# "I WOULDN'T TELL THEM ANYTHING PERSONAL":

# WOMEN'S EXPERIENCES OF PSYCHIATRIC INTERVENTION

by

Jacqueline S. Coates

B.A., University of Toronto, 1990

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in the Department

of

Women's Studies

© Jacqueline S. Coates 1997

SIMON FRASER UNIVERSITY

December 1997

Canada

# Approval

Name:                 Jacqueline S. Coates

Degree:               Master of Arts (Women's Studies)

Title of thesis:      "I Wouldn't Tell Them Anything Personal":  Women's Experiences
                      of Psychiatric Treatment


Examining committee

      Chair:         Dr. Jacqueline Levitin
                      Associate Professor:  School for Contemporary Arts
                      and Women's Studies




                      Dr. Meredith Kimball
                      Senior Supervisor
                      Associate Professor:  Psychology and Women's Studies
                      Simon Fraser University




                      Dr. Arlene McLaren
                      Second Supervisor
                      Associate Professor:  Sociology/Anthropology
                      Simon Fraser University



                      _____

                      Dr. Susan Penfold
                      External Examiner
                      Professor:  Psychiatry
                      Faculty of Medicine
                      University of British Columbia

                      Date Approved:  _December 4, 1997_

# Abstract

Psychiatry continues to play a unique role in the oppression of women, not simply as an overt method of social control as in involuntary hospitalization, but also as a seemingly benevolent institution to which women can turn for help when overwhelmed with the oppressiveness of their daily life as women. The dominance of the biological model of psychiatry ensures that women who are turned in, or turn themselves in, for psychiatric treatment are interpreted through a lens which seeks to diagnose and treat biologically-based mental illnesses with physical treatments such as psychiatric drugs and electro-convulsive treatments. The oppressive living conditions of women are rendered invisible in the process of psychiatric diagnosis and treatment, leaving psychiatrically treated women with the same living conditions with which they entered treatment, and additionally with the damages caused by labelling and stigmatization, drugging, incarceration, and shock treatments.

Twenty-four women were interviewed about their experiences of psychiatric treatment. The women were interviewed in the Lower Mainland of British Columbia, an urban centre in Saskatchewan, and an urban centre in Ontario. The interviews revealed experiences of psychiatric treatment not only in these three provinces, but also in Manitoba and Quebec. The interview guide featured both open-ended and closed-ended questions in an effort to explore the women's experiences of psychiatric treatment and their perceptions of the psychiatric system and its impact on their identity. The results emerged as a number of themes which have been organized into chapters of this essay: the biological focus of psychiatric ideology and practice; how the women first encountered the psychiatric system; the ways in which psychiatric treatment was experienced as ineffective, harmful, or positive; and the women's expressions of resistance to the psychiatric system and their visions of alternative services which would better support and promote healing for women in crisis. The women's stories and experiences are discussed primarily in relation to feminist and antipsychiatry literature.

This work is dedicated to

Jean


a lesbian feminist therapist,

a wise woman,

and my first model

of psychiatric survival

Lately I've become more aware of how society responds to women who are angry. They fear it and they fear us. So they drug us, lock us up, react to us with threats and violence, ignore us, and tell us we are crazy. They make us crazy, they make us more depressed, they make us deny our truths and fear ourselves. They reinforce our abuse from others and self-abuse. They try to make us weak so that we can't speak up.

I think it's because women are so powerful.... Believe me, they will never get me back into one of those hospitals or drugged out of my mind as they did a few years ago. My sisters and I are becoming way too strong for that and we help each other.

(Angel Anne Lowen, study participant, letter 1995)

**Table of Contents**

# CHAPTER ONE

## Introduction

For women, psychiatry institutionalizes the divorce of feeling from doing.

(Smith, 1975, p. 110)

Dorothy Smith's words quoted above summarize the unique way in which psychiatry as a social institution operates with the effect of controlling and dominating women. Women are controlled by psychiatry not only in obvious ways, such as when a woman is hospitalized against her will, but more insidiously by the ways in which psychiatry both prescribes normal behaviour and promises relief for emotional and social problems living in the world. Women who *do* something about how they *feel*, depending on their actions, may be controlled by the criminal justice system in a more overtly punitive way, often with help from the psychiatric system as well. But the psychiatric system also acts as a net in which to catch the emotional casualties of living with oppression, with the effect of producing a paralysis of action. As Smith writes, " it appears to do so as a routine maintenance activity, picking up and organizing as its problem a socially structured situation in which doing is radically restricted and feeling has nowhere to go" (p. 110).

Although individual patients have resisted psychiatry throughout the history of psychiatry,[1] organized resistance to the social control powers and practices of psychiatry began in the 1960s with the antipsychiatry movement, followed shortly by the second wave of feminism in the 1970s. I became motivated to research and write about women's experiences of the psychiatric system out of my own experiences working inside a psychiatric research hospital in Ontario. I was alarmed at the situations I witnessed and what seemed to me a diminishing attention from feminist activism and scholarship to the oppression of women by psychiatry. Although there have been noteworthy feminist texts published

since Chesler's (1972) book, *Women and Madness* (for example, Penfold & Walker, 1983; Ussher, 1991; Russell, 1995) these works seem few relative to the importance of the issue. Rather than open floodgates of feminist analysis of psychiatry, Chesler's work appears to have been taken as a definitive work on women and psychiatry. I have had the experience on more than one occasion of discussing my topic of research with someone only to be asked, 'but has this not already been done?' Such a response seemed to imply either that Chesler's work, although now a quarter of a century old, says everything one could want to know about women's relationship to psychiatry, or that the psychiatric system has become so legitimately scientific and non-oppressive that its relationship to the oppression of women is no longer in question.

Given my experience working in a psychiatric hospital where I was able to witness the daily life of the institution, the issues involved with women's relationship to psychiatry screamed out (at least in my mind) for feminist attention. It seemed to me that de-institutionalization and the corresponding emphasis on biological origins and treatments for 'mental illness' has had an effect of muting public criticism of psychiatry, which consequently appears both more scientific and more humanitarian. In many respects, psychiatry successfully presents itself as unchallengable, its authority and expertise as indisputable as surgery, radiology, or any other area of medical specialization.

During the time I worked at the hospital, I read everything I could get my hands on about women and psychiatry and volunteered at the Women's Counselling, Referral and Education Centre (WCREC) in Toronto, where as a telephone counsellor I tried to assist women to access feminist or non-sexist counselling and community support services. A persistent problem we encountered at WCREC was how to find counselling services for 'ex-psychiatric' women, who could not afford to pay for private psychotherapy and most often were turned away by feminist therapists who stipulated that they did not want such women as part of their counselling practice. Because it seemed an impossible feat to help keep these women out of the psychiatric system, many telephone counsellors supported

these women in a continuing way, although this was beyond the capacity of the organization, trying their best one day at a time to fill a gap in services we soon recognized to be a chasm.[2]

Getting to know the issue of women and psychiatry from the perspective of a service provider left many questions unanswered in my mind. The point of view of feminist service providers is well represented in feminist works on women and mental health (Chesler, 1972; Penfold & Walker, 1983; Ussher, 1991; Kitzinger & Perkins, 1993; McLellan, 1995). More rare are studies which attempt to represent the point of view of women patients,[3] although autobiographical writings by women patients are becoming more common (Blackbridge & Gilhooly, 1985; Millett, 1990; Capponi, 1992; Grobe, 1995; Shimrat, 1997) and often are more closely connected to the antipsychiatry movement than to the women's movement. It was this theoretical gulf which I sought to bridge in conceptualizing this project, using both feminist and antipsychiatry thinking to inform my analysis and beginning from the feminist premise that the personal is political. I wanted to know and document, in women's own terms, the experience of psychiatric treatment. I hoped that as more of a feminist sociologist than a mental health professional, I could position myself as an ally to women patients and that women would trust me with their stories. I believed that the standpoint of women patients was significantly different than that of feminist mental health professionals, and that beginning from the perspective of women patients would yield different, and arguably more comprehensive, information.

With this intent, I set out to interview women who were or had been patients in the psychiatric system.[4] I wanted to ask them questions about their life experiences, their experiences in psychiatric treatment, and their perceptions of themselves and the institution of psychiatry -- questions I would have liked to have been able to ask of the patients I knew at the institution in which I worked. My framework was intentionally broad so that I could capture whatever information and perspectives women patients shared with me. Some of the research questions which propelled this work forward were: Does the category of 'mental illness' adequately describe women's emotional distress and/or

3

problems in living? How do women labelled 'mentally ill' perceive themselves and the institution of psychiatry? How adequate is the current state of feminist theory to account for the experiences of contemporary psychiatrized women?

Two bodies of thought bear most directly on the relationship of women to the psychiatric system: those of feminist and anti-psychiatry theory respectively. While each volume of work relies in minor ways on the other for reference points, essentially the two lines of thinking have developed separately but concurrently over the past twenty-five years. Both have made important contributions to an understanding of the social control functions of psychiatry, but few writers bridge the divide between anti-psychiatry and feminism. Two works which I regard as exceptions are Bonnie Burstow's *Radical Feminist Therapy* (1992) and Jeffrey Masson's *A Dark Science: Women, Sexuality and Psychiatry in the Nineteenth Century* (1986), each written by mental health professionals who radically critique the institution of psychiatry, unflinchingly document its abuses, and position themselves as allies to psychiatric survivors. Each of these works, however, has more in common with anti-psychiatry than feminist thought in the respect that they reject psychiatry outright as a useful resource for anyone. Feminist theory has tended to be less absolute in its convictions about psychiatry, leaving open, indeed often affirming, the possibility that psychiatric treatment is appropriate for some individuals who are regarded as 'really mentally ill.' For example, even Kitzinger and Perkins (1993), feminist theorists who take the unconventional stance of rejecting psychology, including feminist therapy, promote psychiatric intervention as necessary for women they see as 'socially disabled' and 'worlds apart' from other women.

The ambiguity of feminist theorists' criticisms of psychiatry combined with a neglect of the analyses of psychiatrized women as truly expert on women and psychiatry has led some psychiatrized women to ally themselves with the anti-psychiatry movement and to critique feminists as ultimately

more aligned with mental health professionals. As Judi Chamberlin writes in criticism of Chesler's

*Women and Madness* (1972):

> What makes me most angry now is that she separated us into 'genuinely mad women' and 'women who are hospitalized for conditioned female behaviour', and then proceeded to tell us which is which and what we should do about it. I guess the genuinely mad, those of us who are 'truly' schizophrenic or manic-depressive or whatever, should take our medication and do what we're told, while feminist therapists go about their good work of liberating the others, leaving us to languish in the institutions or in drug-induced stupors (1994, p. 285).

Phyllis Chesler's response to Chamberlin exemplifies a tendency for feminist mental health

professionals to dismiss the analyses of psychiatrized women, as she characterizes psychiatric

survivors as "unstable, fragile, demanding, destructive, easily excitable, given to sudden

disappearances, or rage, and very, very, needy" (1994, p. 301) -- in short, too crazy and too properly in

need of psychiatry to be useful to political struggle.

The anti-psychiatry movement is largely comprised of former psychiatric patients and their

mental health professional allies who are critical of the psychiatric system. Much of the body of

literature identified with anti-psychiatry is testimonial in nature, written by women and men who have

been locked up, drugged, and shocked against their will. Many anthologies of these kinds of writings

have been published (Burstow and Weitz, 1988; Grobe, 1995) along with extended autobiographical

accounts (Millet, 1990; Capponi, 1992), and most recently a collection of interviews with activists in

the 'mad movement' combined with autobiography (Shimrat, 1997). Central to anti-psychiatry

thinking are the writings of mental health professionals who have 'defected' (Breggin, 1994, 1991;

Burstow, 1992; Masson, 1990, 1986; Szasz, 1974, 1963) and use their expertise to expose the

oppressiveness of psychiatric practices and the fallacies of psychiatric thinking. A central tenet of anti-

psychiatry thinking is Thomas Szasz' concept (1974) of mental illness as a metaphor rather than

anything akin to physical illness. As mental illness is diagnosed through behaviour rather than physical

symptoms and does not produce lesions which can be seen under a microscope, Szasz argues that what

is diagnosed as mental illness is more properly described as moral problems in living. As such, anti-

psychiatry activists assert, madness is part of the human condition, particularly as a response to

experiencing oppression, and has no place being categorized as an illness and controlled by medicine.

5

Feminist theory, meanwhile, has identified a number of important premises regarding the relationship of women to the psychiatric system in Western cultures. The practices by which women and men are diagnosed, relegated to particular psychiatric settings, and psychiatrically treated indicate gendered patterns. Women clearly predominate in some diagnostic categories (eg. mood disorders and some personality disorders), men predominate in others (eg. substance abuse disorders, sexual disorders, and other personality disorders) and in some there is no significant gender difference. Some statistics indicate that a clear majority of those diagnosed and treated as mentally ill are women (Ussher, 1991, p. 163; Chesler, 1972, pp. 312-318; Gove and Tudor, 1973). Dorothy Smith's analysis of Canadian statistics on women and mental illness (1975, pp. 73-111), however, cautions that statistics must be read carefully in a way which includes consideration of the means by which statistics are produced. Smith's reading suggests that the numbers of women and men receiving psychiatric treatment are more balanced when the diagnostic groups of substance abuse and more clearly organically based disorders (eg. dementia, head injuries) are included as psychiatric disorders. She reveals that women's psychiatric treatment clusters more in general hospital wards and outpatient treatment, thereby suggesting that psychiatric treatment tends to disrupt the everyday functioning of women less dramatically than the psychiatric treatment of men.

If it is true that more women than men wind up in psychiatric treatment, the phenomenon seems to suggest three possibilities. First, researchers have considered that women may actually experience more emotional, mental, or social distress because of the stress of living in conditions of oppression (Gove and Tudor, 1973). Comparable research has demonstrated a correlation between social class and both mental and physical illness, indicating that the stress of living in poverty is an important contributor to the development of distress which becomes defined as mental disorders (Kleinman & Cohen, 1997, p. 87; Coutts, 1995). Internationally, the most recent research suggests that the rates of particular disorders vary dramatically from country to country. For example, the relationship between gender and both suicide and schizophrenia are completely different in China than in Western countries. The suicide rate in China is twice that of the United States, with suicide being most common among rural women, while in China the rate of schizophrenia is seventy-five percent

6

higher among women (Kleinman and Cohen, 1997, pp. 87-88). This type of cultural variability suggests that, far from mental disorders having a simple biological causality, people display particular symptoms in relation to the social conditions in which they live.

Second, feminist theorists have engaged the question that women may manifest psychiatric symptoms as a form of social protest (Ussher, 1991, pp. 88-92; Ehrenreich & English, 1978, pp. 133-140). Feminist historical work has illustrated the ways in which the treatment of classic female 'diseases' such as hysteria, anorexia nervosa, and 'nervousness' became "a microcosm of the sex war intended to establish the male doctor's total authority" (Showalter, 1985, p. 137), and women's symptoms could be interpreted as a refusal to live according to their ascribed gender role. As Ehrenreich and English summarize, "Doctors had wanted women to be sick, but now they found themselves locked in a power struggle with the non-so-feeble patient." (p. 137). Psychiatrists and doctors alike responded to nineteenth-century women's symptoms with a type of warfare against women's bodies designed to break women's spirits. Practices such as clitoridectomy, cauterization of the clitoris, and removal of the ovaries were common-place medical responses to women diagnosed as hysterics (Masson, 1986; Mitchinson, 1991; Showalter, 1985).

Third, feminist researchers have theorized that women are more likely to be targeted for psychiatric treatment because of gendered expectations. One study (Broverman *et al*, 1970), for example, found that mental health professionals equated psychologically healthy adult characteristics with attributes they considered characteristic of healthy men. The qualities expected of women in order to be considered feminine (eg. passivity, altruism, dependence) were not regarded as desirable for psychologically healthy adults. In this respect, women are thrown into a double-bind, pathologized both for following gendered expectations too closely and for rejecting them too vehemently.

Feminist theorists have also identified a way in which Western culture has produced an ideological association between madness and femininity, an assumption that madness is produced somehow intrinsically by women's bodies. As described above, feminist historical work has revealed the ways in which nineteenth-century medicine and psychiatry were obsessed with locating a connection

between women's madness and women's sexual and reproductive organs (Ehrenreich and English, 1978; Mitchinson, 1991; Masson, 1986; Showalter, 1985). Pre-menstrual syndrome can be seen as a more contemporary manifestation of this inclination. Despite feminist opposition (Caplan, Meyers and Gans, 1992; Kendall, 1992), Pre-menstrual Dysphoric Disorder has been included, albeit in the appendix, in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Feminist thinkers continue to critique psychological assumptions that women are inclined toward wild mood swings and unstable behaviour during normal biological processes, such as pregnancy, lactation, and menopause (Russell, 1995; Ussher, 1991).

Feminist theories on the relationship between women and psychiatry tend to position a rather monolithic category of 'women' which does not adequately account for differences between women based on the complexities of race, class, and sexual orientation. As with other feminist theory which does not critically examine gender in relation to other elements of women's identities, feminist thinking on women and psychiatry bears the limitation of speaking from the perspective of white, middle-class, heterosexual women, rendering the experiences and analyses of other women invisible. It remains for feminist theory to examine the types of relationships which particular groups of women experience with psychiatry, for it cannot be assumed that feminist work to date on this issue can speak for all women. Other studies which reflect women's experiences with the psychiatric (or medical) system have generally not addressed differences between women, nor do they note which women have participated in generating the resulting data.[5] Some studies have deliberately created homogeneous samples, such as the sampling criteria used for a study on women diagnosed as schizophrenic in the 1950s (Warren, 1987) which required that women be white, married, between the ages of twenty-six and forty, and with at least one child living at home (p. 5).[6] My own study shares the limitation of speaking again almost entirely from the experiences of white women raised mostly middle-class; however, the significant numbers of study participants who defined their sexuality as other than heterosexual gives this study the potential to illuminate the experiences of lesbian, bisexual, and celibate women.

The chapters which follow speak in favour of bringing together feminist and anti-psychiatry modes of analysis, and taking as a starting point the experiences of psychiatrized women. When

feminist theory operates from its own conviction that the personal is political, it must begin from the experiences and authority of women who have experienced psychiatric treatment. Perhaps it is lack of attention to this basic premise which has led feminist theory astray: that the unproblematized beginning point instead has generally been the standpoint of feminist mental health professionals. As Lilith Finkler writes:

> Who assumed that those who live a particular oppression are unable to theorize its existence? Are women unable to engage in feminist theory? Should lesbians not analyze heterosexism? Or is it that psychiatrized women, in particular, are inadequately prepared for the intellectual rigour of an academic milieu? (1993, p. 72)

Although as a researcher I am in the uncomfortable in-between place of being neither a mental health professional[7] nor a woman who has been a psychiatric patient, I have tried throughout this work to position myself as an ally to women who have experienced psychiatric treatment and to begin my enquiry from a place of listening to and honouring their experiences. The analysis which emerges, however, is of necessity my own and will unavoidably disagree in places with the perspectives of individual women I have interviewed. I have tried to expose these sites of disagreement, when I have become aware of them, so that readers may gather a more complete picture and reach their own conclusions.

The image which emerges through the stories of the women interviewed for this project is largely one of women who are deeply unhappy or enraged about the conditions in which they live their lives. Although this work is qualitative and thus cannot be read statistically, there is nothing extraordinary about the twenty-four women who shared their stories with me. Apart from their psychiatric involvement, their lives are like those of other women. Most have experienced some form of violence, whether sexual or physical abuse as children, sexual assault as adults, or battering by an intimate partner. Most were living in poverty at the time of our interviews, either working in low-wage job ghettoes, or staying home with children, or unemployed. Many bore the sole or primary emotional,

and often financial, burden for parenting children or caretaking elderly parents. Some experienced

oppression because of their sexual orientation or cultural heritage. In short, there is not a single

woman whose voice is heard in this work whose psychiatric 'symptomology' is incomprehensible when

read in the context of her life. I believe that readers will find the women's lives described in this work

to be familiar, and that what sets these women apart is the framing of their experiences and personhood

in the terms of psychiatric disorders.

This study joins a relatively small number of others which similarly examine the experiences of

patients (women patients or patients in general) with the psychiatric (or medical) system. Many of

these have been interview studies (Chesler, 1972; Miedema & Stoppard, 1993; Warren, 1987; Roberts,

1981). Two studies with which I am familiar have been based on quantitative questionnaires. Trott

and O'Loughin surveyed psychiatric patients in British Columbia about their perspectives on mental

health law (1991); the Manitoba Division of the Canadian Mental Health Association conducted

surveys with women who had been sexually abused by mental health professionals about the experience

of such abuse (1993). Another two studies are based in an ethnographic model: one in which a team

of sociologists admitted themselves to hospital complaining of hallucinations (Rosenhan *et al*, 1973)

and another in which a psychologist who worked with women incarcerated in a maximum security

psychiatric hospital used information from her daily work to expose the abuse of women patients in this

institution (Potier, 1993). Each of these studies has provided insights into the experiences of women

patients with the psychiatric system and echo themes which emerge in my own study. For example,

Trott and O'Loughlin identify that psychiatric patients want a liberalization of mental health legislation

together with a stronger safety net of community-based support services. Miedema and Stoppard

identify the ways in which psychiatric hospitalization becomes a way for women to have a rest from the

drudgery of their lives and a reprieve from abusive marriages. Both Potier and the Canadian Mental

Health Association convey the vulnerability of women patients to unethical mental health professionals who abuse their power and re-victimize patients.

In order to set the stage for a discussion of women's experiences of psychiatric treatment, I found it essential to engage broader questions around the concepts of mental health and mental illness. My intention in this thesis is not so much to focus upon the lives of women involved as patients in the psychiatric system, for I believe that patients have been studied enough and it is not they I wish to make problematic. Rather, my focus in this work is upon the psychiatric system itself, using the perspectives of women patients as a source of knowledge. As I intended for this work to have more far-reaching implications than merely whether women believed that the psychiatric system had treated them well or badly, and with or without obvious forms of sexism, the second chapter provides some analysis of the biological underpinnings of the psychiatric system. In this way, the experiences of study participants can be read in the context of an analysis of what is going on from the psychiatric system's point of view when a woman is labelled mentally ill and treated with psychiatric drugs and electro-convulsive therapy. Chapter three details the research methods I used to conduct the study and introduces the women who volunteered to be interviewed. The fourth chapter describes more fully the lives of the women whose experiences are the basis of the study, and examines the life situations which preceded and occurred alongside psychiatric intervention. Study participants' actual experiences with psychiatric intervention, both positive and negative experiences, are discussed in the fifth chapter. The thesis concludes with an exploration of the resistance expressed by study participants to the psychiatric system and the alternative methods of care for themselves as individuals, and for women as a social group, which they were able to imagine or actualize.

# NOTES

[1] For two examples of nineteenth-century patient resistance, see Charlotte Perkins Gilman (1892) *The Yellow Wallpaper* and A Sane Patient (1879) *My Experiences in a Lunatic Asylum.*

[2] For a description of the challenges faced by the Women's Counselling, Referral and Education Centre in finding non-psychiatric services for 'ex-psychiatric' women, see Lepishak (1992), pp. 29-40.

[3] An exception is Miedema and Stoppard's (1993) study on women's experiences of hospitalization in New Brunswick. Although Chamberlin's (1978) work on alternatives to the psychiatric system is not a 'study' in the same sense, it is a review, partially autobiographical, of psychiatric and alternative services written by a woman who was formerly a psychiatric patient.

[4] I use the term 'patient' consciously throughout this work in reference to women who have experienced psychiatric treatment. Other terms are in more frequent currency these days, such as: 'mental health consumer,' 'psychiatric survivor,' and 'ex-inmate.' I have chosen to use the term 'patient' for several reasons, but mostly because it underlines the starkness of the medical power relationship it describes, and seems in this way most honest. 'Inmate' necessarily refers to someone imprisoned against their will, and thus would exclude the majority of women I interviewed. 'Psychiatric survivor' is a label taken deliberately by many activists in the anti-psychiatry movement, and seems presumptuous to apply to people who do not refer to themselves as such. Finally, the term 'consumer,' which is most popular, I believe disguises the power relation implicit in psychiatric treatment and imposes a capitalist framework on medical treatment which I consider inappropriate. One does not 'consume' psychiatric treatment the way one 'consumes' dishwashers or designer clothing. On occasion, I also use the term 'psychiatrized' to describe women who have experienced psychiatric treatment. This term, used often in the anti-psychiatry movement, emphasizes that psychiatric treatment is something 'done to' a person which helps produce the feelings and behaviours referred to as 'mental illness.' I do not use the term 'women with mental illness' as it suggests that mental illness just happens to women and leaves psychiatry out of the equation. Instead, I believe it is important to use language which brings the involvement of the psychiatric system to the foreground. As Dorothy Smith writes: "...becoming mentally ill is a process in which psychiatric agencies participate.... When you seem to be counting people becoming mentally ill you are in fact also counting what psychiatric agencies do" (1975, p. 88).

[5] For example, Miedema and Stoppard's (1993) study neglects to mention the race and cultural background of women who were interviewed and renders lesbian and bisexual women invisible entirely. The Canadian Mental Health Association (1993) study on sexual abuse of women by mental health professionals notes that most participants were white women and that "the number who said they were Native or Metis was roughly representative of the percentage of native people in the province" (p. 9), but makes no mention of sexual orientation. Roberts' (1981) study of the relationships between women and their doctors includes rural, suburban, and urban women born between 1921 and 1931, but makes no mention of race, class, or sexual orientation of participants.

[6] Warren's (1987) study is a re-conceptualization of a study done almost thirty years earlier, using a second set of interviews with the original sample of women. Therefore, the sampling technique used was conceived in the late 1950s.

[7] As a transition house worker, I do not consider myself a mental health professional, although I do work to support individual women in crisis. That my job title is officially that of 'counsellor' I believe says more about the way state co-optation of transition houses (Faith, 1993a; Quinby, 1995) imposes a mental health model upon work which historically has been done by feminist community activists. I position myself instead as a listener and an advocate, my training being grassroots and feminist activism combined with Women's Studies, rather than clinical psychology.

# CHAPTER TWO

## The Biomedical Model and Its Discontents

...Experiments have produced little more than hints: what is now known about the brain is dauntingly reminiscent of a 16th-century European conception of Africa: boats have landed and a few search parties have returned with stories of fertile river valleys and mysterious, unclimbed peaks, but few coordinates have been precisely plotted. Only since the mid-1980s have the PET scan and the MRI allowed researchers to peer directly into the brain's glimmering, wet-wired sponge of neurochemicals and electromagnetic fields and get a glimpse of its 100 billion branching neurons at work. Researchers have measured the hippocampus, but have only the sketchiest idea of what it does. Far more is unknown than is known.

(Butler, 1996, p. 44)

The most pervasive model which constructs psychiatric discourse and informs the processes of diagnosis and treatment is the biomedical or biological model. This model assumes that individuals can be clearly determined to be either normal or mentally ill, and classifies the types and subtypes of mental illnesses or disorders. As the causation of mental illness is seen to be biological, the psychiatric system responds with biological treatments aimed at altering brain chemistry. Extremely powerful psychiatric and pharmaceutical industries have grown up around the hypotheses that mental illness can be distinguished from normal states of mind, that mental illness is biologically caused, and that altering brain chemistry is the appropriate and desirable response. The pharmaceutical empire controls through economic power what research questions can legitimately be asked. Because of its power base, the psychiatric and pharmaceutical industries are able to hold a virtual monopoly over services for those in emotional distress, leaving a dearth of options for individuals who might wish to choose a different intervention or none at all.

Contemporary psychiatry attempts to distance itself from its predecessors in the eighteenth and nineteenth centuries, acknowledged to be barbaric, and to present itself as now both scientific and humane. However, throughout this century the psychiatric system has inflicted torture and taken many lives in the name of scientific progress. Current psychiatric practices such as drugging, electroshock, and involuntary

hospitalization are considered a renewed form of brutality and social control by critics, among them many former psychiatric patients. Yet the psychiatric establishment continues undaunted, perhaps unhearing, of those who would question its analyses and its practices. In many ways, any discipline functions in such a way as to discipline its followers and members. Among the mental health professions, psychiatry, with its status as a medical specialty, effectively disciplines all who work or study in the areas of mental health, psychology and social work, as well as patients and ordinary citizens, so that the biological perspective is reinforced as truth and the voices of dissenters are silenced.

This chapter will consider the key elements of the biological model of psychiatry with reference to three categories of 'mental illness' of interest to feminist critics: schizophrenia, depression, and post-traumatic stress disorders. As a non-scientist, I am not in a position to evaluate the validity of existing scientific studies on mental health and illness, although I will make use of the arguments of those who are able to do so. My intention, therefore, is not to dismiss particular scientific perspectives on mental illness, but rather to elaborate on contemporary psychiatric theories and the criticisms which exist about them. I would like for this chapter to provide context to the experiences of the women interviewed in this study, and to illustrate the various layers of interpretation which operate when a woman is considered to have a mental illness.

**Setting the Stage: On Learning to be a Custodian**

In the fall of 1995 I enrolled in a community college certificate program for 'community mental health workers.' I did so because I wanted an entry point to learn about psychiatric discourse. I needed a way to de-mystify psychiatric discourse enough to understand the major premises of psychiatry, so that I could comprehend from another angle what the women I interviewed experienced as patients in this system. Although I did not explicitly tell either instructors or students that I wished to use the materials and discussion as part of my research, I did introduce myself as a researcher doing a study on women and

psychiatry who wanted to learn more about the psychiatric system from a different perspective. I gained this knowledge and much more from my experience in the community mental health class.

The students in this class were being trained to be workers at the bottom rung of the mental health field hierarchy. In mental hospitals and psychiatric wards, they would be the psychiatric aides who spent the most daily time with patients and yet had the least power in the hierarchy.[1] In the context of de-institutionalization, community mental health workers staff the boarding homes and group homes set up in the community for people being discharged from large-scale mental institutions. Such facilities are more often privately than governmentally-run, and employ psychiatric nurses to oversee a staff of mental health workers who do the daily labour of enforcing psychiatric control of patients.[2] For the majority of students in the class, this course came as a bureaucratic requirement for continuing in a job they had been doing for many years: some had worked as psychiatric aides and mental health workers without training for more than ten years. One woman in the class reflected to me about how she had become a nurse's aide at Riverview Hospital. She had started out working in the kitchen, and then someone had said, 'come on, we need a nurse's aide.' As she tells the story, you would just change your white uniform for a blue one, and with no training become a nurse's aide. Most of the workers lacked formal post-secondary education; many were immigrants; most were women. The average salary, even after ten years of experience, was between ten and eleven dollars per hour.

Although the course was never intended as an introduction to psychiatric discourse, it served my research purposes very well. I was able to be among the workers who spend the most time with psychiatric patients, learning the daily currency of psychiatric thought, language, and practice. Throughout the remainder of this chapter, I shall refer periodically to examples of my experience in the mental health worker class to illustrate points about the biological model of psychiatry.

16

# I    Key Concepts of the Biomedical Model:

Three inviolable convictions form the foundations for the biological model of psychiatry. The first is that mental illnesses exist as a phenomenon like physical illnesses; therefore, a person who is mentally ill can be distinguished from one who is mentally normal or healthy, and a precise diagnosis can be made. The second conviction upon which biological psychiatry rests is that mental illnesses are biological and genetic in origin, and that symptoms of mental illness arise because of malfunctions of brain chemistry. The second tenet leads to the third, which is that since the problem is biological in nature, biological treatments which alter brain chemistry are the answer. These three elements, all of which reflect an assumption that mental illnesses are physical illnesses, are essential to the biological model of psychiatry, and all three were repeatedly reinforced throughout the community mental health class. A fourth and related theme which upholds the biological model is that the evidence for the above three assertions is too complicated for patients and laypeople to understand; thus, these principles are simply to be accepted at face value by workers in the mental health system, by patients, and by the rest of the community. To question the truth of these claims is considered evidence of 'lack of insight'[3] which can be remedied through a repetition of the three claims which everyone accepts as truth.

These four elements combine to produce an image of biological psychiatry as a rapidly advancing science, which has at heart only the interests of solving the puzzle and relieving the human suffering of mental illness. Consider this cautiously optimistic perspective on the progress of the science of psychiatry.

> There is still a long way to go, but the goal is in sight. Mental illness is less of a mystery every day, distressing symptoms can be overcome with the careful use of drugs, and other types of therapy have become quicker and more sophisticated. Someone in the near future may be able to write: 'Mental illness is now easily curable' (Morgan, 1988, p. 12).

Psychiatry emerges in this portrayal as a science which does not at this stage have the answers to mental illness, and yet is seen as being on the right track in terms of its biological focus and new and technical treatments.

Because the biological model attempts to address criticisms from antipsychiatry, it presents itself with a tone of reasonability, rendering the elements of social control increasingly invisible and hence more insidious. Three major shifts in the biological model were readily apparent in the community mental health course: first the use of a 'bio-psycho-social' model which gives the impression that psychiatric treatment is somehow holistic; second, some acknowledgement of the oppressive history of psychiatry; and last, a philosophy of de-institutionalization and 'community care.'

The first recognizable shift in approach has the effect of 'toning down' the emphasis on biology, in language if not in actuality. In the community mental health worker course, there was talk of a new model of psychiatry, known as the 'bio-psycho-social model,' which recognizes that patients are more than the sum of their biology, that they are individuals with psychological and social dimensions and needs. In the course, students were taught that the role of the community mental health worker is to assist 'people with mental illnesses' to be all that they can be -- within the context of supporting the biological theories and interventions of psychiatry. Rather than inviting an integrative analysis which would tease out the socio-political and psychological roots and dimensions of 'mental illness', the bio-psycho-social model is additive in nature: 'psycho-social' is merely added, like an afterthought, to the biological, which is considered the 'meat and potatoes' of the meal. For example, the bio-psycho-social approach might hypothesize that psychiatric patients have a need for social activity and thus encourage them to play cards with each other; however, this approach does not consider the impact of social and psychological elements of oppression in either the development of distress in an individual, or in the process by which that distress is viewed as a mental illness.

18

The second apparently progressive shift which was evident from the community mental health course was some acknowledgement of the oppressive history of psychiatry. On the first day of class, the instructors spoke of the evolution of psychiatric treatment and the abusive ways in which 'people with mental illness' were treated in the past. The ways in which institutionalization has damaged and diminished the lives of people confined in mental hospitals was admitted and discussed. However, all this was a means of describing the development of psychiatry as a progressive scientific program in order to disassociate contemporary psychiatry from its oppressive history, as well as from any media representations of psychiatry as a form of social control. One cannot help here being reminded of Thomas Kuhn's analogy that the textbook descriptions of the history of science "is no more likely to fit the enterprise that produced them than an image of a national culture drawn from a tourist brochure or a language text" (1970, p. 1). The history of psychiatry, as presented in the community mental health worker course, was a history of discovery and enlightenment whereby old and cruel practices of confinement and restraint are replaced by scientific knowledge and humane medical procedures. The instructors also took pains to distance psychiatry from negative images in old films: in particular, *One Flew Over the Cuckoo's Nest* (Zaentz & Douglas, 1975) was mentioned in the course, as it is very often elsewhere in popularized biomedical literature (Andreason, 1984, p. 207; Sakheim, 1992, p. 50; Yudofsky et al, 1991, p. 331), as an untrue representation of the experience of electroshock treatment.

The third shift in the biomedical model that was evident from the community mental health course is the change manifested by de-institutionalization and the spreading of psychiatric influences throughout the community. The course was intended as training for workers who staff the boarding homes where many ex-inmates now live when released from institutions and the 'clubhouses' where they socialize with one another and receive vocational and day programming. The instructors themselves drew attention to the formation of 'mini-institutions' in the community, and observed that

the process of institutionalization can happen anywhere. What is presented as a cost-cutting yet

humanitarian measure, a downsizing of services, seems rather like an expansion and diffusion of the

psychiatric system beyond hospital walls and into the lives of virtually everyone. This corresponds

with the widespread use of psychiatric drugs in the community, taken by no means only by de-

institutionalized patients but also in increasing numbers by people with no experience of psychiatric

hospitalization whatsoever.[4]

The understanding of mental illness as a physical disease process is central to the biomedical

model of psychiatry. Psychiatric patients are seen to be suffering from mental diseases, which have

genetic and biochemical origins. Although the bio-psycho-social model acknowledges that social and

psychological factors can play a role in the development of mental disorders, these factors are merely

seen as environmental triggers which activate a biological predisposition to develop a particular

disorder. Due to massive public education campaigns by pharmaceutical companies and organizations

like the B.C. Schizophrenia Society,[5] popular perception tends now to accept that schizophrenia is a

biological disease. At the same time, the public generally tends to have some reservation about

categorizing other psychiatric diagnoses, such as depression, as a physical disease.[6] In discussing my

work, friends and colleagues have frequently reflected to me that the psychiatric abuses of women are

obvious in relation to depression; a feminist perspective can generally identify that many women have

good reason to be depressed and that antidepressants and shock treatment are damaging, in addition to

being beside the point. However, these same people will maintain that schizophrenia is clearly a

different case, obviously a biological disease rather than a manifestation of social distress. The women

who participated in this study are a case in point: most tended to consider themselves as having a

mental illness if they had been diagnosed as having schizophrenia or manic depression. On the other

hand, most of those who were diagnosed with depression, anxiety disorders, or personality disorders

tended to view themselves as not having a mental illness, even if they believed that some people actually do experience mental illness.

Despite popular beliefs, the dominant trend in psychiatry is to view *all* diagnostic categorizations, from schizophrenia to depression to personality disorders, as biologically-based diseases. This tenet in psychiatry runs counter to critics such as Thomas Szasz (1974) who assert that the very concept of 'mental illness' is unfounded, illogical and an invention of psychiatry in order to ensure power and credibility as a medical discipline. The assumption of biological disease is the foundation for everything that follows in terms of psychiatric discourse, power and treatment; therefore it is essential for psychiatry that this assumption be taken as fact. This point was illustrated for me most explicitly in the community mental health course when one of the instructors, after lecturing us on the biological origins of mental diseases, looked quizzically around the classroom, identifying particular individuals and demanding to know *if they believed* that mental illnesses were physical illnesses. In this rather extreme moment, when psychiatry seemed to collide with evangelism, it became clear to me how essential is the biological theory to all that follows about psychiatry.

But are we to accept the biomedical model on faith alone? Based on what kinds of evidence do workers on various levels of the psychiatric system, patients, and other members of the public accept the premises that mental illness, like physical illness, is biologically caused and best treated with biological interventions? Like Thomas Kuhn, I would argue that these principles are accepted, as are other scientific theories, "from an authoritative source that systematically disguises... the existence and significance of scientific revolutions" (1970, p. 135). Any non-scientist eager to critically evaluate the evidence underlying bio-psychiatric theories is likely to be frustrated by the lack of substance to evaluate in psychiatric materials designed for public, and even medical, education. Pamphlets and brochures tend to speak in generalities without citing studies which readers could pursue.[7] Medical

textbooks tend to also defend biological theories in general terms with occasional references to a study but little critical evaluation of studies in relation to one another.[8] Generally speaking, biological psychiatry has a captive audience, whether among lay people or medical students.

My own experience in the community mental health worker course supported the observation that workers in the psychiatric system, in addition to others, are to accept the biological model on the basis of faith and authority. I received my stack of reading modules only to realize that, although studies were cited by surname and year, no bibliography was attached and it was thus impossible to return to sources which were cited. When I asked the instructors for a bibliography, it became apparent that no bibliography could be found to give to me. From that point forward, it was clear to me that whatever was presented as scientific fact was more likely professional opinion, in part arrived at through clinical observation and in part transmitted from the same authoritative source to which Kuhn (1970) refers. My own limited forays into psychiatric literature have shown me, however, that much that was presented throughout the course as established fact is in actuality hypotheses for which there is contradictory evidence.

A number of thinkers have exposed the political rather than scientific process behind the creation of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the fallibility of psychiatric diagnoses, and the potentially harmful consequences of being labelled with a mental disorder (Caplan, 1995; Kirk & Kutchins, 1992). In the following sections I will discuss as examples several of the diagnostic categories which have been applied to women who were interviewed for this project: namely schizophrenia, depression, borderline personality disorder, and post-traumatic stress disorder.

**Schizophrenia:**

Schizophrenia, referred to by Thomas Szasz as 'the sacred symbol of psychiatry' (1979), is often considered the stronghold of scientific evidence supporting biological psychiatry. As mentioned earlier, I have found in talking to friends and colleagues who are generally critical of psychiatric approaches to women that criticism tends to stop at the gates of schizophrenia. This observation tends to be true also of much feminist work which is critical of the psychiatric system: Phyllis Chesler (1972), Celia Kitzinger and Rachel Perkins (1993), and Betty McLellan (1995) all view schizophrenia as 'genuine madness,' an illness for which the approaches of biological psychiatry are both justified and necessary.[9] It is for this theoretical reason, as well as because several women I interviewed were diagnosed schizophrenic, that I would like to address schizophrenia specifically, even though current statistics from Western cultures do not indicate that women are diagnosed more frequently with this particular disorder.[10]

Schizophrenia is considered by the psychiatric establishment to be a biological disorder which has genetic causes. Schizophrenia research has concentrated on several areas: the dopamine hypothesis, genetics, and brain imaging technology. Denise Russell (1995) identifies interestingly that scientists in each area of schizophrenia research admit that their own research is inconclusive, but extend far more hope that research from other areas will produce the key needed to understand the biological origins of schizophrenia (p. 83).

In the community mental health class we were taught the dopamine hypothesis: that schizophrenia is a medical disorder characterized by an excess of the neurotransmitter dopamine in the synapse between brain cells. The major treatment for schizophrenia, neuroleptic or anti-psychotic drugs, interrupts the transmission of dopamine by blocking it at the receptor sites, preventing its re-absorption. The evidence for the dopamine hypothesis rests in the fact that neuroleptic drugs seem to

work to reduce psychotic symptoms. As Bonnie Burstow (1996) points out, the theory for the workings of the illness is 'reasoned backwards' from the drug: that is, because the drug is seen to 'work' by blocking dopamine, therefore schizophrenia must be a manifestation of too much dopamine. R. Walter Heinrichs (1993, p. 225) reviews the dopamine hypothesis as faulty for a number of reasons. First, neuroleptic drugs may have some effect on the positive symptoms of schizophrenia (i.e. hallucinations and delusions), but they demonstrate no effect on negative symptoms (i.e. social withdrawal, impoverished communication, etc). Secondly, neuroleptic drugs work to varying degrees to reduce positive symptoms of schizophrenia in some patients and have no effect whatsoever on other patients. Third, the blocking of dopamine happens within twenty-four hours of taking neuroleptics and yet the reduction of psychotic symptoms can take months. Finally, there is scant evidence to support elevated levels of dopamine in patients diagnosed with schizophrenia. Russell points out that it is hardly surprising that neuroleptics reduce psychotic symptoms since they produce a feeling of disinterest in one's environment (1995, p. 78). Does the action of these drugs justify the dopamine theory of the origins of schizophrenia?

Genetics studies do not fare much better. Serious methodological problems have been identified in genetic studies, including one of the most famous studies by Franz Kallmann who sometimes diagnosed one of a set of twins after death and on the word of relatives. Other studies of adoptees have added vague diagnoses such as 'uncertain borderline schizophrenic' in order to stretch the probability of a genetic link (Russell, 1995, pp. 74-76). Kallmann's affiliation with the Nazi regime and the use of his work to promote eugenics programs has been noted (Breggin, 1991, p. 102-104). Another famous genetics study, by David Rosenthal, is a case study of the Genain quadruplets. The four young women, all diagnosed with schizophrenia, are used as an example of 'a dreadful gene'

or 'dire birth,' despite their shared history of extreme childhood physical, sexual, and emotional abuse clearly documented in the study (Breggin, p. 106).

Brain imaging techniques are used to defend hypotheses that people diagnosed with schizophrenia have brain abnormalities such as abnormally enlarged ventricles or a decreased level of metabolic activity in prefrontal brain regions. This research is very much in an experimental stage, and across studies it is difficult to replicate results. Some studies support the hypotheses, others refute them, and still more studies produce no findings either way (Heinrichs, 1993, pp. 225-226). Many normal subjects have these characteristics and many subjects classified as schizophrenic do not (Russell, 1995, p. 82). Additionally, drugs used to treat schizophrenia are believed to affect the results of brain imaging (Russell, p. 82; Breggin, 1991, pp. 68-91). Ethical concerns in brain-imaging research are paramount as well, since the intervention is not therapeutic and the long-term effects of exposure to radiation is unknown (Russell, p. 83).

Overall, reviews of schizophrenia research show little other than that the cause of schizophrenia is unknown and that biological research is inconclusive. As Heinrichs concludes his research review: "...the search for neuropathology in schizophrenia is replete with inconsistent, even contradictory, findings, and replications of promising results are scarce" (1993, p. 226). Given this, it does not make sense for feminist critics of psychiatry to grant the biomedical perspective authority in terms of schizophrenia.

As students in the community mental health course, we were not invited to explore the state of schizophrenia research: we were merely told that schizophrenia was a biological illness with genetic causes that required neuroleptic medication. Alternative approaches were not entertained in the class when I attempted to bring them to light. For example, we were told that when a patient is 'delusional' a worker should never talk to them about the content of their delusions, but should rather say that this

is not so and change the subject. One student shared her experience of working with a woman who persistently spoke about a male teacher she had ten years earlier whom she believed continued to exercise authority over her life and cause her harm. The therapeutic approach advocated by the instructors would have workers dismiss this woman's thoughts and feelings, when it seems plausible to validate the woman's feelings and inquire further about the nature of the relationship between the woman and her teacher. Indeed, there are some voices in the schizophrenia debate who maintain that delusions are metaphors for troubling experiences a patient has endured (Breggin, 1991; Burstow, 1992), and there is an active school of thought which sees psychotherapy as a useful approach for people with schizophrenia.[11]

Peter Breggin, himself a psychiatrist who had the benefit of doing his early medical training in the 1950s before drugs were commonplace treatment for schizophrenia, has testified that one of the most helpful interventions for schizophrenia that he has ever witnessed was one he was a part of as a college freshman in 1954. Breggin was part of a large volunteer project which saw hundreds of students volunteer in a local state mental hospital to make the conditions more livable. He and thirteen other students began to work individually with fourteen patients considered 'back-ward schizophrenics' over a period of one year, talking with them, building trust, taking them for walks, assisting them with practical matters. By the end of the year, eleven of the fourteen patients had been discharged, and only three returned to hospital in the two-year follow-up period. As none of the patients were yet receiving drug treatment, Breggin attributes their success to showing patients care and attention, hardly the stuff of a scientific revolution (1991, pp. 3-8).

In the community mental health class, students were taught that patients diagnosed with schizophrenia would follow a downward course, that they would require neuroleptic medication for the rest of their lives, and would likely not be able to accomplish much socially, academically, or

vocationally. We were taught that patients should strive toward goals such as card games with other psychiatric patients, personal hygiene, and for those with particular aptitude, janitorial work. Critics of psychiatry maintain that if patients diagnosed with schizophrenia function at a low level, it is due to the lobotomizing effects of neuroleptic drugs. Given this, it is particularly disturbing to note that empirical research which tracks patients diagnosed with schizophrenia over two decades reveals that "a surprising number (at least 25% - 50%) were completely off their medications, suffered no further signs and symptoms of schizophrenia, and were functioning well" (Harding & Zahniser, 1994, p. 143).

**Depression and other 'affective' or 'mood disorders:'**

Unlike schizophrenia, depression is a more common topic of feminist discussion, because it is well established that women in western cultures are diagnosed with depression at least twice as often as men (American Psychiatric Association, 1994, p. 341; Penfold and Walker, 1983, p. 172; Janzen, 1994, pp. 18-19). This is true across studies in both hospitals and outpatient treatment and community surveys. Feminist theorists commonly address the topic of depression in women both because of the high proportion of women compared to men who are given this diagnosis, and because for feminist theorists depression in women is clearly linked to the oppression of women.

Nevertheless, biological psychiatry does not treat depression as part of a normal range of human emotion nor a response to social conditions, but rather views depression as a biologically-caused mental illness. The community mental health course taught that two kinds of depressions exist: those that are 'reactive' or environmentally caused, and those that are biologically caused. The first type of depression, or 'endogenous depression,' is seen as within the normal range of human experience, and as a minor problem which will disappear on its own or with psychotherapy. Major depression, on the other hand, is viewed as a serious mental illness which most likely has biological and genetic causes, is unlikely to respond to psychotherapy, and is best treated with antidepressant drugs or

electro-convulsive therapy (ECT). The claims of biological psychiatry regarding depression bear striking similarity to psychiatric theories of schizophrenia. For example, the *American Psychiatric Association Textbook of Psychiatry* states: "Clinical observers, confirming popular lore, have long noted that the major affective illnesses tend to run in families. We now know that heredity accounts for a large part of that vulnerability" (Talbott, Hales & Yudofsky, 1988, p. 417). Of course, one can argue that many things run in families -- political and religious beliefs, levels of education, or food preferences, for example. Things common in families are not necessarily indicative of either a genetic link or an illness. As Denise Russell points out, "the social contagion of unhappiness could easily explain the results." Twin studies are often used to support a genetic link in depression, but, as with twin studies in schizophrenia, recent studies have not been able to implicate genetic causation (1995, p. 55).

As with schizophrenia, much biological research into depression is governed by the assumption that depression is a chemical imbalance caused by the malfunction of neurotransmitters -- this time, with serotonin or norepinephrine. Antidepressants function to block the re-uptake of serotonin or norepinephrine, causing more of these neurotransmitters to stay in the synapse (Talbott, Hales & Yudofsky, 1988 p. 789). Depression, then, is thought to be a depletion of serotonin or norepinephrine, although studies have shown that this biological link is flawed since these neurotransmitters are depleted in some depressed patients, but not in others (Russell, 1995, p. 56).

Biological psychiatry has also focussed on the dexamethasone suppression test (DST) in an attempt to find a reliable diagnostic test for depression (Talbott, Hales & Yudofsky, 1988, p. 419; Russell, 1995, 56-57). Subjects are injected with dexamethasone in order for their responses to be measured. Normal subjects will suppress a certain hormone, cortisol, for 24 to 48 hours after the injection. Some depressed subjects (around 45%) indicate an abnormal response. Denise Russell

maintains that this finding is not strong enough to establish a causal basis for depression, and points out that the abnormal test result could be a result of lack of adequate nutritional intake, since people with anorexia nervosa also exhibit an abnormal result (p. 57).

Biological psychiatry considers women to have a natural predisposition toward depression because of hormonal or genetic reasons. One hypothesis is that depression is chromosomally linked to the X chromosome, but there seems little support for this view (Penfold and Walker, 1983, p. 174; Russell, 1995, p. 56). A great deal of attention is paid to the impact of hormones on depression in women: women are considered to be predisposed to depression in relation to the menstrual cycle, after childbirth, and during menopause. Feminist critics have been prolific in challenging the biases inherent in biological hypotheses which pathologize women on the basis of their hormones (Caplan, Myers and Gans, 1992; Kendall, 1992; Russell, 1995; Ussher, 1991).

Doing research into the biological origins of depression is an immensely lucrative enterprise, well supported by the pharmaceutical industry. As of 1991 statistics, ten of the two hundred most widely prescribed drugs in the United States are anti-anxiety or anti-depressant agents (Drake and Uhlman, 1993, pp. 116-120). With the introduction and rapidly expanding popularity of Prozac and other selective serotonin re-uptake inhibitors (SSRIs) like Zoloft, and Paxil, the profit to be made from a biological approach to depression is even more pronounced.

Looking for social causes of depression is much less profitable, even though we may need look no farther than what makes good sense. One sociological study found that depression in women was highly correlated with the following factors: a poor marriage; bad housing conditions; threat of or actual separation from a key person; economic loss; being working-class; lack of an intimate relationship with someone to trust and confide in; having three or more children under the age of 14 at home; having experienced the loss of a mother before age 11; and lack of employment outside the home

(Brown and Harris, 1978). Another study showed a significant relationship in middle-aged women between depression and the fulfillment of the traditional female gender role (Bart, 1971). Additionally, feminist research on women and depression supports a strong link between depression in women and the experience of violence in women's lives, whether in the form of childhood abuse or assault and battering of adult women (Burstow, 1992; Penfold and Walker, 1983; Russell, 1995; Ussher, 1991). Quite simply, women living in patriarchal societies have distinct reasons to be depressed because of the violence which is daily inflicted upon us or threatened, our gender role expectations, our mothering, our relationship to poverty, and other realities of our everyday lives. Depression is an understandable response to living under social conditions of oppression, alienation, and powerlessness.

Some social and psychological theorists find no reason to separate depression into two categories based on what is seen as biological and what is seen as an understandable response to environmental conditions. Peter Breggin (1994) advocates a view of depression as a common human experience, which in his background as a psychotherapist has never required antidepressant drugs and has always had understandable social and/or psychological roots.

Although biological causes of depression have not been proven, billions of dollars are poured into research attempting to find a biological or genetic link when a myriad of social factors are obvious and sufficient to explain depression. The emphasis on biological causes and responses like drugging and electroshock has clear material reward in our global economy, while more human (or maternal) responses of compassion, caring, and social justice do not. The consequence to ideology, culture, and human beings of drugging and shocking our unhappiness is alarming. We have much to lose in terms of our concepts of self and emotion, as well as our caring and responsibility toward others. Furthermore, as I will discuss, the primary and 'side' effects of psychiatric drugs and electroshock are far from benign, and these treatments have as many critics as they have supporters. However, before addressing

the primary treatments for 'mental disorders,' I would like to draw attention to one more catchment area of diagnosis for women patients: the disorders frequently attributed to women as a response to their histories of abuse and violence.

### 'The Trauma Spectrum':[12]

Judith Herman (1992) narrates the strange and repeated history of western culture's discovery and renunciation of knowledge of the psychological consequences of trauma. She writes of three periods in history in which knowledge about a particular form of trauma has surfaced into consciousness. The first was Freud's announcement that hysteria, a common affliction of nineteenth and early twentieth-century women, was caused by a sexual trauma early in life. As others have documented (Rush, 1980; Masson, 1984), Freud's 'discovery' met with a chilly reception. In response to professional isolation and disapproval, Freud renounced his position that hysterical women had been sexually abused, and where he had once listened to his women patients, he re-interpreted their allegations of abuse as fantasy. The second period of awareness, beginning after the first world war and reaching its climax after the Vietnam War, surfaced about the psychological impact of trauma on soldiers. Men returning from war often demonstrated 'shell shock' or 'combat neurosis,' the symptoms of which resembled hysteria enough to be termed 'male hysteria' (Showalter, 1985). The most recent surfacing of awareness has been of rape, woman battering, and childhood sexual abuse which has come to public attention through the second wave of the women's movement in the 1970s and 1980s.

Herman cautions that the symptoms of denial, dissociation and repression common to trauma survivors operate also on a social level (1992, p. 2), and that knowledge of trauma has never been sustained in public consciousness without the context of a political movement. She wonders if society will be able to hold onto the awareness of trauma it has gained through the political movements of

feminism and human rights, or whether this knowledge will disappear, like it has at other times in history.

Women who participated in consciousness-raising groups in the 1970s and 80s spoke to one another about their experiences as victims of violence, and made the deduction that these experiences, once thought of as private and shameful, were in fact political. Due to the outspokenness of feminists who continue to speak, write, and research about women's experiences of violence, our society has more knowledge about the prevalence of sexual violence and its consequences for women and girls than ever before. It has been established that women are more often killed by men who know them than by all other forms of violence combined, that 2,000 women per year are murdered by their husbands in the United States, and that one in four adults report having been sexually abused as children (Root, 1996, p. 363). We now have the opportunity to acknowledge that rape, battering, and childhood sexual abuse are commonplace occurrences for women.

While in some ways it seems impossible that such staggering statistics of the abuse of women and children could be displaced or forgotten, Herman (1992) is on the mark in questionning whether our social consciousness will be able to sustain this knowledge. Feminists are already well aware of the activities of organizations such as the 'False Memory Syndrome' Foundation, formed by accused perpetrators of childhood sexual abuse to defend themselves and discredit sexual abuse survivors and therapists.[13] I will argue that a danger even more insidious and less charted by feminists than the waters of FMS, lies in the diagnostic categories of borderline personality disorder and post-traumatic stress disorder and in emerging psychiatric research on the biology of trauma.

Women with histories of sexual and/or physical abuse in childhood who enter psychiatric treatment for assistance dealing with distress, may receive any number of diagnoses. Certainly, abused women who participated in this study received a full range of diagnoses, including bipolar disorder,

major depression, anxiety disorders, borderline personality disorder, and schizophrenia. Only one

woman whom I interviewed considered herself to have post-traumatic stress disorder, but this was a

self-diagnosis she thought more accurate than the diagnoses of major depression and bipolar disorder

which she had professionally received. It is well documented that women psychiatric patients in all

diagnostic groups have rates of childhood physical and/or sexual abuse that exceed the rates of women

in the general population. Study results indicate that anywhere from fifty to eighty-one percent of

female psychiatric patients have histories of severe abuse in childhood (Carmen *et al*, 1984; Herman,

1992, p. 122; Kroll, 1993, pp. 36-49; Root, 1996, p. 372). Borderline personality disorder (BPD),

multiple personality disorder (MPD), and post-traumatic stress disorder (PTSD) are diagnoses which

tend to be applied most frequently to women psychiatric patients with histories of abuse in childhood

(Herman, 1992, pp. 123-126; Miller, 1994, pp. 153-180; Russell, 1995, pp. 45-47). For this reason,

these are diagnoses to which feminist critics need pay particularly close attention.

Borderline personality disorder is a diagnosis given predominantly (seventy-five percent of the

time) to women, and characterized by instability of interpersonal relationships, intense abandonment

fears, inappropriate anger, self-mutilating behaviour, an unstable sense of self, and conflicting feelings

about one's sexual orientation (American Psychiatric Association, 1994, pp. 650-54). While receiving

any psychiatric diagnosis can be harmful in terms of one's self-concept and one's treatment by others

(Caplan, 1995), the borderline diagnosis is uniquely and curiously stigmatized. Dusty Miller writes

that:

> the woman with a borderline diagnosis, more than any other type of client, is viewed as causing
> problems for herself and is often blamed for her interpersonal failures.... Mental health
> practitioners are more likely to have negative reactions to supposedly borderline clients than to
> any other group. Borderlines are called manipulative, blameful, rageful, sexually provocative,
> unstable, messy (in terms of suicidal and self-injuring behavior), and splitting (known to set up
> professionals against each other) (1994, p. 160).

The diagnosis of borderline personality disorder seems to serve as a shorthand among mental health professionals that a particular woman is difficult, manipulative, troublesome, enraging, untreatable, and responsible for her own problems. Many therapists refuse to work with a woman diagnosed as 'borderline' because they do not want to go to the trouble (Cauwels, 1992, p. 16). One woman I interviewed who carried this diagnosis had numerous encounters with psychiatrists and other mental health professionals who insulted her and sent her reeling from their offices within fifteen minutes.

It is as though a mental health professional, when confronted with a woman with the label of 'borderline,' has unwritten permission to behave in any number of outrageous ways and then hold the patient responsible. Janice Cauwels, in *Imbroglio: Rising to the Challenge of Borderline Personality Disorder* (1992), documents a number of disparaging remarks by mental health professionals about women diagnosed as borderline. One therapist is quoted as having said: "Everything... about her... shouted 'borderline,' the word that strikes terror in the heart of the middle-aged comfort-seeking psychiatrist.... My first impulse was to get the hell away, far away -- and not see her again... But soon I heard my voice offering her another appointment (p. 17).

A distinctive quality of borderline personality disorder is its feature of therapeutic counter-transference, described throughout the clinical literature (Gunderson, 1984; Gabbard & Wilkinson, 1994; Cauwels, 1992). A therapist's reaction to a 'borderline' patient is in itself considered evidence that the patient is 'borderline' and is supposed to reveal insights about the patient rather than the therapist. Gunderson writes that: "...the intense countertransference reactions these patients generated in therapists -- countertransference responses characteristically marked by feelings of helplessness and rage... reflected something perversely troublesome within the nature of these patients themselves" (1984, p. 2). If the therapist discovers him or herself violating professional boundaries, calling the client at home to check up on her, committing desperate acts inside or outside of sessions, clinical

wisdom seems to be: 'the borderline drove me to it.' An example cited by Cauwels is a therapist who loaned his client hundreds of dollars, moved her into his home, and slept on the floor in front of her bedroom so that the patient could not leave without his knowledge (p. 19).

A generally accepted axiom within psychological discourse is that an individual is responsible for his or her own feelings. It is most interesting, then, that the borderline diagnosis allows a therapist to understand and diagnose a client through the therapist's experience of that client. Indeed, the 'borderline' patient is thought to possess almost supernatural powers to create feelings in others and to drive them to desperate acts, a concept which appears to defy psychology's own principles of individual responsibility. Consider this statement by experts in the borderline field: "Borderline patients possess an uncanny ability to tune in to the therapist's vulnerabilities and exploit them in a manner that induces feelings of guilt" (Gabbard & Wilkinson, 1994, p. 5). Or: "Borderline patients are notorious for evoking deviations from the therapeutic frame that lead to ill-advised boundary crossing" (p. 6). According to these specialists, borderline patients provoke feelings of rage, hatred, helplessness, guilt, anxiety, and terror in their therapists, in addition to inducing rescue fantasies and ethical violations (pp. 5-9).

A personality disorder is defined by the *DSM-IV* as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (American Psychiatric Association, 1994, p. 629). Because by definition personality disorders are so completely integrated into the personality of the person afflicted, they are considered almost beyond treatment (Wylie, 1995, 30). In fact, many people considered to have personality disorders do not seek treatment because their personality organization is not subjectively experienced as a problem, even though it may be troublesome to others. BPD is an exception to this rule, for those

diagnosed with BPD tend to experience intense personal distress for which they repeatedly try to get help.

Borderline personality disorder, which has a strong psychoanalytic tradition, has been a site of contention for psychoanalytic and biological psychiatrists. Psychoanalytic perspectives suggest that BPD is a disorder pertaining to distorted object relations resulting either from developmental problems or traumatic experiences in childhood (Cauwels, 1992; Celani, 1993; Gabbard & Wilkinson, 1994). The biological paradigm, by contrast, posits that BPD is an atypical affective disorder (Kroll, 1993, p. 31), and hypothesizes that genetic influences (Paris, 1994, pp. 29-31) and the malfunctioning of neurotransmitter systems (Paris, pp. 38-39) are responsible, similar to biological theories of other mental disorders. Biological research on BPD is considered to be an important new area to develop, even though the evidence at this point in time is considered "indirect but suggestive," and that "thus far no specific biological risk factors have been identified that could specifically predispose to BPD" (Paris, p. 27).

Despite lack of evidence, biological and psycho-pharmaceutical approaches are considered by some BPD experts to have made "impressive developments" in contrast with the "conservatism of how [psycho]therapists practice therapy... [with their] resistance to biological inroads" (Kroll, 1993, pp. 10-11). It is interesting, therefore, that in the absense of compelling evidence, biological research on borderline personality disorder is considered to be 'cutting edge' in contrast to the psychoanalytic tradition. Given the clinical image of the 'borderline' in therapy, whether the treatment approach is psychotherapy, drug treatment, or both, the experience of a woman thus labelled in the mental health system is likely to be unpleasant in the extreme.

For reasons I hope are obvious at this point, the borderline diagnosis is an especially dangerous one for women. Feminist theorists and therapists have documented that histories of severe sexual and

physical abuse in childhood can lead to feelings and behaviour in women which resemble some of the symptoms of BPD. Dissociation or 'spacing out,' intense feelings of abandonment and rage, self-mutilation, substance abuse and troubled eating are well-known in feminist therapeutic literature as ways in which women cope with the experience of serious trauma from childhood (Burstow, 1992; Herman, 1992; Miller, 1994). Indeed, the link between abuse in childhood, particularly sexual abuse, and BPD has been well-established (Herman, p. 126). To diagnose a woman with a history of sexual abuse as having borderline personality disorder is to ensure that she will be stigmatized and mis-treated by mental health professionals.

Because of the relationship between childhood abuse and BPD, many favour the collapse of the borderline diagnosis into that of post-traumatic stress disorder. The category of 'complex post-traumatic stress' as a replacement for BPD is gaining in popularity (Herman, 1992, pp. 120-22), and the instructors in the community mental health course predicted that the next edition of the DSM will reflect this change. While this is likely a step in the right direction, I think we must also be cautious lest the stigma of one diagnosis flows into the other. The diagnosis of post-traumatic stress disorder also contains significant dangers which are beginning to emerge through new directions in biological research.

The diagnosis of post-traumatic stress disorder (PTSD) has been greeted by many feminist mental health professionals as a progressive step. Maria Root reflects that its advantages lie in the fact that it is the first diagnosis to incorporate much feminist literature on violence against women and to recognize the toll that such abuse has on women, and that it is one of the few diagnoses which recognizes an outside environmental event as the cause of psychological distress (1996, p. 374). PTSD is considered to be an anxiety disorder which results from the experience of severe trauma; PTSD is characterized by clusters of symptoms which involve the re-experiencing of the traumatic event,

avoidance of stimuli associated with the traumatic event (or numbing), and increased arousal or hypervigilance (American Psychiatric Association, 1994, p. 428). Although most of the research for PTSD has been done based on the experience of war veterans, the disorder is considered to be characteristic of those who have experienced torture, rape, bombings, natural disasters, and other horrific events.

Some advantages can be seen to derive from the PTSD diagnosis: it appears to consider reactions to traumatic events as understandable and as such to provide a more normalizing diagnostic category which could be used to describe all women who have traumatic reactions to sexual violence. This has the potential to avoid the pitfalls of diagnosing survivors of sexual violence with a myriad of mental disorders which remove symptoms from the context of trauma. However, diagnostic systems differ in terms of what is considered to constitute PTSD, with the *DSM-IV* criteria being far more restrictive than that of the *ICD-10* manual of the World Health Organization (Gerrity & Solomon, 1996, p. 97).[14] Therefore, in practice, many women who experience distress related to sexual violence are excluded from a diagnosis of PTSD and likely diagnosed with other disorders, such as borderline personality disorder, major depression, or bipolar disorder (van der Kolk, 1988, p. 281).

While applying any diagnostic label to people dealing with the aftermath of trauma is not comfortable for many, using a less stigmatizing diagnosis is seen by some to be useful in that it may cover the requirements of insurance companies to cover treatment costs. Feminist psychologists such as Judith Herman (1992) have devoted much energy to researching post-traumatic stress in women, and influencing the process by which PTSD is included in diagnostic frameworks like the *DSM*. Other feminist theorists, while seeing the advantages of positing one abuse disorder compared with the alternative of disbelieving or diminishing the impact of abuse, question whether PTSD should be considered a 'disorder' at all (Russell, 1995, p. 50). Given that the experiences of childhood sexual

abuse, rape, and battering are common among women, and produce understandable distress in survivors of violence, feminist theorists need to be wary of the consequences of pathologizing usual and expected reactions to trauma as a mental disorder.

Indications of such consequences can be seen by examining the directions of current research on post-traumatic stress disorder. Contemporary PTSD research tends to take one of two general paths: either that of prevalence studies or studies of physiological responses to trauma. Prevalence studies measure rates of post-traumatic stress disorder both in the general population and in specific groups exposed to trauma. Physiological response studies evaluate biological changes resulting from traumatic events: changes in heart rate, startle response, and specific areas of brain functioning. While such research directions may seem benevolent at first glance, more thorough analysis reveals disturbing trends.

Prevalence studies reveal rates of PTSD in the general population ranging from one percent to fourteen percent; in studies of groups exposed to trauma, PTSD rates vary even more broadly from three percent to fifty-eight percent (Talbott, Hales & Yudofsky, 1988, p. 426). Even though there is a large range in study results, the emphasis of the most recent research tends to be on the premise that since not all people exposed to trauma develop post-traumatic stress disorder, there must be some form of inherent vulnerability in those who do show symptoms of PTSD (de Girolamo & McFarlane, 1996). Those who develop post-traumatic stress disorder following a traumatic event tend more often to be female, to have lower educational levels, more job instability, a family history of psychiatric involvement, parental poverty, experiences of childhood abuse, separation of parents before the age of ten, and pre-existing anxiety or depression (de Girolamo & McFarlane, p. 46). Each individual will inevitably respond to traumatic events through the context of personal experience, and many of the above risk factors can be seen as social and environmental rather than evidence of pre-existing

individual pathology (Root, 1996, p. 378). However, other aspects of the search for vulnerability factors emphasize a genetic predisposition toward psychiatric disorders, a pre-existing anxious or depressed personality, and co-existing psychiatric disorders (Talbott, Hales & Yudofsky, 1988, p. 481).

One PTSD researcher, profiled in *Maclean's Magazine* in January of 1996, "is trying to understand why horrific events affect the brains of some people so severely that they develop the condition known as post-traumatic stress disorder." Through his research on rat brains, this PTSD expert concludes: "'There is something about the way a person's brain is wired that is relevant'" (Nichols, 1996, p. 46). The impact of such research is to focus attention on what is wrong with the individual who experiences distress following a trauma, rather than to view such emotional response as appropriate to the circumstance. The research question can be seen as defying common sense: it makes sense that a woman who is raped or battered will experience fear and hypervigilance, difficulty sleeping, and a startle response. One might better ask what is going on when a person exposed to such serious trauma does not respond emotionally in this way. Such research detracts attention from the actual event of the trauma, and instead focuses on the victim, individualizing and problematizing her responses. One psychiatric textbook states that there is evidence of a "pretraumatic personality predisposition in those persons who develop persistent symptoms following a trauma" (Talbott, Hales & Yudofsky, 1988, p. 481). Such claims should sound a warning to feminists concerned about the pathologizing of rape victims, battered women, and survivors of child abuse. The 'external factor' supposed to cause PTSD is not so external at all, according to new directions in PTSD research.

The counterpart to prevalence and vulnerability research is research documenting physiological changes induced by PTSD. Various studies have suggested biological changes in response to trauma, which include both a flooding and a depletion of the hormone cortisol, excessive neurotransmitter

activity in the brain, an exaggerated startle response, increased heart rate when exposed to stimuli reminiscent of the trauma, and smaller hippocampi (Butler, 1996, pp. 41-44). While there may appear to be nothing amiss in such research at first glance, its aim is to posit biological reactions to trauma as more primary than psychological reactions, and hence to promote biological treatments for trauma survivors rather than psychotherapy.

Methodological problems with this research include the fact that much of the research is done on animals exposed to "inescapable shock." One wonders at the ethics of research done on "monkeys who died from the stress of prolonged laboratory overcrowding" (Butler, 1996, p. 43) or on rats and other animals inflicted in laboratories with "inescapable shock" (van der Kolk, 1988, p. 275). Animal research, by design, can only measure biological responses in animals and can tell us nothing of the unique social meanings of trauma, particularly as it links to political oppression, in human societies. Furthermore, extrapolating results from animal studies to humans is fraught with well-known difficulties. Much of the research done on humans is conducted in laboratory settings in which PTSD patients and controls are subjected to audiovisual simulations of their traumatic situation or injected with drugs while their physiological responses are recorded. While such research done on humans may inform us about the responses of the physical body to stress and trauma, it is of little help to a woman struggling to integrate the experience of sexual violence into her framework of personal and social meaning.

The drive of PTSD biological research is to prove that responses to trauma thought to be psychological, such as repression of memories and hypervigilance, are in fact the result of physiological changes of the brain in response to trauma. The results produced by this research direction have the potential to revolutionize the types of psychiatric treatment given to trauma survivors. A recent article in *Maclean's Magazine* proclaims the "ultimate hope" of such research:

"...that by understanding how post-traumatic stress disorder arises, scientists may be able to find a way to intervene -- after a potentially traumatic shock -- with drugs that can prevent permanent changes from occurring in the brain" (Nichols, 1996, p. 46). Thus, the new face of trauma treatment increasingly resembles biological treatments for other psychiatric disorders. At present, biological psychiatry offers little more for trauma survivors than antidepressant and anti-anxiety drugs to moderate symptoms. Prozac is recommended by many mental health professionals (Butler, 1996, p. 44). As with other psychiatric disorders, a course of drug treatment is much cheaper than counselling (or community support services), and it is easy for third-party payers to mandate drug treatment. This approach focuses everyone's attention on what is intrinsically wrong with the victim, and puts health-care dollars in the hands of drug companies rather than human services. Even more insidious is the prospect of the "ultimate hope" quoted above: that the contemporary directions of PTSD research will allow psychiatric professionals to identify potential PTSD patients immediately after a traumatic event and intervene directly with drug treatments before any symptoms even emerge.

## II      Psychiatric Treatments:

Physical treatments have become increasingly important to psychiatry since its inception as a medical specialty. As Foucault has written, the insane first came under the control of the medical profession more because of the moral authority of the doctor, his position as a wise man, than because of any scientific expertise (Smart, 1985, p. 25). Yet psychiatry would continue to occupy the lowest status among medical specialties, unless it could elevate itself with evidence that it was treating medical illnesses with specifically medical treatments. Early attempts at treating insanity through the body are easily seen through contemporary eyes as the workings of 'a dark science.' Clitoridectomy and removal of the ovaries were common treatments for hysteria in nineteenth-century women in North

America and Europe, as has been well documented (Masson, 1986; Mitchinson, 1991; Showalter, 1985). During the same period, Canadian doctors believed that the shock to the body brought by any surgery, whether or not the organ operated upon was diseased, was beneficial in treating mental disorders (Mitchinson, 1991, pp. 344, 346). From the 1930s forward, the type of shock to the body seen as useful in treating psychiatric disorders became more localized to the brain. The dominant forms of treatment for schizophrenia through the 1950s were insulin coma treatment, electroconvulsive treatment (ECT), and lobotomy, all treatments which sent the brain into shock. Insulin coma was found to be ineffective and dangerous, and is no longer practised; lobotomies are still performed, but rarely; and ECT is now widely practised as a treatment for depression. Psychiatric drugs began to be introduced in the 1950s; chlorpromazine, a neuroleptic, was the first psychiatric drug to be discovered, followed by imipramine, an antidepressant chemically similar to chlorpromazine.

The past four decades have seen a proliferation of psychiatric drugs. There are now six major groupings of psychiatric drugs: neuroleptics (sometimes called antipsychotics), antidepressants, antianxiety agents (also called benzodiazepines), anti-manic agents, sedatives and hypnotics, and anti-parkinsonian drugs used to manage the side-effects of neuroleptic drugs. These drugs, together with ECT, now form the dominant treatments of contemporary psychiatry. The psychiatric profession and pharmaceutical industry insist that these treatments are the appropriate and necessary medical response to mental illnesses, despite continued protest from antipsychiatry critics and patients that drugs and electroshock are ineffective and often harmful. If psychiatric drugs can be claimed to work, as Denise Russell reflects, "then perhaps there is no great ethical problem, except that certain other possibly more fruitful research directions aren't taken up. If, however, the treatments are not shown to be very beneficial and carry significant dangers, then an ethical problem emerges quite clearly" (1995, p. 95).

**Psychiatric Drugs**

In the community mental health course, a metaphor was used repeatedly to illustrate the central position of psychiatric drugs in the treatment of mental disorders: that psychiatric drugs are to the mentally disordered what insulin is to those with diabetes. In other words, the deficiency in insulin experienced by a person with diabetes is proposed to be akin to the deficiency in seratonin alleged to be experienced by a person with depression. The equation of psychiatric drugs and insulin also suggests that the taking of psychiatric drugs, like insulin, is a life-long endeavour. This is a common metaphor used to 'educate' psychiatric patients about their need to take psychotropic drugs: several of the women I interviewed made reference to this metaphor in discussing the psychiatric treatments they were receiving. The urging of the biomedical model to view all psychiatric diagnoses as diseases leads to the solution of taking psychiatric drugs over the long term to correct supposed biochemical imbalances in the brain, whether the manifestation is schizophrenia, depression, or anxiety.

Throughout the course, great emphasis was placed on 'educating' psychiatric patients about the importance of taking drugs, and all students were expected to participate in role plays in which we were to attempt to convince a recalcitrant patient to take his or her medications. Students were told that patients would frequently want to go off their medications, and that such an action would inevitably result in relapse. The instructors informed us that it is much more difficult to work in the psychiatric field now than in the past due to mental health legal reforms which do not permit forced drug treatment of patients who are not certified. This leaves the onus on mental health professionals, no longer legally entitled to force treatment on a majority of psychiatric patients, to persuade patients to accept treatments 'for their own good.' The mechanism of social control thus becomes more covert and insidious, as patients, given more legal rights, are taught to internalize the surveillance of the psychiatrist.

There are many reasons why people may prefer not to take psychiatric drugs. Virtually all psychiatric drugs come with what are termed 'side-effects' by the medical community, which range in severity from uncomfortable to debilitating, and in rare instances can even be fatal.[15] Many psychiatric drugs from all drug groups leave patients feeling heavily sedated and unable to stay alert, concentrate on tasks, or drive a vehicle. Psychiatric drugs are popularly hailed as the reason that psychiatric patients are less frequently institutionalized (Morgan, 1988, p. 11), but critics point out that the drugs act as a 'chemical lobotomy' or 'chemical restraint' rather than a cure (Breggin, 1991, pp. 54-56; Burstow, 1992, pp. 30-31), and that deinstitutionalization is a product of social policy rather than a medical miracle (Breggin: 64-65). Lithium is likewise exalted as a miracle drug and a natural substance, although it carries a significant risk of causing the body to 'go toxic' in short-term use, and can cause kidney failure when used long-term. Antianxiety drugs, such as valium, are popularly known to be tremendously addictive. The latest innovation in antidepressants, the selective serotonin reuptake inhibitors (SSRIs), have been shown to have amphetamine-like properties and to be implicated in suicidal and violent reactions (Breggin, 1994; Teicher *et al*, 1990). It is understandable that many people, properly informed, would choose not to feel lobotomized, risk kidney failure or suicide, or become addicted to a prescription drug. However, tremendous pressure is exerted upon psychiatric patients and professionals to say yes to drugs.

The 'side-effects' of some psychiatric drugs are so considerable that the political elements insisting upon their use become increasingly obvious upon examination. Neuroleptic drugs are used to treat schizophrenia, hallucinations, delusions, and psychotic or disorganized thinking; their 'side-effects' are commonly divided into two groups: autonomic effects and extrapyramidal effects. Antidepressants, which are chemically similar to neuroleptics, can cause some of the same effects. Autonomic side-effects, which the community mental health instructors described as 'uncomfortable'

include: dry mouth, blurred vision, flushing, dry skin, headache, constipation, urinary retention, dizziness, palpitations, lightheadedness, fainting, tinnitus (ringing in the ears), sweating, depression, shortness of breath, increased heart rate, and a decrease in blood pressure upon rising. Such effects are common responses to antidepressants as well as neuroleptics. Extrapyramidal effects, known to be far more serious, include: mask-like face, tremor, rigidity of muscles, drooling, and a shuffling gait, akathisia (extreme restlessness and discomfort alleviated by pacing) and akinesia (immobility, weakness, fatigue, and lack of muscle movement), severe muscle spasms, protrusion of the tongue, extreme facial grimacing, difficulty swallowing, stiff neck or neck frozen to shoulder, and oculogyric crisis (rotation of eyes upward).[16] Extrapyramidal effects are sometimes masked by the use of anti-parkinsonian drugs, which reduce symptoms such as movement tics and spasms. It is no exaggeration to record that the 'side-effects' listed above filled every blackboard in the community mental health classroom; yet, we were to understand our role as that of 'educating' patients that it was in their interest to injest such 'medications.' One might well wonder if the cure is not worse than the symptoms it is brought in to treat.

Also mentioned in the course, albeit briefly, was tardive dyskinesia (TD), a neurological disease thought to be caused by the dopamine-blocking properties of neuroleptic drugs. Because of the similar chemical properties of neuroleptics and antidepressants, TD can also be caused by antidepressants (Talbott, Hales & Yudofsky, 1988, p. 781; Breggin, 1994, p. 156), although it is rarely referred to in the context of antidepressants. 'Tardive' refers to late-developing, or persistent; 'dyskinesia' means abnormal movements. The disease is characterized by involuntary movements of the face, tongue, neck, trunk, or extremities, and is extremely disfiguring and stigmatizing to those who experience it. Generally accepted prevalence studies show that tardive dyskinesia occurs in twenty to twenty-five percent of chronically-hospitalized patients (Talbott, Hales & Yudovsky, p. 781; Yudovsky

et al, 1991, p. 186), and that ten to twenty percent show more than minimal disease after routine drug use of a duration from six months to two years (Talbott, Hales & Yudofsky, p. 781; Breggin, 1991, p. 74). The risk of TD increases with age and length of drug treatment; studies of psychiatric patients over sixty years of age show TD rates of fifty-four percent in men and fifty-nine percent in women (Breggin, p. 74).

Tardive dyskinesia has often been minimized by the psychiatric establishment, which, as Peter Breggin notes, "for twenty years... simply failed to notice that a large percentage of its patients was twitching and writhing from the drugs" (1991, p. 77). The written modules community mental health students were given attempt to confuse the cause of TD by attributing the movement disorder to schizophrenia itself, a common misconception which has stigmatized psychiatric patients for decades. The module reads:

> Reports of symptoms resembling tardive dyskinesia were recorded many years before the antipsychotic drugs were used. It is possible that Tardive Dyskinesia may be related to central nervous system changes occurring in some schizophrenic clients, irrespective of their treatment (Overview of Psychotropic Medications, 1995, p. 14).

This mis-information is extremely troubling, given that students in this class were being trained to 'educate' patients about psychotropic drugs, and that other sources are uncompromising in holding psychiatric drugs responsible as the cause of TD (Talbott, Hales & Yudovsky, 1988, p. 781; Breggin, 1991, p. 69; Yudovsky *et al*, p. 186). The instructors also minimized TD by stating that it is most often reversible if caught early, simply by switching drugs, and that some studies now indicate that it is curable. They did not provide us with references to those studies, whose conclusions are dubious according to the works I have consulted. Not mentioned at all in the community mental health course was neuroleptic malignant syndrome, a more rare reaction to antipsychotic drugs, which is characterized by high fever, severe rigidity, abnormal blood pressure fluctuations, kidney failure, coma, and even death (Talbott, Hales & Yudovsky, pp. 783-84; Breggin, 1991, pp. 72-73).

The investment in covering up tardive dyskinesia and other reactions to psychiatric drugs is obvious for the psychiatric and pharmaceutical establishments. Popular texts on psychiatric disorders and treatments do not pay much heed to such problems. One text states that TD is "more commonly seen in the elderly and with prolonged use" and hastens to say that "it seems strange to say that in spite of all these possible side effects, antipsychotic drugs are relatively safe, but they are" (Morgan, 1988, p. 106). Another tells readers that "tardive dyskinesia is not painful, but patients may feel it is embarrassing or disfiguring," and that "most of the time, doctors and patients conclude that the benefit outweighs the risk" (Andreason, 1984, p. 211). This author goes on to suggest that the abnormal movements "may go away temporarily if the patient is placed on larger and larger doses of medication" (p. 211), a rather horrifying proposition, given that other sources recommend removing the patient from the drug (Talbott, Hales & Yudovsky, 1988, p. 783; Yudovsky et al, 1991, p. 186).

It has been well documented that women generally receive almost twice the prescriptions for psychiatric drugs compared to men (Penfold and Walker, 1989, p. 186; Lexchin, 1984, p. 23). Statistics from Saskatchewan show that twenty-six percent of the province's women were prescribed psychiatric drugs in 1989 compared to twenty percent of men (Janzen, 1994). A breakdown of drug types show women receiving prescriptions for antidepressants twice as often as men, antianxiety drugs almost twice as often, and neuroleptic drugs just slightly more (pp. 2-6).

Such difference in prescribing rates has been explained in a variety of ways. One explanation is that women have been conditioned to seek help more easily than men, to be more conscious and vocal about their emotional lives than men, and may go to their doctors in situations when men may not. Another is that doctors may view problems presented by women patients as psychological in origin more frequently than they do in men, and hence may provide prescriptions for psychotropic drugs more readily to women. One interview study of middle-class, middle-aged women and their relationships

with their family doctors revealed that many such women turn to their doctors for advice with situations extending far beyond their physical health into family issues and general discontentment with their lives (Barrett & Roberts, 1978). In such situations, critics of medical practice and the drug industry have argued that a prescription at the end of a doctor's visit leaves the patient feeling that the visit was necessary and the doctor that something has been done (Lexchin, 1984, p. 22). Some critics have suggested that since psychiatric drugs are known to decrease functioning in some areas, it has been thought a more appropriate form of treatment for women working at home to raise their children, as compared to men who are assumed to need to function in a workplace. Betty Friedan (1983) described the feelings of dissatisfaction, emptiness, and unhappiness that housewives often experience, as 'the problem that has no name.' When women sought help from their doctors for such feelings, psychiatric drugs were thought to make it easier for a woman to adapt to her situation rather than resist it. Valium, for example, was known as 'mother's little helper,' so often was it prescribed for women doing the unpaid work of raising their children.

The imbalance in prescription rates for psychiatric drugs between women and men seem to suggest either biased prescribing habits or that women are more likely to be mentally ill. The psychiatric profession has an interest in demonstrating that the latter consideration is the most significant, whether women are considered to have a greater predisposition for mental illness for biological or social reasons. Regardless of psychiatric theories of why more women than men are diagnosed with depression and anxiety disorders, prescribing habits are defended as the appropriate response. One psychiatrist has gone so far as to suggest that "antidepressants are feminist drugs, liberating and empowering" (Kramer, 1993, p. 40) in that they will encourage a woman to leave the house and go into the workforce.

While the pharmaceutical and psychiatric industries may need to 'push' certain unpopular drugs, such as the neuroleptics and some classes of antidepressants, other drugs such as antianxiety drugs, sleeping pills, and the new SSRI antidepressants need little help. The climbing rates of psychiatric drug use tell us relatively little about the proper treatment of 'mental disorders' but reveal much about the changing climate of social policies and attitudes toward mental health and illness and the relentless drive toward profits of multinational drug corporations.

**Electro-convulsive Therapy (ECT)**

Electro-convulsive treatment originated in Italy in 1938, where it was developed on the premise that the grand mal seizures it produced would act on the brain similarly to the seizures experienced by epileptics who were erroneously thought to be immune from schizophrenia. ECT is currently used primarily for depression and bipolar disorder; it is now hardly ever used for schizophrenia. The primary recipients of shock treatment are women, particularly elderly women (Breggin, 1991, p. 193). A normal course of treatment consists of six to ten treatments in total, one treatment administered three times per week (Talbott, Hales & Yudovsky, 1988, p. 839; Yudofsky *et al*, 1991: 341).

Electro-convulsive, or 'shock,' treatment is experiencing a resurgence of popularity in the psychiatric field. Contemporary professional and popular psychiatric texts extol the benefits of ECT and attributes the low usage of this method of treatment to the media's inappropriate exposure of its harmful use in the past (Cleghorn and Lee, 1991, pp. 22-23; Yudovsky *et al*, 1991, pp. 332-333). One text claims that ECT is "the single most effective treatment for severe depression and has a number of advantages over other treatments" (Griest & Jefferson, 1992, p. 75). Despite this, the accounts of many people who have experienced ECT continue to describe the practice as traumatic and inhumane,

ineffective, and a procedure which was imposed on them with some measure of coercion and little or no explanation of 'side-effects' or complications.

The women interviewed for this study who experienced shock treatment revealed a remarkable similarity in their accounts regardless of the decade in which they had been given the treatment. It is noteworthy that their narratives of the experience of ECT and its effects, particularly on memory, resemble one another such that if one did not know the context, it would be difficult to tell whether the treatment occurred in the 1950s, the 1970s, or the 1990s. I will elaborate more specifically about their stories of ECT in chapter five, but would like to note for now that their accounts of ECT very much resemble published personal narratives of those who have experienced ECT (Blackbridge & Gilhooly, 1985; Gotkin, 1995a), as well as critical accounts (Breggin, 1991; Burstow, 1992).

Information about ECT put forward by the psychiatric establishment tends to dismiss public concerns about this 'treatment' as uninformed sensationalism originating more in the early days of "excessive and inappropriate use in the past" (Cleghorn & Lee, 1991, p. 21) than in its more sophisticated current usage. One source claims that ECT is now underutilized, particularly by the socioeconomically disadvantaged, due to its excessive use in the past "both for conditions for which it was indicated and those for which it was not indicated" which led in those times to the injury of "a few patients" (Yudovsky *et al*, 1991, pp. 332-333). Certainly, there are some important differences between shock treatment now and shock treatment in its original days, as contemporary psychiatric texts will tell us. The most significant difference is that anaesthesia and muscle relaxants are now used for the procedure where they were not in the past; anaesthesia allows the patient to sleep through the procedure, while the muscle relaxant lessens the physical response of the seizure induced, and prevents the breaking of bones and teeth which were common in the early days of shock treatment (Grobe, 1995, p. 75). Without doubt, these changes must reduce the level of trauma involved with the experience of

shock treatment; however, as my interviews indicated, many patients continue to feel alarmed and threatened at the prospect of ECT, and describe it afterwards as something inflicted upon them without truly informed consent.

One of the major concerns with electroconvulsive treatment voiced by critics is the 'side-effect' of memory loss, a common complaint of those who have experienced the procedure. Information from the psychiatric establishment consistently minimizes the memory loss suffered by ECT patients as short-term and just as likely caused by depression itself. One source claims that a patient given electroconvulsive treatment usually experiences memory loss and confusion for anywhere from twenty to sixty minutes, and that memory can actually improve after ECT because memory loss is often caused by depression itself (Griest & Jefferson, 1992, pp. 76-77). When instructors in the community mental health class reported that the memory loss which can result from shock treatment is short-term, I requested clarification of what constitutes 'short-term.' I have heard this phrase repeatedly from psychiatric professionals, and yet it has not concurred with what women I have interviewed have told me or what I have read in patient accounts. The instructors responded to me that the memory loss could last two or three days. At this point, I informed the class of a woman I had interviewed once before her series of shock treatments and once six months after, at which point she was experiencing noticeably large gaps in her memory that had not been present before, as a comparison of her two interview transcripts will attest.[17] To this, the instructors responded that this must be a most unusual situation and quickly moved the class to another topic. The memory loss reported by participants in this study who had experienced ECT was far more significant than what the psychiatric literature predicts. Many of the women I interviewed expressed reassurance when I quoted to them the experience of Sheila Gilhooly:

> After shock treatments my memory was kind of wrecked, even for following conversations or remembering what I'd had for breakfast. My shrink said it had nothing to do with shock -- it was 'cause I didn't want to remember and stuff like that. When I got out of Birchwood it was

really hard. At first I was all casual and would say, 'Oh, how's Aunt Agnes these days?' And it would turn out she'd been dead for six months. It got so no one ever called me 'cause they thought I was too weird (Blackbridge & Gilhooly, 1985).

Like Sheila Gilhooly, they had been told by the mental health system that the memory loss they experienced was really a result of their depression or was a product of their imagination; this left them feeling alone with their experience and as though they must truly be 'crazy.'

The explanation for the return to popularity of electroconvulsive treatment, albeit a 'new and improved' version which uses anaesthesia and muscle relaxants and places electrodes in various sites for differing results, is ultimately an economic one. According to Breggin (1991), in California a month's stay in hospital with shock treatment costs $20,000, much of which is reimbursed by health insurance (p. 190); a psychiatrist who bills for nothing other than giving shock treatment to five patients three times per week will earn $150,000 U.S. per year (p. 191). The treatment itself is expensive, and so public health dollars are spent to profit companies which manufacture shock machines and psychiatrists and institutions which practice shock treatment. Patients tend to experience an initial euphoria after ECT, and therefore can be released from hospital seemingly improved (p. 198). Any memory or cognitive losses resulting from the treatment can be attributed to the depression itself, and thus does not 'count' in assessing the risks and benefits of the treatment.[18] A return to depression is not seen as a failure in treatment, but rather a relapse of a problem inherent to the individual; the patient returns for more and different drug treatments and another round of ECT.

This chapter has discussed the ways in which the biomedical model of psychiatry constructs unhappiness, loneliness, despair, fear, rage, and eccentricity as illness, and seeks causes in genetics and brain chemistry rather than in social conditions. This biomedical model has acquired the status of 'truth,' even though its biological theories remain largely unproven, and alternative hypotheses are not pursued. As the origins of `mental illness' are seen to involve variations on the themes of

malfunctioning of neurotransmitters in the brain and genetic predisposition, the treatments invoked by psychiatry are physical in nature and aimed at altering brain chemistry. Any harms reported by patients from such treatments as psychiatric drugs and electroshock are dismissed or minimized within psychiatric discourse. The dominance of biological psychiatry continues despite the nagging failures of studies to turn out as they should, and despite continued patient reports of harm. Such dominance can only be accounted for by the power of psychiatric discourse to represent 'truth' in the face of all odds, fuelled by the economic power of pharmaceutical empires.

The voices of women patients tell a different story, one which runs parallel to psychiatric discourse yet challenges its very underpinnings. The subjugated knowledges of women patients about the psychiatric system will be the subject of the remainder of this work, as I move now to discuss the interviews I conducted with women about their experiences of psychiatric treatment. In the next chapter I will discuss the methodological issues I worked with in conducting a qualitative feminist interview study, and I will introduce the women study participants who gave their time, energy, and ideas to this project.

## NOTES

[1]  Rosenhan (1973) found a relationship between the power of the worker and the amount of time spent with patients. Psychiatrists, with the most power and authority, spend the least amount of time with patients; psychiatric nurses spend a little more time but are subordinate to psychiatrists; psychiatric aides, considered unskilled, dispensable labour, spend the most amount of time with patients.

[2] People living in residential facilities in 'the community' have additional contact with psychiatrists and psychiatric nurses and social workers through community mental health clinics or 'mental health teams' which see them regularly to monitor their medications. On an as-needed basis, these 'community patients' will be re-hospitalized for medication changes and 'drug holidays' (ie. time off all medications in order to switch to different drugs).

[3]  'Lack of insight' is a common accusation applied to psychiatric patients when their views of their conditions differ from the views of their psychiatrists. Lack of insight is sometimes remediated by a process

of 'education' in which the patient is persuaded to accept the views of the psychiatrist. Lack of insight is also sometimes considered a symptom of a mental disorder.

[4] For example, the overwhelming popularity of the antidepressant Prozac indicates that the 6 million Americans and 4 million people worldwide who have taken the drug (as of 1993) have been considered by their doctors to have a clinical depression appropriately treated with drugs (Breggin, 1994: 3). Prozac was the 19th most commonly prescribed drug of any kind in the United States in 1991; the anti-anxiety drug Xanax came in fifth place (Drake and Uhlman, 1993: 116-120).

[5] For example, one transit ad which has lined the buses of Vancouver for the past several years, entitled 'Schizophrenia: It's Not What You Think,' states unequivocally: "Schizophrenia is the result of physical and biochemical changes in the brain... believed caused by genetic or viral damage... usually treatably by medication... not caused by childhood trauma, parents, or poverty... your understanding can end the stigma." The ad refers readers to the B.C. Schizophrenia Society, formerly Parents and Friends of Schizophrenics, and is sponsored by Janssen-Ortho Incorporated, a pharmaceutical company.

[6] The trend to see depression as an understandable human response to stress rather than a biological illness, however, is shifting. A case in point is a letter to the editor which recently appeared in the Simon Fraser University newspaper, *The Peak* (September 1, 1997), written by John Stubbs, President of Simon Fraser University. In his letter, Stubbs explains his absense from university life at the direction of 'doctors rather than lawyers' and indicated that he was suffering from 'the illness of depression' but that he was now receiving top medical care for his condition. Stubbs explains his situation entirely in medical terms; entirely absent is any discussion of the horrendous stress in which he was placed due to the media's unprecedented focus on what became a high-profile sexual harassment case, which Stubbs was accused of mis-handling.

[7] For example, see the pamphlet series on schizophrenia, written by Thornton, Seeman and Plummer of the Clarke Institute of Psychiatry, with funding provided by Merrell Dow Pharmaceuticals.

[8] As an example, see *The American Psychiatric Press Textbook of Psychiatry*, edited by Talbott, Hales and Yudovsky (1988).

[9] There are important exceptions of feminist theorists who challenge psychiatric authority on schizophrenia, most notably Bonnie Burstow (1992) and Denise Russell (1995).

[10] According to the *DSM-IV*, hospital studies show higher rates of schizophrenia in males than females, while community studies show equal rates of schizophrenia between the genders. Women are more likely to be diagnosed with schizophrenia later in life than males, who are frequently diagnosed in adolescence (American Psychiatric Association, 1994, p. 281). This gender ratio is not constant across the globe. In China, for example, women are seventy-five percent more likely than men to be diagnosed with schizophrenia (Kleinman & Cohen, 1997, pp. 87-88.

[11] For example, see *The Psychotherapy of Schizophrenia*, edited by Benedetti and Furlan, the proceeds of a conference held in Italy in 1993, for 51 presentations on various modes of psychotherapy and schizophrenia.

[12] The phrase 'the trauma spectrum' was coined by Bessel van der Kolk (1988), one of the leading researchers in biological approaches to post-traumatic shock disorder.

[13] While 'false memory syndrome' is not currently a mental disorder classified in the *DSM-IV*, feminist critics should think twice before using this fact to discredit the FMS organization. In consideration of the political rather than scientific variables which contribute to the inclusion of a disorder in the DSM (Caplan, 1995), as well as the psychiatric interest in the fabrication of childhood sexual abuse (for example, Kroll, 1993), it would be as easy for 'false memory syndrome' to enter the *DSM* as it was for premenstrual syndrome or self-defeating personality disorder.

[14] According to Gerrity and Solomon (1996, p. 97) the criteria for PTSD used by the American Psychiatric Association is more difficult to fulfill than that of the World Health Organization in that *DSM* requires specific intrusive symptomatology in addition to the experience or witnessing of, or being confronted with, an event that involves actual or threatened death or serious injury. *ICD-10* requires only that intrusive symptomatology be present within six months of the traumatic incident, does not require numbing or avoidance symptoms, and views arousal and other disturbances as of secondary importance. Gerrity and Solomon thus claim that these differences in diagnostic systems lead to epidemiological estimates for PTSD being lower in populations measured by the *DSM-IV* (p. 97).

[15] In June of 1996 a woman who was a former resident of the women's shelter where I work died suddenly and unexpectedly. The coroner indicated that the probable cause of death was a drug reaction to neuroleptic medication she had recently been prescribed.

[16] Information on all of these 'side-effects' has been taken from lecture material and hand-out modules from the community mental health worker course and confirmed with the *American Psychiatric Press Textbook of Psychiatry* (Talbott, Hales & Yudofsky, 1988).

[17] I will discuss the experience of this study participant, Sharon Wilkins, with ECT more fully in chapter five.

[18] For example, Greist and Jefferson suggest that when extreme memory loss is claimed by a patient who has experienced shock treatment, this memory loss "may not be apparent when tested objectively" (1992, p. 77).

# CHAPTER THREE

## Listening to Subjugated Voices:

## Research from the Margins

A sense of outrage and anger can be enabling in doing research. While status quo researchers may describe the social world as an interesting thing to study, people on the margins often have a compelling need to do research because they find the status quo so outrageous, inequitable and unsatisfying.

(Kirby & McKenna, 1989, p. 35)

Throughout the process of writing about women's experiences with the psychiatric system, I have been a researcher propelled by a need to understand something I found incomprehensible rather than a detached gatherer of data. Instead of distancing the research from my own personal intersections with the psychiatric system, I have attempted to put my own experiences of psychiatry to work as a research tool. Thus, the research process has been informed by various parts of my own identity as a social activist, a support worker and advocate, and a daughter in search of knowledge of what happened to her mother. I have been guided by the philosophy that engaging my own experiences and values will enrich both the process and outcome of this project, and produce a work which in the end is more honest than one which conceals the researcher and lays claim to objectivity. I have tried throughout this project to balance my own views with those of the research participants, and I hope that the resulting analysis will be broad enough to encompass both. This chapter is about the process of conducting the research: the routes I chose to gather information and form insight, the places where I have encountered theoretical or practical trouble and have had to reconsider my steps. The final section describes the demographic characteristics of the women who were interviewed, thereby beginning the process of placing their psychiatric experiences within the broader context of their lives.

My initial inspiration for this project came from a five month placement as a temporary office worker at a psychiatric research hospital in Ontario, where I worked as a receptionist in 1990. My job involved answering the telephones in a reception area on the geriatric ward, an adult in-patient ward, and in the emergency ward. I was given unfettered access to all conversations, happenings, and papers

which crossed or came near to my desk. On each floor my desk was situated within earshot of the glassed-in nursing stations, directly across from the elevators which many patients tried to use in weekly unsuccessful escape attempts. Before long, my chief interests in going to work were to observe staff-patient interaction, to talk to patients, and to type patients' charts. Each day held troubling observations for me: patients waiting days to speak to their psychiatrist and leaving messages through me which were ignored, nurses speaking in loud voices to one another in disparaging or mocking terms about various patients, the three times weekly trips to the electroshock floor taken by half the ward. As I began to conceive of this project, I became driven to find out more about what patients thought and felt about the treatment the psychiatric system was giving them.

I have found it not uncommon for people who research and write about the psychiatric system to be the adult children of psychiatric patients. Jane Ussher (1991, p. 3) and Bonnie Burstow (1992, p. xvii) each write of the experience of growing up with a parent who is on the receiving end of the psychiatric system, and the desire instilled in them to learn more about what happened to this parent. Similarly, my search for knowledge about psychiatry has been motivated at a deep level by my desire to understand the life of my mother, whose shadowy involvement with the psychiatric system shaped much of her life and my childhood. I have learned little specifically of my mother's story, for she is not alive to tell it, remaining family do not talk about it, and medical records have long since been destroyed. I have my own fragmented memories of having to be careful not to bother her because of her 'bad nerves,' and the family story that she left school at the age of fifteen and on the advice of a doctor who thought that school was bad for her nerves. My most concrete evidence was found not long ago in her old file of resumes: a letter to prospective employers from a doctor informing them that she had lost her last job due to a 'nervous disorder' which was now controlled through medication. My mother never again held a paid job, and what exactly this elusive nervous disorder was I will probably never know. Although I have but distorted snapshots of her life, interviewing women about their experiences with psychiatry has taught me much about the conditions under which my mother likely lived, and has helped to bring me more understanding of her life.

As anyone who has been close to me over the past few years will attest, this research project was 'lived research' in that I have carried the interviews and research with me into every facet of my life; reciprocally, this research has been informed by my own history and personal experience. During the research and writing of the project, I have had the opportunities to work at both a community-based peer counselling helpline and at a women's shelter with women and children escaping violent relationships and struggling to establish the material and emotional supports which will enable them to live independently. In my various work with women in crisis, I will always be guided by the women interviewed for this project, who taught me what it means to be listened to, believed, validated, and supported -- and alternatively, what it is like to be disbelieved, blamed, mocked, judged, and otherwise mistreated. With their guidance in mind, I have attempted to establish myself as the type of support person who is clearly 'on the side' of the women I work with. This research has proven to me that recipients of community and mental health services are frequently the best teachers for those training to work in the field.[1]

## In Search of Feminist Methods

My approach to choosing a research methodology for this study was influenced largely by the ideas of Shulamit Reinharz (1983) on experiential analysis, Maria Mies (1983) on qualitative research, and Ann Oakley (1981) on interviewing. The main principles which I bring from their methodologies to my own are: the perspective of reciprocity between researcher and participants, a respect for the subjective experience of participants, a desire to include the analysis of participants in my own analysis, and a self-reflexive approach to my own role and impressions as a researcher.

I chose a qualitative methodology in order to explore in detail women's narratives of their histories with the psychiatric system. I hoped to get to know through intensely personal accounts the ways in which involvement with the psychiatric system shapes women's identities and perspectives, what their particular treatments involved, and how they felt about what had happened to them.

Quantitative and qualitative methods have the potential to contribute in different ways to feminist research projects. For example, a recent questionnaire-based study on the views of psychiatric patients about mental health legislation in British Columbia (Trott & O'Loughlin, 1991) forms an interesting parallel with my own study. To illustrate the ways in which quantitative and qualitative data echo one another, the quantitative survey reveals that slightly more than sixty per cent of those who responded had been locked in a quiet room; using qualitative interviewing, my study is able to discuss in more depth the subjective meaning, for a woman, of being locked in a quiet room. I wanted the richness of women's own words and stories to reflect the quality, subjective meaning, and nuances of their experiences.

Feminist researchers have attempted to adapt and devise methodologies which, at very least, are non-oppressive, and, at best, hold liberatory potential for all involved. There has been discussion over whether there is such a thing as a distinctly feminist methodology, or whether feminist researchers merely apply a feminist perspective to their projects. Several feminist perspectives on conducting research influenced me in my decisions about how to proceed. Maria Mies (1983) proposes methodological guidelines for feminist research. Mies suggests that feminist research begin from a position of challenging the status quo, and replace a value-free approach with conscious partiality. The uninvolved spectator stance characteristic of traditional social science is displaced by a researcher who actively participates in social movements, and the research becomes a process of conscientization for both researchers and participants (1983, pp. 122-128). Shulamit Reinharz submits an approach she terms 'experiential research' which involves using the researcher's subjective experience of the research process as data, approaching participants as equals, and beginning without clearly formed ideas of the research outcomes (1983, pp. 175, 181).

Similar to many qualitative projects, I began this research without a clearly formulated hypothesis. Since the intention of the research was to document women's experiences with the

psychiatric system, how could I presuppose what those experiences would be before I had heard them? As Reinharz suggests, I made efforts not to develop arguments or categories of analysis prior to conducting the interviews, "so as not to create self-fulfilling prophecies in [my] research" (1983, p. 175). Since my preliminary reading and my personal experience had left me with some undeniable preconceptions that women's experiences of the psychiatric system would invariably be oppressive, I attempted to suspend my anti-psychiatry bias[2] so that it would not interfere with my ability to listen to what my interviewees had to tell me. I wanted to ensure that I would be open to learning from whatever the women I interviewed had to share, particularly when it challenged my own thinking.

A central tenet of my approach to the research was believing the women I interviewed, viewing them as the 'experts' of their own experience. This strategy led me to re-think Mies' (1983) guidelines to feminist research, which require that the research process entails consciousness-raising and is linked with broader political movements. For what was I to do when encountering a woman who was invested in a biological model of mental illness, who believed she was mentally ill and required psychotropic drugs? Mies' guidelines would place me in the role of 'expert' educating a woman about feminist critiques of psychiatry. Phyllis Chesler found herself in this situation and chose to follow a strategy similar to the one Mies suggests:

> I participated very actively in the conversations and, after no more than an hour's grace, expressed my views, sometimes beyond the point of mild disagreement.... I remember arguing with someone about whether or not she was 'crazy:' after six years of therapy and two hospital commitments, she thought she was, I thought she wasn't. Slowly, some remembered fear silenced her. Slowly, and quite emphatically, she began agreeing with me -- with *Dr.* Chesler, of course (1972, p. 123).

I chose not to argue with participants or attempt to persuade them to my views, for this seemed disrespectful of their own abilities to analyze their situations. This is not to say that 'believing the interviewee' is a simple principle, free from tension, for it is not. There were many times in which a woman's assessment of her situation diverged from my own. In such a situation, I would ask questions of the woman to see if I could suggest a line of analysis she had not considered. But I would neither

argue, nor attempt to persuade. Ultimately, the situations in which an interviewee and I disagreed represented sites of tension which signalled to me a need to re-think my position in light of her perspective.

'Believing the interviewee' is a process which operates on more than one level. One criticism likely to be levelled at this project from the mainstream is that it takes as its source of authority the words of psychiatric patients, a group of people not generally considered a credible source of information. Accounts of professional misconduct recorded in this study may be dismissed as the ramblings of 'crazy women.' My position of 'believing the interviewee' requires this research to be based on the belief that what women say about events in their lives and the ways they were treated by psychiatric professionals is credible. The women interviewed for this project represent what Michel Foucault terms 'subjugated knowledges,' that is:

> a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity (1980, p. 82).

This is not to say that the women interviewed for this project speak the 'truth' about psychiatry, for the truth will be spoken differently by invested parties with experiences of psychiatry from both professional and subjugated positions. Indeed, the women interviewed for the project frequently diverge from one another in their analyses about psychiatry and mental illness.

Feminist standpoint theory would argue that women psychiatric patients have access to a more encompassing knowledge about the psychiatric system, precisely because of their subjugated position.[3] Believing the interviewee involves listening to, and finding credible, women's accounts of their experiences of subordination in relation to psychiatry. I discovered in conducting the interviews, however, that there are many places where the women's knowledge about specific aspects of their treatment was sketchy and incomplete. Often this was because the women had not been fully informed about their treatments and diagnoses. This situation also produces a certain kind of knowledge about the relationship between psychiatric system and patient. At other times, the interviewees' knowledge was limited because of the failure of memory. This also has the potential to produce knowledge about

62

psychiatry, if it were possible to distinguish between commonplace memory loss due to the passage of time and extraordinary memory loss induced by specific psychiatric practices such as electroshock and certain drugs. However, the knowledge of the women patients I have interviewed is necessarily limited in that it is only one half of the relation. Specific knowledge of what kinds of treatments were given to the women, and for what reasons, can only come from those in authority who treated them.

My desire to better contextualize the experiences reported by study participants within the broader context of the psychiatric system led me to seek knowledge about the psychiatric system from sources beyond the interviews. As Reinharz observes, "it is easy to understand how a feminist ethnographer can take information in from everywhere, at all times, for her project" (1992, p. 55). Although I was able to make use at times of my own experiences working within a psychiatric institution, my need to understand psychiatric discourse and practices more specifically led me to register for a community college course designed for community mental health workers. My experiences in this course provided much of the groundwork for chapter two, thereby allowing me to frame the interviews with study participants with some analysis of the psychiatric system itself.

In summary, the primary method I selected for this project was in-depth, semi-structured interviewing. Interviews were taped and transcribed verbatim; interviewees received and commented upon their transcripts, and the transcripts were revised according to the request of the interviewees. Transcripts were analyzed through content analysis, a process by which I read the interviews carefully in relation to one another. I excerpted quotations by theme from each interview, and housed them in computer files according to theme. I analyzed my journals from the community mental health worker class, and incorporated these experiences where they seemed best to contextualize information from the interviews.

## The Interviews

I interviewed a total of twenty-four women between August of 1993 and August of 1994: twelve women from the Lower Mainland in British Columbia, eleven from an urban centre in Saskatchewan, and one in an urban centre in Ontario. In the course of my interviewing year, I brought

63

my tape recorder wherever I travelled and interviewed women from the communities in which I stayed. Most participants came to me through posters I distributed in public places such as community centres, women's centres, libraries, universities and colleges, community service agencies, and public swimming pools. Several participants were previously known to me and expressed an interest in being interviewed for the project; five came to me through the snowball technique, referred by others who had taken part. Interviews were conducted in a private location chosen by the study participant, in most cases the participant's home. Several interviews were conducted in my home at the interviewee's request, usually for the sake of her convenience or her privacy. Two interviews occurred in a university office for the sake of mutual convenience.

Participants signed a consent form (Appendix A) before the interview began, and at this time selected a pseudonym, consisting of both given and surnames, by which they wished to be known in the project. Several women wished to use their own names. In the end, three participants chose to bring their pseudonyms closer to their real names, and one elected to alter her pseudonym to ensure that her identity was more completely disguised.

Interviews lasted anywhere from an hour and a half to four hours, based on the pace at which the participant told her story. Women were interviewed alone unless they requested otherwise: one mother-daughter pair and two friends asked to be interviewed together. Mostly, the interviews took place in one sitting with breaks initiated by either myself or the interviewee. Two interviews were scheduled in installments over several days, one for the sake of scheduling, and the other to allow the participant a break due to painful memories raised for her in the interview.

I was influenced in my interviewing style by Ann Oakley (1981), who writes of the ways in which she found the conventional interviewing paradigm inadquate to account for her experience of interviewing women. Oakley notes that the sociological tradition demands that interviewer and respondent behave in ascribed social roles, which become inappropriate when a feminist interviews women. For example, conventional social science interviewing tends to position interviewer as an impersonal authority who must juggle professional aloofness with the necessity of achieving a certain

degree of rapport. Adopting such a professional demeanor when interviewing women, Oakley argues, leads feminist researchers to the paradoxical situation of "objectifying your sister" (p. 41).

With Oakley's (1981) arguments as guidance, I set out to do my interviews in a manner which consciously attempted to equalize the interviewing relationship. I assumed a presence that was non-judgemental and more inclined toward listening than talking, in order to elicit whatever information a woman wanted to share. In the place of the traditional researcher's distance and neutrality, I attempted to convey my genuine interest in each woman through taking time to build rapport. I shared with each woman at the outset my personal reasons for conducting the research, hoping to set a tone for personal disclosure and lend some balance to the power differential inherent in interviewing.

Similar to Oakley (1981), I found that the women I interviewed asked many questions of me. Women asked me about my experience as a daughter of a woman involved in the psychiatric system. They asked me about my own experiences in feminist therapy, my personal relationships and support systems, and my experience of women's studies. The women also expressed great interest in the research, what sorts of trends I was noticing, and what types of experiences other women I had interviewed had reported. While textbooks on interviewing instruct interviewers to shrug off such questions, Oakley interprets this type of interviewing behaviour to be disrespectful and irresponsible. Similarly, I found that the women I interviewed offered me the gifts of their personal stories; some also shared with me journals, letters, excerpts from hospital files, and photographs of their families. To refuse to answer their questions would have created almost a mirror image of an encounter with the psychiatric system: a relation in which one party emotionally disrobes before a professional voyeur. To avoid this type of interviewing relation, I chose at times to disclose information about myself, certainly when questioned, and to clearly position myself as an ally of the women being interviewed. I wanted the interviews to have a quality of informal sharing of information and experiences between women talking about a subject of mutual interest. In reflecting upon the interviews, establishing rapport was critical to ensuring that the interview was a positive experience for the women who participated. Taking care to build a level of comfort and trust with the women interviewed, I would argue, also contributes to achieving a higher quality of data: an interview participant who is at ease

with the interviewing process is more likely to share experiences honestly and at a more intimate level than one who must defend herself against an authoritarian and objectifying research experience.

I used a structured questionnaire (Appendix B) as a guide, choosing the questions appropriate to elicit each woman's story.[4] Upon receiving clearance from the university ethics committee, I pre-tested the questionnaire by interviewing two friends whom I had consulted in planning the study and who had experiences of psychiatric treatment. Based on their interviews I made slight modifications to the interview format, and I have included their interviews in the total. The majority of participants (n=21) requested their transcript, and all asked for the summary of results. Most of those women who received their transcripts corresponded with me again, either by telephone or in writing, and made some (usually minor) editorial changes. Many took the opportunity to share with me any ways that their thoughts had changed about psychiatry since we had last spoken, information about additional psychiatric treatment they had received, and projects they were now involved in to empower themselves or other women.

Feedback from study participants indicated to me that for many of the women the interviews were an important part of a process for them of understanding their psychiatric experience and placing it in the context of their lives as women. Some of the participants, particularly the women from Saskatchewan, were overwhelmingly enthusiastic about the project. In contrast to the participants in British Columbia who contacted me slowly, I received three telephone calls within hours of placing my first sign in Saskatchewan at a public library. Cara Sun[5] told me in our initial telephone conversation: "I have no words to express my feelings at seeing the ad." For the women in Saskatchewan, the opportunity to talk to someone about their psychiatric experiences was often a first; that I was an outsider was to my advantage, for the community was small and the stigma ran deep.[6] For many women, both in Saskatchewan and the Lower Mainland, the chance to tell someone about their experiences was extremely cathartic. Janet Moffat told me at the time of her interview, "nobody's listened to my story, nobody's listened to my full, comprehensive story -- except now I'm telling it with you." Such comments speak clearly not only to the experience of the interview, but also to the women's experiences in the psychiatric system and the isolation which characterizes their lives.

Another source of feedback came from follow-up interviews I conducted with three of the women, approximately one year after their original interviews. Angel Anne Lowen and Tessa Jones, both from Saskatchewan asked if they could meet with me again when they were vacationing in British Columbia. We spent a day together in Vancouver and spoke about the interviews we had done one year before. At the end of the day we recorded a follow-up interview which was spontaneous and interviewee-guided. I began with no questions other than to ask them if their perspectives on the psychiatric system had shifted over the year since we had last talked. The interview developed as a dialogue among the three of us. The transcript of this interview gives perspective to each of their first interviews and reveals the development of their analyses about their respective relationships to psychiatry.

The other follow-up interview, with Sharon Wilkins, was initiated by me, after she returned her edited transcript with a poignant letter describing two further suicide attempts, a hospitalization, and a series of shock treatments which had happened in the past year. I had felt uneasy after the first interview, uncomfortable with my sense of Sharon's well-being, and thought about her for many months. I was relieved to receive her returned transcripts, and out of my own desire to re-connect with her, asked her if she would talk with me again about her experiences over the past year. Our second interview lends perspective to the project and to Sharon's personal history, as will become clear in later chapters. I have no idea whether our conversations were useful for her. I felt torn between my role as a researcher and a helper role I wanted to be able to take. This interviewing situation formed for me a microcosm of the problems I discovered about women's relationship to psychiatric and other mental health services. Ethical issues were raised for me about interviewing a suicidal woman: does a researcher in this situation have an obligation to 'blow the whistle' and call in psychiatric authorities in an attempt to prevent another suicide attempt? Could I contact non-psychiatric, alternative crisis services to try to 'save' her? I walked on eggshells throughout both interviews, trying to decipher whether another suicide attempt was imminent and whether Sharon was talking to me in order to try to get help. In the end, I could do little more than listen; sadly, Sharon was only too well connected with helping professionals. The one suicide prevention counselling service in town had referred her back to

her psychiatrist because their mandate does not allow them to counsel psychiatric patients; she was in regular contact with the only help available to her, her psychiatrist and a mental health clinic. Their involvement following her suicide attempts in the past had seemed only to drive her further into her state of apathy toward life, and her memory was still seriously impaired from the last round of shock treatments she had received six months before.

Looking back on my years of interviewing and transcribing, I can clearly recognize in myself the types of stress responses that have been described by interviewers involved in feminist research projects which document women's painful experiences (Reinharz, 1992, pp. 34-46). Many, if not most, of the interviews I conducted contain poignant accounts of emotional, physical, and sexual violence; mothering without support and resources; poverty and hopelessness; suicide attempts; and re-victimization by those in helping positions. Being the container for these stories has left me feeling alternately hopeless, filled with rage, and inspired.

## The Interview Participants

My initial intention was to interview as diverse a group of women as possible. In this effort, I have succeeded in some respects and failed in others. The twenty-four women included in the project range broadly in terms of age, socio-economic background, sexual orientation, mothering experience, and physical ability.[7] They are, however, a relatively culturally homogeneous group. All but one of the women interviewed is white and of European descent; the one non-white woman is of First Nations heritage. Four of the women were born outside Canada: in England, Holland, New Zealand, and the United States, respectively. Four of the women identify their cultural background as Jewish. Three of the women are French Canadian. Therefore, while my sample reflects some limited diversity in cultural background, noticeably absent are the experiences of women of colour.

Without much doubt, the cultural homogeneity of my sample is both a product of my own identity as a white woman, and the limitations of hanging posters as a recruitment strategy. Usually, a self-selected sample responding to posters placed in public areas tend to be literate white women raised in middle-class families. Cannon *et al* (1991) have documented that it is far more labour-intensive to

attract women of colour to participate in research than white women. Conventional recruitment techniques such as using the media and mail-outs to organizations elicit response overwhelmingly from white women. Attracting women of colour to participate in research requires personal contact and building trust; it is also advisable for women of colour to be involved as researchers and to financially compensate research participants for their time, since women of colour on average are more economically disadvantaged than white women. Phyllis Chesler's (1972) success in interviewing a number of women of colour for *Women and Madness* may in part be a reflection of the fact that she arranged for a woman of colour to conduct interviews with this group of women.

While this study bears the limitation of speaking almost entirely from the experiences of white women, a truly diverse sample would likely have yielded information difficult to analyze. "To generate theory, it is much more useful if the small samples under study are relatively homogeneous, since extreme diversity makes the task of identifying common patterns almost impossible" (Cannon *et al*, 1991: 115). This study, then, must be read bearing in mind that it will not illuminate the experiences of all women; documenting the experiences of women from specific cultural backgrounds with the psychiatric system will need to be the topic of other studies.

A self-selected sample of people who respond to posters in public places will suffer from limitations other than cultural diversity. Noting interest in a poster and calling up a researcher to be interviewed requires being out in the community somewhere to see such a sign, the ability to focus upon and read such a sign, and enough confidence to make the phone call. As a result, this sample also represents a group of women who, on the whole, are surviving the psychiatric system well enough to respond to a poster. This is not a random sampling of psychiatric patients any more than it is a random sampling of women. Although some of the women in the sample have undergone psychiatric treatment in a continuing pattern over many decades, none have been hospitalized for more than four months. Therefore, this sample does not at all represent women who have been institutionalized for years of their lives.

The majority of women who volunteered to participate in this study have had some exposure to mental health services other than those provided in psychiatric settings. Many had experiences in

particular with feminist therapy, and self-help groups and literature. Only five women had experienced no counselling or psychotherapy of any sort. Ten women had experiences with 'mainstream' counselling or psychotherapy from mental health professionals such as psychologists, social workers, or other psychotherapists with varied forms of training in counselling. One woman held a Master's degree in a counselling discipline and practised as a psychotherapist herself. Twelve women had experienced a counselling relationship with a professional they recognized as a feminist therapist. Six women had attended self-help groups adhering to a twelve-step model, such as Adult Children of Alcoholics. Many were familiar with self-help literature directed toward survivors of childhood sexual abuse. Two women spoke of using self-help books as a regular method of self-care. One woman had experiences with 'alternative healing' methods such as First Nations spiritual practices and bodywork.[8] One woman had volunteered in a women's centre; another in a women's shelter. Without doubt, the women interviewed for this study reflect and interpret their experiences with the psychiatric system through a lens which is constructed not only as a response to their psychiatric histories, but also through experiences with other forms of mental health services, self-help, and the various discourses of popular psychology which are in common cultural currency.

That a large number of study participants had experiences with psychotherapy, and feminist therapy in particular, may speak partly to their reasons for participating in this study. It stands to reason that experiencing the contrasting approaches of biological psychiatry and psychotherapy, particularly feminist therapy, may have inspired study participants to respond to an opportunity to speak to a feminist researcher about their experiences with the psychiatric system. Experiencing a different approach to mental health issues may well have led many study participants to understandings which made them more critical of the psychiatric system than patients who had not experienced feminist and other modes of psychotherapy. This sample also contains a large number of women who told me about having what I refer to as a 'psychiatric role model,' that is, a person in their immediate family growing up who was psychiatrically treated prior to their own treatment. Experiencing the double impact of one's own psychiatric treatment and that of a close family member may also have led study participants to be interested in such a study.

Despite the limitations due to sampling technique, the women interviewed do represent some diversity of experience (see Appendix C). At the time the interviews were conducted, the women ranged in age from twenty-four to sixty-three, with an average age of forty. Four of the women were in their twenties; eight in their thirties; eight in their forties; two in their fifties; and two in their sixties. Their experiences with the psychiatric system spanned from the 1950s through the 1990s, with the majority of women having episodes of treatment in more than one decade and the highest concentration of experiences in the 1980s and 1990s. Although the interviews were conducted in urban or suburban locations, the actual psychiatric experiences depicted occurred in a mix of rural, urban, and suburban settings.

I interviewed a large proportion of women who identified their sexual orientation as other than heterosexual. This was likely influenced by my own identity as a lesbian, since a significant number of the lesbian, bisexual, or unsure women (8 of 14) either were previously known to me or were referred by their friends who had participated. Ten of the women identified themselves as heterosexual; nine, as lesbians; two, as bisexual; and three indicated that they were unsure of their sexual orientation. Two of the women told me that they were celibate. That more than half of the women who volunteered for this study positioned themselves outside the institution of heterosexuality undoubtedly has a strong impact on the results, and allows for some comparisons of experience based on sexual identity. The non-heterosexual women, for example, were far more likely to seek out the services of feminist psychotherapists. Ten of fourteen non-heterosexual participants had experiences with feminist therapy, as opposed to only two of ten heterosexual women.

At the time of the interview, four of the women were married to the same spouse they had originally married; two had re-married after a divorce, and one of the re-married women was widowed. Three women were in long-term same-sex relationships. Twelve of the women had never been legally married; five were divorced. Eleven of the women were mothers; collectively they had been responsible for raising twenty-one children. Of six women who currently had young children living at home, only one of these women was raising her children in the context of a heterosexual marriage. Two of the mothers were raising their own or their partner's children in the context of a lesbian relationship; one

was a lesbian single mother. Another woman was raising two foster children on her own. In contrast, the five women with grown children had raised their children in the context of a traditional marriage.

Feminist theorists have noted the difficulty in defining the socio-economic status of women using traditional sociological methods which attribute a woman's status inconsistently based on the occupation of her husband, her father, or herself, depending on the study and the woman's marital status (Delphy, 1981). Additional difficulties arise in terms of accounting for women's unpaid work in the home and their high concentration in part-time work, as well as the vulnerability of married women to poverty in the event of the dissolution of marriage. As shown in Appendix D, the variable of socio-economic class is particularly complex in this sample, in part because it consists entirely of women, and in part because of the women's interaction with the psychiatric system. Five of the women were raised working-class, although at the time of the interview fourteen were working-class or poor in terms of their own income and/or occupation.[9] Ten of the women had been raised middle-class, six lower-middle-class, and three upper-middle-class. Fourteen of the women experienced a decline in their socio-economic status in relation to their parents. Three experienced a rise in socio-economic status, and seven were economically stable intergenerationally. The poverty of the majority of the women appears to be a complex interaction between the feminization of poverty and the poverty produced by a psychiatric history. Of the fourteen women living poor or working-class at the time of the interview, none was in an intimate relationship with a man who contributed to the household income. Most lived alone; three lived with their children; one lived with a woman partner.

Despite their low incomes, the women in this sample are relatively well educated. Two hold graduate degrees; seven are university graduates; eight have attended some university; two have completed a community college program; and the remaining five completed high school. Of the seven university graduates, two did their university training as mature students, after having raised their children. Seven of the women were working full-time, and seven part-time, at the time of the interview. Three were unemployed and looking for work; two were unemployed on long-term disability benefits; and one was retired. Two women were housewives, doing unpaid work in the home.

The women also varied in the extent of their psychiatric treatment, as shown in Appendix E. Nineteen of twenty-four had been hospitalized. Of those nineteen, ten had been hospitalized involuntarily. Five had been hospitalized at least once in a provincial mental hospital; the remaining fourteen had been hospitalized only in general hospital psychiatric wards. As a group, they had experienced at least fifty hospitalizations. Of these hospitalizations, at least seventeen were involuntary and at least twenty-four were voluntary.[10] The longest hospitalization recorded in the study was four months: three of the women had been hospitalized for a four month period. The shortest hospitalization was a matter of hours, when a woman checked herself into hospital and then changed her mind and left; two other women successfully escaped from hospital the same day they had been certified.

Five of the women interviewed for the project had never been hospitalized but had experienced outpatient treatment, consisting of counselling or medication monitoring by a psychiatrist, or an outpatient program run through a hospital. Of twenty-four women interviewed, only three had experienced psychiatric treatment consisting of counselling and no physical treatments. Twenty had been treated with psychiatric drugs; seven with electroconvulsive treatment (ECT); and two with insulin coma treatment. Of the seven who experienced ECT, two had been treated in the 1950s, one in the 1960s, and four in the 1990s. Both of the experiences with insulin coma treatment had occurred in the 1950s.

Nine of the women had never been informed of a psychiatric diagnosis given to them, although one had been told she had a 'nervous disorder.' Seven had been diagnosed with depression; six with bipolar disorder (otherwise known as manic depression); four with schizophrenia; four with anxiety disorders; and four with personality disorders. One woman had been diagnosed with pre-menstrual syndrome and another with organic brain disorder. Eight women had experienced at least one shift in their diagnosis; two of the women had respectively been given four different diagnoses.

Of the twenty women treated with psychiatric drugs, seventeen were given antidepressants; ten, antipsychotics or neuroleptics; eight, antianxiety drugs; seven, anti-manic drugs; seven, sleeping pills; and two, anti-parkinsonian drugs to counter 'side-effects' of other drugs. Six of twenty-four women

interviewed consider themselves to have a mental illness; two others consider that they had a mental illness in the past. One woman does not like the term 'mental illness,' but does perceive that she has a psychiatric disability; another woman believes that what is 'wrong with her' is hormonal rather than psychiatric. Two women were unsure whether they would consider themselves to have a mental illness or not. The remaining twelve do not consider themselves to have, or ever have had, a mental illness.

In summary, this research is grounded in the voices of twenty-four women who have been interviewed about their experiences of psychiatric treatment. Where I have assessed a need to contextualize these women's words in the wider context of psychiatric thinking and practice, I use my own experiences in the community mental health course to expand arguments or provide background knowledge. This chapter additionally has introduced the reader to the women interviewed for the project in terms of their demographic characteristics as a group. Through the chapters to follow, I will use the words of the women interviewed wherever possible to express their experiences and analytic viewpoints in their own voices. The next chapter reveals some background about the lives of the women who were interviewed for this project and the circumstances which led to them to enter the psychiatric system for the first time.

## NOTES

---

[1] This observation was confirmed for me in the final class of the community mental health worker course in which a mental health 'consumer' activist participated as a guest speaker. Many students commented that it was this class in which they had learned the most.

[2] My ideas around suspending bias are derived from the concept of suspending disbelief which I learned years ago in a religious ethics class. Suspending disbelief is the exercise of acknowledging one's own feelings and ideas about an issue and the cultural roots which inform these opinions, then attempting to suspend these opinions while listening to those of the other side. Such an exercise may be conducted to assist people to come to more complete understandings of controversial and culturally-laden issues such as abortion and suicide. The aim is to allow a thinker to develop a more comprehensive analysis by 'trying on' both sides of an argument.

[3] Dorothy Smith builds an analysis of the standpoint of women in *The Conceptual Practices of Power*. Toronto: Univ. of Toronto Press, 1990.

[4] Many interview participants jumped ahead of the questionnaire and told their entire story as it made sense to them. I allowed, indeed encouraged, this and later went back through the questionaire to ask questions which would elicit information not yet revealed.

[5] The names of all study participants to whom I refer are the pseudonyms chosen by the women themselves.

[6] Several of the Saskatchewan participants told me that they would not have consented to participate in the study had I not been from a community outside the province.

[7] Four women identified themselves as having a physical disability. Two of these disabilities were visible, two were invisible. One additional woman identified herself as having a psychiatric disability.

[8] Bodywork therapies are enormously varied. Some popular techniques include reiki, cranial sacral, healing touch, and rolfing. Although there are many varieties of bodywork, they tend to be informed by a common philosophy that mind, body, and spirit are connected, and that working with the body and its energy fields helps to release traumas and tensions which are held in the body.

[9] In order to determine socio-economic status, I asked each woman questions about the education level and occupation of each of her parents, her own educational background and occupation, and her personal and household income. I also asked each woman to tell me what she considered the social class of her family to have been while she was growing up, and what she considered to be her social class now. In most cases, given the information the woman provided, both she and I agreed upon her current and family's social class. In order to address the situations in which a study participant's and my own assessment of social class differed, I asked a third person to assess social class given the background information. If the third person and I both disagreed with the study participant's assessment, I relied on my own determination.

[10] These calculations are approximate, as one woman who had been a psychiatric patient consistently for four decades could not remember the exact number of hospitalizations she had experienced, but estimated at least ten. At least two, but perhaps more, of these hospitalizations were involuntary.

# CHAPTER FOUR

## It's Been a Long Road Getting Here:

## Becoming a Patient

Women as a group have less access to power, less access to resources in society, and yet are expected to care, to mother, to provide that particularly female gift, nurturance and security. At the same time, women are subjected to abuse, verbal, physical and sexual -- abuse which erodes a sense of positive identity. The all-caring, coping woman is both marginalized and derided. And who cares for women? Perhaps that is part of the problem. Even when they are in supposedly supportive relationships, such as marriage, women seem to suffer... for marriage is not good for our health -- despite the myth of 'happy ever after' we are reared on.

(Ussher, 1991, p. 259)

Erving Goffman wrote that people in psychiatric hospitals often suffer more from contingencies than from mental illness (1961, p. 35). By this he meant that those who wind up in psychiatric institutions get there as the result of circumstances in their lives; additionally, on their way to the mental hospital patients pass through the hands of many agents, including relatives, neighbours, police and doctors, who aid in the journey to the hospital. The same can be said of the women in this study. Each woman I interviewed came to the psychiatric system through a number of life experiences, most of which were mediated by gender, combined with an absence of other resources and options. Women in this study suffered from such 'contingencies' as: childhood physical, emotional and sexual abuse; abuse in intimate relationships; sexual assault; coming out as lesbian or bisexual; mothering without support; the institution of marriage; and poverty and unemployment. A significant number of them also had a psychiatric role model, in terms of a close family member who had become established as a psychiatric patient while they were growing up. In this chapter I will describe the ways in which the specific histories of the women interviewed for this project brought their lives to the point of intersection with psychiatry, and relate what the women in retrospect think they needed at the time. Using their stories, I will argue that the social and political conditions of the women's lives are sufficient to account for their involvement with the psychiatric system without any need to resort to theories of biological origins of mental illness.

Adolescence and young adulthood were the most frequent points of initial entry to the psychiatric system for the women interviewed for this project. Half of the women experienced their first encounter with the psychiatric system before their twentieth birthday. All but two had experienced their first encounter before the age of thirty. The earliest age at which a participant first experienced psychiatric intervention was twelve; the latest, thirty-five. Women who were lesbian, bisexual or unsure of their sexual orientation experienced their first encounter with psychiatry at an average age of 19.64, in contrast with the heterosexual women in the sample who experienced their first encounter at an average age of 23.1. These findings are in agreement with those of Phyllis Chesler, whose interview study also found that lesbians experienced psychiatric intervention on average several years younger than heterosexual women (1972, p. 128).

Most of the women first treated before the age of twenty were victims of child abuse. In the group first treated between the ages of twenty and thirty, the first psychiatric episode was most frequently triggered by abuse in a relationship, sexual assault, surfacing memories of childhood sexual abuse, or issues around sexual orientation.

For one quarter of the women (n= 6) interviewed, their psychiatric experience was thus far an isolated event in their lives, usually correlated with a specific situational factor, such as child abuse, coming out as a lesbian, or mothering. For another quarter of the women (n= 6), their psychiatric experiences followed an episodic type of pattern throughout their life stages. For example, Sharon Wilkins had one brief psychiatric episode at the age of seventeen in response to the death of her mother; her far more serious psychiatric episode did not occur for another thirty years when she was mothering her own children. Another variation on this pattern is expressed by Mabel Abelone who experienced her most significant encounters with psychiatry between the ages of twelve and seventeen as a result of childhood sexual abuse; Mabel then had one brief psychiatric episode in her fifties triggered by her need to decide whether to leave her alcoholic husband.

Half of the women interviewed (n= 12) had a continuing pattern of psychiatric episodes in which the initial experience with psychiatry, at whatever age, was followed quickly by another episode

and then another, sometimes over a number of decades, such that episodes were not distinct from one another. Cara Sun, for example, first became a psychiatric patient when she was hospitalized at the age of nineteen following a background of childhood sexual abuse, the suicide of her father, and a recent sexual assault. Cara's psychiatric involvement continued on an outpatient basis throughout her adult life until the point of our interview when she was nearly forty years old and mandated by social services to continue psychiatric treatment in order to receive disability payments. Mari Smith was first hospitalized in her late twenties after a sexual assault and after expressing a desire to leave her husband. Mari was diagnosed schizophrenic, treated with ECT and insulin shock, and spent many years in and out of the provincial mental hospital in revolving door fashion. When I interviewed her, Mari was in her early sixties and living in subsidized housing for psychiatric patients; she was continuing to be treated with neuroleptic drugs and monitored by the local mental health team.

Some interesting patterns emerged involving sexual orientation and course of treatment. Five of six women whose treatment followed an episodic pattern considered themselves heterosexual. The sixth woman was unsure about her sexual orientation, but had a heterosexual relationship history. Four of six women whose psychiatric treatment was an isolated event were lesbians. Nine of the twelve women for whom psychiatric treatment was continual considered themselves non-heterosexual: four were lesbians, two were bisexual; two were celibate, and one was unsure. This pattern suggests that heterosexual women may be more likely to encounter psychiatric treatment at particular life stages which are heavily gender-laden, such as adolescence, motherhood, marital breakdown, and middle-age. The women who did not identify as heterosexual had greater likelihood of experiencing psychiatric intervention as a singular event, often around the time of coming out as a lesbian, or as a continuing pattern, possibly suggesting a way in which their sexual identity constructs them as problematic in a continuing way.

These few examples illustrate the startling commonalities and differences among the life histories of study participants and the ways in which psychiatric treatment became integrated into various stages of their lives in response to specific traumas or struggles. In the next sections I will

attempt to unravel the ways in which particular social and political conditions of the participants' lives, combined with the resources available to them, paved the way to their involvement with the psychiatric system.

**Experiencing Violence**

Pat Capponi, who describes herself as a psychiatric survivor, writes in her autobiography of her first escape to a psychiatric ward from the sadistic child abuse she endured from her father. When her father attempts to persuade her to return home with the threat of what might happen to her in hospital -- "drugs, shock treatments, operations on your brain" -- she thinks to herself, "anything is better than going back with you." (1992, p. 54). As Capponi phrases it: "At times a hospital, in spite of all its terrors, is the only place left to run" (p. 50). Like Capponi, many of the women interviewed for this study turned to the psychiatric system to escape, if only temporarily, an intolerable situation in their lives. Others were turned over to psychiatrists and psychiatric hospitalization by the very people in their lives from whom they might have wanted to escape, thus enhancing the image of an abusive partner or father as all-powerful.

Sexual abuse, described by Bonnie Burstow as "our common plight as women" (1992, p. 113), was without doubt a common experience of the interview participants. Twelve women told me directly that they had been sexually abused when they were children; two others did not use the term, but described incidents in which they had been sexualized as children in combination with other forms of abuse. The rate of childhood sexual abuse of the women interviewed for this study (between 50 and 58%) contrasts with the generally accepted estimates of one in four women (Rush, 1980, p. 4) or one in three women (Herman, 1992, p. 30) in the general population. Nine women in the study revealed that they had been physically abused in childhood; seven women had been both physically and sexually abused.[1]

A conservative reading of the childhood histories of the study participants would indicate that fifty-eight percent (n=14) described sexual or physical abuse. This finding is similar to another study

which used conservative criteria to define abuse and found physical or sexual abuse histories in fifty-three percent of women patients in a study of 188 psychiatric in-patient files (Carmen *et al*, 1984). Using conservative criteria, however, would exclude the experience of emotional abuse and covert sexual abuse[2] which many participants described as extremely relevant to their development of identity and self-esteem. For example, Ann Johnstone has no memories of physical or overt sexual abuse, and yet links her life-long problems with eating, intense unhappiness and anxiety to severe emotional abuse and covert sexual abuse while growing up. Sixteen of twenty-four women described growing up with emotional abuse. Eighteen of the women in total described some form of abuse in childhood.

In contrast to Pat Capponi, quoted above, most of the women coping with abusive situations did not turn to the psychiatric system as a strategic way to find protection from abuse; rather, they encountered the psychiatric system, in desperation, when all other avenues were either exhausted or inaccessible. Usually, seeking help from psychiatric avenues signified that a woman viewed the problem as internal; being taken by others to psychiatric services signified that the woman herself was viewed as the problem by others. Regardless of the intentions of those seeking help, however, for those who first went to psychiatric services as adolescents living in abusive homes, the psychiatric interaction represented an opportunity to stop the violence. However, in none of the situations where this opportunity existed was the psychiatric system successful in addressing child abuse.

One painful example is Angel Anne Lowen's first psychiatric encounter when she was sixteen in the mid 1980s. Angel Anne's childhood was punctuated with physical and sexual abuse by her father. One incident she remembered as particularly horrible: "[My father] fractured my skull that time. He almost killed me. Busted chairs over me, threw me through a wall, threw me up against the bed, busted stools over me." After this beating, Angel Anne's mother and grandmother pleaded with her to agree to see a psychiatrist with her parents; they convinced her that it was the only way that her father would seek help for his violence. Reluctantly, Angel Anne agreed, and the family drove from their small town to the mental health clinic in the city. The mental health professionals involved interviewed Angel Anne and her father separately, and told Angel Anne that she would need to press

assault charges against her father before they could remove her from the family home. Being too afraid to press charges, she was released back to the family home, her father having been given a verbal warning that child beating was illegal. The professionals requested that Angel Anne's father return for several more sessions, which he did. Although he did not beat his daughter again, the sexual abuse continued unchecked. Years later, Angel Anne did charge her father with assault and found that the evidence of her physical assault contained in the mental health clinic files was strong enough to have her father convicted. However, it did not give her protection when she needed it most. Angel Anne reflects:

> I really did think it was my fault.... Because of the way I acted and I didn't have any support in the community. I mean, I was known as a big slut. And I just didn't feel very good about myself.... The teachers knew because he beat me up in front of them at a party, and every time I went off he called the RCMP, if I went out he'd always get them to go pick me up and everyone was scared of him. I didn't feel like I could talk to anybody. I was scared to go get help.

Angel Anne's psychiatric involvement was continuous after her first encounter, as was her drug and alcohol abuse. She understands her subsequent psychiatric episodes to be the result of coping as an adult with the long-term emotional consequences of her childhood abuse.

Other adolescent women were forced into psychiatric treatment when they inadvertently spoke of the sexual abuse they endured at home, or when their abuser was most afraid that they would tell. Mabel Abelone remembers her first imprisonment in the provincial mental hospital at the age of twelve in the early 1950s as being directly linked to the sexual abuse she endured at the hands of multiple offenders.

> [I was sexually abused by] a hired man.... And it was like -- well, at least somebody's paying attention to me. Before that, I guess it was my brother. And then after the hired man was my other brother, and then my other brother, and -- none of them were harsh or forcing; it was just like, we're going to do this now. And why I didn't scream or run away I don't know. Then, the last one was my dad. And with my dad, I actually had sexual intercourse. I think I was probably eleven.... I just vowed that I would just never ever *ever* be alone with him anywhere. And I made sure that never happened again. And that *was* the last time.

Mabel eventually became seriously ill and spent a summer bedridden with what may have been a sexually transmitted disease. She does not remember telling anyone about the sexual abuse, but thinks she may have spoken during her delirium. Mabel was first taken to a general hospital to treat the physical disease, and from there was transferred to the provincial mental hospital where she was given shock treatment and confined for four months. She remembers that a doctor and nurse were going to give her a vaginal examination, but decided against it when she became upset. Mabel also remembers a pattern of moral interrogation from a social worker:[3]

> The social worker used to come in and... she would try to get me to say that I'd done something bad. And she'd say, 'well, you must have got drunk,' or 'maybe you're pregnant,' or 'maybe you did this or that.' And I'd say, *'No!'* And I never broke down. I just got more and more hard.

Two decades later, Mary Taylor experienced a similar systemic response to her sexual abuse. In Mary's situation, her father, who held a prominent position in the town in which she grew up, managed to arrange for her commitment to a hospital for the criminally insane. Mary was eighteen years old and had recently left home to escape sexual abuse from her father and brother. Although a lawyer was able to arrange for her release within a week, the trauma of having been imprisoned remained.

> It took everything I had just to survive it. I had nightmares for about seven years every night after being locked away. So that was the effect it had. It totally shook me up that somebody could take me away and lock me up when I hadn't done anything wrong.

Other women described the ways that they coped with abusive and oppressive home environments; frequently coping mechanisms for managing emotional pain were noticed and resulted in the adolescent being referred for psychiatric treatment. Bonnie Burstow writes that feminist therapeutic work with sexual abuse survivors "involves addressing the cutting, the burning, the starving, the drinking, the blanking out, the fragmentation, the 'slutting,' the prostituting" (1992, p. 126) which are common coping behaviours. Certainly, many of the abuse survivors interviewed for this project used such behaviours to manage their emotional pain; these behaviours were pathologized

by the participants and others in their lives, and when discovered made them vulnerable to psychiatric intervention.

For study participants like Cara Sun and Graham Black, it was the discovery of their cutting behaviour which led each to her first hospitalization. Both were adolescents. Cara had a long history of sexual abuse and had not long before been raped. Graham was coping with an authoritarian father who terrorized his family, and his friends who sexualized her along with her mother and sister. Graham cut herself to relieve "the feeling of acid in the blood." Other women mis-used alcohol and drugs following histories of abuse or exposure to violence. Glenda Lennox became addicted to drugs and alcohol coping with the sexual and physical abuse she suffered in foster homes. At the age of seventeen, she quit taking substances 'cold turkey' and without assistance. The withdrawal she experienced landed her in psychiatric treatment because there were no alcohol and drug facilities for youth in her community. Similarly, Naomi Windfeathers developed addiction problems in response to growing up in an environment of terrorism in which her alcoholic father went on rampages of physical abuse toward her mother. Naomi remembers it as being "almost like a hostage situation... weekend after weekend." Naomi was taken to see her mother's psychiatrist as a result of her substance abuse, failing grades, and lack of interest in activities she had once enjoyed.

Most of the women I interviewed who were abused in childhood continued to experience emotional distress in adulthood. Sometimes this distress became expressed in coping mechanisms such as eating disorders, alcohol and drug addiction, and self-mutilation, all behaviours which resulted in psychiatric interventions. Ten of twenty-four women interviewed had experienced problems with substance mis-use; eight of the women self-mutilated; three struggled with eating disorders. All three of these coping mechanisms were expressed only by participants who described childhoods of abuse.

Some of the women experienced a resurgence of emotional distress as adults when repressed memories of sexual abuse in childhood surfaced. Hannah Green was in her mid-thirties and in the middle of an educational upgrading program when sexual harassment from her instructor triggered an intense emotional response, which she describes as 'going crazy:'

This guy wouldn't take his eyes off me and made really strong sexual innuendos and I just flipped out. By about the fifth week, I had a seizure and I fell under the desk.... I just felt like this huge pressure was coming right on me, and when I got home, I spent about three or four days just flopping around on my futon, just seeing things like crazy. And then it was like an egg that broke, and I realized that it was my father had come on top of me.... I had put on a lot of weight, and I was constantly wearing black, and I was stinking a lot. It was just like my whole body had just kind of blown up on me and gotten weird. Really, I felt like some monster walking around.

Hannah turned to her female doctor for assistance and explained that she was having flashbacks of sexual abuse from her father. Her doctor wanted to refer her to a psychotherapist, but Hannah could not afford to pay privately for counselling. Because psychiatric services were covered by provincial health insurance, Hannah was referred for the second time in her life to a psychiatrist. Most unfortunately, the psychiatrist to whom she was referred sexually propositioned her during the course of Hannah's 'treatment.'

Eight of the women who participated in the study were sexually assaulted as adults, four more than once. Six of these eight women had also been sexually abused as children. For many of these women, the experience of sexual assault precipitated psychiatric involvement. Beth Playsted's second psychiatric episode followed on the heels of being gang-raped, an experience which opened up the wounds of abuse and alienation in her childhood. Similarly, Tessa Jones' psychiatric history was triggered in her late twenties in 1990 when she was raped, echoing an earlier rape she had experienced at the age of fourteen. Tessa refers to the rapes as "a well-kept secret until a few years ago." Her emotional response alternated between depression, wanting to overdose, and intense anger at the family friend who had assaulted her. The psychiatrist to whom she was referred by her counsellor at a local mental health clinic convinced Tessa that she had a chemical imbalance and arranged for her to be hospitalized for shock treatments. During the hospitalization, Tessa says she needed to 'work on her anger.' "I honestly felt I'd kill [the man who raped me]. I felt so out of control and that frightened me."

Abuse in marriage or intimate relationships was another factor which precipitated psychiatric involvements. Some women either sought help from psychiatrists or landed in psychiatric treatment

84

when their misery in their relationships was too much to bear. In these situations, psychiatric treatment often served to pathologize the woman's unhappiness while upholding the marriage or relationship. More menacingly, Gin Cote's experience illustrates the way in which the psychiatric system can collude with an abusive partner, similar to the way it colluded in the child abuse of Mabel Abelone and Mary Taylor, thereby maintaining a situation of domestic violence. Gin lived for twelve years in an abusive lesbian relationship in the late 1970s and 1980s in an urban centre in Saskatchewan.

> I was unable to see anybody, I was unable to talk to anybody -- family, friends, etcetera. I was not to associate with people at work. She was very possessive.... She threatened me. She told me that... if she couldn't have me, nobody else could. She made innuendos about doing something to my parents. Innuendos about what she would do to certain people that we both knew, if they became too involved with me.... I was living in fear. I was scared. She had made one hell of a hole in the door of the apartment, to sort of emphasize what could happen if I didn't listen.... I couldn't turn to my parents, because of the threats she made; secondly, because I could not admit I was in a bad relationship with a woman.

In 1987, as Gin was moving closer to leaving the relationship, her partner brought Gin to their family doctor under another pretense and managed to have Gin committed to the psychiatric ward. Rather than determining that Gin was a danger to herself or others, the criteria used by most provincial mental health acts to justify involuntary hospitalization, this doctor seemed only interested in Gin's belief in reincarnation. Gin only remembers being questioned about her religious beliefs before security guards were summoned to take her by force to the ward. Gin was kept there against her will for two and a half weeks and treated with powerful neuroleptic drugs. She was then released to return home to her partner.

Other women in the study had less dramatic psychiatric intervention around their abusive relationships. Several women consulted doctors and psychiatrists about their unhappiness in their relationships and the ways in which they were mistreated. Nine of the twenty-four women described abusive intimate relationships involving physical or emotional mistreatment and fear of their former or current partners. Seven of these relationships were heterosexual; two were lesbian relationships. For many of the women who were involved in heterosexual relationships, experiences of wife abuse were so

thoroughly woven into the fabric of marriage as a social institution that I have chosen to discuss their experience in the following section.

**Institutions of Marriage and Heterosexuality:**

> Ever since I've been married, it's like I have some kind of anger -- I have no idea what
> it's about -- which at times would cause me to feel kind of depressed.

(Mabel Abelone)

Although not all the women I interviewed who had been married experienced abuse within marriage, unhappiness and dissatisfaction with marriage were common to most. Four of the nine women who had been heterosexually married experienced their first psychiatric episode when they were over the age of twenty and in the context of their marriage and mothering roles. Of the nine women who had been married, five were divorced at the time of our interview. Two of the divorced women had re-married; one of these second marriages lasted just four years and the other was as distressing to the woman as her first marriage. Of the four women still married at the time of our interview to their original husbands, two seemed relatively content, although their marriages required more than a little work to maintain[4] and two women were actively dissatisfied with their marriages. For example, Mabel Abelone confided in me the day of our interview that she was struggling with the question of whether or not to leave her husband:

> I have a seventy-five dollar deposit on a suite that I'm probably going to move to in two weeks
> [laughter]. You're the first to know! I've been really struggling with it.... I've been trying to
> make the decision for ten years, and more in the last three or four years. And trying to decide
> *how*. Like -- it's the money.

Many studies have linked marriage to mental health problems in women: single men and married women share higher rates of mental illness (Gove & Tudor, 1973, pp. 827-28) indicating that marriage seems good for the mental health of men while it is a risk factor for women. The participants who had been married indicated a number of ways in which marriage contributed to their emotional distress. First, participants tended to be involved in marriages in which they felt lonely and alienated in the relationship and frustrated with the traditional gender role they occupied. Secondly, some of the

participants experienced or feared violence from their husbands. Third, a number of the women were economically dependent on their husbands and feared after many years away from the labour force that they would not be able to survive economically on their own.

Many of the married women felt deeply alienated within their marriages and were isolated from other supports such as women friends. They described relationships with their husbands that lacked communication and intimacy. Shirley King, who had worked out a more livable marital situation over the years said of her husband:

> He's very supportive, but we don't talk an awful lot. We do have a communication problem; we still do.... He's a typical ... farmer: he *feels* very deeply, but he has difficulty expressing his emotions. And he doesn't *know* what to say -- he's learned a lot, but in those days he didn't know what to say, so he didn't say anything.

What Shirley describes as a trait typical to farmers is, of course, also well established as a gendered characteristic of men. As such, the lack of communication in marriages was common among the women interviewed. Sharon Wilkins described to me in our first interview the ways in which she attempted to become closer to her husband following her psychiatric hospitalization.

> I talked to my husband and I said that he would have to talk to me, like not about inconsequential things. He would have to have in-depth conversations with me. And it would have to happen quite often, and he couldn't postpone it, you know. We'd have to have it maybe every night.

Traditional gender roles in marriage contributed to women's sense of isolation and frustration. It was often at a point of complete exhaustion that a woman 'broke down' and sought help from her doctor or the local hospital, or attempted suicide and was taken to hospital. As a twenty-four year old housewife in the mid-1960s, Janet Moffat attempted suicide after her second miscarriage, so tired was she of being abused in her marriage and blamed for not being able to carry a baby to term.

> They didn't invade *his* body to check *his* thing -- my husband. They invaded my body and put me on the table and I had to undergo the anaesthetic and the operation, the invasiveness, to find out. Right? It wasn't a two-way equality issue -- it was just that women were defective.... And I carried that. I carried it alone. There was no one to share it with.

Claire Baker was so tired of her antagonistic relationship with her husband and the demands of looking after her baby that she "wouldn't -- couldn't -- do the dishes at night" and went to her doctor to ask for

87

tranquillizers. Shirley King, isolated on a farm with two young children in the late 1960s at the age of thirty-five, developed heart palpitations that disappeared when she was admitted to hospital for tests and returned when she went back home. She told her doctor that her problems were neurotic; after running more tests he agreed and prescribed tranquillizers. One day Shirley could not stop crying and refused to let her husband leave the house. Her husband took her back to the hospital, this time to the psychiatric ward. Under these conditions, the hospital was sometimes experienced as a welcome rest, a reprieve from responsibilities, so long as the woman entered the hospital of her own volition. While psychiatric treatment usually upheld the institution of marriage by pathologizing the woman as the source of trouble, some women experienced psychiatric treatment as beneficial in some respects. Hospitalization meant a reprieve from domestic responsibilities and dynamics; the woman's unhappiness was validated, if only by being pathologized; and some women gained some relief from taking psychotropic drugs, particularly tranquillizers.[5]

Secondly, marriage contributed to study participants' distress in that it was a site of volatility and potential danger. Both Claire Baker and Mabel Abelone were married to alcoholics and told of how they were terrified on occasion of what their husbands might do. When Mabel first realized that her husband was an alcoholic she began to realize how afraid she was of the guns he kept in the house.

> One day we had a fight and he sat at that kitchen table and said to me, 'well, I fully expect that some day you're going to come in here and shoot me with a gun.' And it was like -- I don't believe what I'm hearing. I'd better hear it again -- *'What did you say?'* And he repeated the same message and then there was like silence.... Then in my head, I started thinking that maybe that's what *he* wants to do -- maybe *he* wants to shoot *me*.

Their stories echoing one another eerily across the divide of provinces, Claire Baker describes a similar scenario:

> He came home absolutely stinking drunk. And ran around in his underwear. He had lots of hunting guns around -- there were 22s and 303s and stuff like that he had ammunition for.... Anyway, he came home and he [little laugh] -- he was so drunk, he said I was going to shoot him. Me. Who was afraid of guns. Never wanted them in the house in the first place. I was going to shoot him. And I remember he was so so drunk, he really really scared me.

In some marriages, a woman's depression appeared to reinforce a husband's power and sense of his wife's submission. Claire Baker reflects:

> He said the only time I was nice to him was when I was depressed or in trouble. And -- in some ways, I sort of believed that, but I think he was confusing... being nice with being hopeless and helpless.... Once I was back on my feet and back to myself, then I guess I didn't seem so submissive to him.... I wasn't a weakling after.

Finally, married women often felt that their fate was sealed because of their economic dependence on their husbands. For women who had not held a paid job for years, if not decades, the prospect of entering an increasingly competitive labour market seemed almost impossible. Many women revealed that they had stayed in unhappy marriages, at least for a time, for economic reasons. Such was not misguided thinking, for those women who did become divorced traded their freedom for poverty. When Hannah Green began to have flashbacks of childhood sexual abuse and could not afford to see a private psychotherapist, she considered returning to her husband so that she could pay for therapy fees, but chose to see a psychiatrist instead. Janet Moffat also experienced the feminization of poverty despite having been trained as a nurse and obtaining a university degree as a mature student. After losing one job due to sexual harassment and another for exposing poor safety conditions, Janet found herself in her fifties and unable to get a job. She describes her position in the current economy as "throwawayable."

Staying in her marriage for economic reasons and for the sake of the children, Mabel Abelone nevertheless dreamed of becoming independent as she watched her children leave home.

> My oldest son left home. And the next year my other son left home. And the next year my other son left home. And then it was like -- *okay, what about me?* I used to think that when the youngest one left home, *I* was going to leave home. Because I didn't like being married anymore. I don't know if I ever did.

During our interview, Mabel weighed the economic risks of leaving her husband and wondered if she would be able to make it.

> I keep thinking I don't have enough confidence to go to work. I'm really scared. And every time I turn the radio on, another company's been closed down and 800 people are out of work, so that scares me too. I'm at the point now that it doesn't matter. I don't care if I have to live on welfare, I don't.... But then I think, 'God, I have enough education, enough know-how, I

surely can find something besides washing dishes.' So I probably will end up leaving.... The last time I tried to talk to him, he said, 'well, I don't know what you're so worried about -- I'm going to be dead in ten years anyways.' And I thought, 'ten years -- good. But ...don't you want to live for ten years?'

As an interviewer, I sat on the edge of my seat wondering whether Mabel would leave her husband to take the apartment for which she had paid a deposit. With optimism, I mailed her transcript to the address of the apartment and was encouraged by the news that she had left her marriage. In her letter, Mabel writes that she feels a wonderful freedom being separated from her husband, something she has not felt since she was a young woman first leaving home. However, I am left to conclude that, given a choice between marriage and poverty, economic security can become more important than freedom. The forwarding address at the end of the letter was that of her husband -- Mabel was moving back home.

Many women who participated in this study chose to live outside the institution of heterosexual marriage. Ten of these women defined their sexual orientation as lesbian or bisexual; three were unsure of their sexual orientation; two women identified as celibate. Of this group of women, only one had been married. I have chosen to combine these groups for the purposes of my analysis, as the lesbian, bisexual, celibate, and unsure women have all placed themselves on the outside of the institutions of marriage and heterosexuality. For a number of these women, their discovering or questioning of sexual identity coincided with episodes of psychiatric treatment. At least six women began identifying as lesbian or bisexual during their psychiatric treatment, although their psychiatric treatment did not encourage their development in this direction. Their sexual and emotional orientation toward other women and the cultural silence and pathology placed around lesbianism was likely part of the context which encouraged these women to seek psychiatric treatment. Graham Black, for example, was quietly aware prior to her first encounter with psychiatry that she was a lesbian and felt alienated from heterosexist culture. She remembers: "I had a lot of pain, because I lived in a small town, and nobody was like me. At least, I never found anybody. Everybody talked about guys and marriages and all that."

Christine Forrest first sought psychiatric treatment at the age of twenty in response to having fallen in love with a woman, a phenomenon she had considered abnormal.[6] Christine was unique among the women interviewed in that her psychiatric treatment was psychoanalytic; as a young psychology student she was fascinated with the process of psychoanalysis and remained in treatment for about two years. Her treatment ended when she married her husband, the man to whom she was still married thirty years later. Christine and I discussed whether the psychoanalysis had any impact on her choice to leave a lesbian relationship and 'move over into' heterosexuality and marriage, Christine responded:

> That's a good question, because it would have been subtle if he'd had anything to do with it. I don't remember any kind of pressure. Well, pressure was coming from me because I wasn't happy with the relationship. I was uncomfortable with it and I was pleased to find that I was attracted to a man. So it may be that he supported that.

Although Christine ultimately made her own decision; however, her 'conversion' to heterosexuality would have fit the mold for successful psychoanalytic treatment nonetheless. In 1964 when Christine began her first psychiatric episode, homosexuality was still considered by the psychiatric establishment a form of mental illness (Bayer, 1981, p. 3). Classic psychoanalytic theory is clear in its equation of lesbianism with immature female sexuality (Freud, 1931, pp. 54, 58).

While other psychiatrists who treated women in this sample were often disapproving of their patients' lesbianism, the women interviewed generally considered their opinions of little value and merely representative of the heterosexism encountered as a rule in the social world. In 1973, the year that the American Psychiatric Association removed homosexuality from its diagnostic manual, Gin Cote was first taken to a psychiatrist at the age of twenty-four by her mother after she had told her mother that she was a lesbian. Gin's mother responded by insisting that Gin accompany her first to a priest and next to a psychiatrist. Being comfortable with her sexual identity, however, Gin at this time refused to accept either psychiatric or religious treatment. Erin Fremont and Beth Saunders each sought counselling from Family Service associations in the 1980s as young women in the process of 'coming out' as bisexual or lesbian. Erin's counsellor suggested she attend a professional consultation

on make-up and hairstyling, while the counsellor consulted by Beth Saunders pronounced that Beth was likely uncomfortable with her femininity. Similarly, Beth Playsted found that she received positive reinforcement on the days she wore a dress to her psychiatric day program.

Gin Cote and Erin Fremont each experienced more direct challenges to their sexual identities by the medical and psychiatric establishments. In the mid-1980s, the general practitioner who would later collude with Gin's abusive partner in having her certified, behaved in an unethical manner while conducting a vaginal exam.

> The general physician -- on the table at the hospital when I was getting a physical done, by the man who referred me to the psychiatrist the first time -- began doing a physical, doing an internal. And as soon as the nurse walked out he began to ask me questions of this nature, 'what is it a woman can give you that a man cannot?'

In the early 1990s, Erin Fremont's psychiatrist felt entitled to question and instruct her about her sexual practices in a way which felt so violating that Erin stopped going to see him.

> He had this problem with my flipping from having male partners to having female partners.... I don't know what his problem was with that, but we talked about it in some of our sessions.... He sort of had it in his mind that... I just wasn't enjoying sex with men because I wasn't -- he started to explain that I should use my vagina, kind of thing.... I didn't go to see him anymore. I didn't even keep my appointment.

It seems apparent from the experiences of the women interviewed for this project that the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973 has done little to normalize the existence and experience of lesbians and bisexual women in mental health practices. As such, the lesbian and bisexual women I interviewed were treated as problematic in their sexual identities and behaviours, and perceived themselves as outside mainstream culture. When psychiatrists were not able to effectively challenge or change a woman's lesbianism, ultimately they attempted to silence her. In the late 1980s, Gin Cote's female psychiatrist told her to stop making reference to her lesbianism, because "it was not considered normal to be homosexual." Gin continued nonetheless to insist on speaking openly to her psychiatrist about her lesbianism and involving her female partner in her psychiatric treatment. This psychiatrist eventually conceded that "you two are just like an old couple."

Despite the resilience expressed by the lesbian and bisexual women interviewed for this study, it was evident that living outside the institutions of heterosexuality and marriage places stresses associated with marginalization on women. Tessa Jones, even at the time of our first interview, preserved a heterosexual image by dating a man in order to cover her attractions for women. Tessa seemed reluctant even to talk to me about her sexuality, but finally revealed:

> Just within the last six months [I have started talking about my sexual orientation], and it's been hard. With my counsellor I've been working on it. I believe all these years that was a big part of it [my psychiatric involvement]. I guess a lot of denial, embarrassment, my own homophobia.... The first big secret of my life was the rape, and the second was sexuality.

## The Institution of Motherhood

The women interviewed for this study encountered the institution of motherhood in at least three ways. First, as daughters, many women described an absence of bonding with and support from their own mother. Second, as mothers of children, and, third, as caretakers of elderly or disabled adults, the women experienced a lack of social support around their role as caregivers and a dearth of resources to assist them. Eleven of the women were involved in raising children: eight women mothered their biological children, and three raised grandchildren, foster children, or the children of a partner. Six women had the experience of managing as single mothers, at least for a few years. Additionally, once children were grown, two women experienced the responsibility of caretaking vulnerable adults: Janet Moffat, her elderly mother; and Shirley King, her mentally disabled son.

Many of the women experienced ambivalent relationships with their own mothers for a variety of reasons. Six women grew up with mothers who were themselves psychiatric patients, and as such were distanced and stigmatized to their daughters. For example, Hannah Green summarizes her relationship with her mother:

> We had an awful relationship, my mother and I. I know she blamed me a lot, because I was six months old when she was first institutionalized. And so I think she thought that my birth had something to do with her craziness, and she wouldn't admit that the man she married was

mean.... Most of the time, the whole situation just got to her and she raged like a raving lunatic most of the time -- especially when I was a teenager, my mother was nuts.

Shirley King describes her mother who was twice hospitalized during her childhood as "a very neurotic lady, [who] had a couple of nervous breakdowns, hysteria, things like that." Beth Playsted says of her mother who was hospitalized and given shock treatments in the provincial mental hospital: "She sort of cracked up after my brother was born.... She had always been pretty unstable and pretty problematic, and certainly not a nice person." Jill Smith was just five years old when her mother was taken for the first time to the provincial mental hospital. She describes how it was for her and her siblings as they became older.

> I knew that my mother was -- was crazy, and had to go in the hospital in a recurring pattern, and -- we were very adept at picking up the cues which meant she was losing it. And to us, it was really clear she was losing it.... And we would report this to my father or to her sister or to whoever.

Even the two women whose mothers were more superficially treated with psychiatric drugs and no hospitalizations were experienced by their daughters as peculiar and estranged. Beth Saunders remembers that when she admitted herself to hospital as an adolescent, her mother's reaction was only, 'oh, I've always wanted to do that,' as though Beth were taking a vacation rather than staying on a psychiatric ward.

Other women found their mothers unavailable to them as allies and supports, as their mothers were busy dealing with their own dynamics within their families. Some mothers colluded with abusive fathers, and their daughters, like Mary Taylor, thus became estranged from them. Other women, such as Angel Anne Lowen and Mabel Abelone, maintained relationships with their mothers, yet were disappointed that their mothers had not been able to protect them from abuse in their families. Some mothers were abused by their husbands, or overwhelmed with coping with their husbands' alcoholism. Adrienne Joffey and Cara Sun both lost fathers during their childhoods, Cara's to suicide when she was only six, and their mothers had to contend with grief and widowhood. At the time of our interview when she was thirty-nine, Cara still felt terribly resentful that her mother did not acknowledge or talk about Cara's hospitalization as an adolescent, and felt that she chose not to know that Cara had been

sexually abused as a child or raped as an adolescent. Other women, such as Ann Johnstone, experienced their mothers as harshly critical toward them. Mari and Jill Smith, the mother-daughter dyad I interviewed, had been separated from one another since Jill was eleven, due to Mari's psychiatric treatment. They had managed to bridge the estrangement in their relationship only recently before our interview. Of the twenty-four women interviewed, most described relationships with their mothers which were highly ambivalent and frequently negative. Only Anna Black described her mother as a good friend and source of support.

Death of a mother in childhood was described by one woman as having instilled in her a life-long sense of loss. Sharon Wilkins experienced the death of her mother when she was seventeen, an event so monumental that she and her family were not able to think or speak about her mother. Sharon and her younger sister were left on their own "rambling around in this really big house" while their father was at work, with no support system to help them grieve their mother's death. When Sharon began to break down emotionally, her father arranged for her to see a psychiatrist, who wanted to hospitalize her. Not wanting this, Sharon's father instead sent Sharon for a holiday with some relatives. Sharon describes how she repressed her feelings of grief because she had no way of dealing with them.

> I subverted all the feelings I had and I knew that I couldn't think about my mother at all, because I couldn't deal with it. So I made sure I didn't think about her at all. It was a long time before I could even say her name [speaking carefully] or anything. And it was so in my family too that nobody mentioned my mother, because we knew that it was too hard to deal with. And it seemed sort of disloyal to not think about her. But we just felt so bad.

The death of her mother was exacerbated three years later by the death of her father. Sharon explains that these losses had a great impact on her subsequent choices about what to do with her life.

> I remember my dad died three years after my mother.... But he got married just before. When I was nineteen. It was worse because both my mom and dad died, and then everything was left to this woman that we didn't even know. So we were left penniless.... I got married at twenty-two, and that's really young. But the reason I think I got married at twenty-two was... because my mom and dad had died. Otherwise, I would have gone and challenged the world. But my older sister, she went travelling -- she went and got a university degree and then travelled a lot.

95

Hope Edelman (1994) documents the ways in which daughters continue to grieve the loss of their mother throughout their lives, that grief is not a linear process but rather one that cycles through life repeatedly with each new developmental phase. Thus, the loss of a mother has an impact on the rest of a woman's life; with the passage of each landmark in her own life -- the birth of a child, reaching the same age her mother was when she died -- she encounters again the grief which was part of her adolescence. Sharon's most significant interaction with the psychiatric system happened almost thirty years after her mother's death with seemingly nothing sufficient to explain it. Despite her deeply alienated relationship with her husband, Sharon's depression and suicidal feelings and actions seemed so impenetrable as to far surpass any aspect of her contemporary context. Edelman's theory would draw attention to the fact that Sharon was approaching the one landmark of which motherless daughters live in dread -- the age her mother was when she had died. Equally striking, Sharon's eldest daughter was now the same age Sharon had been when she lost her mother. In our interviews, Sharon raised these points, declaring that she was certain her daughter would not need her as much as she had needed her mother if one of her suicide attempts had been successful.

Whether or not mothering their own children triggered unresolved feelings from their own childhoods, the women I interviewed described many crazy-making aspects of being the primary parent to young children in isolation and without support systems. Shirley King speaks of her experience of mothering two young children in the 1960s:

> I was a city girl and had gone out to the farm and I'd had a baby right away. And he was a terrible baby! I used to sit and hold him -- he used to start crying around five o'clock in the afternoon and he wouldn't stop. And I used to sit there holding him, trying to stop him crying, and thinking, 'it would be so easy to crush his skull.' I was that close to doing that -- and that's scary. But I can understand why mothers kill their babies. And I was alone. My husband used to go off at seven o'clock in the morning and come home at seven o'clock at night.... Our nearest neighbours were about seven miles away. Half the time I didn't even have a car to get out, so I couldn't go anywhere anyway, and I had this screaming baby who didn't thrive, who threw up.... I had no supports whatsoever. It's no wonder I had a nervous breakdown.

Having the resources of enough money to pay for childcare, a husband who supported her desire to do what she chose, and professional training, Shirley was able to go back to work, encouraged by a woman friend who "pulled me -- screaming, kicking, and yelling -- back into humanity again. It was the best thing that ever happened to me. And I worked for the next twenty years."

Paid work did not have the same benefits for women who worked by necessity rather than choice. Claire Baker worked as a secretary throughout both her marriages and during the time she was a single mother. Sometimes Claire worked as many as three part-time jobs to make ends meet, and then went home to her housework and mothering. Claire coped with her life for more than twenty years by taking tranquillizers. Nor was paid work a solution for Anna Black, a single mother struggling in the 1990s to raise her two extremely active boys. Looking for work, trying to make ends meet, and finding childcare added yet another stress to her life, leaving her feeling that she could not meet both the physical and emotional needs of her children.

> I wasn't taking care of [the children] in the day; I was looking for work. But... this sounds awful, but I couldn't take care of them at night either. Like, I've always met their physical basic needs; I've fed them, clothed them, kept them clean, that kind of stuff. But emotionally. I was very short-fused.... I get very very depressed and pessimistic.... Then I get irritable with my children. I change with my children. Any parent isn't going to be a... bottomless pit of nurturance and patience, but I get extremely irritable and I don't have anything to give them. I'm just kind of empty. I get fatigued.

At times Anna felt so terrible that she thought of killing herself, and had also consulted the Children's Aid Society about giving her children up for adoption. Assessing her feelings as too serious to handle on her own, Anna sought help from a counsellor at a mental health clinic who quickly referred her to a psychiatrist when he found her to be suicidal.

Women were not relieved of the responsibilities of the institution of motherhood once their children were grown, for as women they cared for the elderly and disabled members of their families, and at times adult children who had not yet left home. Shirley King cared for her mentally disabled son until he was well into his thirties and her own deteriorating health forced her to seek alternative housing

for him. Claire Baker not only shouldered most of the responsibility for caring for an elderly mother

and a brother with a disability, but also allowed her twenty year old son to live with her rent-free, even

though he was as violent as her first husband had been. Janet Moffat was the sole family connection

for her elderly mother, whom she was forced to place in a nursing home. Without support from her

brother, she coped alone with finding that her mother was not being properly cared for by nursing home

staff. Shirley, Claire, and Janet all suffered their most recent psychiatric episodes, in their late forties

and fifties, in the context of these situations combined with other stresses such as unemployment,

deteriorating health, and anti-semitic violence.[7]


## Role Modelling a Psychiatric Career

One of the most striking experiences shared by the women I interviewed was that of having a

close family member also involved with the psychiatric system as a patient. Fourteen of the women

interviewed had a family member when they were growing up who was also a psychiatric patient; for

thirteen women, the family member was part of the immediate family.[8] In ten of these cases, the

woman grew up in a situation in which one of her family members was being psychiatrically treated

before she ever experienced her own psychiatric treatment. In the other four situations, the family

member was psychiatrically treated around the same time or shortly thereafter. Several women had

more than one close family member psychiatrically treated. Collectively the women had six mothers,

five fathers, one sister, and two grandmothers who were also psychiatric patients.

Ten women in total experienced what could be regarded as a psychiatric role model in their

immediate family growing up. While one might argue that this speaks in favour of genetic

predisposition theories, in three situations the family member concerned was not a blood relative. One

was an adoptive sister; another an adoptive father; and the third, a step-grandmother. What all ten

situations had in common was that each of these family members was an important figure in the

woman's life as a child and adolescent, who taught them their first lessons about psychiatry and mental

illness. Although Jill Smith volunteered that she could not imagine having 'learned' her predisposition for schizophrenia from her mother, I think there is a good argument to be made that a child cannot help but learn something about emotions, social control, and help-seeking from watching a parent cope with moving in and out of psychiatric hospitals, shock treatments, and psychiatric drugs.

It is a matter of conjecture what exactly the women learned from their psychiatric role models which would have propelled them to move their own lives in the same direction. Women did tell me some survival lessons they had learned from their psychiatrized family members about what types of treatment to avoid and where to draw the line. For example, Hannah Green says, "I had a humungous fear of mental hospitals, because my mother was in and out of them when I was a child, and she had electric shock, and I saw her being tortured and destroyed." Hannah managed to avoid hospitalization herself, even though she described descending into the depths of craziness. Jill Smith asked her counsellor at her local mental health team to promise her that he would never send her to the provincial mental hospital: "I think if I had gotten there, my feeling was I would never have gotten out. Since Mum never got out of the system, once she was there." Jill also learned from her mother's experience that it was better to sign oneself into hospital voluntarily than to be taken in by force, as her mother had been treated with brutality when she was held against her will. Knowing this, Jill made sure that each of her hospitalizations were with her consent. Glenda Lennox also learned from her adoptive sister's experience:

> I felt like I was heading down the road.... What had happened with my older sister, I was afraid that was going to happen to me, that I was going to be hospitalized and medicated and stuff like that. And I didn't want to be.... She told me herself. 'Stay out of here. Don't let them get ya' was her words. 'Stay out of here.'

When Glenda's psychiatrist wanted to hospitalize her, Glenda refused and tried to find other solutions with her psychiatrist. Glenda also decided when she was ready to stop taking the antidepressants she had been prescribed, and reported to her psychiatrist afterward that she had flushed them down the toilet and was through with taking drugs.

Some women additionally had a familiarity with the psychiatric system when they were children, as their parents or older siblings worked in the psychiatric system. One woman's sister was a psychiatric nurse married to a psychiatrist; this same woman's brother interned in a psychiatric hospital. Another woman's brother-in-law interned in a psychiatric hospital. One woman lived throughout her childhood on the grounds of the provincial mental hospital, as both her parents were psychiatric nurses.

That nearly half the women interviewed for this project had someone close to them in their childhood, usually a parent, model the way to psychiatric treatment and mental illness is provocative, to say the least. It helps to seal the argument that traumatic events along with an oppressive social context, an absence of other options, and a psychiatric role model who clears a path to psychiatric treatment helps a woman along the road to her own psychiatric career.

## Biological Theories

Despite clear reasons women held in their own lives for feeling depressed, anxious, suicidal, or out of touch with reality, many of the women preserved a sense in which they viewed their feelings as determined by their biology. Although most of the women recognized that their feelings were in part informed by the environments in which they lived or had grown up, some saw the most crucial component as somehow intrinsic to their personalities, if not biological. For example, Adrienne Joffey describes her feelings in the following way as an essential part of herself:

> I was just miserable. I'd been miserable all my life and I never knew why.... My life has never changed.... My life has been the same, always. And it's always me, it's just the same, you know..... I thought those awful feelings were just me. I just thought that -- like some people have black hair and some have blonde and some have awful feelings. I just thought that's who I was.

Throughout our interview, Claire Baker repeated again and again that her emotions nearly always vacillated between depression and anxiety. Although the psychiatric drugs she had taken for decades did not much alter her feelings, Claire could not imagine living without them. She says of her

constitution: "When I say I'm okay, I'm always just mildly depressed, you know. I don't think I'm ever going to be a happy person, or clinically free of the depression. I don't think I ever will be."

Several women who had been diagnosed with either bipolar disorder or schizophrenia[9] accepted a biomedical analysis of their situations. Essentially, they believed that they suffered from a biological predisposition to a chemical imbalance in their brains which could be aggravated by stress. In Jill Smith's words, "you have to have a predisposition towards kind of losing the paths of how the world works, and then you need to be under stress." This type of theory of the interaction of biology with environmental stresses is typical of the education given to psychiatric patients by psychiatrists and other workers in the mental health system, as discussed in the previous chapter.

Those women who viewed themselves as having a biologically-based mental illness evaluated the information they received from the psychiatric system in the light of their experience of 'going crazy' and concluded that their reactions were too intense and bizarre to constitute understandable responses to trauma or adversity. Erin Fremont found that her moods were so extreme and her behaviours so outrageous as to be often experienced as though outside herself:

> I was feeling there was something wrong inside me. And I was feeling like I was crazy. And out of control.... I was floating around and drinking too much, was taking lots of poppers.... I didn't have food. I would go to the bars at the right time of the month, so that the guys would buy you drinks, and basically I was quite loose. And I was so depressed and crying all the time.... I'd be happy, bozo the clown, entertain, whatever. I'd walk home and transform into the woman who dressed in black and carried a knife.... I went through depressions and thinking I was crazy and acting really weird, and not having any control over it, or not feeling like I had any control over it. And really ashamed of my behaviours that I was doing.

Anna Black, whose original diagnosis of depression had led to her hospitalization and shock treatments, concurred with the later diagnosis she received from a gynecologist of premenstrual syndrome. Anna evaluated the evidence for PMS in light of re-constructing her history, and found that her intense depressions and suicidal feelings were related to her menstrual cycle. When she tried the fledgling treatments for PMS of antidepressants to no avail, Anna eventually decided to have a

hysterectomy. In a letter wrote to me nearly a year after the surgery, Anna relates that: "At first I was

a bit disappointed that I still had powerful emotions, but my doctor insists that this is short-term."

Anna was still being treated with antidepressants "to help with the emotional adjustment to hormonal

changes," and although it seemed that the hysterectomy had not been quite the cure-all she had hoped,

she maintained that she was "100 percent happy with my decision to have a hysterectomy" and that "it

felt quite natural and freeing to reject the organs that caused my life such misery." While it may be

uncomfortable to dispute a woman's analysis of her own situation, the many feminist critiques of PMS

(Kendall, 1992; Caplan et al, 1992; Russell, 1995: 62-71) invite questions. I am particularly drawn to

Jane Ussher's comments on the relationship between women's biology and women's madness:

> ...It is not biology *per se* which is at the root of madness or distress; but because woman's
> reproductive cycle and sexuality are socially constructed as unnatural, polluted, and somehow
> indecent... women learn to experience our biology as negative.... Women's *perceptions* of our
> biology may be of central importance. For if a woman believes herself to be affected
> detrimentally by her body, by menstruation, this may result in poor use of coping skills, or
> internal attributions for any difficulties she is experiencing (1991, p. 253).

Ussher's words prompt me to wonder how Anna, a passionately Christian woman, was able to

integrate into her senses of personal meaning and morality the contradictions she embodied as a single

mother who had just had an abortion. In our interview, Anna described her sexual activity which led to

her pregnancies as an unmarried woman as 'promiscuity' and her enormous moral and emotional

struggle around her decision to have an abortion just prior to her psychiatric episode.

> I thought, I can't bring this life into the world, because I had already been experiencing really
> bad PMS symptoms. And I thought emotionally I just can't do it. So I had an abortion. And
> that is really against every fibre in my being. I know I've taken a life. And I had to go through
> an enormous amount of grief over that.

Considering the tremendous difficulties of parenting two children alone and the strength Anna gained

from her religious beliefs and support system, it is understandable that she would accept a biomedical

diagnosis and "reject the organs that caused my life such misery."

Given that most women I interviewed had been exposed only to information from a biomedical

perspective, it is hardly surprising that biological theories of mental illness were popular even among

those women who recognized the impact of trauma and oppression in their lives. The vast majority of women had no familiarity with literature which was critical of psychiatry, nor had they ever attended a meeting organized by former or current patients without the presence of mental health professionals. Most were unaware of the existence of an anti-psychiatry or mental patients' liberation movement. As I will discuss further in the next chapter, controlling which types of information patients receive is one method by which the psychiatric establishment maintains control over patients.

The words and perceptions of women who evaluate their situations according to a biomedical model attest to the terrible intensity of the 'madness' they experience, a frame of mind so extreme that they cannot conceive of it as part of a realm of understandable human response. One woman in particular, Jill Smith, was well informed of anti-psychiatry theory and mental patients' liberation movement in part because her mother adhered to this perspective, and yet Jill's experience of her own madness and the success of her biologically-based treatments convinced her that she is indeed schizophrenic and in need of psychiatric drugs. There is no unanimity of opinion among this group of women, nor in literature written by former and current mental patients. However, what is noteworthy to me in reviewing the histories and life circumstances of the women I interviewed is that *without exception* each woman described to me conditions of life and histories of trauma which resonate with reasons for unhappiness, anxiety, rebellion, and removing oneself from reality.


## Available Options and the Needs of the Women

Almost invariably when I asked women what they most needed during the times they became treated psychiatrically, their responses reflected a need for support and friendship, counselling and guidance, or assistance in leaving an abusive environment. Such needs can be fulfilled in different ways depending on the way in which the community structures caregiving. Within our social context, these needs tend to be met by formally structured mental health or social services, or counselling professionals; however, for many of the women interviewed, the friendship of a peer or an elder may have come closer to meeting the needs expressed.

For some women, the emotional landscape in which they lived was so utterly barren of nurturing and caring people that they felt terribly lonely. For example, Adrienne Joffey responded:

> I had an image all my life of what I was looking for [voice breaking].... I think somewhere someone would be nice to me. So I didn't think of psychiatrists as opposed to any other thing.... The feeling was that I wanted some kindness, but I didn't even know what that was at the time.

Cara Sun echoes, "I so much wanted to have a friend, anyone who would be a friend." Mabel Abelone said she needed "for somebody to say, 'I *care* about you,' or 'I *care* what's going on.' Just that word. I heard it so little." Ann Johnstone, who was so isolated that she would periodically go to hospital emergency wards when she was in crisis, said she needed human contact. When she went to emergency wards she most needed: "a hug. Someone to say, 'I know you're hurting and I care, and I'll help you.' Sometimes just the crisis lines aren't enough."

For women who were first psychiatrically treated as adolescents, a common theme was that they needed support and caring from an adult who could listen to them in a way that their parents could not. I asked Sharon Wilkins what she needed most when she was sent to a psychiatrist after her mother died when she was seventeen, and she responded:

> I think that if there was someone, you know, that would accept that I was going crazy, and that would just hug me and that it was okay. That all people felt like I felt. That that's what happens, that people just collapse, and that it wasn't such an unusual thing. That if someone just was there and would hug me and that we could just talk and cry and say whatever crazy thing I wanted to say. And they weren't going to *do* anything to me.

Hannah Green echoes that what would have been vital to her was:

> Probably someone who was listening to me, a supportive friend.... Everybody I knew was... really successful, really wrapped up in their careers. So they didn't have time for one teenager who is just depressed and miserable.

Several women commented that what they really needed was assistance leaving an abusive relationship or family. Cara Sun said she needed to tell someone that she was being sexually abused.

Angel Anne Lowen's comment was: "I needed not to be in that home. And I needed for someone in

that town not to deny what was going on." Similarly, Mary Taylor said:

> I think I needed to be heard without fear. I needed an adult to walk me through it.... I think I
> needed someone to hear me that things were really not okay in my family. Instead I felt that
> society protected my dad and protected his image. I needed someone to be clear and have
> knowledge about abuse, to be able to name what was happening.

Women also needed help leaving abusive marriages or relationships. Janet Moffat needed to leave her

husband, as did Mari Smith. Gin Cote reflects that what she needed was:

> some counselling in order to assist me in getting my life together and working towards being
> independent of the person I was stuck with. Because I don't think there would be any doubts
> in anybody's mind that I wanted to have that element of my life removed which was extremely
> unhealthy.

The practicalities of finding "just somebody" to talk to were at times almost insurmountable.

Living in communities in which there was an absence of trusted friends, elders, mothers, or neighbours

willing to listen and share the wisdom of experience drove women in search of professional counselling.

Cara Sun reflected to me that in her experience people in her community with whom she has risked

sharing personal things have indicated that they are not willing to interact with her on that level.

> I think caring people could have helped me more than the professionals. Professionals are not
> helping me at all. You know, and I don't depend on them at all. I do not depend on them at
> all. So when I need somebody to talk to and I have nobody to talk to, I just hate having to talk
> to, say, my social worker -- but there's no one else, because I have no other connections. No
> other connections in this city that really want to hear me, or hear how I'm doing, or hear
> what's going on. Because they all say, 'well, do you have a therapist?'

Cara's experience is a rather sad commentary on the ways in which professional mental health services

have come to replace community as a place where people can gain support from one another and share

personal aspects of their lives. Kitzinger and Perkins reflect that a psychological way of thinking has

rendered community members self-absorbed: "Psychology actively encourages us to be *less* available,

less giving, less sensitive to others" (1993, p. 142). The selling of counselling as a market commodity

removes us as community members from the functions of listening to and sharing personal experience:

when we need to talk about personal issues, we are compartmentalized off to a mental health service.

Six of the women responded that they needed counselling, although most of the study participants had difficulties finding counselling which felt appropriate to their needs. Naomi Windfeathers researched different counselling approaches and concluded that she needed 'client-centred' psychotherapy, an approach which would mainly consist of her being allowed to talk while a counsellor listened. She searched her city for a counsellor she could afford to see who would counsel her using this approach, but did not manage to connect with a counsellor, although she tried several. Instead, she ended up seeing a psychiatrist who prescribed antidepressants. Anna Black spoke about how difficult it was for her to find counsellors who would listen to her rather than imposing their own beliefs about what she needed.

> If somebody would have sat down with me and said, 'what has been going on in your life? I want you to tell me from at least ten years ago to now what's been going on, and how have you been depressed; how have you been suicidal? What happened just before it happened?'.... If I think about what I needed, I needed somebody to really sit down and *ask me to tell them* what the scoop was.

Some women in retrospect thought that they needed services which were not available in their communities. One problem encountered by many women were procedures used by counsellors to whom they disclosed that they were suicidal. A common experience once a counsellor knew that a woman was feeling like ending her life was a speedy referral from counselling into psychiatric treatment. Generally, this meant that 'the talking cure' was finished and that physical treatments and hospitalizations would begin. Beth Playsted thought that what she needed was:

> Better school counselling, definitely.... In my day, it was the gym teacher usually who got to be the school counsellor. And she was probably having to cover her ass by making sure I got professional help. Because I was talking suicide, but I mean, I didn't need to be put into that medical setting.

Glenda Lennox also needed better services specifically for youth when she was struggling with her addictions and the only treatment centres available in her community were for adults. Glenda says:

> I think I should have gone to that treatment centre. I mean, I don't know, maybe there was an age limit. But I wish that there would have been a youth drug and alcohol treatment centre, because I would have just benefitted so much rather than going through it on my own.

At a later stage in her life when Beth Playsted was dealing with emerging memories of abuse, she felt that what would have been most useful would have been "some kind of safe house for women in emotional crisis." Instead, Beth was admitted into a psychiatric ward, a service which she says was expensive to tax payers and not useful to her. As Beth phrases it, "there was money in that pot to pick me up and put me back in the world, but once I'm back here I'm basically left with what I can put together for myself."

The major obstacle to counselling for almost all the women interviewed for this project was the lack of money to pay privately for it. Only the services of psychiatrists, other medical doctors, or counsellors in mental health clinics supervised by psychiatrists, are covered by health insurance in Canadian provinces. While the option exists in most communities to pay privately for the counselling services of psychologists and other counsellors, the fees were prohibitive for the women in this study. This is a problem which unfortunately reflects a broader social trend. The Women's Counselling, Referral and Education Centre in Toronto, a non-profit service which refers women to feminist and non-sexist therapists in private practice, reports that the service is overwhelmed with counselling referral requests it can do nothing about for economic reasons. Between seventy-five and eighty percent of their callers were unable to afford a minimum fee of $30.00 per session charged by the therapists on the referral list, and ninety percent could not afford the average fee of $47.00 (Lepischak, 1992). Given the difficulty in finding any counselling whatsoever that is affordable, being a 'good consumer' of psychotherapy is simply not an option. As Glenda Lennox phrases it, "as I got older and wanted to choose my therapist, then there was fees. *And fees are high. They're really high.* They're like sixty bucks an hour. I mean, I make five bucks an hour." My own informal survey of psychotherapists has shown me that the services of therapists in Vancouver are even more expensive. Therapist fees range on average from sixty-five dollars an hour for counsellors with masters degrees to one hundred and ten dollars an hour for psychologists.

Because the women could not afford to pay for counselling, they had little option but to resort to the services which health insurance in Canada does support -- the services of psychiatrists. While some non-profit agencies offer free counselling, their waiting lists tend to be years long when waiting lists are open at all. In Vancouver, for example, the one centre which offers free counselling to victims of incest and sexual abuse has an indefinitely closed waiting list. In the community in Saskatchewan where I conducted interviews, free counselling could be found at a local women's centre, a service some women I interviewed managed to access after years on the waiting list. Hannah Green spoke of the bind she was in when even her doctor was reluctant to refer her to a psychiatrist, knowing that she needed counselling for emerging memories of sexual abuse in childhood.

> I went to my doctor and got her to refer me to a psychiatrist. But she was reluctant to, because I think it was really obvious to her what was going on. And she was going, 'psychiatrists are really bad, you have to go to a therapist.' And I thought, 'I don't have any money. I can't go to a therapist. I can barely afford my rent and my groceries.' She said, 'well, borrow the money or get the money.' And I felt like I didn't have anybody to borrow the money from.... I really felt pinned. So I had to see a psychiatrist, I felt, because it was free, because of the finances.

Erin Fremont remembers being on the psychiatric ward after the annual weekend of the spiral gathering in her city in Saskatchewan, a weekend of workshops for survivors of sexual abuse. Erin went to the spiral gathering from the hospital, and remembers, "there were a handful plus of women that ended up in the psych ward after that weekend. There was no net to catch them, and they ended up in the psych ward with me." Erin says of her own psychiatric treatment: "if I didn't go through the manic depressive psychiatric unit method, I wouldn't have the services I have now. Being sexually abused, there isn't any services available specifically for that."

This chapter has endeavoured to establish clear links between the social and political conditions of women's lives and their movement toward psychiatric treatment. We have seen that the women interviewed for this project had substantial reasons to experience distress. The vast majority of study participants were survivors of violence, whether as children or as adults. As children, the women had coped with a range of traumas including sexual, physical, and emotional abuse; the death of a

parent; and the psychiatric treatment of their own parents. As adolescents and young adults, a number of the women coped with their pain by using alcohol and drugs, slashing or mutilating themselves; and developing eating disorders. Many women survived sexual assaults. Some women came out as lesbians in an environment in which they felt further marginalized. Other women coped with abusive, or otherwise unequal, marriages in which they were expected to fulfill a role which left them isolated and oppressed. As mothers, the women struggled to provide for the physical and emotional needs of their children, often under less than ideal circumstances.

Forty-two percent of the women grew up in an environment in which a significant family member had already paved a pathway to psychiatry as a place to go with pain or feelings of craziness. Without supportive resources in their personal relationships and communities, the women interviewed for this study turned, or were taken, to psychiatric services as a solution to their situations. Psychiatry had and continues to have all the legitimacy of a medical specialty, and some researchers have shown that women frequently view their doctors as a source of help for managing emotional distress (Barrett & Roberts, 1978). In addition, counselling fees for professionals not associated with the psychiatric system were out of financial reach of most study participants. Psychiatry and the medical management of social distress was the only option for the women in this study when the pain of living their lives became too great to bear alone.

# NOTES

[1] The women who identified as lesbian, bisexual, celibate, or unsure of their sexual orientation were more likely to have been sexually or physically abused as children than their heterosexual counterparts.

[2] Covert sexual abuse refers to an environment of sexualization which occurs without any actual physical contact. Examples of this might be staring at or commenting about a girl's body or making sexual jokes. A situation in which a girl is placed in the role of surrogate wife could also be described as covert sexual abuse. Bonnie Burstow describes covert sexual abuse as "the norm in patriarchal households" (1992, p. 113).

[3] The treatment Mabel Abelone describes is consistent with the ways in which incest survivors were treated between 1910 and 1960, according to Linda Gordon (1988, pp. 218-249). Vaginal exams were a common means of deciding whether a girl was telling the truth -- only a punctured hymen would reveal whether the complaint would be considered legitimate. Between 1910 and 1960, incest victims were re-constituted as delinquents.

[4] One of the more 'successful' marriages had eventually worked out a seasonal separate living arrangement in which the woman lived in town while her husband worked on the farm. After years of isolation on the farm, the woman was much happier to live independently in an urban centre. The other woman told me several years after our interview that she could now say that she was happier being married more of the time than not.

[5] As I will explain in more detail in chapter five, the 'relief' brought by tranquillizers had potential for addictiveness, particularly when the woman's living situation did not change and she used tranquillizers for many years to help her cope.

[6] I considered Christine Forrest among the heterosexual women interviewed for the study, since she identified herself as heterosexual and had been married to a man for thirty years since the lesbian experience with which she had struggled.

[7] In the late 1980s Shirley King's farmhouse was set on fire as an act of anti-semitic violence by unknown vandals who scratched swastikas into the walls. This incident combined with being diagnosed with a permanently disabling illness and deciding that she could no longer care for her son sent Shirley into what she terms "a reactive depression."

[8] By immediate family, I mean parents, siblings, or grandparents. I am excluding aunts and uncles, cousins, and more distant relatives.

[9] Gin Cote had actually been diagnosed and treated as schizophrenic for many years; at the insistence of her partner and parents, she switched to a different psychiatrist who changed her diagnosis to that of bipolar disorder. It is the diagnosis of bipolar that Gin accepts.

# CHAPTER FIVE

## Weeds in the Garden:

## Women's Experiences of Psychiatric Treatment

I'm not saying [psychiatrists are] all like that!  God, we're in trouble if they are!.... I just happened to find him -- the weed in the garden.

(Gin Cote)

The 'bad apple' theory so often advanced to explain cases of gross abuse is not sufficient, however, to account for the negative experiences of psychiatric interventions reported by numbers of patients.

(Penfold & Walker, 1983, p. v).

Psychiatric treatment for most of the women interviewed for this project generally was either ineffective and missed the point of what was wrong in their lives; or worse, compounded the problems the women already had by adding another layer of oppression and victimization.  This extra burden was by no means insignificant, as psychiatry carries all the authority and credibility invested in it as a medical specialty and as the only system aside from criminal justice which has the power to enforce involuntary confinement.  As Jill Smith says of her mother's psychiatric career, the psychiatrists were "very heavy-handed about their ways of trying to control the situation, while having no effect on it." For most of the women who participated in this study, psychiatry brought a perspective which was irrelevant to their needs and life experience, extended false hopes of offering a useful service, and sometimes violated their human rights along the way.  Most were left feeling as badly, if not worse, than they felt before they first visited a psychiatrist or psychiatric facility.  This was not always the case; however, those instances in which women had mostly positive experiences of psychiatric treatment were more often reflective of a respectful and supportive individual mental health professional than of any biomedical expertise.

This chapter will delineate the various ways in which the women's interviews portray the psychiatric system as ineffective, oppressive, or helpful.  Gin Cote's metaphor which opens this

chapter expresses the idea that her negative experience with a psychiatrist was unique -- he was a 'bad apple' or a 'weed in the garden.' The compiled experiences of study participants dispute the bad apple theory of psychiatry; namely, that negative experiences are isolated and the product of poorly trained or unethical individual practitioners. My intention in this chapter is to present the ways in which the experiences of study participants, read in connection with one another, paint a picture of psychiatry as *systemically* flawed such that the women were more likely to feel angry or violated as a result of their experience than they were to feel better. The few times when women did feel better serve generally to instruct us as to the extraordinary actions of individual mental health professionals and to contrast with the far bleaker overall perspective. For a weed in the garden can only be an isolated event in an extremely well-cultivated garden; without constant attention, any garden will be overtaken and choked by weeds.

## The Myth of Psychiatric Psychotherapy

Those women who turned to psychiatry at a point in their lives when they badly needed support and guidance, hoping for counselling to better understand their lives or make changes in their situations, were for the most part terribly disappointed. Although all study participants had experienced outpatient psychiatric treatment, only four had experienced psychotherapy as their primary form of psychiatric treatment. All four of these women were never hospitalized, and three of four evaluated their experiences as generally positive. The remainder of the women were often confused in their outpatient treatment about whether psychotherapy was even taking place, so bizarre were some of their encounters.[1] Rather than entering a counselling relationship, most women found that their appointments with psychiatrists were, in fact, short doctor visits at which their prescriptions were monitored and renewed. Shirley King described it as "very quick in and out as opposed to counselling. It was very much a conveyor-belt type of situation.... Fifteen minutes. If that."

Study participants almost unanimously described the psychiatrists they consulted as outpatients, most of whom were men,[2] as cold, distanced, and lacking in empathy and rapport. This professional demeanor did not inspire the women to share their personal feelings and thoughts, and many women informed me that they protected themselves by withholding thoughts, feelings, and information from such professionals because of lack of trust. Graham Black describes the discomfort she felt as a seventeen year old with her psychiatrist's demeanor and her resulting confusion about what was supposed to happen in their sessions.

> You'd go into that room and the psychiatrist was a male, a tall guy with a big beard and a pipe. And he'd say hello, and I'd say hi. And we'd sit there for an hour saying nothing. That was it.... He'd puff on the pipe -- 'What do *you* think?' [laughs] -- I'm not kidding. I suspected that was all he ever said in sessions, so I checked it out in my next session with him. That's *all* he said. He just sat back there behind his desk with his pipe, with crossed legs. If I had a question -- well, I guess I actually must have said some stuff -- because the silence for an hour is kind of -- confusing.... Even the body language. He was so far away. Not that I wanted anybody to get close to me. But looking back, he was far away behind a desk, with his legs crossed, leaning back, smoking his pipe, being quiet, staring at me, all the time staring at me.

Sharon Wilkins encountered a similar lack of warmth from a psychiatrist she went to see when she was suicidal.

> I went there and there were four chairs. I was testing him, first of all, you know; he might not have known it but I was testing the psychiatrist. And he asked me to have a chair, so I picked the one facing him, and the one -- farthest away. And I was really asking to be invited to sit next to him, but he never invited me to sit next to him. Because usually when you're going to share things that are like secrets you want to be close to that person, you know. But he was not inviting me to sit there. And he didn't ask to take my coat... to sort of invite me -- which is normal, like for *normally* when you go someplace, people do this. And I was such a distance from him I felt so ridiculous. Like, I was shouting everything that was wrong with me from a distance of ten feet away.

Feeling no approachability or compassion from this psychiatrist, not even the civility one would expect from a neighbour, Sharon could not imagine the possibility that he would be able to help her. Since she viewed him as her last resort, she made her first suicide attempt after this appointment.

The building of rapport was extremely important to the women in this study. Although rapport and trust can take time to create, the women I interviewed generally wanted some sense in a first

session that the psychiatrist was a person they could trust in order to discuss personal issues and experiences. If the psychiatrist's manner was abrupt, superior, unengaged, and uninviting, the women tended to feel badly about their appointments and discouraged about returning. Claire Baker tells of her initial appointments with a new psychiatrist:

> I knew the minute I walked in there that this man was not the doctor for me. I've never gone into a doctor's office and been... how can I explain it? -- I felt more un-at-ease in his office. I've never had that, ever. And he wasted almost the whole hour, talking about things that were totally irrelevant, like taking a history -- who was my mother? who was my father? what did he do? what did she do? -- all these kind of dumb questions that had no bearing at that particular point on what I needed. You know, I needed to talk to him and get these things out in the open.... So then he says, 'well, I've got a drug for you; you obviously are suffering from terrible anxiety more than anything else.' And he said, 'I'll put you on this parnate.'[3] And so I left.... And then when I went back after my first visit, he was asking me how I was feeling, and I was telling him how I was feeling, and he was forcing me to feel better than I was -- 'oh, no, you're 100% better than what you were!'

Many women described situations in which they felt that psychiatrists were not listening to them, and instead would make pronouncements about what they felt or needed rather than listening to what they actually said. Many of these psychiatrists appeared more interested in giving unsolicited advice and making erroneous assumptions than in genuinely listening. Anna Black provides an example:

> He was very arrogant and controlling, very disrespectful to me as a woman. I felt that he had a definite problem with women. And I simply base that on... just the way he talked with me. He talked with me in such a way that what I had to say didn't matter. And he told me how I was feeling, and he told me what my life was about rather than actually eliciting from me *answers about what has been going on in my life for the last however many years.* So he told me. You didn't tell him [laughs]. That's how he operated.

Several women described the ways in which their psychiatrists or mental health counsellors talked during the sessions more than they did. Sharon Wilkins was certain that her sessions with her doctor and mental health counsellor only lasted as long as they did because they did all the talking. Shirley King recalls of her sessions with her psychiatrist: "He tended to talk a little too much. I had to poke my nose in every once in a while and say, 'hey, that's not what I said; that's not what I meant.'"

Many women related the ways in which their interactions with psychiatrists left them feeling invalidated and humiliated. As Adrienne Joffey explains:

> I felt quite shamed by some of the things he said.... I think what was harmful was that it was yet another person I went to who didn't validate me. And I think I so desperately needed to be validated. So I think in that sense it contributed to the already huge pool of people who don't feel good.

Beth Playsted echoes, "I didn't have the consciousness to name what was going on, but I remember feeling often confused or bad." Considering the vulnerability of the women at the time they sought help and the power inherent in the professional relationship, it is more than understandable that women felt confusion, shame, or hopelessness in response to a professional's judgement or lack of attentiveness. Some women who stayed in such professional relationships over months or years developed strategies of managing or resisting these dynamics. Cara Sun even attempted to personally bring the nurturance to her relationship with her psychiatric social worker by bringing him cards and chicken soup, perhaps hoping (in vain) to set an example.

Some women gained confidence in their perceptions over time and began to realize that professional inattentiveness was no reflection of their own personal lack of value. Both Cara Sun and Erin Fremont told me that their therapy sessions with their respective male psychiatric professionals degenerated into 'shouting matches' and 'yelling and screaming' as each woman tried to assert her needs and expectations. After twenty years of being a psychiatric patient, Cara corrected me when I made reference to her 'psychiatric treatment.' She told me: "I really don't like the term 'treatment' because over the period of -- it's been continuous -- and I've never had 'treatment.'... I've never had therapy." Yet for Cara this realization came after many years of pain, not being able to comprehend how her various psychiatric professionals could be so distant and uncaring. Cara showed me a passage in her journal in which she had written:

> I would be in deep deep deep pain, the pain would be just awful, i would be crying and crying and he would just be sitting there, sitting there doing nothing, nothing at all, as if sometimes he wasn't even there, his face would go white, his jaws would tighten, and his eyes small, he would do nothing, when I would ask him, why he never ever not once would not touch me, to

115

console me, or would not reach out his had to shake mine, when he would respond by saying 'you are not supposed to touch survivors,' he read that somewhere, I told him that I had all of my memories, him touching me when I would be in deep deep pain was not, not at all going to enrage me, it would have helped me a great deal. It would have helped to ground me, it would have helped me to feel that I am still o.k., and I am with you, he would have been with me in my deep pain.

The examples outlined above are remarkable not only for the relative lack of counselling skills they portray, but also the absense of even the most basic compassion and respect. Certainly from the subjective experience of many of the women interviewed for this project, a great many psychiatric professionals seemed to come from a theoretical and practical base very alien from the values and needs of the women they served. In some situations, not feeling better after treatment was also considered a woman's fault. One of Claire Baker's psychiatrists eventually dismissed her because she was not cooperating in getting better: "One of the comments he made on that last visit to me was, 'well, I have 200 patients on a waiting list that need to be seen,' and more or less, 'if you're not going to get better, I'm not wasting my time.'"

These reports are perhaps surprising if one has an expectation that psychiatric professionals will provide psychotherapy and a caring approach. When one considers that psychiatrists are, first and foremost, medical doctors, however, that their training is in physiological processes and interventions rather than psychology, emotional needs and caregiving, the professional behaviour reported by the women I interviewed becomes more comprehensible. Training in counselling or psychotherapy is by no means a major topic of study in psychiatric programs compared to counselling psychology and other psychotherapy programs in which students spend years training to become counsellors. As Peter Breggin points out, "some leading psychiatrists now propose to eliminate psychotherapy entirely from the basic training of psychiatrists, something that has already occurred in individual programs" (1991, p. 12). Yet because of the mistaken association between psychoanalysis and psychiatry, many of the women I interviewed expected to lie on a couch and be listened to, although Breggin maintains that psychoanalysts "never made up more than ten percent of the profession" (p. 10).[4] One might expect

better counselling from other professionals working in the psychiatric system, such as psychiatric social workers and nurses. In some cases, women did feel more listened to by these mental health professionals. Graham Black and Beth Saunders, for example, each felt more ability to talk to psychiatric nurses or social workers in a day program setting than they did to their psychiatrists. However, this was not the rule among the women interviewed, who described as many ineffective or oppressive experiences with other mental health professionals working under the psychiatric rubric as they did with psychiatrists. This also should not be surprising, as the division of labour in psychiatric wards, hospitals, day programs, and mental health clinics places psychiatrists in a supervisory capacity, and other psychiatric system professionals are also trained in the hegemonic biomedical model.[5]

Some interview participants related interactions with psychiatric professionals which would be seen as abusive or inappropriate by ethical standards set from within the professions. These interactions can be set apart from the more ordinary instances of professional aloofness, inattentiveness, and paternalism in the sense that they would be considered breaches of professional codes of ethics. It is these more extreme actions of individual professionals which are readily identified as the acts of 'bad apples' working in the system. While such experiences happen to patients and inform the reality of being a patient, they are not explicitly tolerated within professional circles.

Violating patient confidentiality was one type of infraction experienced by two women interviewed for this study. Christine Forrest's first psychiatrist saw fit to discuss her prior lesbian relationship with her *fiancé*. Similarly, Mary Taylor's psychiatrist disclosed information given to him in the course of their professional relationship to Mary's family. Other women experienced verbal and emotional abuse by psychiatrists. Sometimes this abuse took the form of turning a woman's expectations of counselling on their head by implying that she was not worthy of their attention or was

too sick or crazy for them to waste their time. Ann Johnstone experienced this a number of times when seeking psychotherapy from psychiatrists to help her deal with childhood abuse. One psychiatrist told her, "'I've been reviewing the notes I made after your last session and I want you to know: I DON'T TREAT LOSERS.'" In the same vein, Adrienne Joffey relates what happened when she made an appointment to see her psychiatrist when she was feeling distraught:

> I walked in and I just burst into tears and I was just like sobbing and sobbing and all this kind of stuff. And he just went up one side of me and down the other. I mean, he got just so angry at me. And I don't remember exactly what he said, but it was kind of like, 'you can't just walk in here and think I'm going to be a soft shoulder to cry on.' He was just really -- it was horrible. I was so stunned.

The women interviewed experienced sexual misconduct of psychiatric professionals in a variety of ways. Several of the lesbian or bisexual study participants encountered inappropriate sexual comments from psychiatric professionals, described in more depth in the previous chapter. Mary Taylor also experienced intrusive sexual questioning from a psychiatrist on the ward when she was committed. She remembered him asking her: "Would I have an affair and would I have premarital sex? I never thought he was helping at all. He just seemed to be really interested in me sexually." In an initial visit to a psychiatrist in the early 1960s, Janet Moffat was injected with a drug the psychiatrist called 'truth serum' and asked "sexual, very personal sexual questions," an experience Janet referred to as "emotional rape." Sexual misconduct was also experienced by Hannah Green when she was seeking psychotherapy to help her deal with her flashbacks of childhood sexual abuse. The abuse began when her psychiatrist would "do mind games all the time."

> He would always tell me to lie on the couch. And so I would lie down. And then he said, 'if you lie down it means you're crazy. You're not supposed to lie down. Nobody goes into someplace and lies down.' And I'm going, 'well, you told me to lie down.' And he's going, 'well, don't lie down.' So I'd sit up. And he'd say, 'are you comfortable now?' And I'd say, 'yes, I'm fine.' And then he'd say, 'well, it's okay, you can lie down again.'

This type of interaction proceeded over a number of sessions to sexual propositioning.

> One of the last sessions he said he wanted to come and cuddle with me on the couch, come and lie beside me on the couch. And I said, 'not a chance! I'm here because I'm an incest victim and you want to cuddle with me. Like, you're crazy!'.... He stayed in his chair. He didn't

118

come close to me or anything. And I told him he must be really perverted. Because I didn't consider myself a glamorous or sexy or pretty woman.... He was kind of coaxing for a little while. Like -- 'oh, I can see you're depressed. I just want to hold you because you look sad, you look like you need to cry.' I was kind of flabbergasted.

Reports of these types of incidents are noteworthy in their effects upon individual women patients and in their departure from established psychiatric practice. That such events occur would likely not be disputed in professional circles, but they are not accepted as a normative professional response, as are psychotropic drugs, electro-convulsive treatment, or involuntary hospitalization.[6] Such experiences are rather an extreme professional expression of a more generally accepted objectification of psychiatric patients and women, more usually manifested by medical paternalism and lack of compassion.

The three women whose experiences with outpatient psychotherapy were mostly positive describe psychotherapeutic encounters with professionals who inspired trust through their actions, attitudes, and demeanors. For both Glenda Lennox and Diane Duthie, who saw female psychiatrists, being listened to, cared for, and able to identify with another woman was a helpful part of the experience. Both Glenda and Diane expressed a sense of their psychiatrists as maternal and nurturing. Glenda says:

> I felt compassion coming from her. Like, I felt she truly cared about who I was and what was happening to me. I felt that right from the day I walked in. And I also felt that she was concerned with *wellness*, not with prescribing medication or hospitalization. She just wasn't like that. I think she wanted me to be healthy.

Diane describes her psychiatrist as nurturing even in her physical presence:

> She was a big woman -- I don't want to say 'fat' because there's such negative stuff about that -- she was big and round and she was short, you know, so she had a real nurturing look about her. Plus, I liked that because she doesn't seem to conform to what society said was a professional woman of twelve years of education. She didn't need society to tell her how to look and behave.... I found her visually receptive to me.

Christine Forrest, the third woman who had mostly positive experiences with psychotherapy from the psychiatric system, viewed her second male psychiatrist, whom she saw when she was in her forties, more as a skilled professional than a nurturing figure with whom she could personally identify. Christine had experienced many different types of psychotherapy over the years from various professionals, most of whom she had paid privately to see. She hand-picked her second psychiatrist because of his skills in hypnosis, and because as a counsellor herself, Christine knew him as a colleague and respected his approach to his work. In contrast with other psychiatrists she had known, "I had a lot of respect for him, mostly in his respect for patients. I never heard him make jokes about patients or talk down to them. He always spoke of them with caring and empathy and respect."

It was ultimately not specific psychotherapeutic skills, at least not in terms of textbook techniques and psychological testing, that made the difference for women who had positive experiences of counselling from psychiatric professionals. Only two women sought specific skills and techniques from psychiatric professionals.[7] A positive experience in counselling from a mental health professional was more likely to be characterized by an ethic of care, a recognition of the occurrence and impact of violence in women's lives, validation of women's feelings and strengths, honesty, respect for a woman's choices, and the offering of resources.

According to study participants, helpful psychiatric professionals at times revealed ways in which they were critical of usual psychiatric practice. Glenda Lennox was grateful to one psychiatrist who creatively helped her to stay out of hospital as an adolescent when she was suicidal. Glenda agreed to take antidepressants for a short time, but indicated that she would likely overdose if given the chance. This admission would usually result in being admitted to hospital; however, the psychiatrist found a volunteer who would bring Glenda her dose of medication at the appropriate times, whether at home or at school. The embarrassment Glenda felt around her peers when the mysterious person showed up each day soon precipitated her to pull herself together enough to agree to take the

antidepressants responsibly. When Glenda decided she had taken the antidepressants long enough and flushed the remainder down the toilet, her psychiatrist respected her decision and did not prescribe more.

While descriptions of positive experiences with psychiatrists and other mental health professionals who did psychotherapeutic work with their patients illustrate what some professionals did well, they should not be read as an indication of progress in psychiatric approaches. Positive experiences with professionals who provided counselling in psychiatric settings were the exception rather than the rule. The more general experience of the women I interviewed leads me to agree with Beth Saunders when she says, "I would always recommend that women in particular, but people in general, do not go to psychiatrists unless they want to be medicated and that's their only purpose."

## Issues of Consent

The quality of experiences women reported of hospitalization had a great deal to do with whether they were hospitalized with or without their informed consent. Women who were involuntarily hospitalized almost invariably described the experience as violating. Involuntary patients tended to be treated with punitive measures such as physical restraint, forced drugging, isolation in side rooms, removal of clothing and possessions -- institutional practices experienced as abusive. The most overt experiences of psychiatric abuse reported in this study took place during involuntary hospitalization. The issues surrounding consent are more complex, however, than legal definitions of voluntary and involuntary hospitalization, since many women did not know they had the choice to leave and many agreed to admit themselves under conditions of coercion. Additionally, women 'consented' to treatment when they were not aware they had a choice, and with an absense of complete information and knowledge of alternatives.

Of the twenty-four women interviewed for this project, ten had been involuntarily hospitalized or committed. Six of these ten women were lesbian or bisexual; four were heterosexual. Collectively these ten women had experienced at least seventeen committals, a calculation which can only be approximate since Mari Smith had been in and out of hospital so many times she could not remember an exact number. Most involuntary hospitalizations occurred in response to a professional belief that a woman was suicidal, or a danger to herself. Two women, Mary Taylor and Gin Cote, were committed as a result of arrangements made by an abusive father or partner; both of these hospitalizations were described as crude manifestations of control and domination. Mabel Abelone was hospitalized against her will three times between the ages of twelve and seventeen when she was being sexually abused; at the time of our interview she did not know whether her parents had consented on her behalf to have her detained. Mari Smith was hospitalized against her will many times when she was perceived by others as psychotic, or creating an alternate reality for herself; her first hospitalization occurred after she had been sexually assaulted.

Mental health legislation in Saskatchewan and British Columbia, where all but one of the involuntary hospitalizations occurred, tends now to require for committal the certificates of two physicians.[8] The certificates must indicate that the person apprehended has a mental disorder which requires treatment, is likely to be a danger to self or others, and the factors the physician has considered in formulating this belief. In British Columbia, certification enables a person to be detained for one month before entitled to apply for a hearing by a review panel; at the end of one month, the person may be re-certified for another month, then for three months, then for successive periods of six months.[9] In Saskatchewan, a person can be detained for twenty-one days at which point she or he must be either released or re-certified; if re-certified the person may be held for successive periods of six months.[10] Upon any re-certification in Saskatchewan an appeal by a review board is automatic. Mental health legislation appears more progressive in Saskatchewan where an involuntary patient has a right to be

informed of the reasons for their detention (Mental Health Services Act of Saskatchewan, 1986, section 16(1), p. 8) and where the physician has an obligation to:

> ...consult with the patient, explain or cause to be explained to the patient the purpose, nature and effect of proposed diagnosis or treatment and give consideration to the views the patient expresses concerning the patient's choice of therapists, the proposed diagnosis or treatment and any alternatives and the manner in which diagnoses or treatments may be provided (1986, section 25(3), p. 15).

In contrast, the Mental Health Act of British Columbia states that an involuntary patient is subject to the "direction and discipline" of the director of the hospital or psychiatric ward (1996, section 32, p. 14) but does not make explicit the need to communicate to the patient information about her or his detention or medical diagnosis and treatment. Both provinces entitle hospitals and physicians to administer treatment to involuntary patients without their consent, although Saskatchewan forbids psychosurgery and "experimental treatments" under these circumstances (Mental Health Services Act of Saskatchewan, 1986, section 25(5), p. 15).

While changes in mental health legislation are indisputably important in that they can grant involuntary patients more rights and protections, it came to my attention in speaking with former involuntary patients that, in practice, mental health law is difficult to implement in a context in which professionals are viewed as credible sources of information and patients are stigmatized. According to the women I interviewed, hospitals and physicians were easily able to ignore their legal obligations. For example, according to testimonies from my interviews, it was a rare occurrence for women incarcerated in hospitals in either Saskatchewan or British Columbia to have been informed about either their legal status or medical condition. Only one of the hospitalizations described to me went before a review board (with a ruling against the patient), as all but one of the committals in the 1980s and 1990s were shorter in duration than the time at which the patient would have been eligible for an appeal. In most cases, the woman was released from hospital just before she would have been entitled to appeal her detention. In the meantime, however, a woman typically would be terrified that she could

be imprisoned indefinitely, having no information about her legal rights, and exposed to all the indignities experienced by involuntary patients. Study participants described experiencing similar methods of discipline as involuntary patients over the decades and across provinces -- surveillance, physical restraint, forced drugging, isolation in siderooms, removal of clothing and possessions.

In almost all situations, the women I interviewed responded to committal with feelings of outrage, betrayal, violation, and fear. The following narrative tells Gin Cote's story of the procedure by which she was imprisoned in a general hospital psychiatric ward. Thinking they were going to a couples counselling session, she was tricked by her abusive partner into accompanying her to a psychiatrist's office, which was located in a general hospital.

> [The psychiatrist] just sat there and again this fellow asked me strange questions, if I believed in reincarnation -- well, of course I do, it's my belief system! And I thought, 'well, what's this got to do with the relationship?'... And he wouldn't answer my questions. He just sat there. And he seemed very agitated. And he shifted from one leg to another. And I could really feel his -- his nervousness, or whatever it was. It was making *me* feel a little bit uncomfortable. And -- because it seemed that there was something impending, but I didn't know what the hell it was.... And he got up then. He went to my ex [partner], went out. And I sat there for about five minutes wondering *what is going on*.

> So I went to get up to go to the door to find out. And there were three nurses and two securities waiting for me.... When I stood there and I saw these people standing and blocking my exit, I also felt a sense of panic. Like, what the hell is going on here? Why are all these people blocking me, preventing me from getting through? And one of the nurses says, 'you know, you have to come with us.' I said, 'why?' Not at any particular point in time was I told the reason why I was being kept there. All the time that I asked. I wanted some answers. I wasn't ready to go anywhere until I got those answers, and I thought I had the *right* to have those answers. So I stood there and I said, 'I'm not going anywhere until you tell me the reason why I'm here!'....

A number of features of this experience are remarkable. To this day Gin does not know on what basis she was confined -- she was not suicidal and did not believe that she posed a danger to anyone; she wanted only to leave an abusive relationship. She was denied information when she asked for it directly. She was treated as though she was extremely dangerous although she had hurt no one. Despite her determination, Gin was dragged to the psychiatric ward where she was forced to strip in

front of male security guards and injected against her will with a drug, the name of which she still does not know. As Gin describes, even her parents' advocacy on her behalf was ineffective:

> My parents had contacted the psychiatrist... asking about alternate ways of treating me or to remove from treatment altogether and releasing me. The psychiatrist said to my parents that under no circumstances was he going to remove me from treatment, and that if it was absolutely necessary, if he was going to be pressured in any way, shape or form, that he would send me to the back wards of the institution in Weyburn and more than likely have the key thrown away.... Later on in the afternoon ... both my parents came to visit me with a message. My father said to me, making sure that no staff could hear, that if I didn't continue treatment, if I didn't go along with it, that this was what was going to happen to me.

The mental health legislation in effect when this incident occurred in Saskatchewan in the late 1980s was unable to limit the coercion Gin experienced in this episode. She was released from hospital before an appeal to a review board would have been mandatory.

The element of force present in Gin's account was not unusual according to other study participants who had been hospitalized against their will. Angel Anne Lowen described "being treated like street trash, like... this Indian girl" when she was in the emergency ward being treated for injuries following a drug and alcohol binge. When she was finally able to contact her psychiatrist requesting help dealing with her substance abuse, Angel Anne was taken against her will to the psychiatric ward. Her experiences inevitably reinforced the abuse she endured in childhood and the message that she would not be believed and could be violated with impunity. That Angel Anne was both the only First Nations woman interviewed and the only woman physically assaulted in hospital is suggestive of the racism which may play a role in the degree of force used against women from particular groups when they are hospitalized against their will.

The use of force against involuntary patients is not unique to these situations or to this study. Seclusion rooms and forced drugging are standard practices of control in psychiatric institutions (Trott & O'Loughlin, 1991; Pilowsky, 1994); the stripping of female patients and use of excessive physical restraint by male staff may be highly contentious but is documented elsewhere (Potier, 1993, p. 340). The women interviewed for this study generally considered such experiences the worst thing that ever

125

happened to them in psychiatric treatment. The moments in our interviews when women described

what it was like to be locked in a seclusion room inevitably elicited emotional responses from interview

participants. Mabel Abelone told me about being locked in seclusion for three days in the mid-1950s at

the age of fourteen:

> I have no idea what I was doing, but they said I couldn't sleep in that ward with the twenty to
> thirty beds. I had to sleep by myself. Obviously, I might have been causing a disturbance by
> talking too loud or screaming -- I have no idea what I was doing. So they took me to this
> room... and they locked the door. And I was inside there [starting to cry] for three days -- and
> I didn't do anything.... And they would bring me food. And then I said, 'well, just open the
> door; I want the door open.' And then one night [crying], I banged on the wall until my hand
> was so sore, it was pretty near bleeding. And then five guys came in to give me a needle to go
> to sleep.

The women interviewed described being put in seclusion rooms from the 1950s through to the

1990s, although shorter durations of isolation were experienced in more recent years. In the early

1990s, Beth Playsted was placed in isolation overnight because she was feeling worse and was not

complying with the requests of hospital staff.

> I started to feel really bad and I withdrew and wouldn't talk or come out of my room or take
> my medication. And at some point in the night, they came and carted me off and they lied to
> me. They said they were moving me because they needed the room and they put me in
> isolation, in a side room. It was basically like being arrested. They read the riot act to me, you
> know, that I would be in there and the light would be left on, until I was willing to cooperate....
> They came and took my things, because I mean, you're on camera, and at that point I was
> sitting in a corner covered with a blanket and they came and took all my possessions. They left
> my expensive prescription eye glasses on the table in the hall overnight.... I spent a terrible
> night in there just trying to get through. In the morning, they came and asked me out for
> breakfast, but I wouldn't leave at that point, I was feeling so humiliated.

Such techniques of suppression served an obvious purpose of imposing control upon psychiatric

patients while providing dubious therapeutic benefit. The effects upon study participants was to

humiliate, enrage, and eventually break any spirit of resistance.

While the women interviewed were generally opposed to involuntary hospitalization, several

felt that some type of service was necessary in order to protect them from self-harm. While this did not

need to be imprisonment in a hospital, our current system of social and mental health services provides

no other option. Beth Playsted considered in retrospect that it was important that she had been kept in hospital for her own protection, since she was suicidal. "I realize that I was really right to resist the system," she explained; however, "I wouldn't have been right to choose dying over going into it, because I did need to be protected." At the same time, Beth would have preferred to have gone to an emotional safe house for women, if such an alternative service existed in her city. A similar view is expressed in Trott and O'Loughlin's survey of psychiatric patients in British Columbia which reports that "time after time, respondents pointed out that if reliable alternatives to hospital were available in their communities, they would almost always choose that option over hospitalization" (1991, p. 9). Although Beth too was subjected to the distressful experience of isolation in a side-room, her committal was made easier by having been assigned to a psychiatrist whom she described as "quite a together young woman." She was impressed by the psychiatrist's honesty in providing clear information about her reasons for detaining her. "It was important to me that she understood the power, she did seem to have some consciousness of the power dynamics involved. And she was very straightforward with me."

In contrast with this experience, the information given to most other study participants about their legal status was usually confusing or non-existent; in fact, some were unsure at times whether they were classified as voluntary or involuntary. They were not visited by legal representation or told of their rights; neither were they aware that they had a choice to leave. For example, Erin Fremont maintains that during her one month committal in 1989, "I didn't know the difference between voluntary and involuntary, or what made up the difference. I didn't know that I could have left at any time. I don't know if there was any point where I could have left at any time." Janet Moffat felt she had no choice about being in hospital the first time in the 1960s even though she does not believe that she was committed:

> As far as I know, it was a voluntary admission, that I'd gone from the medical floor to the psychiatric unit. But in my recollection... there was a lack of information in the difference between voluntary and involuntary.... It was all just doing what others told me to do. I felt I

127

had no choices; in fact, I know I didn't.... Nobody said, 'you have a choice.'... No one offered me alternatives. No one suggested anything else.

Janet's second hospitalization thirty years later after a suicide attempt was, by contrast, involuntary, a fact that she was told once she re-gained consciousness. The experience was eased by the fact that she was so physically weakened by the injury she sustained and the drugs given to her that she had no energy with which to resist being confined. As she phrases it, "I could come up out of all that fog and just concentrate on wash, toothbrush, dress." Once she was physically able, however, she began the process required for an appeal, but the hospital struck a deal with her that she could leave after a certain period of time. As Janet concludes, "I got the hell out of there. I did my own healing."

Involuntary hospitalization represents but the furthest position on the continuum of consent to psychiatric treatment; there were many other situations in which the women interviewed were deemed to have given consent under conditions of coercion or with an absense of complete information and alternatives. Feminist theorist, Catharine MacKinnon has problematized the concept of consent in the context of American rape law, which attempts to decide whether a woman has indeed been raped according to the standpoint of whether the rapist believed she consented. MacKinnon maintains that the law therefore operates from the perspective of "a reasonable rapist" rather than from that of a reasonable woman (1989, p. 182). Consent to psychiatric treatment can be seen to be analogous. What psychiatric professionals may have deemed consent from patients was not seen to be consent in a genuine sense for many of the women I interviewed.[11] As Carol Pateman writes, "Consent as ideology cannot be distinguished from habitual acquiescence, assent, silent dissent, submission, or even enforced submission. Unless refusal of consent or withdrawal of consent are real possibilities, we can no longer speak of 'consent' in any genuine sense" (1980, p. 150). Coerced consent to hospitalization and specific treatments took place for study respondents both under threat of reprisals (i.e. consent because

it will be worse for you if you don't) and with a paternalistic lack of information about procedures and alternatives (i.e. consent because I am the doctor and it is best; consent because you have no choice).

Women consented at times to be hospitalized voluntarily because they were afraid of being committed. Angel Anne Lowen gives one example of this: "What the psychiatrist told me was that basically because I was suicidal and because I had told them that they could have me certified if I chose not to. So I should go in voluntarily." In this situation, Angel Anne submitted to a voluntary hospitalization because she was afraid of being committed. At times the fear of certain psychiatric practices, particularly isolation in side rooms and shock treatments, led women to consent to treatments that seemed less frightening. For example, Janet Moffat's exposure to shock treatment as a nurse left her feeling afraid that it would happen to her. Her horror at the ECT she had witnessed in a professional capacity convinced her that she should do as she was told in order to get out of hospital intact.

> *I'd seen that you must do what they say;* that the system is hierarchical and authoritarian, and *you must do it.* I went up there meekly silenced, absolutely silenced and controlled.... I slept, I took the pills that they gave me, I slept, I obeyed the rules. Because I was frightened that I would get ECT.... I'd seen the system -- we marched them through like they were -- ants, robots.... That's what I did! ECTs three times a week, and we'd have twenty patients lined up in the hall like zombies. Medication before, night-gown on, false teeth out, rings off, all ready for the shock. And then the quick general anaesthetic and then the shock treatment and then all out in -- like an army system, into this room, and then moved out by noon.

A form of coercion took place for some women when they believed that if they did not consent to a particular treatment a psychiatrist upon whom they had come to depend would refuse to work with them. This type of situation formed part of the context in which Angel Anne Lowen consented to shock treatments after years of managing to avoid them.

> I knew they'd get me anyways. Basically. By that time I was in a position where I just didn't care anymore. I really didn't have the strength to fight anymore. You know, I was convinced that I was long gone and I was crazy. But I didn't have any choices anymore. And I'd fear a long time after that being certified and taken by force.... I remember my psychiatrist telling me that they couldn't do anything else for me, that they'd tried all the antidepressants, that the only alternative left was shock treatment. So either take a hike -- she told me she wasn't willing to

help me anymore, she wasn't willing to do anything unless I would do the shock treatments. And if I wound up back in there, she was going to give them to me anyways. So I signed.

Many of the women I interviewed considered in retrospect that they had consented to treatment under duress -- when desperately unhappy, with a dearth of other options and only the most sketchy of information about the treatments they would receive, lured by the security promised by medical specialists. Anna Black explains how, under circumstances like these, she found herself getting shock treatments:

> He [the psychiatric social worker] put me in the hands of a psychiatrist, who saw me for *five minutes* -- I kid you not. And then -- bang, I was in the hospital getting shock treatments. And a person might say -- well, why did I do it? Why did I sign the consent form? But when a person is that bummed out and -- like, my whole thinking process is affected when I get these symptoms and... so I thought, 'well, whatever; I don't care.' I didn't want to live, let alone care about how I got treated. So I signed the consent form and I got the shock treatments and all it did was make me forget things.

Beth Saunders felt similarly out of control of the process of her treatment once she relented to pressure from her psychiatrist to admit herself to hospital. Beth had attempted to be cautious at the beginning: "I negotiated the terms under which I would go in. Like not having to take medications and I agreed to go in for the weekend. That was the deal." Once she was in hospital, however, Beth's original consent became a slippery slope as the arrangement she had made became progressively distorted.

> He put me in for the weekend and then disappeared. My impression was that I would be seeing him, but of course that wasn't the case.... At the end of the first weekend it was like, 'okay, I really am going to go.' But the nurses have a whole role to play here; they try to connect with you. So they encouraged staying longer to find out what was going on, to stay the week or whatever.... By the end of the first week they were trying to convince me to take drugs, and then trying to see if it would make any difference. I think if I hadn't had the drug reaction I would have been out in three weeks.

As it turned out, the neuroleptic drug which Beth was prescribed caused her to experience serious seizures which extended her hospitalization from a weekend to a total time of seven weeks.

For consent to treatment to be genuine, according to the experiences of the women interviewed for this project, certain conditions must be met. No element of threat or coercion, however covert, may play a part in the decision. In addition, a full range of information, critical perspectives as well as

promotional, must be presented in language and at a pace so as to be understandable to a person in distress. Alternative support services (for example, counselling and psychotherapy, distress centres, trauma reduction techniques, peer support, parenting relief and support) must be available alongside biomedical interventions so that a person in distress may choose among options as opposed to choosing between psychiatric help or no help at all. Consent to treatment in the face of misinformation, authoritarianism, and lack of options does not constitute genuine consent. The experiences of study participants reveal many instances in which women consented under conditions of threat, coercion, intimidation, and duress and in the absense of other options. Such reports suggest that the psychiatric system is indeed a long way from obtaining consent to treatment in any meaningful sense.

**The Myth of Hospital as a Therapeutic Environment**

Study participants described many common features of psychiatric hospitalization. Those who consented to hospitalization in hope that it would bring solutions to their despair were usually astounded at the lack of attention given to patients in psychiatric wards. Some were expecting a psychotherapeutic environment, or at least a place where they could talk about their feelings, but were disappointed that the treatments available were limited to psychiatric drugs and shock treatment. Eighteen of the nineteen women who had been hospitalized were treated with psychiatric drugs, and seven with shock treatment. In spite of the lack of caring attention and the focus on biological treatments, however, many women had an ambivalent experience of hospitalization in that the hospital was seen as a place of rest or retreat from responsibilities. For some women, the hospital represented a 'safety' difficult to leave and to which there was a strong temptation to return.

The lack of quality attention the study participants experienced in outpatient treatment was consistent on the whole with what they experienced in hospital. Most study participants experienced the hospital as a holding place where they merely passed time until they either felt, or were evaluated to

be, self-composed enough to return to their lives outside the hospital. As Beth Playsted comments, "it seemed to me inherently crazy that to make people well you're shut in an airless, lightless, artificially-lit place with very little to do." Mary Taylor recalls, "somebody basically kept their eye on me to see that I wasn't suicidal, but no one really got to the root of it." The hospital generally was neither a centre of emotional healing nor even a place to find someone to listen to personal problems. The women I interviewed spoke almost unanimously of the lack of attention bestowed on patients by psychiatrists in hospital wards. For example, Anna Black, who feels she never should have been admitted for shock treatments describes the ways in which her psychiatrist assessed her as appropriate for this treatment and monitored her condition: "He talked with me for maybe five minutes before [hospitalizing me for shock treatments], and then he talked with me about two minutes during [the hospitalization], and then that one last session [two months later]." Anna's experience of the unavailability of her psychiatrist during her hospitalization was not at all exceptional. The following two responses are typical:

> All the psychiatrists would come in maybe once a week, or once every three days, and see people for fifteen minutes, and never deal with stuff. They would just write medication. And that's really unhelpful. And that's all you would get (Beth Saunders).

> It was a fifteen minute shot. That's it. She did no counselling literally. The only time when you could even say it was on the form of counselling was: what are you doing? how are you doing it? and why are you doing it? In the hospital. When I went out it was the same thing. Fifteen minutes in and out fast. Drug monitoring. No counselling whatsoever (Janet Moffat).

The amount and quality of interaction with psychiatric professionals indicated by the hospitalized women I interviewed is consistent with what has been reported in other studies. For example, Rosenhan's (1973) ethnographic study in which researchers admitted themselves to psychiatric wards calculated the availability of psychiatric attendants, nurses, and psychiatrist. Rosenhan found that while all staff tended to keep to themselves and away from patients, the amount of time spent with patients decreased dramatically with the power of the professional. Attendants spent

the most amount of time, an average of 11.3% of their shifts, with patients, while nurses spent significantly less time, and psychiatrists practically no time (1973, p. 254).

Sometimes psychiatric nurses reinforced the omnipotence of psychiatrists by intercepting patients' requests to see their doctors. As Claire Baker remembered, "The nurses themselves said... 'Dr. [X] comes to see you when he wants to; he doesn't respond to any requests or anything like that, whether it be from the nurses or the patients." Such stories reminded me of my own experience as a receptionist on a psychiatric ward, where I was frequently placed as a buffer between patients and their psychiatrists. Patients who wished to contact their psychiatrist often attempted to do so through leaving messages through me when other measures had failed. Sometimes the messages were regarding the unwanted effects of drugs; sometimes they were requests for information about their legal status and when they would be allowed to leave. I would pass patient messages to psychiatrists only to have patients return to me hours and sometimes days on end having heard no response. Claire and some of the patients hospitalized with her were so mystified by the absense of psychiatrists from the ward that they came up with this theory: "There's a shortage of psychiatrists.... Somebody said they're not paid enough -- I don't know -- one of the patients in the hospital said she figured they weren't paid enough and that's why there aren't that many of them."

The hospitalized study participants remembered psychiatric nurses spending more time with them than psychiatrists, although they were not necessarily more available for emotional support. A number of women described psychiatric nurses who were intrusive, critical, and authoritarian. For example, Sharon Wilkins related one incident in which:

> the nurses were really upset with me, because they thought that I was ungrateful for the help that I had received there. And I told them that -- well, I'd had enough of it, you know. I wasn't going to stay anymore.... And so the nurse said to me, 'well, we need the room; there's lots of patients that want this room, and we'd like you to pack it up as soon as possible.

Cara Sun related another interaction with a psychiatric nurse "who used to tell me to grow up, smarten up, act your age. *'How old are you? Put your feet on the floor! Don't sit like that!'"* Tessa Jones

remarked that nurses were often inconsistent in their approaches to patients; in particular, she found

that nurses gave her contradictory messages around expressing emotion.

> One nurse in particular was more of a putting me down and to me it was degrading, kind of
> made my self-esteem go lower yet.... I did a lot of crying and stuff, and she'd tell you, 'what
> are you crying about?' You know? And at that time I was learning that it was okay to cry.
> For years I wouldn't cry. And then all of a sudden it's mixed reactions, you know. One tells
> you you can cry and the next one -- no.

Janet Moffat coined the term "the nursing thing," to depict professional behaviours she

experienced as characteristic of psychiatric nurses: "observing and then doing intensive questioning...

[when] I was not ready to share." She described most of the nurses who worked with her as "pseudo-

compassionate" or "pseudo-caring," an idea reinforced by Sharon Wilkins who summarized her

feelings about nurses in this way: "I don't really feel that they're working for me, they're working for

the hospital, they're working for an institution, they've got a job to do, and they're being that friendly

because that's part of their job."

The women interviewed for this study had very mixed experiences with psychiatric nurses; as

Beth Playsted phrases it, "there was great variation in the nursing staff." Mari Smith remembered the

nurses from her psychiatric treatment in the 1950s and 60s as "overbearing and brutal," whereas some

in more recent years "have talked to me about my problems. And they've sympathized with me when

I've said I was having trouble with my psychiatrist. They haven't immediately rushed off to him and

said, 'she doesn't like you.'"[12] Some women interviewed for this study had positive interactions with

psychiatric nurses. For several women, an attentive and empathetic nurse or social worker made the

experience of hospitalization more tolerable. Tessa Jones, Erin Fremont, and Angel Anne Lowen were

all introduced in the early 1990s to reading material for sexual abuse survivors by psychiatric nurses

who took the time to talk with them about their experiences. Angel Anne describes what was most

helpful to her during that hospitalization.

> She [the nurse] started doing one-on-one with me. We would take some time every day and
> they actually got a copy of *The Courage to Heal* book[13].... They developed what they called a
> memory box. And if I had a memory, I was supposed to write it down on a little different

134

coloured pieces of paper and put it in the box. And when my nurse came along I was supposed to discuss it with her. And that was good. Like, I really connected well with her. She was very helpful.

According to the women interviewed, the professionals most helpful during a hospitalization were those who paid attention to what patients needed in the moment and attempted to interact with patients accordingly. At times, women patients wanted privacy and time alone; at other times, they wanted to talk with an empathetic listener. Helpful professionals were respectful, knowledgeable, and resourceful. Positive experiences with mental health professionals during hospitalization were less frequent, however, than experiences of neglect and stigmatization. Generally, positive experiences tended to reflect more the rapport between an individual patient and professional than an overall helpful encounter with the mental health system. In part, this represents the positive impact of caring individual professionals who choose to work in the field out of a desire to help others, some of whom manage to integrate a feminist approach into their work. While individual compassionate professionals can make a difference to the experience of individual women patients, the impact of the psychiatric system is determined by more than the actions of individual practitioners. In fact, it can be argued that the more compassionate workers may, by their presence, encourage patients to invest trust and hope in a system which pathologizes them and ultimately proves ineffective or damaging. We must look beyond the interactions of individual patients and practitioners to the biomedical diagnostic and treatment practices which are most indicative of the function of psychiatry in contemporary society.

Most of the women interviewed for this project were surprised to find that they did not receive treatment in hospital in the sense they expected, and that what treatment they did receive seemed to them ineffective. Adrienne Joffey expressed utter disappointment with her hospitalization: "I guess what I wanted -- I felt like I needed someone to talk to. I just needed to dump. And I needed to not have to worry about food or socializing or anything. And that was what I needed. And the only thing that I got that I needed was that I didn't have to worry about food."

Angel Anne Lowen remembers the boredom and lack of structure and attention from her first

hospitalization as an experience which fed her depression.

> I actually think I became more depressed and more isolated while I was in there, because there
> was nothing to do. There was nothing to structure my time; there was nowhere to go; there
> was nobody to talk to.... The nurses... you were lucky if you got to talk to them once for five
> minutes, and they'd just check your affect and this and that for five minutes in an eight hour
> shift or whatever. So I just -- passed most of my time sleeping. All I did was sleep. And they
> would come and wake me up at seven in the morning to get up and eat breakfast. Well, I
> figured, what the hell for -- get up and eat breakfast, so you can sit around and do nothing all
> day.

Although many women were unimpressed by structured activities in hospital such as ward meetings,

occupational therapy, and recreation therapy, both Tessa Jones and Naomi Windfeathers felt that they

had learned valuable skills in these settings. Tessa found that the group exercises helped her to think

about stress management, relaxation, and exercise in a new way and to be more comfortable expressing

her emotions. Naomi reported that the exercises "taught me that I needed to be around people" and

helped her focus on the things she wanted in her life. Beth Saunders also found it useful to be "in a

group environment with other people who were experiencing a variety of things.... I didn't make friends

quite, but I certainly made a lot of contacts that were really different than I had in my life." Other

women considered the structured activities ridiculous and resented them if they were mandatory. Judi

Chamberlin writes of the ways in which during psychiatric hospitalization every activity in the hospital

becomes a type of therapy. Thus going to a dance or movie becomes recreation therapy, reading a

book is considered bibliotherapy, and "custodial mental hospitals, which offer little treatment,

frequently make references to 'milieu therapy,' as if the very hospital air were somehow curative"

(1978, pp. 120-21).

Miedema and Stoppard's (1994) study of women's experiences of psychiatric hospitalization

in New Brunswick revealed that what was most helpful about being in hospital to many women was

having a rest away from family responsibilities. This was also a theme among the women interviewed

for this study. Anna Black maintained that having a rest was the only benefit to her stay in hospital:

"the psych ward was only a place where I could be apart from my kids for three weeks." Mabel Abelone described her hospitalization in these terms: "I was rested... a break from responsibility... that's basically it." Cara Sun was able to be away from her mother; Beth Saunders and Mary Taylor had a rest from their entire families. For Erin Fremont, the hospital provided a place of safety where she would not be harassed by a former boyfriend who had been stalking her: "At that time, I felt going there would be safer than being where I was." Claire Baker discovered an unforeseen benefit to being in the hospital: "My going to the hospital seemed to make [my husband] realize what a pounding he was giving me, so maybe that was good."

A number of women revealed that it was difficult for them to leave the hospital when they were discharged and that they felt differently able to cope outside hospital. This process of growing dependent on the hospital, often referred to as institititutionalization, is usually associated with patients who have been in hospital over a period of years such that they have lost the skills required to live independently. The process of institutionalization can happen in a matter of weeks, according to many of the women interviewed for this project. Beth Saunders described how after seven weeks in hospital it was so difficult to adjust to being outside that she would return to walk by the hospital to look up at the ward where she had stayed. Having experienced the dependency on the hospital before, Tessa Jones recognized the initial signs and endeavoured to get herself discharged before she felt that way again.

> I know after the first time -- or was it the second time -- it seemed like the longer I was in there I was scared like hell to go home, because you get so dependent on them.... With the longer stay, I was really scared at being so dependent that it was scary to leave.... I'd go away on weekend passes and you just can't wait to get back there where it's safe.... And I guess the third time I wanted to get out of there before I started feeling that way again. And continue on with my life.

Many of the women used the term 'safety' to describe the hospital, and their sense of being unsafe in their lives outside hospital. By 'safety,' the women I interviewed tended to mean protection from their own self-injurious or suicidal feelings and behaviour. The hospital provided an environment

137

in which a woman could be protected from any impulses to harm herself through being observed in a controlled environment. The hospital also provided safety by temporarily shifting a woman's daily circumstances -- respite from parenthood and other responsibilities, separation from an abusive or alienating relationship, a break from isolation. When a woman had no other way of getting a break from the circumstances of her life, the hospital could serve as a chance to have a much needed rest. Mabel Abelone describes how she prepared for the hospitalization she experienced most recently.

> When I was packing to go, I thought, 'I don't know how long I'm going to be there,' so I packed a whole bunch of stuff. I brought some knitting and I brought some embroidery and I brought a big pile of books. Because I thought, 'I've got to have something to do. I'm not going to just sit there and do nothing. And that was really funny. Because I was so tired I just slept and slept.

Shirley King reflects on her most recent hospitalization.

> I was delighted to be in there. I didn't want to leave. I was terrified of leaving [whispering]. The night before I left I talked to one of the psych nurses all night long. I was petrified to leave. It was so safe in there. And [my husband] just hated the thought of me being in there.

> While being in hospital did nothing to affect change in the women's living circumstances, it did

provide a temporary escape, a situation in which the women could experience a quality of being taken care of by others. This phenomenon reflects the ways in which women consistently care for others while no one cares for women. In order to receive care and a break from the often grinding conditions of their daily lives, however, women must become sick and enter into the role of patients. The price of this 'rest' is another layer of oppression, as a woman becomes lulled into a career as a psychiatric patient as an alternative to returning home. The safety of the hospital becomes a trap, as a woman is diagnosed as suffering from biological illnesses and then bombarded with biological treatments.


**Experiences of Psychiatric Diagnosis**

The women interviewed for this project had a variety of experiences with psychiatric diagnosis. Many had little or no information about what diagnosis they had been given. Of those women who

were aware of the diagnoses given them by psychiatric professionals, their diagnoses often shifted over time or co-existed with other diagnoses, limiting the credibility of diagnostic procedures. Several women experienced diagnosis positively, as a process of naming and granting legitimacy to their feelings and reality. Additionally, it was noteworthy for me in comparing women's experiences with one another that the diagnoses women were given corresponded to some degree with their sexual orientation.

The lack of information women were given by psychiatric professionals about their diagnoses is strikingly similar to that reported by Miedema and Stoppard (1994, p. 255). Nine of the women I interviewed never received any information relating to a diagnosis at any stage in their psychiatric treatment. Five women were uninformed of a diagnosis in earlier psychiatric episodes but learned their diagnosis later. Several women who were never formally spoken with about their diagnoses learned them through covert measures such as peeking at their files or a computer screen.

Since knowledge is power, the mystery surrounding one's diagnosis exacerbated unequal power relations between patient and professionals, for women knew that they were labelled in some way but this knowledge was not shared with them. For Jill Smith, the lack of information about her diagnosis made it impossible for her to accept her situation and plan around her needs.

> They wouldn't tell me what I had. They wouldn't give me my diagnosis. They'd say, 'let's just say you're sick.' Which put me into denial for ten years or so.... They were quite patronizing.... [There was] no discussion of the illness or reality of mental illness. No discussion of my future. No discussion of planning.... It wasn't until... nine years later... that I figured out it was schizophrenia, same as my mum.

At other times a psychiatrist's refusal to give a woman a diagnosis appeared to come from a disagreement with diagnostic procedures and requirements rather than medical paternalism. Glenda Lennox was told that she had "a healthy mind dealing with an unhealthy situation, but that there was nothing wrong with me. There was no diagnosis, no label." Adrienne Joffey's psychiatrist "didn't want to say what he put down, because he said he didn't want me to categorize myself, and because the

only reason he put that down, whatever he put down, was because he had to for B.C. Med. But that as far as he was concerned, it didn't really mean anything." While this professional undermining of diagnostic practices made a certain impact on both women, each continued nonetheless to consider herself to have a mental illness or psychiatric disability. This suggests the influence of a broader psychiatric discourse which assumes that there must be a meaningful diagnostic category regardless of the actions of individual psychiatrists.

At times a woman's belief that she must have an accurate psychiatric diagnosis sustained her through times when she was misdiagnosed or given a diagnosis which was different than what she thought it should be. Gin Cote carried the diagnosis of schizophrenia for years before insistent persuasion on the parts of her parents, her partner, and herself convinced a psychiatrist to switch her diagnosis to that of manic depression and her treatments to lithium. Gin felt vindicated at the time of our interview that the diagnosis of manic depression was the correct one, that the symptoms of this disorder matched her feelings, and that lithium did not debilitate her the way neuroleptic drugs had done.

Other women were misdiagnosed or given multiple diagnoses, all of which could not be correct. Within one psychiatric episode, Beth Saunders was diagnosed with schizophrenia, an anxiety disorder, and an organic brain disorder, all of which proved either incorrect or irrelevant since she has had no further psychiatric treatment over the following fifteen years. Tessa Jones has been diagnosed with an anxiety disorder, depression, bipolar disorder, and borderline personality disorder; Angel Anne Lowen with both bipolar disorder and borderline personality disorder. Since the purpose of diagnosis is to ensure as much as possible that two psychiatrists treating the same patient will diagnose the same disorder, these examples indicate fallibility in diagnostic theory and procedures.

While misdiagnosis shook the faith in psychiatry of several women, others were determined to find an accurate diagnosis. For many women, having a diagnosis granted legitimacy to their feelings

that something was wrong. For example, Diane Duthie describes how she felt when she heard her diagnosis:

> It was wonderful that it had a label. It was great that I could say, okay, this is what I'm dealing with here, so I could pick up things on depression and I could read them. Or I could hear what people had to say about depression. I'm still ashamed of it a little bit, because of the stigma associated with it... but it was wonderful to have a label, it was wonderful that I could say, well, that's why I'm feeling this way and it's not normal feelings. Not everybody feels this way. Not everybody goes through this.

The need for legitimacy and for the naming of their emotional realities led several women to seek out diagnoses which they felt more truly represented them than the diagnoses given them by psychiatrists. Following her hospitalization and shock treatments for depression, Anna Black consulted a gynaecologist who diagnosed her with pre-menstrual syndrome, a diagnosis Anna accepts over depression. Angel Anne Lowen considers herself to have multiple personality disorder, a diagnosis given to her by counsellors she has seen outside of the psychiatric system, which makes sense to her in terms of her history of abuse. Interestingly, Angel Anne does not consider MPD to be a mental illness "because I know there's recovery. And I see myself as being really gifted in a lot of ways, even though there's the down sides and the hard things you have to deal with." However, Angel Anne's psychiatrist did not believe in the diagnosis of MPD (although it is listed in the *DSM*) and laughed at her when she told him. "He told me if somebody was filling my head with that garbage that I was done in for and that I would never recover, and that I was never going to get better. I was just going to get worse and worse if I allowed myself to get caught up in that scam." In response to her history of witnessing abuse, Naomi Windfeathers considers herself to have post-traumatic stress disorder, as opposed to bipolar disorder, her official psychiatric diagnosis. Naomi found that the label of PTSD:

> ...really provided... a legitimacy to what's happening to me. Especially when working with professionals.... For me, it's provided a way to legitimize what I've been through. Like, I can say, 'look here, it's here in print; this is what happens to me.' And it's not because there's something wrong with me -- because I've carried that around for a couple of years, that idea that there's something inherently wrong with me, and that's why I'm not getting better. But it's not; it's because you're misdiagnosing the problem.

Despite the prevalence of abuse and violence in the lives of the women interviewed for this project, none of them to their knowledge were officially diagnosed with PTSD. Of the sixteen women who learned or surmised their diagnosis at some stage in their psychiatric treatment, seven were diagnosed with depression; six with bipolar disorder; two with borderline personality disorder; four with schizophrenia; four with anxiety disorders; one with a dissociative disorder; one with organic brain disorder; and one with pre-menstrual syndrome.[14] Although Denise Russell questions the practice of diagnosing women who have experienced abuse at all, she suggests that positing one abuse disorder may be more useful than dividing abused women into clusters of disorders based on descriptions of their reactions to abuse. "If the overwhelming majority of female psychiatric patients have experienced abuse, then the above suggestions would place them in the one category" (Russell, 1995, p. 49). This observation would apply to the group of women interviewed for this project, whose lives and histories shared much in common with one another.

A disturbing trend which emerges in comparing the diagnoses received by study participants is the way in which the diagnoses women received tended to correspond with their sexual orientation. Three of four women who were diagnosed with schizophrenia were lesbian. Six of seven women diagnosed with bipolar disorder considered themselves non-heterosexual: one was unsure of her sexual orientation, two were bisexual, and three were lesbian. Of three women diagnosed with borderline personality disorder, two were lesbian and one bisexual. Heterosexual women were more likely to be diagnosed with depression, and anxiety disorders were distributed evenly between heterosexual and non-heterosexual women. That the women who did not conform to heterosexual norms should be diagnosed with the more 'psychotic' disorders and subjected to the more powerful psychiatric drugs gives some cause for concern. Eight of ten women prescribed antipsychotic drugs were non-heterosexual, as well as six of seven women given lithium. Shock treatment, however, was more commonly given to heterosexual women, corresponding presumably with the higher rate of depression

diagnosed in the heterosexual study participants. Such diagnostic patterns suggest that women who live outside the institution of heterosexuality may more likely be constructed as seriously problematic for the psychiatric paradigm, while heterosexual women are more routinely given the 'feminine' diagnosis of depression. As this study cannot be read to have statistical significance, such reasoning can only be theoretical at this stage, inviting questions for future research.

## Psychiatric Drugs

The one form of psychiatric treatment common to almost all study participants was psychiatric drugs. Twenty of twenty-four women interviewed had been prescribed psychiatric drugs, eleven for a period of two years or more. All but one of the women who had been hospitalized had taken psychiatric drugs. Almost as prevalent as the use of psychiatric drugs was the study participants' lack of information about the drugs they were taking. Only two women indicated that they felt well-informed about their drug treatments most of the time. Most women could not remember at least some of the drugs which had been prescribed for them; some were even unsure of the classes of drugs they had ingested. A number of serious problems with the use of psychiatric drugs emerged from the group of women who were interviewed, including intolerable 'side-effects' and drug reactions, substance abuse and dependency, and the use of psychiatric drugs in suicide attempts. Despite these problems, several women believed that psychiatric drugs were an essential part of their treatment, without which they would not be able to function in everyday living.

As the interviews attest, study participants were far more likely to be medicated than not when they sought help from psychiatric professionals. Only four of the women interviewed had never taken psychiatric drugs; two of those four women had been offered prescriptions but had refused. Three of the four women who had not taken drugs had received outpatient psychiatric treatment only. The chances of being medicated increased with hospitalization: all but one of the hospitalized women had taken psychiatric drugs. Mary Taylor managed to remain drug-free as an involuntary patient in the mid-1970s; although she was offered psychiatric drugs, she was not forced to take them. A number of women remarked that psychiatric drugs

143

appeared to be the treatment of first choice for the psychiatric professionals they consulted rather than a last resort. Women described being treated with drugs before they could scarcely imagine that the psychiatrist had identified the problem and to the exclusion of any other treatment. As Graham Black reflected, "I agreed to go there [to the hospital] because I wanted a solution. I didn't want to just space out. But... they just gave me pills." Naomi Windfeathers similarly was prescribed drugs immediately, and although she found that they were not helping her, had difficulty asserting her desire for a different kind of treatment.

> I stayed with that psychiatrist for a little while, and then I found that there wasn't anything being *done*... all it was was being medicated. So I switched psychiatrists... and I thought that was going to be better, but it was the same thing basically.... It was just medications.... I would go to his office and say, like, 'well, nothing is changing here; I still have the same problems. I still feel like I'm disconnected from the rest of the world.' And he would say, 'well, take the drugs; take the drugs.' And I would go back and say, 'well, nothing's changing.' And he said, 'well, I don't want to put you in the hospital and hook you up to IV drugs.' And so the implied message was: shut up or we'll put you in the hospital. So I shut up, right?

Outpatient psychiatric treatment was often organized around the dates prescriptions were to be renewed. For example, Sharon Wilkins reflected to me what a typical appointment with her psychiatrist was like: "[My psychiatrist and I] spend as much time as I want, and then -- and then she gives me another prescription, and then I know that when the prescription's up that I am coming back."

The scenarios of drug treatment which were described to me were generally not of the variety whereby drugs are prescribed for short-term use to get through a crisis. Six women took psychiatric drugs for a period of time of six months or less, but each of these women was assertive about terminating her drug treatment, most often against doctor's orders. Three women had taken psychiatric drugs for a period between seven months and two years at the time of our interview. Eleven had taken psychiatric drugs for a prolonged period of two years or longer; five fully expected to take psychiatric drugs for the rest of their lives. Seventeen women had taken antidepressants; ten had taken antipsychotics; ten antianxiety agents; seven antimanic agents; and five sleeping pills. Non-heterosexual study participants were more likely to be prescribed antipsychotic and antimanic drugs and had similar rates of antidepressant and antianxiety drug

use as their heterosexual counterparts. Seven of eight women prescribed three or more different classes of

drugs were non-heterosexual. Sharon Wilkins was prescribed antidepressants, antipsychotics, an antimanic

agent, and sleeping pills. Angel Anne Lowen having been prescribed "almost every kind of drug there was,"

had taken antidepressants, anti-anxiety agents, antipsychotics, anti-manic agents, sleeping pills, and cogentin

to modify side-effects. Angel Anne expressed to me her desire to eventually come off all psychiatric drugs,

but her psychiatrists were not in agreement.

> They figure I should stay on the drugs long-term, for the rest of my life, all the time. And
> he said unfortunately there's the side-effects, but those are -- he talks about them like
> they're just a little pain in the ass but not a big deal, right? I'd rather learn more and more
> how to cope without the drugs, and hopefully one day never need them again, than be on
> them for the rest of my life and live with the side-effects. They don't think it's a big deal to
> live with those side-effects; they just don't. To have your body full of drugs.

Ten of the women felt almost completely uninformed about the psychiatric drugs they had taken.

An additional eight believed they had been partly informed at least some of the time about their drug

treatment; only two women indicated that they had felt informed most of the time. Many did not know the

names of the drugs, and sometimes even had to guess at the class of the drug (for example, whether a drug

being taken was an antipsychotic or a sleeping pill). Many women referred to their drugs by the colour of the

pill rather than its name. Glenda Lennox maintained that what was least helpful about her psychiatric

treatment was the way in which psychotropic drugs were handled.

> I don't even know what the hell I was on to this day! You know, it was just this little red
> pill that I took every morning. And I didn't understand what it was supposed to do. And
> then with [the psychiatrist]s going on holidays, that was difficult, because then she was
> gone and I was more anxious and then I had to see somebody else. And then they gave me
> this other pill, and I didn't know what that was either. So the medication part was the
> scariest, because I didn't know what was happening and my mind felt crazy.

Mabel Abelone did not believe that she had made an informed decision to take antidepressants when she was

in hospital, as the consequences only later became apparent to her.

> I wasn't in the hospital very long, but they put me on a whole bunch of medication to make
> me sleep. And then when I came out I was really mad, because the doctor said, 'well, you
> have to take this medication for three months, because it doesn't work unless you take it for
> three months.' And I was very upset that they didn't tell me what I was going to be given
> and what I had taken in the hospital.... I said, 'I don't want to take these.' She says, 'well,

145

you have to, for three months.'.... She was really indicating that I should be on them for a year and I said no.

Almost all of the women who had taken psychiatric drugs expressed ways in which the drugs were problematic for them. First, drug reactions and unmanageable side-effects were a common complaint. Some women described ways in which the drugs prescribed for them worsened their state of mind and created additional problems. Secondly, drugs were sometimes improperly prescribed or monitored, and in one case seemed to be used solely to facilitate an ethical violation. Third, drugs were prescribed for women with substance abuse problems, which served to introduce another set of chemicals to combine with the alcohol and street drugs already being consumed. Finally, psychiatric drugs provided a method for attempting suicide for five women interviewed for this study.

Study participants described many instances in which taking psychiatric drugs led to an intensification rather than a reduction of emotional distress and to physical health problems. 'Side effects' experienced by study participants included depression, suicidal feelings, mania, insomnia, sedation and fatigue, constipation, nausea and vomiting, and seizures. Sometimes drugs seemed to cause paradoxical reactions. For example, two women reported experiencing intense suicidal feelings while taking · antidepressants. As Naomi Windfeathers explains, she was not at all prepared that the drugs might have this type of impact.

> When I first went on [antidepressants], I had no idea how I would feel when I was on them.... That wasn't explained to me. And it should have been. Because I started taking them on a Friday evening, and I basically came about as close as I've ever come to killing myself on Sunday morning. Because I felt so lousy, and nobody had bothered telling me that you do feel rotten at first, because they knock you out and they don't necessarily improve your mood for weeks even.

One of the most common reactions to taking psychotropic drugs described by study participants was a feeling of sedation. Janet Moffat remembers, "Those antidepressants -- my God, you can't even think! I would be so slow-moving.... Fatigue. Like, I could just drop to sleep. I slept and slept and slept.... There was no emotions." Graham Black had not been informed that she should not drive while taking the

antidepressant she was prescribed, and came close to a car accident when she nearly fell asleep behind the

wheel. Erin Fremont fell asleep during an examination while taking a combination of lithium and haldol.

Gin Cote nearly lost her job during the three years she took antipsychotic drugs. As she relates, her

diminished capacity to concentrate and perform tasks became attributed to her mental state rather than to the

antipsychotic drugs.

> I wasn't functioning. I couldn't write. My writing was totally illegible. I couldn't talk on
> the phone.... It creates a lot of negative feelings within you. And I think that's been
> misinterpreted as being because of your personality. No. It's because you're on this stuff.
> You're frustrated: you can't grasp anything. Somebody will be talking to you and you
> won't hear them at all. It'll be totally blocked out.

While some psychiatric drugs have a sedating effect, others such as the Selective Seratonin

Reuptake Inhibitor (SSRI) antidepressants have been documented to have stimulant properties (Breggin,

1994). Several women interviewed for this study experienced such drugs as prozac, paxil and zoloft as

inducing a discomfiting restlessness. Angel Anne Lowen relates how she felt when on prozac:

> I get really high from it. It makes me manic.... At first it feels really good because you have
> all this energy; you're not crying anymore.... It seems to do what it's supposed to do at first.
> But then after a while, it gets to where I start to get agitated, and I want to act out. I feel
> impulsive. And I'll go for three or four days at a time and I won't sleep, and then I get into
> that whole cycle.... It stops the tears and the weepiness, but really what I find it does is that
> it just shuts me down emotionally. And so when I have things come up where I'm supposed
> to feel emotions, I can't feel them appropriately. And those feelings -- it's like they're stuck
> inside, and I can't get them out. I can't cry; I can't get angry the way I should; I can't
> express my feelings the way I need to. So then I want to act out in the negative ways I've
> learned in the past.

Three women experienced serious and health-threatening reactions to psychiatric drugs. Beth

Playsted, who had a pre-existing heart condition, suffered heart failure after five years of taking

antidepressants known to exacerbate heart problems. Mari Smith, after years of taking antipsychotic drugs,

is beginning to show signs of tardive dyskinesia such as uncontrollable tremors of her hands, face, and

tongue. Beth Saunders experienced a seizure while in hospital in response to mellaril, an antipsychotic drug

she had been prescribed:

> I went to a nurse and I said, 'I'm sleeping all the time. This is really gross. I want to stop
> this.' And she said, 'oh no, that's what happens when you go on this the first couple of

days, and your body gets adjusted to it and you can tell if it's going to be helpful or not.' The same day, maybe a couple of hours later, or maybe even the next day. Soon after. The whole reaction. It started with muscle twitching and stuff. And I was so freaked out. And I didn't trust anybody enough to say what was going on for me. And they'd already said, 'oh, just give it a try.'... So I went through about a day of increasing reactions, and then I guess sometime in the afternoon it totally went wacky and I had a seizure....

Beth's account reveals that none of the psychiatric professionals anticipated this reaction, nor did they seem to know what to do when it occurred. Her psychiatrist first tried to attribute the seizure to an emotional response to his being away for the weekend, then diagnosed her with an organic brain disorder, so convinced was he that her reaction could not be to the drug. However, an emergency ward treated her second seizure as an allergic reaction with antihistamines, and in the years that have followed, Beth has never experienced seizures.

In some cases, improper medical handling of psychiatric drugs caused women further distress. Claire Baker began her twenty year history of benzodiazepine use when she was given tranquillizers by a doctor friend with whom her husband would go on drinking binges. She then took more from her workplace before she gained the courage to approach her own doctor. Her GPs continued to prescribe the drugs over the next decades, although one expressed some concern and referred her to a psychiatrist to evaluate whether or not she could stay on the drugs for the rest of her life. In Claire's words the response was, "he sent a letter back to my doctor that said, yes, it would be fine for me to stay on these pills for the rest of my life." Throughout our interview Claire expressed fears that her doctors would one day expect her to live free of tranquillizers. Close to the time of our interview, Claire had become so frightened that her prescriptions would be cut off by a new psychiatrist that she began to develop a stash of pills by visiting two doctors and having both prescribe the drugs. As Claire told me, "I wasn't going to be able to exist [crying]!... I didn't know how I was going to exist without having medicines to help me through these horrible times."

Angel Anne Lowen took lithium for two years without medical monitoring because a psychiatrist prescribed that quantity of the drug for her. This state of affairs was highly dangerous since lithium has a potential for toxicity, can cause damage to the liver and kidneys, and should be monitored at first a couple of

148

times per week and later at least every three months (Talbott, Hales & Yudofsky, 1988, p. 262). After one year of lithium use, Angel Anne attempted to have her lithium levels monitored at her local hospital. The hospital would not do the monitoring unless Angel Anne was in hospital and committed her. She escaped from hospital the same day and continued taking the lithium for the next year until the prescription ran out.

Yet another situation was described to me in which a psychiatrist made use of a drug without informed consent and for dubious purposes. Janet Moffat was first referred to a psychiatrist in the early 1960s in Saskatchewan after her second miscarriage. In their one and only appointment the psychiatrist injected her with a drug he referred to as 'truth serum'[15] and proceeded to ask her probing sexual questions. Janet lay on the couch, powerless under the influence of the drug to do anything other than answer his questions. Thirty years later in our interview Janet re-lived the painful memory of this experience she referred to as 'emotional rape.'

Another variety of harm was caused to study participants when psychiatric drugs were prescribed to women with pre-existing substance abuse problems. Five women were prescribed psychiatric drugs during a time when they were abusing alcohol and/or street drugs, an oversight which intensified their substance misuse. Angel Anne Lowen recalls, "I spent a lot of my days out drinking. Drinking combined with antidepressants and other pills was not a good mixture." Naomi Windfeathers echoes: "Instead of just taking the antidepressants I started mixing them with alcohol and tranquillizers and stuff.... In my terms, it would bring me back up to normal... to kill some of the anxiety." When psychiatric professionals supported these women to deal with their addiction problems, the focus was entirely on alcohol and illegal drugs without attention to the ways in which prescription drug use combined in the addiction pattern. As Angel Anne phrased it:

> They tried getting me into drug and alcohol treatment. And in the meantime I was on two antipsychotics, cogentin, sleeping pills, valium three times a day, and plus I was on antidepressants. And they wanted to put me into drug and alcohol treatment because of my use of illegal drugs and alcohol!

Despite the problems involved with taking psychiatric drugs described by most study participants, a number of women were steadfast in their belief that psychiatric drugs were essential to their well-being. For some of the women dealing with depression or anxiety, antidepressants and benzodiazepines were seen as tools which could make emotional distress more manageable and help one cope with everyday life. Some women viewed antidepressants as a tool that could be used to "take the edge off" their more extreme times of emotional pain, making daily life more manageable and psychotherapy possible. For example, Beth Playsted explains: "I did feel that when I was on antidepressants I could still get depressed but I don't have the edges; I don't feel quite as risky. Or things don't feel like they're going as far." Adrienne Joffey echoes, "It takes off the very, very bottom. I'm on a very low dose because I get side-effects if I go on more. And I do feel like it takes off the very, very bottom and the part where I feel really out of control and I'm suicidal." While the drugs do not cause the source of the pain to disappear, Adrienne believes that drugs allow her to deal with the pain in stages rather than be overwhelmed with it all at once. Shirley King uses anti-anxiety drugs as needed to help her cope with stressful situations. At times she finds she does not even need to use them, just to know that they are available to her.

For two women, one diagnosed with schizophrenia and the other with bipolar disorder, psychiatric drugs were viewed as essential substances to correct chemical imbalances in the brain. Jill Smith maintains that the neuroleptic drug with which she is injected is the reason she is able to lead a productive life. In Jill's terms, her brain is 'scrambled', and hence the fact that the drug she is prescribed 'works' is all that keeps her from a psychotic state. Similarly, although Gin Cote despises neuroleptic drugs, she accepts lithium as a substance her body needs in order to function normally. Both Jill and Gin use the diabetes metaphor: that their bodies need neuroleptics and lithium respectively as a diabetic needs insulin. Gin's view of lithium as somehow natural and thus not really a drug is a common perception encouraged by pharmaceutical corporations and the psychiatric system:[16]

> It's not a drug, *per se*. It's actually a natural element.... It doesn't control my moods; it doesn't control my emotions; it doesn't control my thought processes. It's like salt. Salt may increase your blood pressure a bit, but outside that that's as far as it goes. It doesn't alter my state of mind; it

doesn't warp it.... I'm not mellowed out.... Lithium does help in making sure that you don't go manic or you don't go depressive.... It's a miracle drug. It's a miracle drug.... But it's just like diabetes.... Manic depression -- it's like you're lacking in lithium. It's just like a diabetic who is lacking in insulin.

Lithium does, of course, like other psychiatric drugs, act upon neurotransmitters in the brain and alter state of mind; it would otherwise not be prescribed for bipolar disorder and psychotic depression. The view of lithium as natural and harmless distracts attention from the damage lithium is known to cause with long-term use to the liver and kidneys. As insulin is intended for life-long use in people with diabetes, both lithium and neuroleptics are viewed as drugs to be taken for life by people with bipolar disorder and schizophrenia respectively.


## Shock Treatments:

In a recent CBC radio interview, the director of an ECT clinic in Montreal claimed that shock treatment is an under-used procedure because of public disapproval induced by the media and entertainment industry (Tourgeman, 1997, February 21). The clinic director used the bulk of the interview to emphasize what she referred to as the 'dramatic' differences between the old and new versions of shock treatment -- namely the use of anaesthesia so that the patient is no longer conscious during the procedure and muscle relaxants to mute the convulsions, thereby preventing bone fractures.

Mabel Abelone experienced the traumatic impact of early forms of shock treatment when she was committed in 1952 to the provincial mental hospital as a twelve-year old incest survivor.

I talk about it now as having the experience of going to the electric chair.... You'd go in the room and there'd be these white curtains... Sometimes they were open a little bit and you'd see all these bodies on the bed covered with white sheets. It looked like they were all dead. And I would see that, and then I'd go up on the table. I don't know how I got through all that. Because there'd be two guys over there on each side... they'd grab you because you'd go into a kind of convulsion, and then there'd be the guy behind you that would put the stuff on your forehead. And then they'd put this big black bar in your mouth and you'd have to bite on it. And -- *that sense of obedience*.... I remember it being very terrifying. Always wondering, maybe I'll die *this* time.

There can be little doubt that the shock treatments had the effect of re-victimizing Mabel, terrifying her into submission and silence; it is difficult to imagine any therapeutic value. Mari Smith, who experienced ECT almost ten years later said she was not afraid of the treatments but could not remember having had them. "I used to plead with them not to give me shock treatment," she said, "because, although it's not too wearing on you because they anaesthetize you before they give you the massive dose, you forget where everything is in your immediate surroundings."

The form of shock treatment which Mari Smith dreaded most was insulin shock or insulin coma treatment, practised widely in the 1950s, and referred to by Mari as "the worst thing that ever happened to me." Both Mari Smith and Mabel Abelone, the two participants who were treated psychiatrically in that decade, experienced insulin shock. Mari describes what it was like to endure this treatment:

> They strapped you down in your bed in the morning with eight sheets folded, so you were in a straitjacket. And they gave you a massive injection of insulin in your arm... You lay there and sweated all morning and listened to the women around you screaming and crying, because they were already in a coma. After that, you went into coma, when the insulin began to take effect. And the doctors would come around and test you to make sure you were out, and then they scored you on how long you died for. And after a certain period of time, they would give you an injection of sugar syrup in your arm to bring you out of the coma.... You'd usually do about fifteen minutes a day, and I did twenty-seven hours in total... over four months.

Insulin shock has been rarely if ever used since the late 1960s (Burstow & Weitz, 1988, p. 320). A more modified version of electro-convulsive treatment has taken its place. Since patients are anaesthetized and not conscious during the procedure, it is no longer experienced as the type of torture recalled by Mari Smith and Mabel Abelone. It was this modern form of shock treatment which was experienced by the remaining five women I interviewed who were treated with ECT. Nonetheless, the enthusiasm with which the psychiatric establishment refers to the revolution in shock treatment is puzzling. The seven women interviewed for this study experienced significant harm from ECT and arguably little benefit. In the context of allegations that ECT 'works' through damaging the brain (Breggin, 1991, pp. 184-215; Burstow, 1992, p. 32; Frank, 1992), anaesthesia and muscle relaxants

are really beside the point. Regardless of the change in procedure, the women I interviewed were almost unanimously afraid of shock treatment. They tended to view shock treatment as an extreme measure indicative of the severity of either a patient's mental state or the control imposed upon patients. The experience of shock treatment tended to set patients apart from one another in a way similar to the division between those who had been committed and those who had not. Shock treatment was experienced by the women who were interviewed as stigmatizing and shameful, the end of the road, or as Anna Black phrased it, "the bottom of the pit."

In the CBC radio interview referred to above, the interviewer asked the director of the electro-convulsive therapy clinic in Montreal if she knew how the treatment worked. The director responded, "no, I don't. There are theories, but nobody knows exactly how it works." To this the interviewer asked, "is this not scary?" The director replied: "it is, but it's true for other treatments in medicine, that we are not certain of the exact mechanism of action" (Tourgeman, 1997, February 21). The information given to patients about ECT, according to the women I interviewed, was sketchy at best. Claire Baker recalls that "the doctor told me... my brain was like a stuck record, and this would get my brain going again." Sharon Wilkins remembers only that she was told that "it would elevate my mood." Many women simply accepted the word of their doctors and agreed to the treatment out of desperation to find a solution. As Claire phrases it, "I was so depressed I didn't care, or I might have even been grasping at straws." Tessa Jones echoes, "at that time I think I was ready to try just about anything. I wanted to get back on with my life and quit feeling shitty."

None of the women I interviewed were sufficiently prepared for the memory loss they suffered after shock treatments. Although some understood that they might experience some 'short-term' confusion and memory loss, professionals tended to diminish the likelihood and impact of these effects of the treatment while over-emphasizing the intended result of mood elevation. While several women reported that they experienced a temporary lift in their mood, none experienced this lift as more than

transitory, and all described memory loss at a level which they found disturbing. For most of the women, a period of time surrounding the shock treatment was erased permanently from their memories. This time period at the very least included several weeks prior to the onset of treatments, several weeks during treatment, and several weeks following treatment. Anna Black told me that she had telephoned a new employer three times because she kept forgetting that she had been given the job. Angel Anne Lowen reported that during the time she was receiving treatments her memory loss was so extreme that she could not recognize her mother. Her testimony against her father on charges of sexual assault was later discredited because the court believed that the memory loss she suffered from ECT would necessarily compromise her memory of the assaults. Tessa Jones had to be re-introduced each day to her friend on the ward. At the time of our interview, Tessa still had to write herself notes in order to remember things she needed to do in her daily life. Mari Smith, who worked as a librarian, had to re-learn the location of everything in the library when she returned to work. Mabel Abelone, Claire Baker, and Sharon Wilkins can remember virtually nothing of what led up to the episode in which they received ECT, nor can they remember much of anything at all about their time in hospital.

My interviews with Sharon Wilkins were most able to illuminate the impact of shock treatment on memory, as I interviewed her for the first time six months prior to her first shock treatments and the second time six months afterward. In her first interview, Sharon demonstrated solid memory functioning in her detailed accounts of her psychiatric and personal history, despite the fact that she was so unhappy that she did not want to continue living. In our second interview, six months after shock treatments, Sharon felt no more positive about her life than she had earlier. She was now more compliant with her psychiatric treatment, however, and she experienced pronounced memory loss which was evidently debilitating her in her daily living. Sharon was no longer able to recall many of her psychiatric or life experiences, and our interview was punctuated repeatedly with her assertion, "I just can't remember." In fact, her memory loss was so severe that Sharon could not remember how

often she saw her psychiatrist, how long their appointments were, or what occurred during their appointments. The only way Sharon was able to know that she had seen her psychiatrist was by keeping appointment cards; writing notes to herself had become her way of re-orienting herself to her environment. She was experiencing difficulty parenting her children, who could tell that their mother could not remember anything, such as who their friends were or where things were kept in the house.

Perhaps most ominously, Sharon was bewildered by her memory loss, thinking it could not have been caused by ECT. She thought this partly because she could no longer remember events that had happened prior to the treatments and also because her psychiatrist had told her that her memory loss was likely due to her depression. Because she had experienced a feeling of elation during the second half of the series of shock treatments and initially afterward, Sharon thought that perhaps the treatments would have worked permanently had she only had more of them.

> After the hospitalization... first of all I felt good. And I remember with the memory loss I was sort of laughing about it, because I thought, this is so ridiculous, you know? And then I was sort of feeling bad at the same time, because I felt like I was just losing it, you know, that I just couldn't remember things. And then I started feeling worse and worse. And [my psychiatrist] was away. And so then I kept wishing I was dead. And every night I was wishing I was dead.

On the advice of her general practitioner, Sharon was considering another course of ECT at the time of our second interview. She could not remember having had a good memory at one time and thought that the memory loss was probably due to either her depression or something inherent in her. The elation she remembered feeling temporarily lured her with a promise that more shock treatments would allow her to maintain that feeling of happiness. As she told me:

> I would like to have the results of the ECT without having the memory loss.... Because they do work.... I just needed more.... I remember laughing.... I don't remember being so happy as that -- when I was having [the treatments].... When I was [in hospital], it was when I was having them, after about the sixth one. I was feeling -- I was feeling better.... I guess when we were talking to the people, like I was -- we were having conversations in a room. Like, I remember I was just feeling like laughing.... I remember coming home, and I mean, I was laughing at home too. It was like just a few days and then I started to feel worse.

Sharon's experience illustrates the ways in which shock treatment presents a danger for women. Conditioned to seek help and accept medical authority, women may consent to ECT given minimal and biased information because they trust their doctors. A woman may feel helplessly unhappy or suicidal; she may have been prescribed a series of antidepressant drugs that have not been helpful; ECT is likely to be presented as the next logical course of treatment; no alternatives are offered or available. Immediately after a series of shock treatments, a woman may feel 'better,' elated, even giggly. She can no longer remember anything, let alone why she was unhappy. She can be discharged from hospital improved. Within weeks, however, she may feel more desperate than before; added to her depression she may now have serious memory impairment which leaves her feeling even more pathological than before. Being able to remember only the initial elation with ECT and being misinformed about her memory loss, a woman may seek more shock treatments hoping only for the anaesthetized joy of that initial period.

The women interviewed for this study suggest a shifting relationship of patients to ECT over time. Those given shock treatment in the 1950s and 60s remember the treatment as horrific and harmful, true to the depiction in the film, *One Flew Over the Cuckoo's Nest* (Zaentz & Douglas, 1975). Although some residue of patient and public fear of ECT remains, as represented by the efforts of several young participants to avoid this treatment, the public face of ECT is changing. Information about the dangers and experimental qualities of ECT can still be passed by word of mouth from patient to patient, exposed in old movies, or relayed in antipsychiatry literature and meetings.[17] Mainstream sources of information which reach the majority of community members, however, tend now to present shock treatment in a positive light as an essential and under-utilized treatment for depression.

This chapter has revealed the ways in which study participants were usually transformed in their psychiatric treatment from women suffering from gendered problems in living into patients with

biological illnesses. Whether in outpatient treatment or in hospital, treatments offered or imposed upon study participants were generally biological in nature, aimed at correcting biochemical imbalances in the brain. While some women interviewed for this study reflected a belief to varying degrees in the biomedical model, many were critical of the ways in which the psychiatric system pathologized them as women and reinforced the oppressions against which they struggled. Overwhelmingly study participants described the ways in which the psychiatric system viewed them as problems to be fixed through biological interventions such as psychiatric drugs and electro-convulsive treatment. The words of the women interviewed leave little doubt that psychiatric intervention multiplied their struggles, often leaving confusion in their own minds about the source of what was wrong in their lives.

## NOTES

[1] A number of women, especially those with psychiatric experiences in the 1980s and 1990s, had their psychiatric treatment divided among different types of mental health professionals depending on the type of treatment. In these situations, typically psychiatrists prescribed and monitored drugs while counselling was sometimes offered by a psychiatric social worker or nurse through a mental health clinic. While counselling visits to the mental health clinic were generally longer in duration than visits to a psychiatrist, counselling from other types of mental health professionals under the psychiatric rubric suffered from many of the same types of problems as psychotherapy from psychiatrists: lack of rapport and approachability, bureaucratization and being referred to a specific counsellor without the ability to choose according to personal preference, victim-blaming, and collusion with biomedical theories. In addition, counsellors in clinic settings were prone to abandoning a woman to the psychiatrist or hospital at any suspicion that she was suicidal, often the time when she most needed to talk to someone she could trust.

[2] Although in this chapter a common theme is that male psychiatrists were generally less well regarded than female psychiatrists and more likely to engage a distanced and invalidating professional stance, this was not always the case. A few male psychiatrists were described as warm and empathic, while some female psychiatrists were experienced as authoritarian.

[3] Parnate is a monoamine oxidase (MAO) inhibitor antidepressant.

[4] Nancy Andreason (1984) concurs with Breggin that psychotherapy as a mode of treatment in psychiatry is declining. Andreason writes: "Over the years... the popularity of psychotherapy for very mild problems may diminish, and intensive psychotherapy will almost certainly be used less frequently for serious mental illnesses. Psychotherapy is costly in terms of time and money.... Intensive psychotherapy has not proved to be a very effective treatment, especially in isolation, for serious mental illnesses (p. 256).

[5] One former psychiatric nurse I spoke with described a situation which occurred nearly thirty years ago in which as a young psychiatric nurse in training she had challenged a psychiatrist's decision to administer shock treatment to a depressed twenty year old immigrant woman who had just given birth to her fourth child. The nurse suggested that depression might be a normal response for a woman living in such circumstances. The nurse was reprimanded severely and told that she was *never* to question a psychiatrist's judgement.

[6] While sexual abuse of patients is not officially condoned, neither is it dealt with seriously by the Colleges of Physicians and Surgeons, as evidenced by a recent situation in British Columbia. A psychiatrist twice convicted of having sex with patients has been returned to the active register of practising doctors following a three year suspension. The College has stated merely that General Practitioners should practice caution in referring "vulnerable patients" to this psychiatrist (Ouston, 1997, p. B1). A survey of American psychiatrists found that 6.4 percent acknowledged sexual contact with their patients (Gartrell *et al*, 1989, p. 7).

[7] As described above, Christine Forrest selected her second psychiatrist based on his specialization in hypnosis. Shirley King also chose her second psychiatrist carefully, based on her decision that she needed cognitive therapy. Both women were by this time in their late forties or fifties; both had earlier experiences with psychiatrists as patients; and both were familiar with their options because of their own background as health care professionals.

[8] The Mental Health Act of British Columbia allows committal upon the certification of one doctor for a three day period if there is no second doctor available (1996, s. 27, pp. 11-12). Presumably such committals occur only in rural areas.

[9] This information is derived from the Mental Health Act of British Columbia, 1996, sections 23 - 25, pp. 9-11.

[10] This information is derived from the Mental Health Services Act of Saskatchewan, 1986, section 34(5), p. 19.

[11] The B.C. Mental Health Act even has a section entitled 'Deemed Consent' whereby in the situation of an involuntary patient any "treatment authorized by the director *shall be deemed to be given with the consent of the person*" (emphasis mine) (1996, s. 31, p. 14).

[12] The chances of encountering an empathetic and helpful psychiatric nurse appeared to improve over time. Study participants with hospitalizations in the 1980s and 1990s frequently described having a positive connection with one nurse on the ward who seemed knowledgeable about issues important to them and not necessarily in agreement with the treatment the woman received from other professionals on the ward. However, these nurses were frequently described as low on the professional hierarchy, often students, with little power to do anything other than express empathy with the plight of the patient.

[13] Ellen Bass and Laura Davis, *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse*. New York: Harper and Row, 1988.

[14] The total does not equal sixteen because eight women were given more than one diagnosis.

158

[15] At the time of our interview Janet did not know what drug had been administered to her and wondered if she had been part of the LSD experiments conducted by Dr. Duncan Blewitt and his colleagues in Regina around the same time. Some research we did together in the University of Regina archives suggested that it was more likely she was injected with sodium amytal, a sedative sometimes referred to as 'truth serum.' Janet's experience occurred several years after the conclusion of the LSD experiments which ran from 1953 until LSD was banned in 1960 (Stecyk, 1984). Blewitt and Chwelos (1959) describe the consent process of the experiments, the many hours in which study subjects were under the influence of the drug, and the administration of LSD orally. Blewitt also states that similar methods such as hypnosis, amytal, and pentothal were used as adjuncts to psychotherapy "to help the patient overcome his reluctance to face himself as he really is" (2). It is likely that after LSD was criminalized, other legal drugs such as sodium amytal continued to be used for the same purpose.

[16] For example, an article which appeared in *The Globe and Mail* September 24, 1994 describes lithium as "the lightest solid element on earth, as cheap as beer and simpler than air... [which keeps] millions of people around the world... from binges of promiscuity, psychotic rages, out-of-control spending and suicide. Doctors aren't exactly sure why" (Miller, pp. A1, A9).

[17] For example, a public presentation by Leonard Roy Frank in Vancouver in February 1996 exposed the historical and current dangers of shock treatment, provided a forum for patients and community members to exchange information about their experiences of ECT, and distributed anti-shock literature.

# CHAPTER SIX

## Bulldozing Against the Huge Rock:

## Resistance and Alternatives to the Psychiatric System

We argue, we argue, we argue, time and time again, it is just awful, it is terrible, it is really bad. And no one knows because he says this is therapy. He says all this yelling and this screaming is therapy. What is it? Is this therapy?... It is like a bull dozer trying to bull doze against a huge rock and going nowhere, it is really awful. And I am the bulldozer trying to get him to understand me, to hear me, to hear my pain, to know me, and he doesn't.

(Cara Sun, journal entry)

I decided on that day *there is nothing wrong with me.* And I guess I just got mad -- I was just like, enough is enough. So I've been doing less [therapy] since then. I feel quite good.

(Mabel Abelone)

No study of women's experiences with psychiatric treatment would be complete without an

examination of the ways women discovered to resist the psychiatric system, and their ability to imagine

alternative ways of helping people in distress. To ignore the resistance of women patients would be to

present a one-dimensional image of study participants which reduces them to their experiences of

victimization, to the status of passive recipients of services. The intention of this chapter, therefore, is to

challenge any temptation to conceptualize women psychiatric patients simply as victims by bringing to light

the ways study participants found to struggle against psychiatry and other oppressions in their lives. Several

women I interviewed made great strides to leave psychiatric treatment behind forever in their pasts and to

always seek out supports they considered alternatives in times of emotional need. Other women expressed

resistance in discrete but recurring and powerful moments.

Michel Foucault (1988a, p. 12) insists that in every power relation, no matter how unbalanced, there

exists a certain form of liberty in the disenfranchised, a potential to express some form of resistance, no

matter how minute or seemingly ineffectual. Certainly, anti-psychiatry movements have sprung up, fallen

away, and risen again in various communities internationally over the past three decades. Anti-psychiatry movements have generally been created by former psychiatric patients and their allies, some of whom are mental health professionals, who tell their own stories publicly and lobby for an end to practices such as committal, electro-convulsive therapy, and forced drugging, as well as a liberalization of mental health legislation. Testimonials by patients, both written and spoken, are central to the movement. As Janet Gotkin writes, "Your story, when you tell it, ends your isolation forever; it joins you with others. It -- the act of telling -- makes you political" (1995b, p. 112). Unfortunately, many organizations which resist psychiatry have met one of two fates: closure for lack of funding, or co-optation when mental health professionals assume leadership.[1] However, some anti-psychiatry organizations have remained strong, such as *The Madness Network News*, an American-based periodical which has been printed for over two decades, and small localized resistance organizations rise up to replace others which have been suppressed.

## Stories of Resistance

Although the women I interviewed, with several exceptions, were unaware of the existence of an organized anti-psychiatry movement, each woman described having experienced at least moments of resistance in which injustices were clearly recognized and some action of opposition was taken. Additionally, most women sought out options they viewed as alternatives to psychiatry as a means of dealing with emotional distress and caring for themselves. Foucault theorized that resistance is possible "even when the relation of power may be completely unbalanced," that even when options for resistance are severely limited, there still remains "the possibility of committing suicide, of jumping out the window or of killing the other" (1988a, p. 12). In this way, acts of resistance do not need to be coordinated by political movements but often occur in localized sites and at an individual level. While it can be argued that such restricted options as committing suicide or jumping out a window do not constitute much liberty, it is true that some action of resistance is often possible, whether or not it has any genuine possibility of overturning the relation of power.

As Karlene Faith points out, "resistance weakens processes of victimization" and "feminist resistance, in particular, begins with the body's refusal to be subordinated, an instinctual withdrawal from the patriarchal forces to which it is often violently subjected" (1994, p. 39). The women interviewed for this study expressed resistance to the psychiatric system in a number of ways: first, "choreographed demonstrations of cooperation" (Faith 1994, p. 39); secondly, withdrawing from and refusing treatment; third, experiencing and becoming aware of their own anger; fourth, standing up to professionals; fifth, gaining political awareness, and finally, forming bonds with other women and other psychiatric patients.

I will turn first to the method of resistance Faith describes as "choreographed demonstrations of cooperation" whereby "the 'willing victim' may be operating from the vantage of strategic resistance..." (1994, p. 39). A number of study participants described a process by which they learned quickly what psychiatry expected of them and performed this role so that they would be released from hospital or judged well. Sheila Gilhooly's account in her book, *Still Sane*, illustrates the way she used this method of resistance in order to finally be released from her involuntary hospitalization:

> Me, I was going to pass for normal and get out.... Normal women don't talk about being a lesbian and they're always cheerful. I was always good and smiling, never complaining or bothering the staff, keeping my mouth shut and smiling, always obedient and quiet and nice and smiling, in the middle of this hellhole, smiling and smiling. And I did it. After three months I got out (Blackbridge & Gilhooly, 1985).

Gilhooly's experience resonates in the words of Janet Moffat:

> I was a good patient... I was a hell of a good patient. I just conformed and shut up to the enth degree. I went again with [my husband] and masked the depression... very quiet. But you had to play the game. I mean, it was a game. In order to survive, you had to play the game. And, I mean, I was well-educated in the game.

Having unsuccessfully resisted her first involuntary hospitalization by physically fighting back, a resistance which was met with physical assaults by male staff, Angel Anne Lowen decided that choreographed demonstrations of cooperation were a more effective form of resistance. Angel Anne found in her next two committals that she was able to escape hospital after several hours if she pretended to be cooperative with her detainment. She would pretend to be the ideal patient, "was very calm and the first chance I got I ran." Given

162

the power of psychiatric professionals to interpret behaviour as evidence of a mental disorder and to react with physical and chemical restraint to any sign of physical resistance, women generally found it more effective to assume a pretense of cooperativeness with psychiatric professionals until they were in a position to refuse treatment.

The second form of resistance expressed by many study participants was to withdraw altogether from psychiatric treatment or to minimize the amount of psychiatric intervention they would accept. Eleven women had made a conscious decision to do whatever possible to avoid psychiatric treatment in the future. For example, Angel Anne Lowen explained that she had decided never to return to hospital.

> I know how to keep myself out of there [hospital], and I'll never go back there *ever, ever, ever, ever*.... I talk about my stuff. I deal with it. I know my body.... If things get really intense and I have lots of body stuff, I do body work.... I use my counsellor; I use my friends; I use my exercise. And I know how to ask for help. That's the biggest thing. And I know what the psych system's about -- and that's not where the help is for me.... I wouldn't tell a psychiatrist a lot of things.... I don't think psychiatrists help your healing at all.... So I wouldn't tell them anything. I wouldn't tell them anything personal.

The choice to avoid future psychiatric treatment was more common among the lesbian study participants. Only three women who reflected this decision were heterosexual: seven were lesbians and one was unsure of her sexual orientation. Some women would make such a resolution at one point in their lives and withdraw from psychiatric treatment for a period of time but return to it later under different circumstances. For example, after Gin Cote was released from the involuntary hospitalization arranged by her abusive partner[2] she:

> did the only thing I could do.... I went to provincial court and... I applied for a restraining order, had her out.... And I stopped going to see the psychiatrist. I had too much on my plate.... I didn't need the haldol and cogentin. I wanted, you know, to clear my head.

Although Gin eventually did return to psychiatric treatment, she chose for a time to be free of psychiatry.

The withdrawal from psychiatric treatment was at times so strong and pervasive as to seem an instinctive survival response, beyond conscious choice. Even when a woman seemed powerless to resist the psychiatric system, such as the state in which Sharon Wilkins must have seemed to arrive in hospital after

each unsuccessful suicide attempt, Sharon managed to resist her imprisonment in hospital. So long as a woman did not begin to believe the psychiatric establishment, she seemed able to relate to it as she would an oppressor. Once she became persuaded that her captors' intentions were to help her and that they truly could help her, resistance would fade away. Early in Sharon's psychiatric career she learned how to escape hospital, no small task on foot and in a hospital gown. An experienced hiker, she would cross highways and cut through brush to find her way home wearing nothing more than slippers and a night-gown. Even when stopped by police, Sharon was able to convince them simply to give her a ride home. Once Sharon became persuaded that she was ill, however, she began to stay in hospital of her own volition, accept shock treatments and drugs, and her resistance subsided.

A number of women expressed a third form of resistance in becoming aware of their own anger. Claire Baker, for example, described a moment in which the experience of anger held curative power. She had been experiencing "a terrible terrible time" in which she "literally crawled round the floor... so tired and so agitated... half-dead." She was intensely unhappy in a marriage with an alcoholic and irresponsible man, and was stuck paying off the mortgage of "an ugly little house" she soon hated. Her husband sent for his mother to come and stay with her for a week, but Claire found that "she wasn't very nice to me" and tended to take her husband's side in conflicts. On one occasion Claire's father-in-law also drove out "and the three of them went off to go to the bank or something and left me all alone." Claire threw herself into the task of mowing the neighbour's lawn, as she had promised the neighbours she would. As Claire tells it, "that seemed to be my turning point. The fact that they had walked out on me made me mad, and when I felt mad, I felt at least some other emotion besides depression and anxiety, and then from that point, I seemed to be able to drag myself out of it."

Experiencing anger helped give some study participants the strength they needed to achieve the fourth form of resistance, which was to stand up to mental health professionals and speak their minds. Five women told me that they either found the courage to confront their psychiatrists during the treatment, or

returned following the treatment for such a confrontation. Anna Black, for example, was outraged that the psychiatrist she saw for only fifteen minutes when she was desperately unhappy and worried about the effects on her children, convinced her to sign herself into hospital for shock treatments. Two months after her hospitalization, Anna sought out her psychiatrist specifically to tell him that his intervention had been inappropriate and harmful:

> I have been *extremely* angry about how he's treated me. But part of my coming to terms with it is that I had the where-with-all to go in there and give it to him, and tell him, 'you ought to be ashamed of yourself. You are not a professional person. You may have that stature in society and you may have the paycheque to go with it, but you do not have my respect. And at one point in your future, if not in this world, then in the next, you'll have to come to terms. And there will be justice. Because it's *completely* wrong how you treated me.'

The experience of confronting psychiatric professionals tended to produce a sense of personal power and a closure for the psychiatric episode. Confrontation did not provide some of the results a woman may have wanted, such as an acknowledgement of mistakes made or harm done, empathy, or apology. In Anna Black's situation, her confrontation of her psychiatrist led to him sending child protection officials to investigate her parenting.[3] Another woman's letter to a psychiatrist who had harmed her, sent ten years after the incident, was acknowledged by a curt written denial of any harm done and reiteration of the appropriateness of the original diagnosis and treatment. Yet another woman was escorted out of the hospital by security guards after confronting a psychiatric nurse who had been particularly authoritarian and hostile. Regardless of the professional response, the experience of confrontation itself tended to restore a woman's confidence and build upon her sense of well-being.

Some study participants expressed a fifth form of resistance by integrating their anger and assertiveness with psychiatric professionals into a political analysis of their experiences and becoming politically active in feminism and other anti-oppressions movements. Angel Anne Lowen wrote me these words in a letter:

> Lately I've become more aware of how society responds to women who are angry. They fear it and they fear us. So they drug us, lock us up, react to us with threats and violence,

ignore us, and tell us we are crazy. They make us crazy, they make us more depressed, they make us deny our truths and fear ourselves. They reinforce our abuse from others and self-abuse. They try to make us weak so that we can't speak up. I think it's because women are so powerful.... Believe me, they will never get me back into one of those hospitals or drugged out of my mind as they did a few years ago. My sisters and I are becoming way too strong for that and we help each other.

Having a political analysis helped some study participants maintain confidence in their sanity and their knowledge that it was the social system which was disordered rather than their own perceptions. For Janet Moffat the realization that she was considered "useless" and "throw-awayable" as a woman who was, in her terms, "middle-aged and unemployed and facing poverty" fuelled her sense of rage and her determination to be politically active. She, along with another woman from the Saskatchewan sample, attended a series of public meetings in her community between feminist mental health professionals and other feminists concerned about women's mental health issues. Engaging in political struggle as a participant in a broader social movement was a way in which some study participants kept themselves strong and experienced community, support, and a reflection of their value which did not mirror predominant social values. Some study participants deliberately sought out political community in order to nourish themselves against the tides which could otherwise easily wear them down. For example, Erin Fremont told me that she never visited a new town without finding out in advance where support systems such as a women's centre were located.

The final form of resistance I noted from the interviews was expressed through the formation of strong bonds with other women and other psychiatric patients. A number of study participants described poignant moments in which their connections with other women gave them strength to survive their ordeals with the psychiatric system. Gin Cote, for example, related the way in which her contact with one woman patient on her ward kept her sane during one of her hospitalizations:

The only thing that would keep me... from going off the wall.... there was one patient there, just one, that was a bit coherent and had one hell of a sense of humour. She was Madeleine. Her and I sat together and we used to, you know, make fun of the system. And we used to have one hell of a time. Occasionally a nurse would come out and wonder what the hell was going on.

166

Connection with a woman patient on her ward was the one element Mabel Abelone described as life-preserving during her incarceration and shock treatments when she was twelve years old. As Mabel recalls, she and this woman would sit waiting for their shock treatments side by side in chairs against the wall outside the ECT room:

> I made friends with this lady who also talked French and we would talk French so nobody else could understand what we were talking about. And we would encourage each other... we're going to come out alive; it's going to be okay.

Mabel's connection with this woman was so strong that a chance meeting with her forty years later evoked strong emotions for them both:

> She looked at me, just this eye contact. She said, *'what's your name?'* And as soon as I said my name, Mabel, something just clicked, and we both instantly burst out crying, and we cried and cried and hugged and cried, and I said, 'it's you! It's you!' And she said, 'it's you! It's you!' Oh, I couldn't believe it! It was that French lady that was with me in the hospital... in 1952.

Several of the young women I interviewed in Saskatchewan had become close friends and a support network for each other after having met when they were all hospitalized on the same ward. Informally these women became linked and began to rely on each other for help staying away from or minimizing their involvement with psychiatry. They confided in one another, could turn to one another for help in emergencies, supported one another's sobriety from alcohol and drugs, and began to train in alternative therapies, such as bodywork, to practice on each other. Most of this group of women had attended twelve-step meetings to deal with substance mis-use and all were accustomed to listening to one another and supporting one another unconditionally. Some of the women used this support in combination with psychiatric drugs. Angel Anne aspired to use the mutual support of her women friends as a means of severing her connection with psychiatry in all respects. She describes the caring that characterizes the relationships between women in her community:

> It's like we're attached by umbilical cords. You know, like I tell my friends, 'don't you dare fucking give up and die on me; don't you get suicidal and die. I couldn't survive. I couldn't survive without my friends.' My friends are my life. I love my friends. They're my family. We kick each other's ass and support each other, totally accept each other.

## Alternatives to the Psychiatric System

Judi Chamberlin (1978) distinguishes between what she terms 'real alternatives' and 'false alternatives' to the psychiatric system. Alternative services can be conceptually divided into partnership, supportive, or separatist models depending on their relationship with mental health professionals. The partnership model of alternative services is characterized by mental health professionals and non-professionals working together to provide service in a setting in which service recipients are supposedly involved also as partners. The involvement of service recipients or 'mental health consumers' in such settings has been critiqued as a token involvement.[4] Chamberlin considers the partnership model to be alternative in name only, as such services continue many of the same abuses (p. 87). As she observes:

> When mental health professionals are involved in setting up 'alternative' services, those services will clearly mirror psychiatric ideology. Even when ex-patients are involved in the creation of the service, the involvement of professionals prevents the ex-patients from developing beyond this ideology (p. 93).

Partnership model 'alternatives' serve the psychiatric system in that they extend psychiatric authority beyond the psychiatric ward or psychiatrist's office into the psycho-social domain of patients' lives. Caron and Bergeron (1995), for example, in their article promoting partnership self-help groups report that patients find the most valuable aspect of such groups to be weekly contact with mental health professionals and information from professionals about symptoms and treatments for mental illness. Clearly such a model performs a function of disseminating psychiatric ideology in a manner more covert and possibly more palatable than what can be achieved in more stark psychiatric settings. More desirable for Chamberlin and other anti-psychiatry activists are the supportive model, in which non-professionals and ex-patients form an organization of mutual support which excludes mental health professionals from all but auxiliary helping roles, and the separatist model in which ex-patients exclusively provide mutual support for one another.

Chamberlin traces the history of a number of supportive and separatist organizations which have over time become taken over and staffed by mental health professionals.

The state of 'alternative services' is such now that virtually all conform to the partnership model. Therefore, aside from several of the young women I interviewed in Saskatchewan, study participants were generally not aware of or experienced in the kinds of alternatives Chamberlin (1978) characterizes as 'real.' Study participants tended to view as 'alternative' any mental health service not provided by a psychiatrist, and any service which revolved around psychotherapy or counselling rather than biological treatments like psychiatric drugs. Therefore, services such as those of a social worker in a Family Service agency, a feminist therapist in private practice, and a self-help group facilitated by counsellors in a mental health clinic were all the types of services study participants regarded as alternatives. While study participants were almost unanimously more supportive of these services than those they viewed as psychiatric, several had negative experiences with such 'alternative' services.

Despite their concentration of experience in partnership model alternative services, the women interviewed for this study were visionary regarding the possibilities for alternative social means of dealing with people in emotional crisis. It was easy for them to imagine the kinds of services that would be useful and empowering for people in emotional crisis if public health dollars were to be re-allocated and social values shifted. In their interviews, women envisioned everything from reforms of existing services to the creation of new and more comprehensive crisis services, specialized support for survivors of violence, and communities in which care could happen less between professionals and patients and more between people as equals.

Both those study participants who continued to accept psychiatric treatments and those who tried to avoid the psychiatric system used their own experiences as a basis for recommending reforms of the existing system. Women commented that information must be more easily accessible about where to get help and that removing the stigma would make it easier for people in distress to ask for support. Some women

identified a problem in that psychiatric treatment is often not immediately available when people in distress do reach out. Sharon Wilkins had difficulty locating a female psychiatrist who offered psychotherapy in addition to medications, and waited months on various waiting lists for an initial appointment. Claire Baker gave examples of times she believed that she needed to be hospitalized but no beds were available and she was instructed to wait at home. Claire commented that the only way to get a psychiatrist quickly was to be hospitalized. A number of women commented on the need for psychiatrists to provide exact information to patients about drugs prescribed for them, including the way in which the drug works, any side-effects and long-term risks, and the fact that taking psychiatric drugs does not resolve problems in living and emotional problems. Several other women believed that electro-convulsive treatment and involuntary hospitalization had no place whatsoever in psychiatric treatment and should be laid to rest along with other obsolete psychiatric treatments such as lobotomy and insulin shock.

Key to study participants' visions of a society which would offer truly beneficial care and support to people in emotional distress, however, were more radical transformations in social structures and a shifting of power from the medical system to alternative health care services. Of central importance was eliminating women's oppression, including such manifestations as violence against women, the poverty of women and children, and the lack of social support for mothers. Some women commented that information about sexual violence must be woven into the education system so that girls do not grow up believing that incest, sexual assault and battering are normal parts of life for girls and women. Information must be readily accessible about how to use social systems to help protect women and children from violence. Building strong communities in which individuals are less isolated, resources more equitably distributed, and vulnerable people supported as community members were seen as integral by study participants to promoting mental health in society. For a number of women, decent and affordable housing was critical to their well-being; for others, universal child care and respite care for parents would make an essential difference in their lives.

For almost all study participants, access to therapy of choice, although considered imperative, was economically out of reach. Sharon Wilkins could not fathom why the Medical Services Plan in British Columbia would not cover the services of a psychologist when it does pay a portion of the costs of chiropractic care, physiotherapy, and massage therapy. Basic medical coverage paid the costs of Sharon's hospitalization and electro-convulsive treatments but would not pay for psychotherapy with a therapist who was not also a medical doctor. Study participants often expressed good ideas of what would help them but could not access such services because their cost is not reimbursed under provincial health plans in Canada. As almost all study participants had low incomes, and poverty is both a cause and effect of psychiatric involvement, this group of women was relegated for the most part to psychiatric services, unable to afford the services of private psychotherapists.

Study participants wanted access to a variety of support services ranging from ones which currently exist but are not publicly funded to ones which could be created to better support women who may otherwise become psychiatrically involved. Primarily, the women interviewed for this project wanted access to publicly funded therapies of their choice, particularly counselling and psychotherapy with feminist therapists and other therapists not associated with the medical model. Women also advocated strongly that there is a need for alternative and more comprehensive crisis services, including safe and non-medicalized places for people to go for comfort and attention when in need, as well as home supports so that people would not be forced to leave their own environments to be supported.

In alternative support services, study participants wanted places in which staff would genuinely listen to people in emotional pain and provide an environment of nurturance, support, and unconditional positive regard. As Hannah Green reflected, such places would need to be characterized by "a lot of attention. Just someone to be there with [a person in crisis]. For you to put them in their bed, under their blankets, and say, 'it's okay, I'll sit here with you,' or 'I'll tell you things.'" Adrienne Joffey echoes:

> I think they need some kind of crisis houses. Like a place where you can get what you want when you go to a psychiatric ward. A safe place to be.... Either just for the daytime, or

171

places to go and take a rest, or to live if you need to live there for a while.... I think just listening is always really important. I mean, I think a lot of the time people just need to be heard.... There are times I just need someone to hear that I'm in pain. Or sometimes I need to hear that it will get better at some point, or I need to hear that there's reasons for it.

Several women mentioned that alternative crisis and support services needed to be, as Erin Fremont phrased it, "a place that reflects growth and is beautiful, in how it looks and how it feels to be there." The following excerpt from my interview with Cara Sun illustrates the ways in which the creative and life-giving environment of an alternative crisis centre would differ from that of the mental health clinic she now attends:

[There would be] lots of glass windows, lots of light. Lots of plants in the building. Nice, comfortable, updated chairs or couch. Chairs where the person has their own space. I don't like those connected chairs because when I'm sitting here and you're sitting here, I might not want you to [sit right next to me]. Really beautiful upholstery. Ornaments. Maybe fish tanks.... Really beautiful music -- not Z99 or country rock or that damned sound system. Maybe a few rooms that are personal. Where a person might want to go in the room, if they have to even wait ten minutes, they can go in there where they've got their own space, their own room, to centre, to focus.

Study participants wanted alternative crisis and support services to be holistic, bridging the separations which currently exist in health care services, and providing, in Beth Playsted's words, "much more body and soul attention." Anna Black, for example, believed that health care services must begin to learn from a First Nations model, and thus address and seek balance in all aspects of a person's life and health: the spiritual, emotional, physical, and mental. In this way, alternative and traditional medicines could be combined to offer more comprehensive health care which would publicly fund counselling and psychotherapy, bodywork therapies like massage and cranial sacral therapy, homeopathy and herbal medicine, as well as encouraging healthy practices such as exercise, nutrition, and meditation. Such preventative services offered in the context of stronger communities, many study participants argued, would help preserve emotional, spiritual, mental, and physical health such that many crisis situations now relegated to the psychiatric system could be averted.

In crisis situations, many study participants believed that psychiatric hospitalization could be avoided were alternative and more comprehensive crisis services to exist. Some study participants envisioned

172

a network of community-based crisis services which would include a twenty-four hour crisis line and home

support service connected with residential safe houses where people in crisis could stay for a period of time in

a supportive environment. As Diane Duthie suggested, "it doesn't have to be highly paid, regimented,

institutionalized supports... it has to be almost like the whole concept of 'neighbourhood watch.'" Such safe

houses would be neither medicalized nor staffed by highly paid professionals; staffing could be provided by

caring emotional support people, preferably those who had experienced their own recovery from crisis,

whose training was not informed by psychiatric ideology. The role of such houses would be as places of rest,

healing, and support. To stay in such a house would not carry the shame, stigma or pathology of a

psychiatric hospitalization, but rather would be a restorative resource open to anyone in stressful

circumstances.

Safe houses specifically for women experiencing crisis related to post-traumatic stress associated

with violence, including childhood sexual abuse, were considered by study participants to play an important

role in dealing directly with women's distress and averting unnecessary psychiatric treatment. Angel Anne

Lowen and her friends have thought a great deal about the significance such a service would have for women.

> What I would *really* like to see happen -- and what really *needs* to happen -- is a place
> where when women are dealing with their issues and they have memories coming up or
> their feelings coming up, a place for them to go and be, just be, just to experience and work
> through it. Without having to be put into the psych ward.... We've talked for years about
> starting something like that. It's kind of a dream.

Those study participants who had been hospitalized in the aftermath of a sexual assault or while dealing with

emerging memories of childhood trauma believed that the existence of such services could have spared them

the experience of psychiatric hospitalization.


**Study Participants' Experiences of Alternative Services**

The women interviewed for this study frequently attempted to locate support through resources they

perceived to be alternatives to the psychiatric system. Such resources included both services provided by

173

mental health professionals, such as counselling or therapy, and resources and endeavours more independent of mental health professionals, such as self-help and peer help models, educational development, and spiritual resources and practices. Six women balanced alternative therapies with psychiatric ones, engaging in counselling relationships with psychotherapists while also taking psychiatric drugs. Eight women avoided all psychiatric treatment and used the services of counsellors and other alternatives exclusively. Seven women used psychiatric services alone -- of these seven, five had never experienced alternatives, while two believed they only needed medications. Three women used the services of psychiatrists who practised psychotherapy with them but did not prescribe drugs. The women who defined their sexuality as other than heterosexual were more commonly distributed among both those women who used alternatives exclusively and those who combined alternatives with psychiatric drugs. Heterosexual women were more likely to use psychiatric drugs in the absense of other services and to visit psychiatrists for psychotherapy.

In our interviews, I questioned study participants about their beliefs about and experiences with various alternatives to psychiatry. With few exceptions, those women who had experienced counselling or therapy with mental health professionals other than psychiatrists expressed preference for therapy of choice as an alternative to psychiatric treatment; feminist therapy was held in particularly high regard as an alternative to psychiatric treatment. While many study participants expressed mistrust at the idea of alternative services which followed a supportive or separatist model, others found healing in places relatively more removed from the mental health system. Some of the women participated in more informal networks in which they were able to find people who would listen to and value them, challenges for their own personal development, and a deeper sense of meaning in their lives.

**Feminist Therapy**

Although psychotherapy can be subjected to criticisms similar to those applied to psychiatry, study participants generally held counselling and psychotherapy in high esteem in contrast to the more biological

focus of psychiatric treatment. In particular, study participants held positive regard for therapy provided by feminist mental health professionals. Twelve of twenty-four women interviewed considered that they had at some time seen a feminist therapist. Study participants who defined their sexuality as other than heterosexual were far more likely to seek out feminist therapy: only two of the twelve women who had seen feminist therapists were heterosexual while six were lesbians, two were bisexual, and two were unsure of their sexual orientation. Many study participants reflected the belief that their time spent with a feminist therapist allowed them to disengage from or minimize their interactions with the psychiatric system. Seven of the women who had seen feminist therapists lived in a community in Saskatchewan in which they had been able to receive free feminist counselling through their local women's centre. Although many of the women waited up to three years to access this counselling, they described feminist therapy as ultimately life-preserving and essential to their recovery. It is noteworthy, however, that many of these women became involved in the psychiatric system while they were on waiting lists for free feminist counselling and had no other resources. The other women who consulted feminist therapists lived in communities in which free feminist therapy was not available; therefore, of necessity, they paid the fees of counsellors in private practice. Hannah Green was fortunate enough to have a friend refer her to a feminist therapist who agreed to see her at first for free:

> I went to see [the feminist therapist] and the first couple of sessions I just said, 'I have no money,' and she said, 'that's fine; that's fine.' I was amazed. I'm especially amazed now when I think about it. But I was just such a mess to be thrown on her doorstep. And she just let me sit there. I don't even remember talking to her in the first couple of times. She was just so kind.

The ability of women to access feminist therapy depended upon either their financial ability to pay fees as high as $60.00 to $85.00 per session, or a therapist's willingness and ability to accept a sliding scale fee of what a woman could afford. One particularly impoverished woman believed she needed therapy so badly that she budgeted money each month for therapist fees ahead of money for food.

Celia Kitzinger and Rachel Perkins (1993), who have delivered a provocative critique of feminist therapy, maintain that feminism and psychology are incompatible and that feminist therapy is a dangerous

co-optation of the feminist movement which has distracted feminist energy from political issues and reified it in the personal sphere. They write of the ways in which the enormous popularity of feminist therapy has become a successor to the political activity of consciousness-raising (pp. 75-81) and is contributing to an erosion of feminist community and friendships (pp. 81-88). Kitzinger and Perkins maintain that feminist therapy is more aligned with androcentric psychology than with feminism. They point out that it can be difficult to ascertain what feminist therapy actually is, since feminist therapists are trained, like other psychotherapists, in male-dominated schools of therapy and feminism appears added, after the fact, as a perspective rather than a technique (1993, pp. 23-24).

Indeed, there are no guarantees of positive experiences with feminist therapy, as feminist mental health professionals are vulnerable to many of the same flaws as other mental health professionals, trained in the same training programs, and regulated by the same governing bodies. The only differences between a feminist therapist and other psychotherapists may be her subjective ideology of feminism and her self-description as such. While study participants for the most part spoke highly of their experiences in feminist therapy, the two negative experiences reported to me indicate that feminist therapists, like their 'non-feminist' colleagues, can and do act in ways which are incompetent or unethical. In Jill Smith's situation, a feminist therapist, eager to substitute her services for psychiatric ones, encouraged Jill to stop taking antipsychotic drugs in an ill-informed manner. Jill stopped the drugs suddenly and suffered an intense relapse. Since this experience, Jill has preferred to accept psychiatric treatments to the exclusion of alternative services. Ann Johntone has continued to seek out the services of feminist therapists despite a devastating experience of emotional and financial abuse she endured for a number of years at the hands of a feminist therapist. Ann described this abuse as far more damaging than abuse she experienced from psychiatrists because of the amount of trust she had invested in the feminist therapist and her resulting vulnerability. After an initial session with a feminist therapist, a third woman elected not to pursue this option because she felt that the therapist would insist on imparting a political message and would not be willing to "just listen."

For the purposes of our discussions, study participants and I generally agreed that a therapist was a feminist therapist if she integrated a politicized gender analysis into her work with a woman's life and feelings, if she brought a woman-centred perspective and an honouring of women as paramount in her work. The experience of being in an environment in which they were listened to, cared for, mentored, and believed in by another woman was described as life-changing for many of the women I interviewed. For some study participants, feminist therapy was the place in which they first made the connections between their personal situations and their political condition as women. Mabel Abelone, for example, had no idea the kind of impact feminist therapy would have:

> [Feminist therapists] take you where you're at. And they acknowledge your pain. You feel as though your life is worthwhile, your story is true and worthwhile; it has benefits; you are more courageous because of it. It helps you believe that you're *not* crazy. When I went the first time, I sat down and the first question she said was, 'why are you coming now?' And I said, 'because I want to save my marriage.' Because I was led to believe there was something *wrong with me*. So if we fix that, then everything would be fine.... Little did I know that it would upset my marriage even more! [laughs]

Many women described the way in which they experienced feminist therapy as the first situation in which they felt they had power. Having a place in which to exercise control and make choices which were respected served as a beginning place for study participants to refuse to be controlled by others and to discover and assert the power of their own will. Glenda Lennox believes that experiencing control over one aspect of her life was a critical part of the reason that feminist therapy was helpful to her.

> It centres on me having control over the process, and me having control over what I'm going to do. And it's not the counsellor saying 'do this;' it's her saying, 'what are *we* going to do?' or 'what do *you* want to do next? What's going to happen? And it's self-motivated, like *I* figure out what I need to do and I do it. It's not so *dependent*. I don't feel so *dependent* on her as I have on other counsellors.

Kitzinger and Perkins (1993) view feminist therapy as connected to the enormously popular industries of psychotherapy, popular psychology, and self-help literature, all of which are damaging to feminist struggle and community in that they focus attention on the individual as a source of problems and solutions. They assert that feminists who are not in debilitating crisis ought to refocus their attention on

political action, since only by political activity can women struggle to achieve social change that will make a difference in the unhappiness that characterizes women's lives. Theoretically, Kitzinger and Perkins' position makes sense until they focus their attention on 'mad' women whom they see as 'worlds apart' from other women. For these women, characterized as 'socially disabled,' they paradoxically appear to accept the authority of biological psychiatry while discounting any benefits that feminist therapy may offer.[5] By contrast, the women interviewed for this study illustrated the ways in which women labelled and treated as 'mentally ill' are very much like other women who have not been labelled and treated in this way. Many study participants attested to the benefits of feminist therapy, both for their experience of personal well-being and for their development of political consciousness. Feminist therapy both helped them to survive and encouraged them to develop a political framework in which to understand their experiences of oppression and strategize about how to live in these conditions. The experiences of study participants with feminist therapy present an important question for feminist theorists and activists: is the very survival of some women not to be valued as a political act in itself?

While Bonnie Burstow acknowledges that feminist therapy is open to many of the problems which characterize mainstream psychotherapy, she encourages feminist therapists to aspire to a different tradition than androcentric psychology for themselves, a tradition which resonates with the experiences of many study participants:

> Feminist therapy is rooted in women's knowledge, in women's help and ways of help. The word *therapy* comes from the Greek word meaning 'to attend' or 'to minister' and only derivatively became connected with medicine. Our ancestors are women who attended to others. We date back to the witches, the midwives, the wise women who defied the patriarchy and brought women's help to those who wanted it (1992, pp. vii-ix).

Many of the study participants experienced feminist therapy as a place in which they could make the links between their personal experience and the political oppression of women. Feminist therapy provided a setting in which study participants examined and struggled with their experiences of oppression in dialogue with another woman. For Janet Moffat, it was valuable to have a woman with whom she could make the

connections between her own personal experience and her political oppression as a woman, and within her social context, determine her own direction:

> You do your own work, but [feminist therapists] give you access to the information to make the choices with. And that's what's life-changing.... The feminist perspective does the linkages between the social structures and the institutes of society out there and the individual, so that you don't take on what the medical model would like you to have and the bureaucracy would like you to have of the individual psychopathology that downs you.

## Alternatives Not Controlled By Mental Health Professionals

Most study participants wanted access to therapy of choice as an alternative to psychiatric treatment, but expressed some hesitance about supportive or separatist alternative services, such as those described by Judi Chamberlin (1978). While crisis houses run by former psychiatric patients, peer counselling centres, Re-evaluation Counselling,[6] and self-help groups were theoretically interesting to the women interviewed, most expressed misgivings about alternative services entirely independent of mental health professionals. The fears women reflected about peer-based alternative models may, in part, be a result of lack of exposure to such models combined with much exposure to a mental health industry which has commodified care and transformed listening into an area of expertise. In part, study participants' fears may also be an indication of a lack of faith in their own ability to help others, a sentiment reinforced by their sense of themselves as 'sick.' Consider these words from Shirley King:

> I am [cautious] because people who are emotionally disturbed are very fragile. And they're very easily swayed, and you can do a lot of damage. You can do a lot of good, but you can do a hell of a lot of damage if you say the wrong thing at the wrong time. And I would be afraid of getting involved with somebody who didn't know -- I would be afraid of saying the wrong thing to somebody whom I didn't know too well, and because I don't know enough about their problem or I don't know enough about my own problem anyway. And I would be afraid of being hurt by somebody else if I was at an emotionally fragile stage.

Beth Playsted echoes Shirley's apprehension, but could consider a peer-based alternative model provided there was some facilitation, not necessarily by a mental health professional, but by someone with facilitation skills present in a professional role rather than to meet their own needs. Beth commented, "I'm a little leery

of some of the self-help [groups] -- it sounds sad, but I'm a little leery because when you're dealing with

wounded people the dynamics can be really weird, and you end up -- things can happen out of control."

Many of the peer-based alternative services described by Chamberlin (1978) which ran according to

supportive or separatist models, have been taken over by mental health professionals, or have folded over

time when funding has been withdrawn. Although other strong networks exist, such as the Re-evaluation

Counselling Movement, most of the women interviewed for this project had experienced peer-based

alternatives in the context of 'twelve-step groups' in the tradition of Alcoholics Anonymous. Many study

participants made use of such alternatives, but usually as a complement to individual counselling with a

mental health professional. This particular tradition of self-help with its emphasis on the feminine malady of

codependency and its rapidly developing industry of self-help popular psychology literature has been

critiqued elsewhere as cultish, based in a medical model of addictions, and both individualizing and de-

politicizing (Kaminer, 1993; Schrager, 1993). Others have identified ways in which some parts of the

twelve-step and codependency tradition incorporate feminist ideas (Haaken, 1993) and provide a vehicle for

reaching masses of women while integrating political consciousness with efforts toward 'self-recovery'

(hooks, 1993, pp. 4-5). The women interviewed had both positive and negative experiences with twelve-step

groups. Many women found the groups helpful because of their structure which provided listening and also

a degree of emotional safety. Adrienne Joffey remembers:

> ACOA [Adult Children of Alcoholics] was the first time when I went in a group of people... because
> I knew I had to tell the truth about myself to a group of people. I had heard that when you go to
> ACOA you just talk and nobody can say anything, and then they thank you at the end and that's it.
> And that felt safe to me.... I think there's a lot of support there.... I just generally find people seem
> to be able to care for me more than I can, better than I can. And they're all just really validating and
> really compassionate.... There's a lot of support for each other in the room.

Anna Black reflected similarly positive recollections of her experience with ACOA, but commented that "it's

pretty sad we live in a culture where you actually have to go to a different group to talk about feelings." Two

participants reported leaving twelve-step groups because of difficulties: one woman found the religious

underpinnings problematic, while another experienced her mixed-gender group as having too much sexual tension and game-playing between members.

Two women participated in self-help groups which had begun out of their counselling with a mental health professional. Both women reported positive experiences with these groups. Adrienne Joffey's group had been initiated and originally facilitated by two therapists; once the therapists had set the tone of the groups and helped develop group structure and communication guidelines, they then withdrew to let the group conduct itself independently. The group Glenda Lennox attended was initiated by women and men who had been in therapy with the same therapist.

> We finished seeing her [the therapist] and then started a support group of our own which has been going for about two years and it's still happening. And that's been really useful. We meet once a week and we have a structure that we use. Mostly just check in, and sometimes we have a topic and a video or a book or something and go from there.... Being with other people and talking to other people -- it does something. It's hard to describe, but there's something there that heals in a group.

While group settings have the capacity to be healing, they also have the ability to be hurtful and abusive, a factor which caused some women to be apprehensive about supportive or separatist settings in which they feared, in the absense of a mental health professional in control of the process, that anything could happen with no built-in safety mechanisms. Even in groups which involved some leadership, group dynamics could occur which were hurtful. Adrienne Joffey had some negative experiences with 'alternative' settings such as human potential movement centres where she was taken as a teenager by her mother in the 1970s.

While a number of young women I interviewed in Saskatchewan who had been hospitalized together had formed an intense circle of support for one another, described earlier in this chapter, this type of radical and independent alternative to the psychiatric system was unique among the study participants. The reluctance expressed by most study participants toward peer-based alternative models reflects a cultural dependence on mental health professionals and a lack of belief that people currently or formerly in crisis have anything to offer one another. As one Re-evaluation Counselling position paper states:

Under 'mental health' oppression, attention becomes a commodity to be controlled and sold like gas, electricity, or water. Utilizing their authority as 'therapists,' psychiatrists and psychologists promote the idea that we should not pay attention to one another.... The myth is that only highly trained, certified experts can provide attention, and that for a lay person to attempt to pay attention to someone who is hurting is highly dangerous and irresponsible. Although 'expert' attention commands a very high price, it is not the healing attention we hope for and expect (*What's Wrong With The 'Mental Health' System*, 1991, pp. 15-16).

In such a cultural environment, the quality of interpersonal relationships suffers, as people take their deepest thoughts and emotions to mental health professionals rather than to one another. Cara Sun experienced this when she would attempt to talk to other women in her community about her experiences and ideas only to be asked if she had a therapist. Mary Taylor reflects her belief that individual therapy is necessary for her in addition to her friendships.

I think for me there is a need to have a combination of both, because there are some places I can't expect a friend to go with me. If I'm going beyond where they've healed, or it's too frightening for them, or it triggers their own stuff. Sometimes they are also in the process of healing. So there is a need for me to do the one-on-one still. I believe in that, although it's been hard to trust after what happened.

Christine Burns was more direct in her analysis that therapy allows us to place limitations upon our friendships.

I suspect the limits [of peer support] are self-imposed. With somebody I'm paying, I feel free to indulge myself.... The other limit [is] my unwillingness to be that committed and intimate with a friend -- I mean, we do it, but we do it more sporadically.... It involves a tremendous emotional commitment, and with a professional there's the safety that we're involved for fifty minutes, we go our own way.... But with a friend -- I think it would work both ways -- my hesitation to put myself that much on the line, to be that involved with a friend. I would feel that if it were me I would have to say, 'call me anytime,' and I don't think I'm willing to do that. And it would also mean that I would need to be willing to make myself that receiving of somebody and I know I'm not willing to do that.

While study participants were less likely to turn to friends or peers than professionals for support, they nonetheless created and found support for themselves in a variety of settings outside the mental health system. Several women found that their healing was advanced by their volunteer work in a women's centre or battered women's shelter. Diane Duthie recalls, "I became involved with a women's shelter.... It was really important for me at that time to do some kind of volunteer work, plus I was really hungry to learn

about this whole process of spousal abuse. I was only realizing that I was, in fact, a survivor myself." A number of other women entered university and completed degrees in their thirties, forties, or fifties, and gained tremendous satisfaction in their own educational development and achievement. As Mary Taylor phrased it, "I think what helped me was going to university actually." Almost all the women I interviewed engaged in practices of self-care, such as: exercise, listening to or playing music, taking hot baths, making pottery, making contact with friends, calling a crisis line, dropping into the local women's centre, taking care of physical needs like nutrition and sleep, writing a journal, and expressive dance.

Spiritual development, expression, and community was a pivotal source of healing for two study participants. Participating in a native healing circle allows Angel Anne Lowen to release powerful emotions and experience deep levels of grief in a supportive and sacred environment. She explains one aspect of the way she uses native spiritual practices toward her personal healing and the healing of her community:

> It's like a sacred ceremony, and you have people you trust come in and... [you] regress back to a certain situation when you need to work through some anger, and you do some prayer meditation and you smudge and you call in the helpers, or whatever your particular way is.... They cover you up in these blankets, and you get this star blanket over top of you, and you go back to that. And then your helpers come in and they say prayers over you.... And you do screaming -- right, right from the gut. And it's hard to explain how it works. It's just something that happens. It's like there's a wall there and there's this block, and if you can get into it and breathe into it, then you can get out. It's just unreal, the release.... After, you get affirmations and you get hugs, and what commonly happens is that people end up bawling like a baby, because behind all the anger there's a lot of grieving and pain that needs to happen.

Although Angel Anne was the only First Nations study participant, other women in the Saskatchewan sample had taken part in native healing circles, were familiar with certain elements of native spirituality, and gained strength from particular concepts like the Medicine Wheel which emphasizes the unity of physical, emotional, spiritual, and mental elements of a person. The First Nations community in this area welcomed non-native and native participants alike, and a number of non-native women had found both healing and politicization in the native spirituality practices in which they had been allowed to participate.

Anna Black found access to the support and healing she experienced as most useful through her spiritual practices as a Charismatic Catholic. While Anna had decided that it was too dangerous to turn to any mental health professional, she discovered in her 'spiritual friend' what she had wanted in a counsellor but had been unable to find:

> I went to a spiritual friend... and she prays over people, and she's like a second mother to me. She holds me. I've cried and just cried... She prays over me. She's a healer. I went to her for about a year, once a week. And that was very helpful.... She is one of my mother's friends and she is known in the city for someone you can go to for prayer. She's got a lot of gifts of the holy spirit. She herself comes from a lot of brokenness and she's not a holier-than-thou type of person. There's lots of alcoholism in her family, and she goes to the twelve-step groups to try to take responsibility for her own healing. So she uses secular things at her disposal, and I think that is very wise, because I think the feminist movement is a secular group that has a lot to offer in terms of healing and empowerment.... She does a lot of inner child healing with me... and she gets visions and she does prophesy.... She's just been so marvellous to me.... That kind of healing... has been so profound and it's been the type of healing that nobody around me can take anything away from.... It's really built up my self-esteem and helped me know who I am.

Like the woman healers Bonnie Burstow considers the precursors to feminist therapy, Anna's 'spiritual friend' ministered to and attended her with 'women's help.' Unlike feminist therapists, however, she was a lay healer who did not take money for her services. The experiences of Angel Anne Lowen and Anna Black suggest that communities organized around spiritual practices seem able to offer a form of non-commodified lay healing which continues to elude secular feminist communities.


This chapter reveals the ways in which the women who gave their time and energy to this project embody resistance to the psychiatric system and other oppressions in their lives. Each woman in her own right discovered ways to struggle against injustices in the way the psychiatric system treated and perceived her, even in times when she was most vulnerable. Whether through feigning a strategic cooperation with psychiatric professionals, withdrawing from and refusing psychiatric treatment, becoming angry and asserting her rights, becoming involved in political analysis and movements, or turning to female friendships as a source of strength, the women interviewed for this study have achieved some measure of triumph

through their acts of resistance. Through their stories and ideas, the women individually and collectively offer their visions for ways people in distress can be treated differently and with honour, care, and respect. It is my hope that their strength, humour, creativity, and resiliency inspire others to action.

The twenty-four women whose voices are heard throughout this essay speak of what the psychiatric system was like for them. Although their testimonies cannot represent all there is to know about women and psychiatry, their experiences read in connection with one another produce a form of knowledge about the psychiatric system from the perspectives of those subjugated as both patients and women. This essay illustrates the ways in which oppressive situations in living, particularly experiences such as surviving violence, parenting and caretaking others without support, and living in poverty can produce feelings of despair and rage which invite a response of psychiatric intervention. The psychiatric response took place for some of these women as a result of others attempting to exercise power and control over their lives, their emotions, and their forms of expression. Other women sought psychiatric intervention, looking for something that would act as a salve to soothe the pain in their lives. Although these women appeared to seek help of their own 'free will,' they did so in an economic climate in which psychiatric intervention is generally the only publicly funded 'mental health' service and thus all that is accessible to women without money to pay for private services. Whether psychiatric intervention was imposed or accepted with a degree of willingness, the women interviewed for this study tended in their times of distress to live in circumstances in which they were isolated from broader community and in particular from strong and supportive women.

Generally speaking, the study participants described ways in which their psychiatric experiences aggravated the original distress in their lives. Those who sought psychiatric treatment expecting counselling and understanding were usually disappointed to find the treatment they received focused on correcting something supposedly wrong with their brain chemistry; counselling was rarely provided to study participants, while psychiatric drugs were almost universally prescribed, and shock treatment was fairly

common. Many women who were interviewed experienced negative consequences of biological psychiatric treatments, which included dangerous drug reactions, troubling side-effects, memory loss, and long-term health consequences. The experience of being locked up against one's will for those who were involuntarily committed to hospital was violating and re-victimizing. Being diagnosed and treated as though mentally ill left many women feeling stigmatized and further isolated, increasing the likelihood of their silence and compliance, and eroding feelings of self-worth.

Despite negative experiences in the psychiatric system, most women interviewed for this study found ways and moments to express resistance to psychiatry, and some came into a solid sense of personal strength from which they speak out against psychiatry and other forms of oppression. Many described their visions for alternative social ways to address unhappiness, anxiety, consequences of trauma, and problems in living. The resistance expressed by women interviewed for this study stands as a symbol of hope that women can find ways to achieve personal triumph and to act in political opposition to a system which serves a function of controlling them.

# NOTES

[1] Two examples of anti-psychiatry organizations which folded due to lack of funds are *Phoenix Rising*, a magazine based in Toronto which closed its doors in the early 1990s, and the Vancouver Emotional Emergency Centre, a patient-run alternative to hospitalization for people in crisis, which operated in 1974 and 1975. The Vancouver Mental Patients' Association, formed in 1971 by a group of dissatisfied ex-patients to provide a patient-run support network, is today run by mental health professionals with only token representation by patients on its board. For a historical discussion of patient-run alternatives, see Judi Chamberlin's *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (1978).

[2] Gin Cote's experience with an involuntary hospitalization arranged by an abusive intimate partner is described in chapter five.

[3] According to Anna Black, the psychiatrist could have sent child protection officials to investigate the well-being of her children any time following her hospitalization, yet waited for two months until Anna confronted him. Anna perceived his report to the child welfare body as punishment, therefore, for having stood up to

him. However, the 'investigation' was terminated within one visit, as Anna was able to explain her situation to the satisfaction of the social workers.

[4] Erin Fremont had been involved as a service recipient 'partner' in one such partnership model in which she perceived her inclusion to be a token gesture. The mental health consumer activist who spoke to the Community Mental Health class described his experience on the Board of such an organization to be similar in that he was asked to leave his position because of disagreement with other Board members who were mental health professionals. He reflected to the class his belief that professionals in such organizations choose as 'partners' service recipients who will 'go along' with the psychiatric ideology which informs such 'alternatives'.

[5] In the chapter, "Worlds Apart: Mad Lesbians," Kitzinger and Perkins develop the concept of 'social disability' to account for women who experience "severe disabilities of thought and feeling that cause profound ongoing distress, lead them to behave in ways that others think inappropriate and unusual, and often render them unable to cope with the demands of life without help and support" (1993, p. 162). They group schizophrenia and manic depression together with conditions which have indisputable organic bases such as learning disabilities, senile dementia, and brain injury (p. 162), thereby accepting psychiatric ideology that these conditions, if not depression and anxiety, are biologically-based. While I think it is useful to think about issues of access for women who experience severe emotional distress and to use the concept of disability in order to gain financial benefits which would be otherwise unavailable to women in distress, I believe that Kitzinger and Perkins encourage a dangerous acceptance of psychiatric treatment for certain women.

[6] Co-counselling, or Re-evaluation Counselling, is a model developed by Harvey Jackins and popular in circles in Europe, the United States, and Canada. Co-counselling utilizes a network of lay people, trained in Re-evaluation Counselling theory and particular techniques involving listening and expression, to counsel one another. The counselling occurs as an exchange of service between individuals who are recognized as peers with no monetary exchange. An analysis of the ways in which a myriad of oppressions, including mental health system oppression, function in society is central to the theory of this model. For an example of co-counselling theory, see the pamphlet, *What's Wrong With the 'Mental Health' System and What Can Be Done About It* (1991). None of the women I interviewed had experiences of co-counselling, although many expressed interest in learning more about it.

# BIBLIOGRAPHY

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*. Washington, D.C.

Andreason, N. (1984). *The Broken Brain: The Biological Revolution in Psychiatry*. New York: Harper and Row.

Barrett, M. & Roberts, H. (1978). Doctors and their patients: the social control of women in general practice. *Women, Sexuality and Social Control*. Eds. Carol Smart and Barry Smart. London: Routledge and Kegan Paul.

Bart, P. (1971). Depression in middle-aged women. *Woman in Sexist Society*. Eds. Vivian Gornick and Barbara K. Moran. New York: Basic Books.

Bass, E. & Davis, L. (1988). *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse*. New York: Harper & Row.

Bayer, R. (1981). *Homosexuality and American Psychiatry: The Politics of Diagnosis*. New York: Basic Books.

Benedetti, G. & Furlan, P.M. (eds.). (1993). *The Psychotherapy of Schizophrenia: Effective Clinical Approaches -- Controversies, Critiques and Recommendations*. Toronto: Hogrefe and Huber Publishers.

Blackbridge, P. & Gilhooly, S. (1985). *Still Sane*. Vancouver: Press Gang.

Blewitt, D. and Chwelos, N. (1959). *A Handbook for the Therapeutic Use of LSD - 25: Lysergic Acid Diethylamide - 25: Individual and Group Procedures*. Unpublished manuscript. University of Regina.

Breggin, P. (1991). *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the 'New Psychiatry'*. New York: St. Martin's Press.

Breggin, P. & Breggin, G.R. (1994). *Talking Back to Prozac: What Doctors Won't Tell You About Today's Most Controversial Drug*. New York: St. Martin's Press.

Broverman, I. *et al*. (1970). Sex role stereotypes and clinical judgements of mental health. *Journal of Consulting and Clinical Psychology, 34, No. 1*, 1-7.

Brown, G.W. & Harris, T. (1978). *Social Origins of Depression: A Study of Psychiatric Disorder in Women*. New York: The Free Press.

Burstow, B. & Weitz, D. (eds.). (1988). *Shrink Resistant: The Struggle Against Psychiatry in Canada*. Vancouver: New Star Books.

Burstow, B. (1992). *Radical Feminist Therapy: Working in the Context of Violence*. London: Sage Publications.

Burstow, B. (1996, February). *Therapy and the Liberation of Psychiatric Survivors: A Radical Feminist Perspective*. Paper presented at the Violence, Language and Responsibility Conference, Duncan, B.C.

Butler, K. (1996). The biology of fear. *Family Therapy Networker*, July/August.

Canadian Mental Health Association. (1993). *Women's Voices shall be Heard: Report on the Sexual Abuse of Women by Mental Health Service Providers*. Winnipeg.

Cannon, L., Weber, E. H., & Leung, M.L.A. (1991). Race and class bias in qualitative research on women. In Fonow and Cook (Eds.), *Beyond Methodology: Feminist Scholarship as Lived Research*. Indianapolis: Indiana Univ. Press.

Caplan, P., McCurdy-Myers, J., & Gans, M. (1992). Should 'premenstrual syndrome' be called a psychiatric abnormality? *Feminism and Psychology, 2*, 27-44.

Caplan, P. (1995). *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Don Mills, Ontario: Addison-Wesley Publishing.

Capponi, P. (1992). *Upstairs in the Crazy House: The Life of a Psychiatric Survivor*. Toronto: Viking.

Carmen, E. *et al.* (1984). Victims of violence and psychiatric illness, *American Journal of Psychiatry 141 (3)*.

Caron, J. & Bergeron, N. (1995). A self-help partnership group for people who have experienced psychiatric hospitalization: an exploratory study. *Canada's Mental Health, 43 (2)*, 19-28.

Cauwels, J.M. (1992). *Imbroglio: Rising to the Challenges of Borderline Personality Disorder*. New York: W.W. Norton and Company.

Celani, D. (1993). *The Treatment of the Borderline Patient: Applying Fairbarn's Object Relations Theory in the Clinical Setting*. Madison, Conn: International Univ. Press.

Chamberlin, J. (1978). *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. New York: Hawthorn Books.

Chamberlin, J. (1994). A psychiatric survivor speaks out, *Feminism and Psychology, 4 (2)*.

Chesler, P. (1972). *Women and Madness*. New York: Avon.

Chesler, P. (1994). Heroism is our only alternative. *Feminism and Psychology, 4 (2)*, 298-306.

Cleghorn, J.M. & Lee, B.L. (1991). *Understanding and Treating Mental Illness: The Strengths and Limits of Modern Psychiatry*. Toronto: Hogrefe & Huber.

Coutts, J. (1995, September 23). Wealth, health, and happiness found closely linked. *Globe & Mail*, p. A3.

Delphy, C. (1981). Women in stratification studies. In H. Roberts (Ed.), *Doing Feminist Research*. London: Routledge and Kegan Paul.

Drake, D. & Uhlman, M. (1993). *Making Medicine, Making Money*. Kansas City: Andrews & McMeel.

Edelman, H. (1994). *Motherless Daughters: The Legacy of Loss*. New York: Delta.

Ehrenreich, B. & English, D. (1978). *For Your Own Good: 150 Years of the Experts' Advice to Women*. New York: Anchor Books.

Faith, K. (1993). State appropriation of feminist initiative: Transition House, Vancouver, 1973-1986. *A State of Battered Women*. ed. Faith and Currie. Vancouver: The Collective Press.

Faith, K. (1994). Resistance: lessons from Foucault and feminism. In H.L. Radtke & H.J. Stam (Eds.), *Power/Gender*. London: Sage.

Finkler, L. (1993). Notes for feminist theorists on the lives of psychiatrized women. *Canadian Woman Studies, 13 (4)*.

Foucault, M. (1980). *Power/Knowledge*. Ed. Colin Gordon. New York: Pantheon Books.

Foucault, M. (1988). The ethic of care for the self as a practice of freedom. In J. Bernauer & D. Rasmussen (Eds.), *The Final Foucault*. Cambridge, MA: MIT Press.

Frank, L.R. (1992). Electroshock: death, brain damage, memory loss, and brainwashing. In Slife & Rubinstein (Eds.), *Taking Sides: Clashing Views on Controversial Psychological Issues, 7th edition*. Guilford, CT: Dushkin Publishing Group, Inc.

Frank, L.R. (1996, February). Public lecture. Vancouver, British Columbia.

Freud, S. (1931, rpt. 1974). Female sexuality, *Women and Analysis*. Ed. J. Strouse. New York: Dell.

Friedan, B. (1983). *The Feminine Mystique*. New York: Dell Publishing.

Gabbard, G. & Wilkinson, S. (1994). *Management of Countertransference with Borderline Patients*. Washington, D.C.: American Psychiatric Press.

Gartrell, N. *et al.* (1989). Prevalence of psychiatrist-patient sexual contact, *Sexual Exploitation in Professional Relationships*. Ed. G. Gabbard and S. Wilkinson. Washington, D.C.: American Psychiatric Press.

Gerrity, E. & Solomon, S. (1996). The treatment of PTSD and related stress disorders: current research and clinical knowledge. In Marsella *et al* (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications*. Washington, D.C.: American Psychological Association.

Gilman, C.P. (1892, rpt. 1988). *The Yellow Wallpaper*. London: Virago Press.

190

de Girolamo, G. & McFarlane, A. (1996). The epidemiology of PTSD: a comprehensive review of the international literature, *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications*. Eds. Marsella et al. Washington, D.C.: American Psychological Association.

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Doubleday and Company.

Gordon, L. (1988). *Heroes of Their Own Lives: The Politics and History of Family Violence*. New York: Penguin.

Gotkin, J. (1995). Electroshock: a modern medical attrocity, In J. Grobe (Ed.), *Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out*. Chicago: Third Side Press.

Gotkin, J. (1995). Bearing witness. In J. Grobe (Ed.), *Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out*. Chicago: Third Side Press.

Gove, W. & J. Tudor. (1973). Adult sex roles and mental health. *American Journal of Sociology, 78,* 812-35.

Grobe, J. (Ed.). (1995). *Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out*. Chicago: Third Side Press.

Greist, J.H. & Jefferson, J.W. (1992). *Depression and its Treatment. Revised edition*. Washington, D.C.: American Psychiatric Press.

Gunderson, J. (1984). *Borderline Personality Disorder*. Washington, D.C.: American Psychiatric Press.

Haaken, J. (1993). From al-anon to ACOA: codependence and the reconstruction of caregiving, *Signs, 18 (2),* 321-345.

Harding, C.M. & Zahniser, J.H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment, *Acta Psychiatrica Scandinavica, 90 (384),* 140-146.

Heinrichs, R. W. (1993). Schizophrenia and the brain: conditions for a neuropsychology of madness, *American Psychologist, 48 (3),* 221-233.

Herman, J.L. (1992). *Trauma and Recovery*. New York: Basic Books.

hooks, b. (1993). *Sisters of the Yam: Black Women and Self-Recovery*. Toronto: Between the Lines.

Janzen, B.L. (1994). Women and prescription drug use: the mood modifiers. Prepared for the Saskatchewan Women's Mental Health Agenda Project.

Kaminer, W. (1993). *I'm Dysfunctional, You're Dysfunctional: The Recovery Movement and Other Self-Help Fashions*. New York: Vintage Books.

Kendall, K. (1992). Dangerous bodies. In D. Farrington & S. Walklate (Eds.), *Offenders and Victims: Theory and Policy*. British Society of Criminology in association with the Institute for the Study and Treatment of Delinquency.

Kirby, S. & McKenna, K. (1989). *Experience, Research, Social Change: Methods from the Margins*. Toronto: Garamond Press.

Kirk, S.A. & Kutchins, H. (1992). *The Selling of DSM: The Rhetoric of Science in Psychiatry*. New York: Aldine de Gruyter.

Kitzinger, C. & Perkins, R. (1993). *Changing our Minds: Lesbian Feminism and Psychology*. London: Onlywomen Press.

Kleinman, Arthur & Alex Cohen. (1997). Psychiatry's global challenge, *Scientific American*, 86-89.

Kramer, P.D. (1993). *Listening to Prozac: A Psychiatrist Explores Antidepressant Drugs and the Remaking of the Self*. New York: Penguin.

Kroll, J. (1993). *PTSD/Borderlines in Therapy: Finding the Balance*. New York: W.W. Norton & Co.

Kuhn, T. (1970). *The Structure of Scientific Revolutions*. Chicago: Univ. of Chicago Press.

Lepishak, B. (1992). *Missing the Mark: Women's Services Examine Mental Health Programs for Women in Toronto*. Toronto: Coalition for Feminist Mental Health Services.

Lexchin, J. (1984). *The Real Pushers: A Critical Analysis of the Canadian Drug Industry*. Vancouver: New Star Books.

MacKinnon, C. (1989). *Toward a Feminist Theory of the State*. Cambridge, MA: Harvard Univ. Press.

Masson, J.M. (1984). *The Assault on Truth: Freud's Suppression of the Seduction Theory*. New York: Farrar, Straus and Giroux.

Masson, J.M. (1986). *A Dark Science: Women, Sexuality and Psychiatry in the Nineteenth Century*. New York: Farrar, Straus and Giroux.

Masson, J.M. (1990). *Final Analysis: The Making and Unmaking of a Psychoanalyst*. New York: HarperCollins.

McLellan, B. (1995). *Beyond Psychopression: A Feminist Alternative Therapy*. North Melbourne: Spinifex.

Mental Health Act of British Columbia, Statutes of British Columbia, 1996, chapter 288, pp. 1-21.

Mental Health Services Act, Statutes of Saskatchewan, 1986, chapter M13.1, pp. 1-24.

Miedema, B. & Stoppard, J. (1993). Understanding women's experiences of psychiatric hospitalization. *Canada's Mental Health*.

Mies, M. (1983). Towards a methodology for feminist research. In G. Bowles & R.D. Klein (Eds.), *Theories of Women's Studies*. London: Routledge & Kegan Paul.

Miller, D. (1994). *Women Who Hurt Themselves: A Book of Hope and Understanding*. New York: Basic Books.

Miller, M. (1994, September 24). Dull, grey metal earns golden reputation, *The Globe and Mail*, pp. A1, A9.

Millett, K. (1990). *The Loony-Bin Trip*. New York: Simon and Schuster.

Mitchinson, W. (1991). *The Nature of their Bodies: Women and their Doctors in Victorian Canada*. Toronto: Univ. of Toronto Press.

Morgan, R. (1988). *The Emotional Pharmacy: How Mood-Altering and Psychoactive Drugs Work*. Los Angeles: The Body Press.

Nichols, M. (1996). Secrets of the brain, *Maclean's, 9 (4)*.

Oakley, A. (1981). Interviewing women: a contradiction in terms. In H. Roberts (Ed.), *Doing Feminist Research*. London: Routledge & Kegan Paul.

Ouston, R. (1997, April 3). Close watch urged on doctor who had sex with patients. *Vancouver Sun*. p. B1.

*Overview of Psychotropic Medications*. Community College Course Readings, British Columbia, 1995.

Paris, J. (1994). *Borderline Personality Disorder: A Multidimensional Approach*. Washington, D.C.: American Psychiatric Press.

Pateman, C. (1980). Women and consent. *Political Theory 8*.

Penfold, S. & Walker, G. (1983). *Women and the Psychiatric Paradox*. Montreal: Eden Press.

Pilowsky, L. (1994). The pharmacological management of aggressive behaviour. In T. Wykes (Ed.) *Violence and Health Care Professionals*. London: Chapman and Hall.

Potier, M. (1993). Giving evidence: women's lives in Ashworth Maximum Security Psychiatric Hospital. *Feminism and Psychology, 3 (3)*, 335-347.

Quinby, A. (1995). Taking back the movement: resisting professionalization and listening to women. *Listening to the Thunder: Advocates Talk About the Battered Women's Movement*. Vancouver: Women's Research Centre.

Reinharz, S. (1983). Experiential analysis: a contribution to feminist research. In G. Bowles & R.D. Klein, *Theories of Women's Studies*. London: Routledge and Kegan Paul.

Reinharz, S. (1992). *Feminist Methods in Social Research*. New York: Oxford Univ. Press.

Roberts, H. (1981). Women and their doctors: power and powerlessness in the research process. In H. Roberts (Ed.), *Doing Feminist Research*. London: Routledge & Kegan Paul.

Root, M. (1996). Women of color and traumatic stress in 'domestic captivity': gender and race as disempowering statuses. In Marsella *et al* (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research and Clinical Applications*. Washington, D.C.: American Psychological Association.

Rosenhan, D.L. (1973). On being sane in insane places. *Science, 179*, 250-258.

Russell, D. (1995). *Women, Madness and Medicine*. Cambridge, MA: Polity Press.

Rush, F. (1980). *The Best Kept Secret*. New Jersey: Prentice-Hall.

Sakheim, H.A. (1992). The case for ECT. *Psychology Today Magazine*. Sussex Publishers.

A Sane Patient. (1879). *My Experiences in a Lunatic Asylum*. London: Chatto & Wyndus.

Schrager, C. (1993). Questioning the promise of self-help: a reading of *Women Who Love Too Much, Feminist Studies 19 (1)*, 177-192.

Shimrat, I. (1997). *Call Me Crazy: Stories from the Mad Movement*. Vancouver: Press Gang.

Showalter, E. (1985). *The Female Malady: Women, Madness, and English Culture, 1830-1980*. London: Virago Press.

Smart, B. (1985). *Michel Foucault*. London: Ellis Horwood.

Smith, D. & David, S. (Eds). (1975). *Women Look at Psychiatry*. Vancouver: Press Gang Publishers.

Smith, D. *The Conceptual Practices of Power: A Feminist Sociology of Knowledge*. Toronto: Univ. of Toronto Press, 1990.

Stecyk, T. (1984, April). LSD: Research in Saskatchewan, *MagaNova*.

Stubbs, J. (1997, September 2). Letter, *The Peak*, v97, i1, p. 2.

Szasz, T. (1963). *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*. New York: Collier Books.

Szasz, T. (1974). *The Myth of Mental Illness*. New York: Harper and Row.

Szasz, T. (1979). *Schizophrenia: The Sacred Symbol of Psychiatry*. Oxford: Oxford Univ. Press.

Talbott, J., Hales, R., & S. Yudofsky. (1988). *The American Psychiatric Press Textbook of Psychiatry*. Washington, DC: American Psychiatric Press.

Teicher, M. *et al.* (1990). Emergence of intense suicidal preoccupation during fluoxetine treatment, *American Journal of Psychiatry 147 (2)*.

Thornton, Seeman, & Plummber. (Undated). *Pamphlet Series on Schizophrenia.* Toronto: Clarke
    Institute.

Tourgeman, V. (1997, February 21). Interview. CBC Radio.

Trott, B. & O'Loughlin, P. (1991). *Voices of Experience: Thoughts About B.C.'s Mental Health Law
    From Those Who Have Directly Experienced It.* Prepared for the West Coast Mental Health
    Network.

Ussher, J. (1991). *Women's Madness: Misogyny or Mental Illness.* Amherst: Univ. of Massachusetts
    Press.

van der Kolk, B.A. (1988). The trauma spectrum: the interaction of biological and social events in the
    genesis of the trauma response." *Journal of Traumatic Stress, 1 (3),* 273-289.

Warren, C.A. (1987). *Madwives: Schizophrenic Women in the 1950s.* London: Rutgers Univ. Press.

*What's Wrong with the Mental Health System and What Can Be Done About It.* (1991). A Draft Policy
    Prepared for the Re-evaluation Counseling Communities. Seattle, WA: Rational Island Publishers.

Wylie, M.S. (1995, May/June). Diagnosing for dollars? *Family Therapy Networker.*

Yudovsky, S. *et al.* (1991). *What You Need to Know about Psychiatric Drugs.* New York: Grove
    Weidenfeld.

Zaentz, S. & Douglas, M. (Producers) & Forman, M. (Director). (1975). *One Flew Over the Cuckoo's Nest*
    [Film]. United Artists.

**Consent Form**

I, _____, agree to participate in the research study being carried out by Jacky Coates as part of her M.A. thesis in Women's Studies at Simon Fraser University.

I understand that:

-        my involvement is voluntary. I may withdraw my participation at any time, or choose not to answer individual questions as I see fit.

-        the interview may involve talking about issues of a   personal nature that may be painful for me. In addition to my right to discontinue the interview or choose not to answer individual questions, the interviewer will attempt to conduct the interview at my pace and according to my level of comfort.

-        with my permission, the interview will be taped. To protect my identity, the tape will be destroyed once transcribed.

-        all information given to the interviewer will be kept  anonymous, although some material may be used in the thesis project. My identity will be protected by the use of a pseudonym selected by me prior to the interview and by changing any personal identifying information.

I understand that if I have any questions or concerns in relation to any aspect of this study, I may at any time make contact with Jacky Coates (253-7626), with her supervisor, Dr. Meredith Kimball (291-4130), or with Dr. Mary Lynn Stewart, Chair of the Women's Studies Department at Simon Fraser University (291-3333).

Signature:     _____        Date:_____

Witness:       _____

( )      I would like a copy of the transcript of my interview.

( )      I would like to receive a copy of the results of this study.

        Mailing Address:              _____

                                      _____

## INTERVIEW QUESTIONNAIRE

## A. DEMOGRAPHICS

1. What is your date of birth?

2. How do you describe your racial/ethnic background?

3. Where were you born? **If not born in Canada:** how long have you been living in Canada?

4. Where in Canada and elsewhere have you lived?

5. What is the highest level of education have you attained?

6. What is your occupation?

7. Do you own or rent your home?

8. What is your annual total household income before taxes?

9. How many people currently live in your household? How many of these people are dependents? How many wage-earners?

10. What is your own contribution to the household income?

11. Have you ever worried about how you would survive financially?

12. I am interested briefly in some background about the people who raised you. What was the family structure like in which you grew up?

13. What was the highest level of education reached by each of your parents/guardians?

14. What sort of work did your parents/guardians do?

15. How would you describe the class background of the family in which you grew up?

16. How would you describe your own class background?

17. Was anyone in the family you grew up in treated psychiatrically? **If yes:** who?

18. Have you ever been legally married? **If yes:** Are you currently married?

19. Are you currently in a long-term relationship?

20. How would you describe your sexual orientation?

21. Do you have children? How many? Ages of children? Do your children live with you?

22. Do you have a physical disability?

## B. PSYCHIATRIC HISTORY

23. How many episodes of psychiatric treatment have you had?

24. Have you ever been hospitalized?

> **If yes:** how many times? In what types of institutions?
>
>> For each hospitalization, was it voluntary or were you detained without your consent?
>>
>> How long ago was your last hospitalization?
>>
>> What diagnoses have you received?

25. What type of psychiatric treatment have you received? Can you tell me about each different type of treatment?

> counselling      medication      ECT           other

26. In what provinces have you received psychiatric treatment?

27. Have you ever been in psychiatric care when outside Canada? **If yes:** in what country? When?

28. What is the longest amount of time you have spent in hospital?

29. What is the longest amount of time you have spent in out-patient counselling?

30. Are you currently seeing a psychiatrist or receiving any form of psychiatric treatment?

> **If yes:** what kind of treatment do you receive now?

31. In each treatment episode, have your psychiatrists been men, women, or both?

32. Have you ever attempted to see your psychiatric records? What happened?

## C. BEFORE PSYCHIATRIC TREATMENT

33. Prior to any encounter with the psychiatric system, did you receive any other form of counselling? What type of counsellor did you see?

34. What were your perceptions of psychiatrists before you received any psychiatric treatment?

**(Repeat following questions for each treatment episode)**

35. I'd like to get some information about the context of your life prior to receiving psychiatric treatment. Could you tell me about what was going on in your life at that time?

> **Prompting Questions:**
>
> Was there an incident that triggered your psychiatric involvement?
>
> How old were you?
>
> Did you live alone?
>
> Who were you living with? (Partner? children?)
>
> Were you working?
>
> Were you having problems with money? housing? children? work? your physical health or the health of someone close to you?
>
> How were you feeling?
>
> What kinds of 'symptoms' did you have?

36. Did you know of any other forms of support you could have used at the time?

> Did you try to make use of such supports?

37. Looking back on the situation now, what do you think you needed most at this time?

38. What were your expectations in going for psychiatric help?

39. How did you end up going for psychiatric treatment? What happened?

> **Prompting Questions:**
>
> Did you see a psychiatrist voluntarily?
>
> Were you forced or coerced by someone else? **If yes:** who?
>
> What kinds of choices did you feel you had?
>
> Did someone accompany you, or did you go alone?

40. Were you hospitalized on this occasion?

> **If yes:** was your hospitalization voluntary?

199

**If yes:** did you feel you had any other choice? Were other choices presented to you?

**If no:** on what grounds did they detain you? Did you feel you were a danger to yourself or anyone else? Did someone else consent on your behalf? Who?

## D. HOSPITALIZATION -- where applicable

**(Note: repeat this section for each hospitalization)**

41. In what kind of institution were you hospitalized? (eg. general hospital psychiatric ward, provincial psychiatric hospital, university teaching facility?)

42. Were you there voluntarily? **If yes:** what did you hope you would gain from hospitalization?

43. How long were you there?

44. What were your first impressions of the hospital?

45. What kind of interaction did you have with:

    doctors? nurses? other patients?

46. Did you know your diagnosis?

47. How did you feel about this diagnosis?

48. Were you prescribed medication?

    **If yes:** what medication were you given?

        Were you informed of possible side-effects?

        Did you experience side-effects?

        What was your experience of the medication?

49. Were you prescribed ECT?

    **If yes:** how many treatments were you given and how often?

        Did you consent to ECT? Did someone else consent for you?

        Were you informed of possible side-effects? Did you experience side-effects?

50. What other kinds of treatments were you given?

51. How did you feel at this time about these treatments? How do you feel about them now?

52. Was counselling part of your treatment?

what form of counselling and by whom? (eg. psychiatrist, psychologist, social worker, nurse, other?)

53. How did you feel about your counselling?

54. What was most helpful to you during this time? What was least helpful? What, if anything, was harmful?

55. How did your family/friends deal with the situation?

56. What do you think got you through this time?

57. What happened when you were discharged from hospital?

Did you feel better? Did your doctor think you were 'better'? Did you leave of your own will against doctor's orders?

58. What kinds of arrangements were made for your release?

Did you have adequate housing? Did you have a job to return to?

59. What kind of follow-up psychiatric treatment was arranged?

60. Was any form of community support arranged for you?

61. How helpful was the support that was provided?

62. Were you given medication to take home with you when you were discharged?

If yes: how long did you continue to use it? Did you find it helpful?

63. Where did you go when you were released?

64. How did you feel being out of hospital?

65. Were you able to talk openly with your family and friends about what you had gone through?

## E. OUT-PATIENT COUNSELLING

**(Repeat this section for each out-patient treatment episode)**

66. Have you been in continuing treatment with a psychiatrist or a General Practitioner on an out-patient basis?

67. Did you shop around for a psychiatrist/doctor, choosing the one you felt best about, or did you see someone you were referred to?

68. How frequent were your appointments? How long did they last?

69. How long were you in therapy with this psychiatrist/GP?

70. Did you have to pay anything for these sessions, or were they covered by medical insurance?

71. What kinds of things did you talk about in your sessions?

72. How did your psychiatrist/doctor define the problems you were having? What did you think?

73. How did you feel about your therapy with him/her?

74. What was most helpful about your counselling? What was least helpful? What, if anything, was harmful?

75. Did you feel that your psychiatrist/doctor really listened to you? Did you feel understood? Was he/she empathic with your situation?

76. Did he/she prescribe medication for you? **If yes:** what was prescribed? What was your experience of the medication?

77. Were you given any diagnosis? **If yes:** what was it?

78. Do you feel that this therapy addressed the issues that were important for you at this time?

79. What kinds of goals did you have in your therapy? Were your goals met?

80. How did your therapy terminate?

### General Questions

81. How long has it been now since you've had any contact with psychiatric professionals?

82. How do you feel now about the treatment you received in the psychiatric system?

83. How have your perceptions of psychiatry changed over the course of your experience?

84. What do you think about the term 'mental illness?'

85. Do you believe that this term applied to you at any time?

86. Have you ever felt stigmatized by your involvement with the psychiatric system?

87. Do you think you have ever been discriminated against because of your psychiatric history? **If yes:** what happened?

88. Do you talk about your experience as a patient with many people?

89. Have you ever grouped together for support with other people who have been through the psychiatric system?

90. Have you had any contact with the mental patients' liberation movement or read any literature written by former psychiatric patients?

**If yes:** did the movement/the literature speak to your experience? What ex-mental patient groups have you been involved with, and where? What has this involvement been like?

91. **If participant was medicated --** Were you informed of side-effects linked to the medication you were given?

Did you experience any side-effects?

**If yes:** What kinds?

Have you experienced addiction to any psychotropic drugs?

92. **If participant was given ECT --** Have you suffered any persistent loss of memory or inability to concentrate or any other symptoms that you suspect might be related to ECT?

**ABUSE AND VIOLENCE:**    I'd like to ask you some questions that can be difficult and painful to talk about. Please remember that you do not have to answer any questions you are not comfortable with.

93. **SEXUAL ABUSE:**  There is increasing awareness of sexual and other forms of abuse of patients by doctors and other hospital staff. Were you ever sexually approached by a psychiatrist or by any other psychiatric staff?

**If yes:** do you feel comfortable talking about what happened?

Have you ever considered making, or have you made, a formal complaint about this incident?

**If yes:** what happened?

**If no:** why did you choose not to make a formal complaint?

94. **OTHER ABUSE:**   Do you think you were abused in any other ways by doctors, nurses, other psychiatric staff?

Can you describe the ways in which you were abused?  How has this abuse affected you?

95. I'd like to ask you also about other forms of abuse you may have experienced at different times of your life.

> Have you ever been the victim of a sexual assault? a battering relationship? child abuse?

> **If yes:** Do you see a relationship between your experience of violence and your psychiatric treatment? What kind of relationship?


## ALTERNATIVES AND OTHER COUNSELLING

96. Since your psychiatric experiences, have you tried counselling with any different types of psychotherapists?

> What kinds of therapists?

> What were your experiences like of these therapists? How was it similar or different from your experience with psychiatrists?

97. Have you ever seen a feminist therapist?

> **If yes:** what was this experience like? How was it similar to/different from other types of professional help you have received?

98. Have you ever looked for support to more community-based or peer support services, like drop-in centres or crisis lines?

> **If yes:** what kind of support service?

> How was it structured?
> > ie. was there a paid staff? was it volunteer-run? peer-based? how were decisions made?

> Was this experience helpful?

> How was it similar to/different from your psychiatric experience?

> Are there limits beyond which this type of support is not helpful for you? Could this type of support replace professional support? If yes, in what ways? If no, why not?

99. Have you ever heard of any alternatives to traditional mental health services for people in crisis that are run entirely by and for patients?

> **If yes:** where and what? How does/did it operate?

> > Do you think such services are viable? Why or why not? Would you want to help out in running such a service if one existed?

## CLOSING REFLECTIONS

100. Have you experienced any periods of emotional crisis since your last psychiatric episode?

      **If yes:** How do you understand this crisis?

           How did you cope with it?

101. What are some of the best ways you've found over time to cope with times that are emotionally difficult?

102. What do you think are the best ways to help people in crisis?

103. What advice would you give to a friend who was considering seeing a psychiatrist because of depression?

Appendix C -- Demographic Information of Study Participants

| Pseudonym | Year of birth | Cultural Heritage | Marital Status | Sexual Orientation | Number of Children | Family of Origin Psychiatrized |
|---|---|---|---|---|---|---|
| Beth Saunders | 1963 | European unspecified | common-law | lesbian | 0 | mother |
| Christine Forrest | 1944 | European unspecified | married | heterosexual | 0 | no |
| Beth Playsted | 1957 | European/ Jewish | single | lesbian/ celibate | 0 | mother |
| Ann Johnstone | 1950 | European unspecified | single | lesbian | 0 | no |
| Hannah Green | 1951 | French/ English | divorced | unsure | 2 | mother |
| Diane Duthie | 1966 | European/ New Zealand | single | heterosexual | 0 | mother's siblings |
| Mary Taylor | 1959 | European/ Jewish | divorced | lesbian | 1 | father, sibling |
| Adrienne Joffey | 1950 | European/ Jewish | single | heterosexual | 0 | father |
| Sharon Wilkins | 1949 | Scottish | married | heterosexual | 3 | step-grandmother |
| Mari Smith | 1931 | English/ French | divorced | heterosexual | 3 | no |
| Jill Smith | 1953 | English/ French | single | lesbian | 0 | mother |
| Claire Baker | 1946 | European unspecified | married | heterosexual | 2 | no |
| Graham Black | 1955 | Scottish/ Irish | single | lesbian | 0 | father |
| Cara Sun | 1955 | Swedish/ Ukranian | single | unsure/ celibate | 0 | father, grandmother |
| Anna Black | 1962 | Dutch | single | heterosexual | 2 | no |
| Janet Moffat | 1940 | Irish | divorced | heterosexual | 2 | no |
| Shirley King | 1933 | European Jewish | married | heterosexual | 2 | mother |

Appendix C -- Demographic Information of Study Participants

| Pseudonym | Year of Birth | Cultural Heritage | Marital Status | Sexual Orientation | Number of Children | Family of Origin Psychiatrized |
|---|---|---|---|---|---|---|
| Erin Fremont | 1966 | mixed European | single | bisexual | 0 | no |
| Tessa Jones | 1964 | German/ Ukranian | single | bisexual | 0 | no |
| Angel Anne Lowen | 1969 | First Nations | single | lesbian | 0 | adoptive parents & sibling |
| Glenda Lennox | 1963 | mixed European | common-law | lesbian | 1 | adoptive sibling |
| Mabel Abelone | 1940 | French Catholic | married | heterosexual | 3 | no |
| Naomi Windfeathers | 1965 | German/ Polish | single | unsure | 0 | no |
| Gin Cote | 1949 | French Catholic | common-law | lesbian | 1 | no |

| Pseudonym | SES origin | SES current | Personal income | Household income | Education | Occupation |
|---|---|---|---|---|---|---|
| Beth Saunders | lower-middle | middle | under $10,000 | $40-50,000 | professional school | student |
| Christine Forrest | middle | upper-middle | $20-30,000 | over $60,000 | graduate degree | professional |
| Beth Playsted | lower-middle | working-class | $10-20,000 | $10-20,000 | some university | clerical |
| Ann Johnstone | middle | poor | under $10,000 | under $10,000 | high school | unemployed /disabled |
| Hannah Green | upper-middle | working class | $40-50,000 | $40-50,000 | high school | foster mother |
| Diane Duthie | lower middle | lower middle | $20-30,000 | $20-30,000 | some university | student/ waitress |
| Mary Taylor | middle | working class | $10-20,000 | $10-20,000 | some university | student |
| Adrienne Joffey | upper-middle | working class | $10-20,000 | $10-20,000 | some university | clerical |
| Sharon Wilkins | middle | middle | under $10,000 | $50-60,000 | some university | homemaker |
| Mari Smith | middle | poor | $10-20,000 | $10-20,000 | university | retired |
| Jill Smith | middle | middle | $30-40,000 | $30-40,000 | graduate degree | semi-professional |
| Claire Baker | middle | middle | $20-30,000 | over $60,000 | high school | clerical |
| Graham Black | working class | working class | $40-50,000 | $40-50,000 | high school | semi-skilled |
| Cara Sun | working class | poor | under $10,000 | under $10,000 | some university | unemployed / disabled |
| Anna Black | middle | lower-middle | $20-30,000 | $20-30,000 | university | semi-professional |
| Janet Moffat | working class | poor | under $10,000 | under $10,000 | university | unemployed |
| Shirley King | middle | middle | $30,000 | over $60,000 | university | retired professional |

| Pseudonym | SES origin | SES current | Personal income | Household income | Education | Occupation |
|-----------|------------|-------------|-----------------|------------------|-----------|------------|
| Erin Fremont | middle | working class | under $10,000 | under $10,000 | some university | part-time clerical |
| Tessa Jones | lower-middle | working class | $10-20,000 | $10-20,000 | high school | cleaning |
| Angel Anne Lowen | working class | working class | $20-30,000 | $20-30,000 | college diploma | semi-skilled |
| Glenda Lennox | lower-middle | working-class | under $10,000 | $20-30,000 | some university | unskilled |
| Mabel Abelone | middle | middle | under $10,000 | $50-60,000 | some university | homemaker |
| Naomi Windfeathers | working class | poor | under $10,000 | under $10,000 | some university | unemployed / clerical |
| Gin Cote | upper-middle | lower-middle | $20-30,000 | $30-40,000 | some university | semi-professional |

# Appendix E -- Treatment Patterns of Study Participants

| Pseudonym | Years of Treatment | Provinces of Treatment | Number of Voluntary Hospitalizations | Number of Involuntary Hospitalizations |
|---|---|---|---|---|
| Beth Saunders | 1983 | B.C. | 2 | 0 |
| Christine Forrest | 1964, 1986, 1989 | Ontario, B.C. | 0 | 0 |
| Beth Playsted | 1971 1976-1983 1992- | B.C., Yukon | 0 | 1 |
| Ann Johnstone | 1965 1973-1995 | B.C. | 0 | 0 |
| Hannah Green | 1970 1989 | Quebec, B.C. | 0 | 0 |
| Diane Duthie | 1988 | Manitoba | 0 | 0 |
| Mary Taylor | 1976 | Ontario | 1 | 1 |
| Adrienne Joffey | 1970s 1987- | B.C. | 1 | 0 |
| Sharon Wilkins | 1966 1993-1995 | B.C. | 1 | 2 |
| Mari Smith | 1959- | B.C. | 5+ | 5+ |
| Jill Smith | 1977-78 1986- | B.C. | 3 | 0 |
| Claire Baker | 1969- | B.C. | 2 | 0 |
| Graham Black | 1972-73 | Ontario | 2 | 0 |
| Cara Sun | 1976- | Saskatchewan | 1 | 0 |
| Anna Black | 1992- | Saskatchewan | 1 | 0 |
| Janet Moffat | 1964, 1992 | Saskatchewan | 1 | 1 |
| Shirley King | 1968, 1989 | Saskatchewan | 1 | 0 |
| Erin Fremont | 1989- | Saskatchewan | 1 | 1 |
| Tessa Jones | 1990- | Saskatchewan | 2 | 1 |
| Glenda Lennox | 1980-82 | Saskatchewan | 0 | 0 |

## Appendix E -- Treatment Patterns of Study Participants

| Pseudonym | Years of Treatment | Provinces of Treatment | Number of Voluntary Hospitalizations | Number of Involuntary Hospitalizations |
|---|---|---|---|---|
| Angel Anne Lowen | 1985- | Saskatchewan | 1 | 4 |
| Mabel Abelone | 1952-57 1987 | Saskatchewan | 1 | 3 |
| Naomi Windfeathers | 1982- | Saskatchewan | 1 | 0 |
| Gin Cote | 1973,1980 1987- | Saskatchewan | 2 | 1 |

# <u>Women and Psychiatry</u>

**Have you been 'psychiatrized'?** Women are the largest consumers of the psychiatric system. Thousands of women in Canada regularly make use of psychiatric services and have no place to talk about their experiences.

If you are a woman who has ever been through the psychiatric system as a patient, either in hospital or in office counselling, I would like to talk to you.

I am a graduate student in Women's Studies at Simon Fraser University, doing a study on women's experiences with the psychiatric system. I would like to make contact with women interested in participating in an interview study about their experiences with psychiatry.

If you decide to participate, it will take a minimal amount of time on your part: one interview of 1-2 hours at the time and place of your convenience. You will never be identified in the results of the study. All information will be kept anonymous and your name will never be revealed.

My purpose in conducting this study is to give women a voice about the type of services they receive. I want this study to help create services that better meet women's needs. I am interested in your suggestions and your input. Study results will be made available to you and to interested community organizations which provide alternative services for women.

*For more information:* call **Jacky at 253-7626**