the ocean due to constantly changing and unpredictable LTTE and SLF checkpoints.

The inability to fulfil economic functions and materially provide for their families was emotionally very difficult for the participants. It meant they were unable to perform socially valued masculine roles which underpinned aspects of masculine identity. During the interviews, it was common for men to berate themselves for being "helpless" or "dependent" during the war period.

Gender norms and role expectations played a major role in participant's war experience. Following the warrior-hero conception of masculinity, and the belief that as men they were stronger and more psychologically resilient than women, men often placed themselves in great danger to protect their families. Aaran, a 34 year old father who survived months of displacement and regular shelling explained:

> I endured tremendous suffering for my family. Many times I gave food that I collected after an enormous amount of effort and danger to my wife and children. I endured my hunger. When I was thirsty I did not drink because I wanted to save it for my family. Other men in the area behaved similarly. We [men] endured all of the suffering to save the lives of our families. Men can manage traumas and sufferings but women cannot.

According to participants, civilian men also faced a high level of institutional violence. The men described how they were often specifically targeted on account of their gender.

Participants described how the Sri Lankan army would assemble and indiscriminately interrogate all the young men from Tamil villages for information, sometimes involving torture. Several participants described how they were "rounded up" without cause and tortured by the investigation bureau. During fieldwork, the first author met a number of young men who had worked in Sinhalese regions in the South and West of the country during the war who described similar experiences.

The torture methods used by the different authorities were highly gendered. During phase 1 fieldwork, the first author spoke to a local aid worker, who had been detained and heavily tortured during the war. This man described an experience repeated by others, in which Tamil detainees were placed amongst the general Sinhalese prison populations. These Tamils were often raped by Sinhalese prisoners at the encouragement of the guards. Similar sexual torture experiences were detailed in other interviews. Some participants described being raped, having their genitals electrocuted and squeezed by pliers, being forced to masturbate in public, and being sodomized with foreign objects.

The extent to which the warrior hero conception of masculinity was implicated in the participant's psycho-social experience was striking. This was witnessed in the events participants described as being the most traumatic. Virtually every participant described how the greatest source of war trauma did not result from events they experienced directly, such as shelling or torture. Rather they were situations in which they could not protect others from suffering. At the heart of these traumas lay feelings of helplessness, incapacity, and the belief that as men they should have been able to offer protection. As Rajan, a young father whose daughter died in a battle explained:

> We reached the army controlled area, but they [the army] did not give us permission to enter the area under their control. They kept us at the seashore for 2 days without meals

> or water. Daytime at the seashore was unbearable because of the extreme sunshine and high temperature. We had to drink sea water to survive. My children were 8, 10, 12 at the time. They suffered hunger and starvation. I could not ease their sufferings. I could not do anything for them [crying]. They separated the men from the women and children. I was taken into a bunker, stripped naked and thoroughly checked. Then the two groups were taken separately on different tractors. The last time I saw my daughter she was suffering from bloody vomiting many times. I guessed she drank sea-water that heavily eroded her stomach. I was helpless and hopeless. I failed as a father and should have protected my family, but I could not do anything for her. The army didn't allow me to do anything for her. I was helpless. I was incapable [crying].

Participants described similar experiences of the internment camps where the main source of suffering did not result from direct violence, but rather from situations in which they were helpless to protect loved ones from unclean and unsafe living quarters. However, these traumas did not only result from the inability to physically protect or provide material comforts. Situations in which participants were unable to offer what they interpreted to be an adequate level of emotional support resulted in similar feelings.

A number of participants described how, as the recognized head of the family, their wives and children often looked to them to alleviate their emotional problems. Participants reported that their inability to provide emotional support resulted in great suffering and negative evaluation by self and others. Through their failure to fulfill socially-valued masculine roles, be it the provider of physical protection or emotional support, many men felt they were responsible for their family's suffering. This was often associated with mental health problems. As Bernard, a 39 year old father whose son disappeared during the war, explained:

> I could not even learn if my son was alive or dead and I could do nothing to find him. I felt incapable and extremely guilty about this. I was highly distressed. I could not even look at my family's face. When I look at my wife's face I was urged to kill myself because I could not be a man. I could not give her any answers and nor could I help her. I remember thinking that I would rather die than have such a life. I was despondent, I was ashamed. Even today my depression deepens every time I think about it. I still become overwhelmed with feelings of guilt (crying).

2) Reduced capacity. The interviews revealed that this prolonged and systematic violence led to a constellation of negative consequences in the present. Participants commonly reported symptoms of PTSD such as flashbacks, intrusive memories, chronic nightmares, sleep problems, headaches and anxiety attacks. Broader problems commonly associated with PTSD were also described, including difficulties trusting others, feeling a lack of emotional attachment to loved ones, and increased bouts of anger and rage.

However, the form of suffering consequent upon their war experience that participants gave the most weight to surrounded a locally specific idiom of distress referred to as "floppy mind" (*neki mentatil*). The experiential components of floppy mind included the inability to concentrate, a lack of situational awareness, forgetfulness, absent-mindedness, and a decreased ability to retain information. As Sivum, a 37 year old man who arrived alone in Canada explained:

> My mind is totally floppy. I cannot concentrate with any consistency. My mind drifts without my control or it becomes frozen. I suffer from severe memory loss and I cannot recall things easily. I forget everything. My mind has no energy; it does not have any urge/drive and it functions slowly. My ability to think and function has been dramatically reduced; my mind can no longer possess clarity.

This experience of 'floppy mind' significantly interfered with the men's daily functioning. Participants described how they could not drive, had problems navigating public transit, and had difficulty holding down work because they could not follow simple directions. Others described how they had difficulty carrying on conversations because they could not remember what had been said or could not follow the theme of the discussion.

Participants reported that their greatest source of difficulty did not come from the psychological experience of floppy mind per se, but more from the functional impact that floppy mind had on participants' ability to fulfill socially desirable 'duties'.

Indeed, many participants noted that the fulfillment of duties is of fundamental importance to Tamil men. A man is judged, and judges himself as a man upon his ability to accomplish his duties. As a community leader in Sri Lanka so bluntly stated, "If one does not fulfil one's duties, he must not be a man."

For virtually every participant, the inability to fulfil duties due to 'floppy mind' and ongoing psychological stress caused by the war led to much psychosocial suffering. Participants lamented their reduced capacity to provide and protect. Rishibalan, a 32 year-old father of two, is emblematic in this regard:

> I lost my characteristics. My worries and memories, losses, and sufferings do not allow me to bring them back. I became anxious. I've become passive. I lost my courage. I lost my adventurous tendency. I cannot make decisions. I am so indecisive. I cannot think clearly and precisely. I cannot properly play the role of man for my family and my community. In the beginning of my arrival in Canada, I could fulfil [a] few duties, especially earning for the family. But I cannot fulfil these duties any longer. I am no longer a provider. War and the impacts of war have made it impossible to accomplish my duties. I used to be so strong. I was not like this in the past (6-9).

3) Redundancy. Another significant source of stress was participants' feelings and beliefs that as men they were no longer relevant or necessary. In Sri Lanka, the men were responsible for the physical, psychological, and economic wellbeing of their family and the wider community. However, in Canada, participants felt that these responsibilities had become redundant. Often this loss of masculine role was attributed to cultural differences between Sri Lanka and Canada. As Rishivan, a 41 year old father of two teenage girls, described:

> My role as a man has shrunk in Canada. I feel that I cannot execute my duties and fulfill my responsibilities as a man. According to Tamil culture, wives and children should follow the husbands/father's guidance and advice. But this is not the case in Canada. My wife and children believe and follow the Canadian culture. They think that my beliefs are inappropriate, older, and unfashionable. What I say and my input makes no difference.

Many participants also described wistfully how they were no longer breadwinners. Similarly many culturally prescribed duties which men routinely perform in Sri Lanka, for example arranging marriages and conducting funeral rites for the deceased, had likewise become redundant in the Canadian context.

Participants also commonly lamented the loss of a valued community role. In Sri Lanka, participants often had respected roles in the community which offered participants a sense of purpose, importance, and contribution. This included valued jobs such as fisherman or farmers, or leadership positions in local organizations. However, in Canada, participants described how their contribution to the community was no longer necessary. As Sivanandrum a 31 year old line cook expressed:

> I want to help the community, but Tamil people in Canada don't need other's help. This is because of economic wealth. Nobody needs anybody else here. It is also a result of the social structure here. In Canada the government fills the duties of men. In Canada men can't make a contribution. There is no place to do good things, even if we want to.

The loss of family and community roles left many participants feeling unnecessary and inconsequential. This significantly affected participant's sense of identity and wellbeing. As Aakesh, a 47 year old father described:

> Men are given important duties and responsibilities in the Tamil community in Sri Lanka. In Sri Lanka, my supportive actions towards my family and community gave me dignity and respect. But in Canada there is less importance given to men. In Canada nobody needs my help. I am definitely not happy about this. There is no importance given to men's role in Canada in the family or in the community.

This eroding family and community role also impacted the men's sense of masculine identity. Referring to his loss of role, Sivam, a 42 year old father explained, "Tamil men can only live in Canada by forgetting their gender." Similar sentiments were echoed throughout the interviews. It was common, for example, for participants to make statements such as "here men cannot behave as men" and "there is no room for men in Canada".

4) Intimate criticism. Many participants reported that their feelings of failure and inadequacy that resulted from their inability to fulfill their family and community duties were greatly exacerbated by negative comments from their wives.

As became quickly obvious to the first author during his fieldwork, gender roles in Sri Lanka are strictly defined. In general, the social realm is that of men and the household realm is that of women. This division could be most dramatically witnessed in the evening when women, adolescent girls, and children retreat indoors and the public streets, parks, and squares become more or less male only spaces. Following these gender norms, provision for the family remains the responsibility of men, while day to day family care is the responsibility of women. During field work in Sri Lanka, the first author noted that it is unusual and often unacceptable for women to be the primary breadwinner in Tamil Sri Lankan culture. These norms are internalized by both men and women.

Cultural gender relations reflect these social roles. This can be clearly seen in the practice of shaming, a common topic of conversation during fieldwork when the first author asked men about their marriages. Shaming refers to a cultural practice whereby a Tamil woman will criticize her husband with the aim of spurring him into greater action. In Sri Lanka, the practice of shaming is associated with the lack of economic opportunity afforded to women. It is widely held that shaming is the central and often only way in which a woman can increase the household's resources or social standing within the community.

Shaming tactics are highly gendered as they are designed to challenge a man's masculinity. A common pattern of shaming was outlined during a field interview in Sri Lanka: First, a wife will personally attack a man directly, questioning his masculinity and ability to provide for the family. If such tactics fail, she will begin to shame him in front of others -

family members and neighbours, claiming that he is more like a woman than a man. If these pressure tactics do not work, the woman will try and eject her husband out of the house and claim to the community that through his incompetence he has forced her to become the man of the household. For a Tamil man to meet such a fate is a cause of great indignity. One participant stated that it is a mark of "tremendous disgrace, not only for the man, but also for his family."

Shaming played a central role in participants' psychosocial experience. Participants explained how their wives, recognizing their low socio-economic status in Canada, would often try to shame the men to earn more money and obtain more prestigious jobs. For many men, the achievement of such goals was impossible, given that their lack of relevant skills for the Toronto labour market (many were farmers or fishermen in Sri Lanka) and some had poor English literacy. This shaming left many men feeling even more emasculated and helpless, greatly exacerbating the feelings of guilt, failure and inadequacy that resulted from being unable to fulfill culturally prescribed duties. Shankar, a 41 year old line cook, describes how his wife criticizes him for not making more money:

> At night when I come home from work my wife criticizes me. She says that I do not work hard and that I am a lazy man. In committing duties and responsibilities, nobody intentionally fails. My wife's criticism aggravates all my guilt and worries. Her criticism wounds me deeply.

Within the interviews, shaming was commonly linked to mental health problems, including alcohol, depression, and suicide. As Bernard, a 35 year old dishwasher explained:

> I lost the respect of my wife as I continue to fail in my duties. She lost trust in me. I am extremely sad when I hear the sentence "Are you a man?" and "Are you a husband?" from my wife. I want to die. I want to commit suicide.

Depleted masculinity

As stated, Sri Lankan Tamil refugee men felt unable to fulfill highly valorized socially prescribed duties in Canada. This was partly attributed to pre-migratory factors, for example trauma experienced during the war. It was also attributed to post-migratory factors, for example lack of relevant labour skills for the Toronto setting.

This inability to fulfil culturally-prescribed duties resulted in a fracture in his masculine self-identity, which grew deeper with each instance of perceived failure. Throughout the interviews, participants described themselves as "incapable", "insufficient", "failed" and "unworthy" men. Participants reported that these negative self-evaluations were often reinforced through shaming by their wives.

The cumulative effect of these experiences can best be summarized as an emotional and psychological state that we describe as *depleted masculinity*. In this state, predominant character traits that men associated with traditional male roles and identity were depleted. This includes self-reliance, psychological strength, sexual virility, providing for the family and contribution to the community. Sometimes, this masculinity was depleted to the point where it was lost completely.

Like other aspects of their masculine identity, participants perceived depleted masculinity through the lens of their duties. As Shivaakan, a 47 year old father and janitor explained:

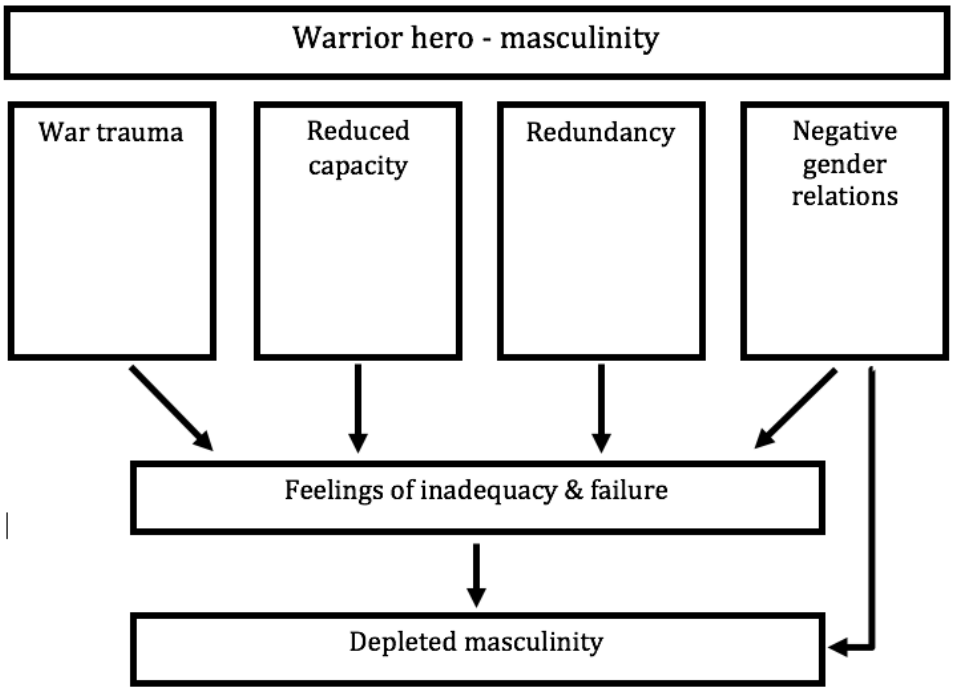
> I have observed that [Tamil refugee] men have lost their qualities as men. They have even lost their sex drives. They have lost all of their motivation, activeness, and involvement with their duties. I too have lost all the motivation to fulfil my duties. I was so supportive and protective of my family during the war, but these qualities have been progressively declining since my arrival in Canada. The only thing I do for my family is attend work. Otherwise I do nothing. Sometimes I feel to leave the house [family]. I do not want to be a father and husband doing nothing and failing in his duties.

The development of depleted masculinity was a progressive phenomenon that was both unwelcome and deeply worrisome. As Anton, a 28 year old cook who was tortured heavily during the war described:

> I realize my failures, but I cannot correct them. I've lost my motivation and desire to fulfil my duties. I do not care to fulfil the needs of my family, even emotionally. I exerted to correct this decline, but I cannot. I am clueless about how to get back to my previous self. I do not know why and how it happened. It is so painful. I fear I cannot bear the agony.

As outlined in this quote, participants often associated the state of depleted masculinity with mental health issues including depression, social isolation, alcoholism and suicidal ideation.

Fig 2. Conceptual model detailing men's Depleted Masculinity



Resiliency factors

The majority of participants could be considered as experiencing a state of depleted masculinity, where they had lost motivation and ability to fulfill culturally-sanctioned masculine roles and duties. A number of participants described how their role as husband, father, and head of the household had become simply "for show". However, a small number of participants discussed activities that they used to help cope with their experience and improve their lives. These included taking long baths, meditation and yoga, and participating in religious rituals. Such activities helped participants to control mental health symptoms through the calming of the body and mind. However, the central coping mechanism that participants outlined involved trying to increase adherence to their perceived familial and community duties. Duties served several therapeutic functions. For example, they offered participants a sense of purpose and meaning, which acted as a hedge against mental health problems. As Sivam, a 31 year old food delivery man explained in relation to suicide:

> Commonly when I'm driving I have a strong desire to drive my car into oncoming traffic and die. My duties and my responsibilities stop me from acting on this thought. I think, 'who is the man if I die?' My death will damage my family. My death will bring grief and pain to my parents. My parents are dependent upon me.

Duties also provided participants with the opportunity to rebuild their masculine identity. In Sri Lanka, work on behalf of the community has a recognized therapeutic quality. It helps men to build both a positive internal sense of masculine identity and his social standing as a 'good man' within the community. This was described to the first author by a member of a local service organization in Sri Lanka who explained why membership in his organization had increased since the end of the war, "this work (on behalf of the community) allows men to feel they are men once again." For participants in Canada, community duties not only helped to rebuild their sense of masculine purpose and identity, but also offered them a much needed

source of self-pride and accomplishment. As Thavam, a 50 year old man whose family was killed in the war explained:

> I run a charitable organization for people affected by the war. We (I and other members of the organization) provide socio-economic assistance to war victims in Sri Lanka. This makes me immensely proud and fulfilled. I believe all the people who seek my support are dependent upon me. They contact me, discuss their problems with me. They ask for my advice, guidance, instructions and support. I provide all of this to them. I empower them. I too feel better. These activities energize me and help with my traumas. Some prefer to call me Dad or Father. I permit and encourage them. This makes me more bound to my duties and responsibilities.

For many participants, work on behalf of the community was the central means they used to help prevent and recover from psychological and emotional difficulties. As Sivam explained:

> Men's adherence to their responsibilities and duties will protect them from developing mental health problems and act as a remedy/therapy to their psychological imbalance. Fulfilling duties and responsibilities may not heal all traumas and sufferings, but it will help to prevent the expansion of trauma or developing deleterious consequences and after effects. It [adherence to duties] will keep you clear about circumstances of family and community. It will give fuel for the individual to function…Men who are strongly committed to their duties and responsibilities to their family and community do not develop deviant behaviors and have more control over their anger towards their families. Occupancy with duties helps men to not develop or reduce these tendencies.

Participants used several methods to help cope with their emotional and psychological difficulties, but they routinely stated that adherence to duties provided the ultimate path to healing and recovery. As Thavam explained:

> Yoga and meditation help me to manage my trauma. It is like applying medication to a wound. It assists to not enlarge my traumas, but these measures cannot heal my traumas. Healing can only take place when I fulfill my duties effectively and completely.

Discussion

Results suggest that participants held culturally sanctioned and socially valued notions of what it means to be a man. This notion revolved around strength, leadership, self-sacrifice, and meaningful participation; in particular fulfilling age-old duties towards family and community. A key finding from this study is that many men reported that they were

consistently unable to live up to those notions, both during the Sri Lankan civil war and after resettlement to Canada. This left them in a state that we label 'depleted masculinity', which had negative impacts upon social functioning and overall mental health.

That participants struggled in this regard is not surprising. The inability to live up to masculine ideals, which O'Neil et al. (1986) labeled *gender role conflict* (GRC) has long been a recognized risk factor for mental health in men. GRC has been associated with poor self-esteem (Cournoyer & Mahalik, 1995); greater risks of depression and anxiety disorder (Heppner & Sharpe, 1991; Good & Wood, 1995), and heightened rates of substance abuse (Blazina & Watkins, 1996). It has also been linked to acculturation difficulties amongst immigrants (Fragoso & Kashubeck, 2000), overlapping with results from the present study.

Cultural consonance

Dressler et al's (2007) concept of 'cultural consonance' dictates that individual well-being is correlated with the degree to which individuals' beliefs and behaviors are consistent with (sub)cultural norms and expectations (Baleiro, dos Santos, Dressler & Ribeiro, 2007). According to Dressler et al. (2007), cultural dissonance results from a mismatch between cultural expectations and individual achievements/ behaviors, sometimes leading to mental health issues. The greater the cultural consensus of a norm, the more strongly cultural dissonance will be associated with its non-fulfillment (Dressler et al, 2007). In other words, a strong mismatch between internalized cultural expectation and actual achievements and behavior can increase mental distress.

As outlined in the introduction, a rigid notion of masculinity centered on fulfillment of duties and self-sacrifice (the warrior-hero ideal) is one of the most cherished cultural norms held in common by Sri Lankan Tamil men (De Mel, 2007; Maracek, 1998). It

could be argued that because it is such a strong cultural norm, this notion of masculinity is ripe for the emergence of cultural dissonance. This may explain why participants found situations in which they could not live up to gender expectations so traumatic. Our findings suggest that cultural dissonance may be high in refugee men, leading to mental distress. Indeed, cultural dissonance could be a testable risk factor for development of mental health issues in this population in future research.

Another surprising finding surrounded the extent to which men were impacted by shaming from their wives. Men's descriptions of being shamed were often accompanied with discussion of depression, alcohol consumption and suicidal ideation. Luhrmann's (2007) theory of social defeat offers insights into the unique impact that shaming had on men. She defines social defeat as "an actual social encounter in which one person physically or symbolically loses to another" (p. 151). Luhrmann argues that demoralization, internalized stigma and helplessness are subjective consequences that are consistently re-experienced when an individual has experiences that he or she interprets as defeats.

Constant shaming could be considered repeated 'social defeats'. Shaming was both a primary trauma, in that it made participants feel helpless and weak, and a compounding stressor in that it greatly exacerbated the feelings of masculine failure and inadequacy that resulted from other instances in which men could not fulfill socially desirable masculine roles.

Learned helplessness theory can also offer insights into the development of the state that we labeled 'depleted masculinity'. Learned helplessness (Seligman, 1975) occurs when an individual experiences repeated aversive stimuli over time, which they cannot control or avoid. Evidence suggests that this can lead to a state of passivity or helplessness, and has

been linked to a number of mental disorders, including depression (Abramson, Alloy & Metalsky, 1989) and PTSD (Foa, Rothbaum & Steketee, 1989).

A pattern of learned helplessness could clearly be seen in our findings. As was detailed in the interviews, participants experienced countless macro and micro-defeats, both during the war and upon resettlement. Participants often experienced these as failures of masculinity and (thus) deep humiliations. Depleted masculinity resulted from the cumulative effect of these micro-defeats. These repeated experiences of failure and humiliation eventually resulted in a loss of characteristics participants associated with masculinity. These included physical and emotional strength, sexual potency, and concern for the wellbeing of their families.

Social defeat and learned helplessness theory offers insights into the nature of the men's experience and the development of depleted masculinity. However, as Whitley (2011) points out, instances of social defeat often engender a reaction of what he terms 'social resistance'; this involves consciously engaging in activities which promote empowerment and resilience.

Indeed, in the earliest stages of the research, we coded our notion of depleted masculinity as 'defeated masculinity'. This was one of the working hypotheses arising from an interim analysis (an integral part of our grounded theory approach). Indeed at that time, 'defeated masculinity' was an accurate description of the state experienced by the majority of participants. However, the code was changed in the light of later data collection and analysis.

It was decided that "defeated" suggests a type of finality and permanency that did not reflect the resiliency demonstrated by some participants. These participants used Tamil masculine norms (for example, fulfillment of family and community duties) to rebuild their

masculine identity and improve their mental health. Indeed this can be interpreted as that valiant, dynamic form of "social resistance" described by Whitley (2011). As such, some participants could be considered resourceful resistors, rather than passive victims of "social defeat".

Public health and health service implications

The study has numerous implications for public health and health services. They suggest that a constellation of individual-level, family-level and societal-level factors interact to produce a state of 'depleted masculinity' and associated mental health difficulties.

The results imply that holding onto traditional notions of masculinity can be detrimental to the mental health of refugee men. Likewise, idealized and overly strict gender norms may have other socially undesirable consequences. For example, they may limit women's ability to fulfill their own potential and economically contribute to the household. They may also prevent men from engaging in potentially rewarding roles such as child rearing or caregiving.

Helping refugee men revise notions of masculinity could thus be considered an important public health intervention. Campaigns or interventions could make visible the dangers of idealized masculinity and offer alternative versions of manhood that are not built upon rigid definitions such as protecting, providing and leading. Such campaigns should not only target refugee men, but also women and members of the wider sub-culture, who sometimes encourage and reproduce idealized (and harmful) gender norms. Efforts could be made to raise awareness about the damage done to refugee men by female to male shaming.

With regards to the host society, much evidence suggests that immigrant and refugee men (and women) have difficulty achieving meaningful functional roles (Este &

Tachble, 2009; Lowe, Mahlik & Nghe, 2003). For example, many immigrants live on a low-income, due to unemployment or under-employment. Indeed this was the case with our sample. This means that they may be experiencing financial strain, or that they may lack the purpose and meaning which many people derive from a fulfilling and satisfying professional life. All this can be detrimental to mental health. As such, offering opportunities for meaningful participation in society could thus be considered a public health intervention in this group. Such meaningful participation (for example gainful employment) overlaps considerably with participants' notions of desirable masculinity.

Indeed, participants stated that rebuilding their masculine identity through increased adherence to masculine ideals of "duties" was the most successful strategy for overcoming their traumatic experiences during the war. This often involved meaningful work and community leadership. This overlaps with Gross' (2009) findings that realignment with masculine ideals of courage, strength, and altruistic self-sacrifice helps Sri Lankan Tamil men to cope with their traumatic experience.

The impact of war trauma on participant mental health clearly suggests a role for formal mental healthcare. Biomedical and psychosocial interventions can help reduce symptoms of depression, anxiety and PTSD, and have proven successful with Tamil populations, both in Sri Lanka (Somasundram, 2014) and in the diaspora (Beiser et al., 2011; Beiser, Pandalangat & Simich, 2003). Educational and de-stigmatization campaigns may help make more Sri Lankan Tamil men aware of the availability and efficacy of such interventions.

However, as in other areas of cross-cultural mental health care, it is vitally important that Western psychological interventions support, rather than replace, indigenous coping and resilience practices (Kirmayer, 2004). Our findings suggest that improving refugee

men's mental health must involve *reviewing* and *rebuilding* masculinity, based on positive models that emphasize contributing to family and society, and participating in valued social roles such as gainful and meaningful employment. Indeed, many aspects of traditional Sri Lankan gender norms correspond with valued roles in Canada (Ryde & Vitale, 2015). This includes working hard, providing for the family, and contributing to the community. Health and social services could harness these norms to help ensure refugee men integrate, flourish and thrive.

Implications for the field of men's studies

Gender-focused research on men emerged in the 1970s, largely as a response to the feminist movement. This early men's research took two broad forms. The first was the mythopoetic movement. This was a strength-based approach in which traditional masculine norms and ideals were considered to be virtuous. It promoted and celebrated attributes such as productivity, camaraderie, protection, provision, and leadership (Moore & Gillette, 1991). This approach is reflected in popular books such as Robert Bly's *Iron John* (1990) and Robert Moore and Doug Gillette's *King, Warrior, Magician, Lover* (1991).

The second group of men's scholars and activists aligned themselves with the women's movement and adopted an explicitly feminist perspective in their approach to men's studies. Feminist men's scholars were deeply influenced by critical Marxism, and saw normative masculine ideals as both the manifestation and the root causes of corrupt social structures such as colonialism and capitalism (Coltrane, 1994). Feminist men's scholars were highly critical of the mythopoetic men's movement, who they accused of furthering the traditional masculine norms and ideals, which they held responsible for the domination of women, gays, and minorities (Coltrane & Hickman, 1992; Kimmel, 1994).

Perhaps nowhere was the ideological difference between the two approaches to men's studies more apparent than in the study of men's mental health. The mythopoetic movement, which was largely spearheaded by psychologists working directly with men, saw traditional masculine norms as protective factors in men's mental health and wellbeing, while feminist men's scholars saw them as destructive.

Over the past 30 years, with support of the media, government, feminist activists, and the dramatic rise of post-modernism in universities - including in psychology - feminist men's studies have come to dominate. The handful of scholars pursuing the mythopoetic approach to men's studies have quietly disappeared or been relegated to the margins.

Feminist Men's Mental Health Research

There are two central philosophical assumptions that underpin feminist men's studies, which, beginning in the 1990s were applied to mental health. First, that Western society, and indeed every society around the world, is a patriarchy. As such, in any given group, men hold the power, and therefore are less vulnerable than women. This is the foundational argument that lies at the heart of the work of feminist men's scholars such as Michael Kimmel (1987) and Michael Messner (1992).

The second, philosophical assumption is that "normative" or "hegemonic" masculinity is inherently corrupt (violent, competitive, oppressive) and is mentally destabilizing and unhealthy for individual boys and men (Connell & Messerschmidt, 2005). This tenant underlies the work of feminist men's mental health scholars such as Joseph Pleck (1995), Jim O'Neil (1981) and Will Courtenay (2000).

These positions are not unreasonable. There are still some segments of our society where men hold the advantage. Likewise, research has implicated traditional masculine ideals such as material success, stoicism, and self-reliance in the development and response to mental health issues in men (Bennet & Jones, 2006). To this end, feminist men's scholars have made important contributions to the field of men's mental health.

However, these assumptions are also problematic, as a result of the conceptual function that they serve. These assumptions provide the organisational framework through which men's mental health issues are viewed. Like all conceptual lenses, these assumptions direct the gaze to include examples that fit their frame, and exclude those that do not. For example, as I discussed in chapters 2, 4 and 5, the use of patriarchy theory can lead to men's vulnerabilities being overlooked, or worse disbelieved (See Michael Kimmel's 2013 book Angry White Men). Likewise, the assumption that traditional masculinity is inherently detrimental to men's mental health can result in the beneficial aspects of traditional masculine norms and ideals being overlooked.

Many of my findings in this thesis align with feminist, or mainstream understandings of men's mental health. For example, traditional masculine norms and ideals surrounding provision and protection led participants to expose themselves to a disproportionate amount of war trauma. Similarly, in line with O'Neil's theory of male gender role strain (1981), the inability to live up to traditional masculine ideals was clearly implicated in the development of the state that I labelled depleted masculinity.

However, there are a number of findings that do not align with these assumptions of feminist men's scholars. For example, my participants used increased adherence to traditional masculine norms as the central strategy to help them cope with their

emotional/psychological issues. This contradicts the central assumption of feminist men's scholars who view traditional masculine norms as inherently psychologically destructive (Courtenay, 2000). Similarly, the fact that my participants used traditional masculine activities as a means of bonding with other men, and increasing their social support, contradicts the position of feminist men's mental health scholars that hegemonic masculinity breaks down rather than promotes social relationships between men (Kimmel, 1997; Phillips, 2006).

These findings point to limitations of the feminist approach to men's mental health, namely the failure to see the emotionally/psychologically beneficial aspects of traditional masculine gender role, and the limitations of patriarchy theory in the study of men's health. More broadly they speak to the value of taking the strength-based rather than the deficit-based approach to men's mental health that is promoted by feminist men's scholars. In so doing, my findings give tentative credence to the idea, first promoted by the mythopoetic men's movement, that if properly channelled, traditional masculine norms can be a source of wellbeing and psychological strength.

Thesis Conclusion

As outlined in the introduction, and reiterated throughout this thesis, men's mental health is deeply gendered. Various masculine identities and roles are implicated in development and course of mental illness, as well as their response to this distress. This project was born out of a simple desire to understand and document civilian men's experience of war-trauma, which, upon initial review, appeared to be overlooked in the literature. Looking back, I could have never have foreseen the depth and complexity of this seemingly simple oversight.

This thesis outlines how gendered social norms, institutional policies, and the motivations of different powerful actors combine to render psychologically/emotionally vulnerable men invisible. This is perhaps nowhere more obvious than in the case of refugees, as the various chapters of this thesis outline.

As Said (1978) and other post-colonialist scholars so well documented, representations of the Other made by those in positions of power reside more in the motivations of the representor rather than in any type of reality. The more vulnerable a population is perceived to be, the more justified outside protection and interference appears. Just like Orientalists before them, accentuating the vulnerabilities of women has advantages for Western actors, including mental health researchers. These representations allow actors to confirm their worldview and justify their work on behalf of the "Other" to themselves and their in-group community.

Numerous scholars have already critiqued the rhetorical inconsistency of this gendered storyline within humanitarianism (Jones, 2000; Lindsey, 2001). Others have discussed the limiting effect that it has on women, pointing out that it denies women agency and reinforces the image of women as helpless victims of external circumstance (Cornwall,

2013). Much less attention, however, has been paid to the impact that the gendered storyline on refugee men.

As this thesis has outlined, at every level, from intuitional ethics policies, to research, to the targeted marketing directed towards a general audience, civilian men are conceptually positioned in such a way as to confirm- or in some cases accentuate - the vulnerability of women. The impact of such representation can been devastating. Men can be- and often are- conceptualized as being 'non-vulnerable' or worst, not deserving of attention and resources. This may help to explain why civilian men are so under-represented in refugee research. It may also explain why, despite experiencing the highest level of violence, interpersonal and systemic discrimination, and rates of acculturation difficulties, there are virtually no gender-sensitive interventions targeted towards to refugee men.

Following Duncan's criteria for a successful project, in this thesis I have sought to make a theoretical, methodological, and empirical contribution. Chapter One offers an over-view of social determinants of men's mental health. This is the first review paper written on this topic, and will help to introduce clinicians and researchers to the main social factors implicated in men's mental health. This article has been submitted to *The Canadian Journal of Psychiatry*.

Chapter Two outlines how the vulnerability of male survivors of trauma are overlooked in research ethics and outlines steps that researchers take to help mitigate their potential vulnerabilities. This paper will help psychiatric researchers recognize the impact of social gender norms and institutional guidelines on the conceptualisation of vulnerability. It also introduces the "Integrative Functional Account" as a tool for assessing vulnerability in human subject research. This paper helps protect male research participants in future traumatic

stress studies, and mental health research more generally. This manuscript has been submitted to the journal of *Accountability in Research,* a top ranked journal in the field of Medical Ethics.

Chapter Three also makes an original contribution to the field of psychiatric ethics. Following from a misunderstanding of the ethical guidelines, traumatic stress researchers/ethicists are attempting to offset their studies with benefits that are not of a moral standard to do so. This has resulted in inaccurate risk assessments. By following Weijer's (2000) Component Analysis Approach to risk assessment, participants in traumatic stress studies can be more adequately protected. This manuscript has recently been published by the journal of *Accountability in Research.*

In the first empirical contribution of this thesis, Chapter 4 quantifies the large under representation of men that exists in the gender-focused refugee literature. This article has recently been published in *Intervention*, a leading journal in the field of global mental health. Along with offering me valuable experience conducting systematic reviews, this study makes an important contribution to the field of humanitarian and refugee studies. According to one reviewer, the paper was "urgently needed". This study identifies and important gap, and will help researcher's seeking to better understand refugee men to help justify future research in this area.

Chapter 5 likewise makes an important empirical contribution. Using a slightly modified search strategy from Chapter 4, this chapter outlines how use of rhetorical representational strategies found in gender-focused refugee research follow the same patterns of "Othering" that Said (1978) first outlined in regard to European colonialism. A number of scholars have drawn parallels between global health research and colonialism. This chapter identifies the rhetorical strategies of demasculation and the use of gender stereotypes as

specific mechanisms through which colonial pattern is perpetuated. This article can give investigators and policy makers an understanding of how gendered representations of the "Other" can contribute to unequal power relations, and is currently in revision with the journal *Transcultural Psychiatry.*

Lastly, Chapter 6, the central study in this thesis, makes a number of important contributions. First, it identifies masculinity as a central feature of Sri Lankan Tamil men's trauma and refugee experience. As the study outlines, masculinity acts as a conceptual framework, providing a lens through which men experience war-trauma and resettlement stress. Masculinity also provides a moral framework, outlining how men should respond to these various traumas and stressors. By better understanding the role that masculinity plays in Sri Lankan Tamil men's refugee experience, clinicians and policy makers can design gender-sensitive interventions that are more effective for this population. They will also be able to attract more men to mental health services.

This study was also the first to discuss the role that gender-relations play in refugee men's experience. This study will help raise awareness of the psychological and emotional consequences of traditional shaming practices. It will also help raise awareness about how idealized masculinity is encouraged and reinforced within personal relationships, and the consequences this can have on individual's and family wellbeing.

Next, this study is the first to outline the state that we call 'Depleted masculinity", which for many participants was the most troubling and difficult aspect of their experience. Recognition of depleted masculinity may offer Sri Lankan Tamil refugee men a culturally relevant pathway to mental health care, and help psycho-social programs to attract and retain refugee men. It may also be a measurable outcome for this population.

Finally, there is a dearth of studies that address resiliency factors in refugees (Beiser, 2011). This study details how, in the aftermath of trauma, Sri Lankan Tamil men rebuild their masculine identity through increased adherence to their community and family duties. This strategy can be found both in Sri Lanka and refugees in Canada. By incorporating such coping strategies into mental health interventions, clinicians and policy-makers can not only create more culturally appropriate and effective interventions, but they can also help refugee men integrate and flourish in their host society.

The astute reader might pick up upon a conceptual gap in my research. According to Duncan, a successful project is one that makes a theoretical, empirical, and *methodological* contribution. So far, I have only discussed the first 2 criteria. However, this study also innovates in terms of methodology. To my knowledge, this is the first study to undertake an in-depth ethnography in the refugee's home country prior to the conducting interviews with resettled refugees in a host country. The understanding of the participant's cultural background prior to conducting the interviews was essential for understanding the nuance of the participant's experience.

This study also advances action research designs. By undertaking PAR approach in two different phrases of the research, this study allowed for maximum stakeholder input in the research design, data collection, and significantly increased local research capacity in both Canada and Sri Lanka. It also paves the way for culturally appropriate translation of the knowledge that this study produced, which will take place both in Canada, and hopefully in Sri Lanka.

Community Contributions

Outside of the contribution to knowledge, there are a number of positive outcomes that resulted from this project. First, I was able to train 4 undergraduate students and 1 CEJEP student in the basics of academic research. These students helped with Chapters 1, 3, & 4. I was able to publish with three of these students and one received academic credit.

Second, through the use of a PAR design, I was able to train colleagues both in Sri Lanka and in Canada. I was able to publish with two of them (U.T. and J.J). Along with increasing local research capacity, this also helped my colleagues professionally. In fact, through his work on this project, my main trainee, Dr. Umaharan was able to obtain a position of research psychiatrist at the University of Jaffna.

Finally, this project resulted in an important international collaboration. My PhD research was interrupted in 2014 when I was unable to return to Sri Lanka. While this was devastating at the time, it turned out to be a blessing in disguise. Dr. Umaharan who I trained as part of Phase 1, was able to continue the project, and Dr. Daya Somasundran, a leading research psychiatrist at the University of Jaffna, agreed to act as local supervisor. So far 25 interviews have been completed and are currently being transcribed. Not only will this project help to build the knowledge base about the psycho-social experience and needs of Sri Lankan Tamil men, it will also allow for an interesting comparative study of how the experience of those men who arrived in Canada as refugees aligns/differs from men who remained in Sri Lanka.

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