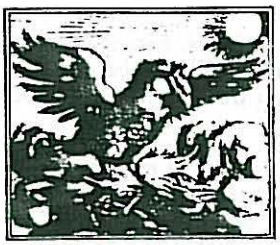


commentary

Mental health and violence against women: a feminist ex-inmate analysis

This position paper is the result of a workshop conducted at the 10th Annual International Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada, on the 14-18 of May, 1982. We do not claim to be representative of all female ex-inmates, given our feminist perspective, our largely middle-class values, our race (white and North American), and our age (24-37). The members of the workshop met to discuss alternatives to the mental health system in dealing with issues of violence against women. As female ex-inmates we have concerns such as rape, battery, expression of anger, that need to be addressed from our particular perspective. As feminist survivors of psychiatry and violence, we have formulated an analysis which has not been articulated by either the women's movement or the anti-psychiatry movement.

Psychiatry and Violence Against Women are Related

1. We are raped, battered and blamed. We are told that we have asked for it, and our childhoods are endlessly psychoanalyzed to find the causes of our "masochistic" behaviour. This perpetuates the cultural acceptance of violence against women by "blaming the victim".

2. When we react by getting upset and getting angry at being raped, battered, pushed around and down, we get therapy, we get treatment, we get locked up in mental institutions. There, we are subject to further sexual harrassment.

3. When we do turn for support to the system, we learn several things. Men define and judge our experience in terms of quality and quantity: rape on the street by a stranger compared to rape by an acquaintance, lover or stranger, compared to incest and battery. Certain groups of women are particularly vulnerable according to their status in society: women who are prostitutes or on welfare are taken less seriously than white, middle-class married mothers of two. This causes women to become divided amongst themselves, by denying the pervasiveness of violence in our culture and in all of our lives. The similarities in our experiences with violence are far more important than the particular details or circumstances of our victimization.

4. As women, our credibility is challenged, our words are discounted, regardless of what we say. If we outwardly express our pain by crying or shaking with rage, we are labeled hysterical. On the other hand, if we remain calm, the experience of our victimization is denied or not taken seriously. For ex-inmates, or any women with a record of "mental illness" this problem is exacerbated. Our status as madwomen is used against us: we're lying, we're hallucinating, or it doesn't matter anyway.

5. Our sisters, feminist therapists, also fail us. They label us, reject us, or just don't see the connections we do.

6. We join the ex-inmate movement, and expect to find sexism, but will not accept the failure of members to recognize it and be accountable for it.

7. Finally, we recognize that we are in a position of relative privilege. We are out of the psychiatric system, we are articulate, and the support we get from each other gives us the strength to speak out. Our passion and urgency derive from the awareness of all the women who are truly powerless; in institutions or aftercare, restrained, secluded, drugged, shocked, raped and battered. We have a responsibility to protest what is happening to our sisters.

Where Do We Turn When We Are Raped or Battered?

Raped or battered, we suffer overwhelming feelings including rage, shame, humiliation, powerlessness, self-doubt and guilt. Where do we turn? Ideally, we would turn to our friends, family and community, expressing our anger and sadness safely, and mobilizing our resources in struggle for change. Sometimes, and to some degree, this happens. Unfortunately, these resources for support are usually not available to us, for a variety of reasons.

One set of concerns arises from cultural attitudes which are male defined and violent. When we turn to the people we love, we find that it is still unacceptable to admit that we have been victims of rape or battering. We are judged, or blamed, or politely ignored. It is also unacceptable to admit a need or desire for support.

The second set of concerns has to do with race, class, status, and geography. Some of us have access to resources over which we are more or less in control. For instance, white middle-class feminists may receive support from some women's groups when raped or battered. Some of us can afford to take a vacation or even move if we need to get away from dangerous or abusive living situations. A wealthy woman who protests battering has a better chance of buying sympathetic and competent legal assistance. A woman who can visit a private physician or nurse practitioner or other

health care giver is in a much better position than one who must go to an emergency room for first aid, and there are countless other ways in which women of colour, poor women, women who are prostitutes, single women, and lesbians are denied help.

If we admit that we have been raped or battered, need support, or are hurt by our victimization, we are very likely to come into some contact with the mental health system. Some of us turn to counsellors or therapists because we are told that this is the place to go if we are in emotional distress. Some of us know that we need to talk to other women about what is happening to us, and the only place to find each other may be in a "support group" in a crisis centre or clinic within the mental health system. Others of us are turned into the mental health system because we protest or show our pain. A battered woman who knocks on neighbours' doors, screams for help, or repeatedly calls the police runs a serious risk of being committed to a mental institution. This is particularly true for women less valued by the dominant culture, including black women or women without economic power. Increasingly, we even find that grassroots or feminist alternative support systems are being infiltrated, co-opted, or swallowed whole by the mental health system.

How The Mental Health System Acts Against Us

1. The first problem is that the mental health system is involved at all. Violence against women is not a personal or individual issue, but a political reality. The concept of "mental health" implies a corresponding pathology, but women who are survivors of violence are not ill. The focus on the individual is destructive for two reasons. Firstly, focussing on the individual woman leads to blaming the victim, either overtly, or through the therapeutic process which searches for hidden motivation. Secondly, this focus leads to an assessment of the rapist/woman-violator as suffering from an individual pathology. He is thus relieved of responsibility for his actions, and the socio-cultural values encouraging violence against women are obscured. We know that rapist/woman-violators are not peculiar. Women's experience attests to this fact. All women are aware that men assume our availability and access to our bodies. This constant is manifested in every facet of our lives; in advertising, in harrassment on the street, in the media and in our relationships. Even by the admission of mental health professionals, it is impossible to distinguish between rapists and "normal" men.
2. Increasingly, our experiences with violence are described in terms of pathological syndromes. For example, there have appeared in the literature references to "rape trauma syndrome", "incest survivors' syndrome" and "battered woman's syndrome". Women have uncritically welcomed this acknowledgement of problems that, until recently, were never discussed. As feminist ex-inmates, we regard as destructive the involvement of mental health "experts" in this discussion. We don't need psychologists to validate our experience. Some of the negative effects of this are:

a) A hierarchy is created based on the circumstances of our assault. A woman who is gang-raped or raped by a stranger on the street is seen as having undergone a "better rape" than a woman who has been raped by an acquaintance. However, a woman who is raped by her husband or the man with whom she is intimately involved is seen as pathological for remaining in the relationship. Women who have been raped by men of a "lower" race or class are seen as "more raped" and are therefore more readily believed.

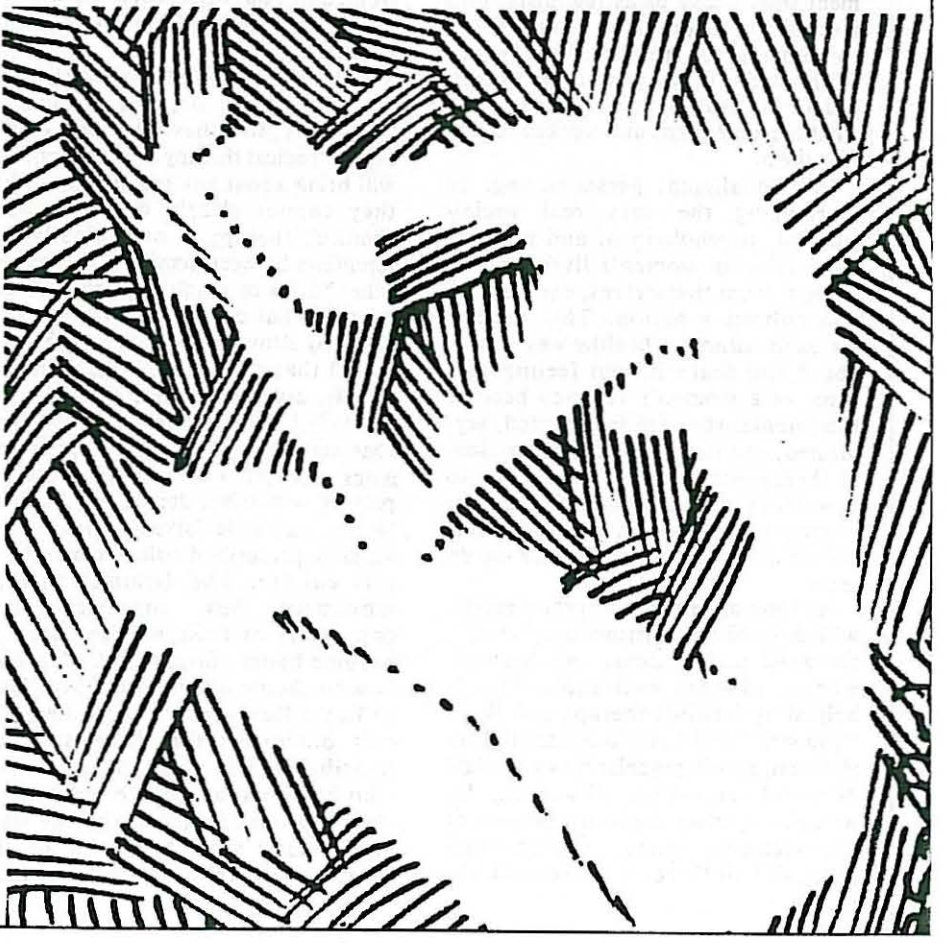
b) When we label our experiences in terms of syndromes, these artificial distinctions act as barriers to recognizing our common experience, supporting each other and working together for change.

c) This delineation is a theft of our right and our responsibility to describe our own oppression.

d) The delineation of symptoms and reactions implies a correct response, which seeks to further control us.

The involvement of the mental health system in issues of violence against women tranquilizes us, either literally or figuratively. At worst, some of us are committed to institutions, and there we are subjected to the most blatant forms of psychiatric oppression: forced drugging, shock, isolation and restraint. Even at best, in relatively supportive, sympathetic and non-coercive situations, we are talked out of our anger or "helped" to direct it in more "appropriate" ways.

The mental health system is insidiously taking over the fight against violence against women. In the face of dwindling financial resources, mental health centres are scrambling for new clients and popular projects to be funded. Women's centres are being co-



opted, at least in the United States, by becoming professionalized and by accepting monies from mental health agencies. Another example arises in the fight for compensation for victims of violent crime. Where compensation is provided at all, as in Canada, validation of pain and suffering as well as of medical expenses is required. We reject the notion that we need a psychiatrist's note to prove that we are upset about our assaults.

Why Feminist Therapy Has Failed Us

Women in a patriarchal culture face threats of violence and oppression on a daily basis. Feminism is a base of support for women to come together to share collective strategies on how to deal with our common oppression. Women come to the Movement with huge expectations and needs for support, and, often disappointed, turn to feminist therapy to fill that void. This and other uses of feminist therapy are extremely problematic to us as feminists who are former psychiatric inmates who recognize therapy for what it is: a mechanism of social control.

Treating women's emotions as illness does nothing to "restore sanity". Instead, this bastardization of caregiving is a direct contradiction to the central tenet of feminism, i.e., that the personal is political. The history of professionalization of medical treatment should give us as feminists some ideas about the problems of this hierarchical misogynist structure. Men became frightened of the power of women practicing healing arts, labeling them witches and lesbians and worked to destroy them.

Individualizing, personalizing, or therapizing the very real social-cultural, psychological, and physical oppression in women's lives isolates women from themselves, each other, and collective action. This process leaves us without a healthy way to talk about and deal with our feelings. As soon as a woman's feelings become too intense, they are fragmented, segmented, and isolated to the professional therapeutic realm. Therapy is so powerful that it can not only cure the victim, but also cures the victimizer. Would it not be healthier to cure the disease?

As long as feminist therapy exists, with its arbitrary distinctions between therapist and patient, and between women who are well enough to be helped by feminist therapy and those "too sick" and in need of institutionalization, so will psychiatry as a method of social control for all women. All women are vulnerable to the excesses of the psychiatric system. Feminist therapists, like all therapists, maintain the professional privilege to commit women against their will, "for their own good". This imbalance in power cannot be overcome. Even more unfortunate is the fact that feminists in growing numbers are becoming therapists, thus supporting the notion of extreme emotions as illness with the need for hierarchical professional intervention.

The kind of "patients" feminist therapists want and attract are not at all dissimilar to the type of female patients Schofield (1960) found with whom male therapists "felt they were most efficient and effective with in therapy". The patient was described as being between the ages of 20-40, without any advanced education. This has been described as the "YAVIS syndrome": young, attractive, verbal, intelligent and successful, or in other words, "normal". Continuing to treat "normal" problems as though they were abnormal not only preys on women's needs for support via an exploitative capitalistic relationship, but also perpetuates and abnormalizes caregiving. This does nothing to change women's perceptions of ourselves as "sick", and in need of "objective", "professional" treatment. Instead, by continuing to "treat" women in "professional therapeutic" relationships, one fosters those self-doubts about one's mental health. If women are treated in abnormal ways, we will feel abnormal, and will expect others to view us as such.

How can feminist therapists realistically expect us, the victims of psychiatry, to believe that this or any other "radical therapy" is different and will bring about any real change, when they cannot clearly delineate what feminist therapy is or critically differentiate between feminist therapy and other forms of psychiatric oppression? A somewhat dated, but still relevant study by Broverman et. al. (1970) illustrated that clinicians, both male and female, utilize masculine definitions of mentally healthy behaviour. It is not altogether surprising that those characteristics associated with being a mental patient — passive, dependent, manipulative, and indecisive — also fit the socially prescribed role for women in this culture. The feminist therapy movement has suggested that consumers of their services need to become better consumers by learning how to choose a therapist. This "How to Buy a Refrigerator" argument not only diminishes the therapist's responsibility, but also ignores women who have had all choice removed in their lives, most directly by the legal system, and more indirectly by the coercive nature of the therapeutic process. This is a more subtle and insidious form of the "blame the victim" theory which has been used to explain virtually every kind of oppression. In addition, this argument totally ignores class issues. Few women can afford to buy a refrigerator — or an hour of talk — when they are now making less than 59¢ for every dollar a white man makes in North America. Estimates show that this figure will be even lower for women of colour. How does an hour of talk change the fact that incest, rape, battery and harrassment are cultural norms? All therapies are an abstraction of reality which keep women talking and not acting. Describing our experience as rape syndromes, as symptoms of incest victims, or by the proper psychiatric label for battered women does not change our experience. Feminist therapies, like all other therapies, are not looking to the survivors for guidance, but are instead relying on clinical judgement. They are not asking us, they are placating us. Treating our anger and our pain as illnesses gets therapists paid by the insurance schemes, but leaves us feeling more "crazy". Nor have feminist therapists taken a position on other critical issues: civil commitment, coercive voluntary commitment, shock, forced drugging. How then are we to trust you? And finally, feminist therapy is a contradiction in feminist terms. Feminism began and continues to survive relying on consciousness raising as the essence for women to come together and support each other, and to collectively define our issues. We are aware of the harmful consequences of having "professionals" define and deal with our issues. Feminist therapy is a part of the psychiatric system and as such it is a method of social control which mirrors larger society.

A Place for Anger

Our anger is real. Our anger at our experiences of oppression as women and as psychiatric inmates, of being raped, beaten, locked up, drugged, shocked, is valid and strong. It is not a "symptom" to be drugged or therapized away. It is, instead, a source of our power, a fuel for our outrage and our activism. We will not allow anyone — psychiatrist or feminist therapist — to convince us that we are sick because we are enraged, because we refuse to calm down and "adjust" to a "reality" that defines us as inferior. We completely reject the idea that there is an inappropriate degree of anger, an inappropriate length of time for our anger, or an inappropriate object for our anger. We rejoice in our identities as madwomen, as furies, strong and proud.

A Summary of Our Analysis

The powers that stand behind the systematic attacks on people who are labeled "mentally ill" are the same powers that stand behind woman-hating in the lives of all women, behind the continuation of violence against women. This power is contained in our economic system, within the system of male supremacy. As feminists and ex-psychiatric inmates, this is the point where issues of violence against women and psychiatric assault come together.

The psychiatric system is, in effect, a microcosm of society. Both play an important role in defining how society will operate. In western capitalist society, men are responsible for participation in the labour force, while women are expected to be primarily child care providers, to reproduce the labour force. These sexual roles have become defined as "normal". However, the psychiatric professionals have defined these roles in terms of pathology. The male sex-role is generally regarded as "mentally healthy", while the female sex-roles are "mentally unhealthy". Thus, women are placed in a position whereby, to be healthy women, we must be "unhealthy people", and to be "healthy people", we must be unhealthy women. Women become both "normal" and "abnormal" at the same time. Furthermore, when one defines another human being as "abnormal" or "different", one can more easily justify any maltreatment, including rape, battering and other violence. In the extreme, we see those defined as "different" (Jews, mentally retarded, etc. in Hitler's Germany or Stalin's Russia) as examples of justified violence against those who are different.

Just as the psychiatric system serves the purposes of social and economic control around the world, so violence against women serves the social and economic control of women.

As female ex-inmates, we take back the pride and dignity of self. We take back our credibility. We demand the right and power to define our own needs, issues, and most importantly, our own strategy for support and political action, without "professional" intervention.

Where We Go From Here

1. We challenge the feminist community to recognize our experience and analysis as ex-inmate women, rather than ignoring us, rejecting us as sick or crazy, or being embarrassed by us. In particular, we ask feminist therapists to acknowledge the contradiction in what they do.
2. We demand that men accept the responsibility for violence against women, and acknowledge the pervasiveness of misogynous assault, and the fact that this violence is a deliberate strategy for social control. We challenge them to stop rape and abuse.
3. We ask our brothers in the ex-inmate /anti-psychiatry movement to recognize the sexism in the movement, at this conference, and in their relationships. We ask neither for an admission nor a denial of guilt, but a willingness to develop an analysis of this sexism, and a commitment to develop strategies for change.
4. We all have a responsibility to be aware of the role of class, race, and status in the violation of women. We accept this responsibility personally for ourselves, and most explicitly refuse to take part in an anti-rape movement that lends credibility or strength to an attack on people of colour.

We know that it is important to recognize the value of the least powerful among us, not only because we care about our sisters, but because it is in our own self-interest to stay together. If lesbians are unsafe and unvalued, every one of us is in trouble. If the rape of women of colour is condoned, then all women are potential victims. If we fail to recognize that a husband forcing sex on a woman is rape, then we are saying that the men we choose always have access to our bodies. If it is acceptable to rape or beat up prostitutes, then not a single one of us is safe. If madwomen, "retarded" women, or women prisoners are acceptable targets for violence, we can all be subject to assault. We speak here because silence is complicity, and we will not consent to assault on any woman. Each of us is precious, unique and valuable.

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