

Special Issue
on Feminist Therapy

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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY



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To regular readers of *Healthsharing*, this issue will appear different in a number of ways. Not only is it 12 pages longer than what you're used to, but the focus of the feature articles and most of our regular columns (*Healthwise*; *My Story*, *Our Story*; *Book Reviews* and *Resources*) all carry one theme: Women in Therapy. These changes are visible at a glance.

What you can't see is the departure from what we're used to in preparing the magazine. This is our first joint venture. Last winter we were approached by a group of feminist therapists in Toronto about organizing a special issue around women in therapy. We were keen about the idea and welcomed their suggestion as it had been a wish of ours for some time to do a special issue. Therapy had different meanings for each of us in the *Healthsharing* collective. Some of us have a personal link with it, having been through various modes of therapy. For others it was something we had felt the need for but hadn't acted upon. And still for others it was a connection from having talked a friend through a difficult period or a suicide attempt. We didn't doubt for a minute the usefulness of a special issue on women in therapy.

While we bargained for perhaps less of a workload than usual, in fact the opposite has been true. Increasing the length of the magazine by a third has meant, quite simply, a third more work! The Feminist Therapy Study/Support Group brought to the project commitment, energy, knowledge of therapy and a collective and feminist perspective; we were needed to bring to this venture the editing and production skills we have gained since publishing our first issue. We struggled through difficult decisions and occasional differences of opinion, and there wasn't one of us who didn't at some point wonder "Will we ever get this issue out on time?" Well, we did, and we're anxious to hear your reactions to it.

We wholeheartedly thank Bev Rodrigue, Shelley Glazer, Judith Weisman, Audrey Wright, Joy Murphy, Phyllis Baldwin and Pat Henderson for sticking with us through the struggle to make this issue of *Healthsharing* come about. When collectives strive to work together, moving beyond the safety of our own enclaves, we further feminist skills and strengthen feminist visions.



Top: Friend of *Healthsharing*, Adelyn Bowland with collective members Diana Majury, Susan Wortman; Middle: Anne Rochon Ford, Jennifer Penney, Madeline Boscoe; Bottom: Connie Clement, Betty Burcher, Lisa McCaskell.

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Newsfronts

Health Hazards of Shift-Work Reduced

The perpetual feeling of jet lag experienced by many shift-workers can be reduced by rotating shifts in the opposite direction to what is usually scheduled for most workers today. According to an article printed in *The Toronto Star* the usual human circadian rhythm, or sleep-wake cycle, is 25 hours, not the 24 hours around which most of us pattern our days.

Because the body can adjust to slight changes in circadian patterns, most of us have no trouble living on a 24-hour basis. However, when people structure their sleeping and waking times around rotating shifts trouble sets in. According to research published in *Science* health problems associated with rotating shifts can be greatly reduced simply by rotating shifts in the opposite direction. Most rotating shifts are scheduled so that a worker advances from night shift to evening shift to day shift. That is, a hospital nurse might work the night shift from 11 p.m. to 7 a.m. and come back the next day on the evening shift from 3 p.m. to 11 p.m.

Shift workers frequently complain of insomnia, falling asleep at work and assert that their schedules change too frequently to allow them to adjust. Most shift workers report that it takes at least two days to adjust to a new shift, and some workers never get a chance to adjust when working traditional week long stints at each shift.

When workers' shifts were adjusted so that workers rotated off the evening shift onto a night shift 24 hours later, or off the night shift onto a day shift 24 hours later, complaints dropped. More than 70% of the workers involved preferred the new direction of rotation. The

researchers argue that traditional scheduling, which involved an eight-hour advance in schedule, is "beyond the usual human range of entrainment."

The study also compared the effects of shift changes every three weeks with traditional weekly shift changes. Among the workers on a 21-day pattern, complaints about shift changes dropped from 90% to 20%, health improved significantly, worker satisfaction increased and the rate of staff turnover dropped to the same rate found among non-shift workers at the company taking part in the study.

It sounds simple. But even if these findings are corroborated by additional research, it may be anything but simple to convince employers to alter long-standing scheduling habits.

Berkeley Bans Electroshock Therapy

Electroconvulsive therapy, often known as electroshock treatment (see page 6), was banned in Berkeley, California in early November. The ban resulted from a public referendum held during the U.S. elections. It is believed to be the first time that the issue of electroshock treatment has been placed on a public ballot

in North America and may be the first time any municipality has banned the treatment within its boundaries.

Opponents held a solid majority of the vote. A *Globe and Mail* article stated that when 70% of the vote had been tallied, 62% voted to ban the treatment and 38% had voted to continue to allow electricshock.

Rubella Screening Urged

One in four Southeast Asian women screened in a small Manitoba study was susceptible to rubella (German measles). This is a much higher rate of susceptibility than generally found among Canadian-born women, who have more often been immunized during child-

hood.

The Manitoba government has undertaken promotion to encourage Indochinese women to have their rubella immunity tested. If a woman is not immune, she can be easily vaccinated provided she is not pregnant at the time.

Fear of Doctors

Silences Questions

A recent study of 400 visits to general practitioners in Britain found that many people are afraid to ask their doctor questions. The Health Education Council found that 20% of the people questioned were afraid they would get a hostile reaction; another 33% thought their doctor would think less of them if they asked a question.

The implications of this study become clear in the findings that 75% of clients were using over the counter drugs without informing their doctors; another 33% suffered from anxiety or depression but did not tell their doctors about their emotional state.

According to a *Medical Post* article about the study, results also showed that 80% of the people "who asked clear cut questions received specific answers." Perhaps it was people's fear of being unable to pose a "clear cut" question which led them to ask no questions at all.

Detection of Endometrial Cancer

New research has been recently released which points towards potential improvements in endometrial cancer detection.

The Alabama Department of Public Health screened 8,505 women using the well-known Pap test and a newer intrauterine wash technique. The Gravlee intrauterine wash technique detected 100% of the 15 cases of endometrial cancer later confirmed. The Pap test, by way of comparison, detected only 33% of those cases. The two tests were comparable in detecting both cervical cancer and cervical dysplasias, with the Pap test being slightly, but not significantly, more accurate.

The Gravlee intrauterine washing device consists of a double-tubed cannula inserted into the uterus. Saline solution is drawn into the uterus by vacuum suction. After the uterus is thoroughly bathed, the fluid is withdrawn. The endometrial cells in the fluid are then checked in a laboratory in the same way that cells removed by a Pap smear are examined for abnormality.

It should be noted that these results were obtained in a public screening program, and are unlikely to be as accurate as results which might be obtained in a more controlled study. However, the results are important at this time when the ability of Pap tests to detect endomet-

rial cancer in asymptomatic women has been called into question.

A second study, an Australian study of 325 women, asserts that it "should be possible to identify 50% of the women who eventually develop endometrial cancer by screening for increased urinary estrogen excretions."

Although researchers aren't yet postulating any mechanism by which cancer is produced under these conditions, they believe that the findings could eventually lead to earlier diagnosis.

The study was undertaken to clarify discrepant results between an earlier Australian study by the same researchers with similar findings and several U.S. studies which found no difference in estrogen excretion rates in women with endometrial cancer and controls.

Drano Sex Test Washed Out

Do you remember the stories the newspapers ran a few years ago about a test a pregnant woman could do at home to find out what sex her baby would be? The test involved adding some Drano crystals to urine, agitating the mixture and then watching to see what colour the mixture turned. If it turned green that predicted a boy; if the colour remained yellow a girl was pending.

Well, someone finally carried out a study to show that this is hogwash. The August 20th edition of the *Journal of the American Medical Association* (yes, really) carried an item by Dr. Robert Fowler from the University of Wyoming. He carried out the Drano test monthly during the last trimester with 100 consecutive patients.

Of these 100 women, 21 failed to have the same colour change consistently, and their babies were 11 girls and 10 boys. Of the 79 who had a consistent colour pattern, the colour predicted the sex born in 37 cases and the wrong sex in 42 cases. Fowler, therefore, concludes that the accuracy of the Drano test "is roughly equivalent to flipping a coin."

Case Against Passive Smoke Increases

Children, in particular, are at risk when exposed to passive smoke. At the recent American Academy of Allergy annual meeting in Montreal, Dr. Heinz Wittig of New Orleans reported on a study of the effects of smoke on pulmonary function of smokers and non-smokers, both asthmatic and non-asthmatic.

The findings showed while heavy active smoking does more harm than passive or second-hand smoke inhaled

from the air, both appear to cause significant damage to small airways. In asthmatic individuals tested, active and passive smoke had equally deleterious effects.

Earlier studies such as a study reported in *OB/GYN* in March, 1982 found that passive smoking in a home can retard a child's height. The study of 4,000 children from the British Isles found that a child's height was inversely proportional to

the number of smokers in his or her home. These findings backed up an earlier study published by researchers at the Harvard Medical School who found that the effect on children of two smoking parents was just about double that of one smoking parent.

In Montreal, Wittig argued that children of smoking parents have more pneumonias, more colds and more general infections than children of non-smokers.

First Canadian Study of Pesticide Effects On Farmworkers

A survey of 270 farm workers in the Okanagan and Fraser River valleys of British Columbia was released at the end of September. The federal government funded study was released following incidents where workers were admitted to hospital in August after being sprayed with the pesticide diazinon while working in fields.

This study, the first of its kind in Canada according to a story in the *Globe and Mail*, found that of workers directly exposed to pesticides 51% suf-

fered headaches, 44% had skin rashes, 34% experienced dizziness and 35% reported that their eyes burned. Further, 90% of the workers using pesticides had no idea what specific chemical they were using or what its hazards were.

Calvin Sandborn, a lawyer with the farm worker project of the Matsqui-Abbotsford Community Services Association, the organization which carried out the survey, reported that 89% of the farmers surveyed

did not know how long they needed to wait after spraying before harvesting crops. A 1975 British Columbia royal commission found that as much as 3.5% of B.C. produce marketed had residues which exceeded legal limits.

The B.C. government is purportedly preparing legislation which would force farmers to use the same precautions and protection when using dangerous chemicals as industry. The legislative move is being fought

by growers who are arguing that it will be too expensive to implement and that crops will be lost.

Economics, not the safety of the chemicals used, is being argued. In terms of safety, Wayne Ormrod of Agriculture Canada admits that most older pesticides do not stand up well under modern scrutiny. Manufacturers, all based in the U.S., won't alter them for present-day Canadian use. Again, their reason is economic.

Healthwise

Translating Psychiatric Terminology

When trying to help a friend or relative who is experiencing an emotional or psychological crisis, you may encounter a number of terms and labels. This is especially true if you find yourself involved in the traditional medical system. Inside this system, standard diagnoses and treatments are often referred to with little explanation. A short glossary of the most commonly used terms follows.

DIAGNOSIS

Psychosis: This term refers to any major mental disorder of organic or emotional origin, marked by derangement of the personality and loss of contact with reality, often with delusions, hallucinations or illusions. Psychoses are usually classified as functional psychoses, those for which no physical cause has been discovered, and organic psychoses, which are the result of organic damage to the brain.

The main types of functional psychoses are schizophrenia, paranoia and affective psychosis.

Schizophrenia — This is the most common psychosis and the one from which the majority of chronic hospital patients suffer. Common symptoms are withdrawal, severe thought and speech disturbances, hallucinations and bizarre behaviour.

Paranoia — This term applies to persistent grandiose delusions. Although these feelings may have some basis in reality, they are dysfunctional when they are grossly exaggerated. A person suffering from paranoia often uses an intricate form of logic to try to explain her delusions.

Affective disorders — This psychosis is characterized by greatly exaggerated emotional reactions and mood swings. The commonly used term is manic-depression although many affected people experience only the manic form and others only the depressed phase. Mood changes are often unrelated to outside occurrences.

COMMITTAL

Patients in psychiatric wards or hospitals have been either voluntarily or involuntarily committed.

Voluntary committal — Technically this means that the patient requests admission and is free to terminate treatment whenever she wants. But once in hospital, voluntary patients are treated no differently from other patients and they could be committed involuntarily if the staff feels it is necessary.

Involuntary committal or certification — This means that someone other than the patient decides she needs to be hospitalized. This decision is based on an assessment that the patient is a danger either to herself or to others. Laws vary from province to province, but include who can certify, length of time that committal is legally permitted and criteria for determining the need for committal. (*On Our Own*, a group of ex-psychiatric patients, has put together a comprehensive legal chart with information on committal practices in all the provinces. See *Resources*, page 39.)

ELECTROCONVULSIVE THERAPY (ECT)

ECT is the application of electrical current to the brain. It is mainly used for patients with what is called endogenous depression, i.e. people who cannot name a clear reason for feeling depressed, who are suicidal and who seem unable to shake the depression under any circumstances for prolonged periods. There is some evidence that ECT can help such people when no other treatment seems to work.

However, there are many problems with ECT. One is that the relief may only be temporary. Second, the main side effect is memory loss, the severity depending on the number of treatments. Memory loss may include past events as well as events immediately after treatment. Sometimes the memory completely recovers, but the effects can be permanent. Third, ECT is often used for people diagnosed as schizophrenic or in acute depression. There is no evidence that ECT is useful in these conditions. Fourth, ECT has often been used as a method of punishing those patients who do not conform.

CHEMOTHERAPY

Chemotherapy or medication is almost always prescribed for psychiatric patients. Several types of drugs may be used depending on the diagnosis.

Minor tranquilizers and/or sedatives — e.g. Valium, Librium, Seconal. These are used for anxiety or sleeplessness.

Major tranquilizers — e.g. Thorazine, Stelazine, Haldol. They help to calm agitation, diminish destructive behaviour and hallucinations and may bring about some correction of disturbed thought processes. Side effects include changes in the central nervous system (affecting speech and movement) and reactions affecting the blood, skin, liver and eyes. Periodic checks of the blood and liver are advisable in any long-term use of such drugs.

Antidepressants — e.g. Elavil. These are normally slow-acting drugs but if no improvement is experienced after three weeks they may not be effective at all. While they do have side effects, these are not as severe as those of the major tranquilizers.

Lithium Carbonate — e.g. Carbolith, Lithane, Lithonate. This drug is used in manic and manic-depressive states to help level the wide mood swings which are part of the condition. This is a potentially dangerous treatment because the therapeutic dose is very close to the amount which would be toxic. Regular blood checks are necessary and side effects may occur throughout the body.

OUR STORY

as told to Barb Ridgway and Jan Fillingham

Our story is the story of the seven-women Feminist Therapy Study/Support Group which undertook this special issue of Healthsharing. It was their wish to dedicate this issue to Karen Crocker who was killed in a car accident in December, 1979. The following is based upon a taped discussion of the group, edited by Barb Ridgway and Jan Fillingham.

We began meeting over three years ago as a group of therapists struggling to integrate our feminist consciousness into our therapy. This process of integration has involved study, discussion, and learning; it has involved opening up to each other and supporting each other.

There are seven of us, ranging in age from 32 to 59. In fact, in this one year we will be celebrating a fortieth, fiftieth, and sixtieth birthday. We come from a variety of backgrounds including teaching, adult education, community organization, social work and private practice. We have worked at family treatment centres, rape crisis centres and birth control clinics, as well as in women's services and psychiatric settings. Although not all seven current members of our group are therapists, we are united by an interest and involvement in feminist therapy. We meet, in each other's homes, for one full day each month.

Together we enjoy the comfort that comes from sharing the positive and negative aspects of our lives, along with the feeling of being accepted by a group of other women. Since most of

us are in private practice as therapists, the group serves as a professional network and links us to the feminist movement. But for all of us, the group has come to play an even more important role in our lives — as a safe, solid place where we can explore what it means to be a woman, a feminist and a feminist therapist.

The impetus for the group came from the Women's Counselling Referral and Education Centre in Toronto who, some five years ago, recognized that many of the therapists on their referral list wanted an opportunity to discuss feminist therapy, a relatively new idea at that time. Our group evolved out of these discussion sessions.

The nature of the group has changed and continues to change basically because different people had different ideas of what they wanted here. Some wanted a pure study group; others were more inclined toward a support group. In order to accommodate both, we combined problem-sharing with learning from external sources. This combination provides us with a much needed balance. The aim is growth in two complementary directions — internal knowledge and external knowledge.

We began our studies of feminist therapy by reading such books as Hogie Wyckoff's *Solving Women's Problems* and by talking about current cases, papers we had heard presented or workshops and conferences various members had attended. We tried to emphasize not just the material itself but our reactions to it, with everybody offering some feedback. On occasion

this led to some pretty volatile arguments; at other times we would agree so strongly with someone's point that we would send up shouts of joy.

While we continue to hold onto this type of study interaction, over time our association has become more intimate. Since the study sessions are conducted informally, it is easy to relax, even be silly at times. In hot weather we might meet around a swimming pool. One day last winter we almost froze to death when the power went out during one of our meetings. Perhaps the most memorable time was the day all the toilets backed up and we found ourselves in a mess that was decidedly not metaphorical!

It was this kind of atmosphere that helped us open up with each other and begin to share our private lives — that's where the support aspect of the group began to grow.

We realized the importance of nourishing ourselves when we are always doing it for others. As therapists, not only did we need help with our work, we needed some place to air what was going on with us. Just in our small group some of the issues we have faced include infertility, sterilization, sexuality, menstruation, affairs, illness, unemployment, job search and our relationships with women, men and children.

Finding a process to deal with these types of problems wasn't easy. By insisting on honesty and confidentiality as well as acceptance, we felt we could maintain a constructive atmosphere. A member should feel free to talk about anything that is bothering her. But

although the acceptance here is unconditional, it is seldom uncritical. Usually someone will bring up a question from her own life and try to discuss her feelings about it. Others respond by describing what they themselves went through in similar circumstances or draw from their experiences with clients. The aim is always to help the individual find a solution that will work for her.

The following is an example of this process in operation. One of our members (who will celebrate her sixtieth birthday soon) was having particular difficulty confronting the fact that she was aging. In discussing the problem with us she came to realize that most of her fears centred around financial instability. As a single woman who had spent most of her life in a low-paying service career, she had never acquired a house and had little money set aside. Her fears made her question whether she had been wrong to invest her time and money in higher education and training that had left her with few tangible rewards.

First we discussed the pros and cons of the choices she had made and we were able to reassure her that her money had not been wasted. Next we strongly advised her to see a financial counsellor to determine if she had a serious problem. Part of her resisted this because she was so afraid of the answer. However, she eventually met with a counsellor who took a realistic look at her income and expenses and helped her draw up a budget that enabled her to set up a retirement fund. With her money problems less pressing, her whole view of aging regained perspective. The feedback from the group meeting had helped her to define her fears and resolve them.

All along the group has been a living organism changing and growing along with the individual members. Among the seven of us we have had a marriage, a divorce, a birth, an abortion, and a death.

This, the death of Karen Crocker, one of our group members, was one of the most devastating experiences for us. Karen's death had a profound effect on everyone, as the loss of a vital force in the group and as a personal loss for each of us. It helped us to talk about the way death is usually treated in our society where there is a ten-

dency to suppress our pain and even to glorify the dead. After talking it out, some of us were able to recognize our own unresolved feelings about death in general. It was a healing process.

Life itself means change. Originally we met together to learn about feminist therapy. Along with this we developed a willingness to trust other women which was equally or even more important to our self-growth. Although we are a small group, our experiences are not unique. We now feel the time has come for us to turn outward collectively and share with others what we have learned. It's another step in our evolution.

At first we were unsure of how we wanted to do this. The idea of writing a book seemed attractive until we took a hard look at the size of that task and decided to scale down our ambitions for now. Then one of the members who had some involvement with *Healthsharing* suggested that we write some articles for the magazine. When we approached *Women Healthsharing* with our ideas, their response was immediate and enthusiastic. Our timing was excellent — their collective had been interested in doing a special issue and our project offered a theme which appealed to them. It was agreed upon and we set to the task with energy and enthusiasm.

Then reality hit — we had no idea of what we were getting into. We were

nearly overwhelmed by the enormity of the work involved. Each of us was so committed to the entire field of feminist therapy that it was difficult to assign specific tasks. We had to choose topics and decide on a format, write our individual sections, conduct interviews, solicit additional articles, then finally coordinate all the material and approve it as a group. Not to mention having to grit our teeth and dig in all over again after running the *Women Healthsharing* editing gauntlet.

The writing itself caused a lot of anxiety, particularly for those of us with little writing experience. The act of putting words on paper meant we had to commit ourselves as to where we stood. These are emotional topics for us and we had to deal with our feelings before we could get down to work.

The results of our work are finally here for you to see. We believe other women will feel as strongly about these matters as we do. We hope we are right. Please let us know your reactions by writing to *Women Healthsharing*, the collective of women who took a chance with us. Thank you *Healthsharing* for the opportunity to share our thoughts and experiences and for pushing us to be more specific and concrete.

Barb Ridgway and Jan Fillingham are freelance writers and students.



top: Pat Henderson, *Women's Program Consultant, City Hall, mother*; Shelley Glazer, *therapist, political activist*; Joy Murphy, *therapist, Bioenergetic analyst*; Phyllis Baldwin, *therapist, adult educator*; bottom: Audrey Wright, *therapist, group-work consultant*; Bev Rodrigue, *therapist, mother of three teenagers*; Judith Weisman, *Neuro-Linguistic Programming therapist, mother*.

SEEKING HELP

by The Feminist Therapy Support Group • graphic by Christina Farmilo

Seeking help is hardest when we need it most. We rarely deal with one problem at a time. When things pile up, we get overwhelmed and it looks like everyone else is coping except us. Women's goal of independence encourages a tendency to go it alone. Stereotyped as too emotional, reaching out becomes an admission of weakness. The psychiatric model of mental illness imbues us with a fear of being "sick". Furthermore, our training as nurturers frequently means we find it easier to give support than to ask for and take help.

Everyone needs support, however, not just in times of crisis but to face everyday problems that we all share. Emotional isolation intensifies and distorts problems and coping eventually breaks down. Small disruptions (like losing a house key or running out of gas for the car) can trigger an avalanche of emotional turmoil.

Rather than a sign of weakness, reaching out and asking for help takes courage. But, whether we open up to a friend, family member or professional, we risk being misunderstood, invalidated or not being heard. Along with courage, getting help requires some careful consideration of our own resources and needs, as well as a methodical assessment of what is available to us. In this article we outline some guidelines to help women sort through the maze of therapeutic possibilities. We begin with four steps which can assist in the process of seeking help.

Four Steps

Identify internally that something is happening and needs attention now. This sounds simple but it's not. We learn to disregard our intuitions and the signs that indicate that something is not right. Instead, if we identify our needs more specifically we are less likely to talk ourselves out of having problems. Taking time to sort out what is really going on is not a selfish act. Prolonged unhappiness is not a normal state.

Identify unmet needs and establish priorities. If we have been denying our own needs for some time, this acknowledgement process may be long and painful. We may also become aware of a number of problems that did not exist before.

Accept these needs as legitimate, worth exploring and getting support for. Before we can accept our needs as legitimate we must value ourselves and respect our own struggle to find meaning in our lives. Acceptance of our emotional, physical and spiritual needs is essential when learning to address life's difficulties as they arise. To neglect any aspect of our personalities is to deny some part of ourselves.

Seek out available and appropriate information and services. During this process we must pay attention to our attitudes, biases and feelings. For example, negative feelings towards an alternative such as therapy or a self-help group may or may not be well-founded. By actively pursuing the support or service we require, the opportunity for a number of problems to sneak up on us and snowball into a

crisis situation is greatly diminished.

There is no particular order to this four-step process. One woman may need support to identify her needs. Another may know of services available but struggles to view her needs as legitimate. Each woman's needs and capabilities are unique and will differ at various stages and circumstances.

Choosing the right person to help

Choosing the right person to talk to is a crucial part of the process of seeking help. We've identified three sources which can provide different kinds of support, depending upon our needs: friends, family and co-workers; self-help groups; and therapists.

Friends, family members and co-workers can often provide all the help we need. Sometimes just talking to those who know us best can relieve stress and help clarify our thoughts and feelings. On the other hand they may be part of the problem we want to resolve and therefore would be unable to offer us support to act. Or, their own lives may be too full for them to have time and energy to listen and offer help. We can diminish the risk of being hurt or rejected if we think carefully about whom we can and cannot talk to. We have to learn to ask directly for the support and encouragement that we need.

Women only self-help groups or problem-solving groups can provide the much needed breathing space where women can let go of inhibitions, open up, take risks and test our new ways of dealing with life situations. Encouragement and support to give up

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old and self-defeating behaviour patterns can be found. This is accomplished through mutual sharing of experiences, practical information, emotional support, understanding and hope. By actively participating and contributing to the group and its process, women begin to experience their own power and capabilities. Women also discover that they are not alone with their concerns nor are their feelings unusual or unique.

Self-help groups are usually informal, non-threatening and leaderless. However, a skilled facilitator or experienced group member is sometimes required for the first few meetings to help the groups define its own needs or goals.

Self-help groups are not therapy groups but they can have great therapeutic value. They are not meant to replace therapy, especially when a woman desires a more structured, intense one-to-one experience with a therapist, nor are they particularly good if a woman is in severe crisis.

Therapists offer yet another kind of support. We need not wait until we are in the middle of a "nervous breakdown" before deciding to see a therapist. A therapist may be our first choice over friends and family or a self-help group. Choosing the right therapist, however, can be a difficult and time-consuming process. It involves planning, research and decision-making as a consumer. (We wouldn't dream of buying a house without checking the inside, shopping around or assessing the market). Our goal in therapy is to discover who we really are. The therapist's role is to accompany us on this journey.

Finding Groups and Therapists

Now that you have an idea of the type of person you might turn to, how do you go about finding that person if she or he is not already an acquaintance? Often you'll be able to obtain assistance from people you know. For instance, the information of friends who have been in therapy or a self-help group could save you time and leg work. Your family physician or clergy will often have a number of therapists to whom s/he refers. Chiropractors, massage therapists and instructors of yoga, meditation or self-defense often have contact with colleagues who share their interest in health and well being.

Women's centres and services nearly always make referrals, provide general information about counselling or have counsellors or therapists on staff. Often nurses working in clinics or as public health nurses are part of a network of women's services and groups and would therefore be able to put you in touch with self-help groups or therapists.

Distress centres and crisis telephone hot lines keep up-to-date lists of organizations and services involved in therapy. Mental health centres may provide either individual or group therapy, and generally speaking have social workers, psychologists and psychiatrists on staff.

Finding a group suited to specific needs is not always easy. Often social service agencies or community information services keep track of specialized groups. As well, a participant or leader of one special needs group, such as Parents Without Partners or Alcoholics Anonymous, can act as a resource for other existing groups.

Choosing a Therapist

If you decide to consult a therapist, we suggest the following guidelines. Start by writing down your questions and concerns before your first visit with a therapist. Basically, you will be looking for someone you feel good about. If it is possible, make appointments with two or three therapists (some do not charge for the first visit) so that comparisons can be made. The feasibility of "shopping around" will depend on your economic situation, your energy level and the extent of your community resources. Feel free to ask questions over the telephone.

Training and Experience. Ask about her training and background. A therapist who has been through her own therapy has more to offer her clients than technique and theory.

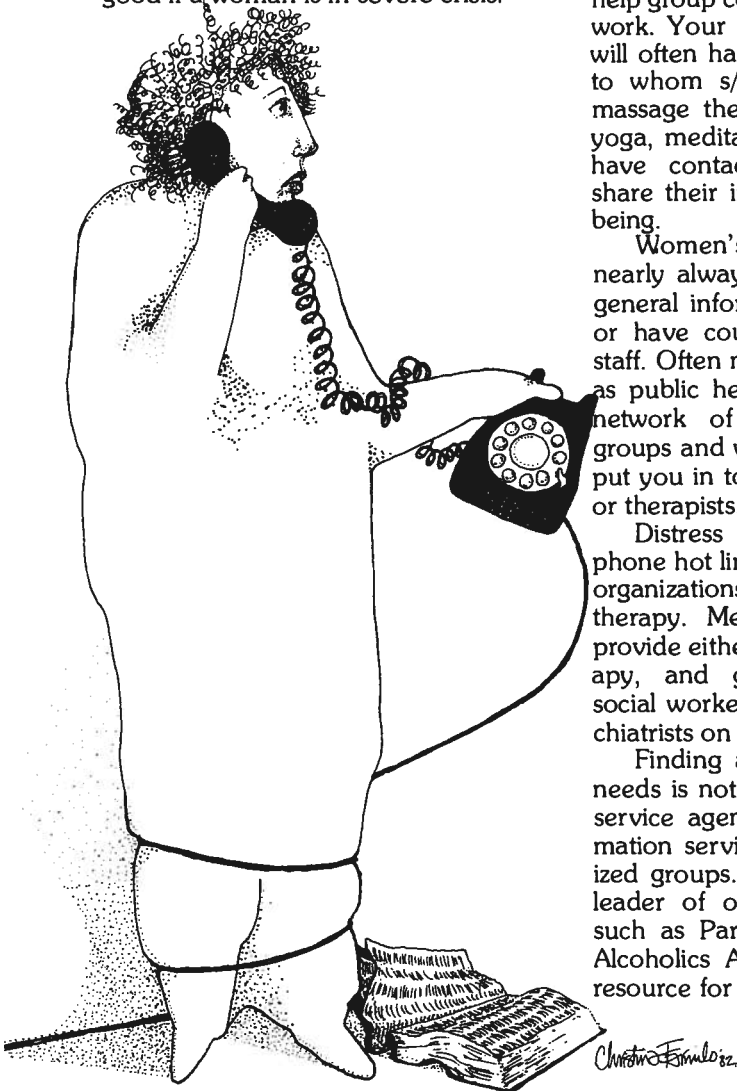
Therapy Session. Having the therapist describe a session, plus a brief explanation of her therapy method is useful. More in-depth information can be obtained by reading about that particular therapy afterwards.

Record Keeping. Asking the therapist if she takes notes or uses a tape recorder is not an outrageous question. You have a right to know why this information is documented, where it is kept and who has access to it.

Medication. Therapists who do not have a medical degree cannot prescribe drugs. They can however suggest them. Consider carefully such a suggestion. Tranquilizers and anti-depressants can be a step backwards in your growth and development. Most women do not need such a drastic approach to their problems.

Relating to You. How willing is this person to answer questions? Is she open and receptive? Does she listen? Does she diagnose without your input? Pay attention to your confused and negative feelings as well as your good feelings about the therapist.

Fees. Some therapists operate on a sliding scale. Others have a fixed fee. Some therapists in private practice are covered by health insurance. The requirement is usually that the therapist be a registered psychologist before she is covered by that health plan. Therapists who are connected to hospitals and social services are fully covered. A therapist whose fees are not covered by health insurance usually charges somewhere between twenty-five and forty-five dollars an hour.



Session Frequency. Most sessions are between fifty and sixty minutes. Longer sessions can be arranged. A therapist may suggest one session per week to start while another may recommend two. It depends on the kind of therapy you want and how desperate you feel.

Perspective on Women's Issues. For some women this will be a priority; for others it will not. Decide if the therapist's politics are important to you. You may want to ask yourself if seeing a woman or a man is an issue as well.

If after a few sessions you realize you are seeing the wrong person, look around for someone else. Changing

therapists is okay. You may want to continue with a therapist until you find another. This is also true for a group that you may join.

As women, we must learn to trust our intuitions and value our intellects. Both are resources we need to rely on to make decisions. The first is our perceptive/feeling part; the second is our logical/thinking part. Making sound decisions is based on exercising both. By doing this, we begin to understand that we can actively participate in the shaping of our lives. We can then experience the satisfaction of our own growth, wisdom, courage and self-knowledge.

BEGINNING THE PROCESS

Looking back, I think I first decided that I needed some professional help when two of my closest friends gently accused me of never confiding in them. They had just finished using me as a sounding board; one at breakfast, the other at lunch.

I always assured anyone who asked that I never had anything that bothered me. No deep dark secrets or strange mysteries requiring any more than a moment of reflection. Well, maybe just one or two or . . . Things had been piling up lately I had to admit (though only to myself of course). My father had recently undergone open heart surgery; I had just changed jobs; I was in the midst of ending a long term relationship of ten years; my best friend had just been operated on for cancer.

In a certain way it seemed strange to me to be considering going to a therapist at this time. I was feeling stronger than ever right now, maybe even strong enough to go.

One of my friends was seeing a therapist at the time. Easy contact for a name and number. A starting place.

I phoned for an appointment, bravely dialing the entire number on my second try. Oh no, she had an answering machine! After three trial runs I had completely memorized her message and realized that this was no way to begin. Only a certified basket case couldn't talk to a tape recorder.

I called a fourth time and hesitantly left my name and number. She'd probably think I want help to overcome my terrible stutter. I was hardly home for the next four days. I hoped that she wouldn't think that I was a suicide case and that she hadn't reached me in time. Here I was worrying about her and we hadn't even met yet.

Finally we connected and arranged to meet. She sounded very nervous or shy on the phone . . . or was that an echo of me?

Now that contact had been made I felt cleansed and realized that I didn't need counselling. But the appointment to see the therapist was written in my date book so I knew I was committed.

I already knew what the waiting room would be like. I had a clear image on it in my mind. It would be furnished in early Freud with pictures of pastoral scenes hung on the walls. Soft muzak would play in the background. All designed to sooth and relax. The magazine selection would include *Psychology Today*, *The Bioenergetic Monthly*, and *Everything You Wanted to Know About Therapy But Were Afraid to Ask Your Therapist*.

Beyond her clinical white coat and note pad, I didn't let myself imagine what SHE looked like. On the big day I arrived early and cased the outside of the place. Things looked normal enough. I climbed up a long flight of stairs and walked cautiously down the hall looking for the right room. Instead of muzak I heard a whirring sound through the door. Inside there were two women at work: one vacuuming and the other on her hands and knees leafing through some files. I stood quietly looking around for a moment trying to blend into the empty waiting room chairs. There were a few posters on the walls, a sign out sheet by a bookshelf, a place to make your own tea or coffee, some magazines The woman who had been filing smiled as she stood up and introduced herself. We went into an inner room together.

Written by Marsha Pine, a special education teacher in Toronto.

OFFERING HELP

Thank you, kind fate for giving me friends who, when they say, "What can I do to help?" mean it.

The first thing is, don't ever ask, "What can I do to help?" without being prepared to do it, whatever it might be.

Sometimes it is just as useful to help the helpers. In any emergency people call each other up to fret and wonder what they can do. They don't seem to realize they can coordinate maximum efficiency. For example, if C baby-sits for B's children, then B can go to the hospital with A.

If the person in trouble is a good friend (the sort of friend, for example, who says, "No, no, I don't need help," and you know she does), then rush right over. Clean the house, walk the dog, water the plants, go to the grocery store, change the beds, drive the bill collectors away from the door. Keep daily life intact. Vacuuming someone's house can be the grand gesture that will keep them from feeling that chaos is closing in.

Answer the telephone for the people in trouble. Keep messages, coordinate information, help turn aside the ghouls and parcel out the problems to be solved. Find the family's personal telephone book, and make sure everyone knows where it is.

Don't call up and vaguely mention a doctor or hot line or funeral home you've heard about. Do all the research first: cost, qualifications, hours, theories. The local crisis hot line will give you information to pass on to the person in trouble.

If you take on a responsibility, find your own reliable replacement. Don't disappear after the immediate crisis.

The people I cherish most are the ones who take on the job of soothing the relatives or friends who have every right to be in the house, but cause trouble. A person who will take the dominating mother for a drive, listen to the meddlesome aunt describe the last four family funerals, or tactfully remove the crazy brother-in-law is a person who will be rewarded in eternity.

Do not, ever, explain how the crisis could have been avoided. Any sentence beginning "If only" should never be finished.

Do not expect to be thanked.

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FEMINIST THERAPY

by The Feminist Therapy Support Group • graphics by Pat Foote-Jones

PART I — THE ROOTS OF FEMINIST THERAPY

1963

A watershed year. American involvement in Viet Nam is rapidly increasing in scale. The first international wave of teach-ins demanding free speech and questioning U.S. involvement in Viet Nam has begun.

1963. U.S. Blacks are demonstrating against continued segregation and discrimination in the South and are about to explode in frustration and rage in the North. Whites, among them many Canadians inspired by the fight, have joined the civil rights movement.

1963. North America has just passed through its second period in this century of severe repression of progressive political views. Consumerism, with its attendant advertising and public relations, has become a fact of life, dominating the consciousness of masses of people.

1963. It is over forty years since the first wave of feminism expended itself in attaining the vote. Fifty percent of all women in the United States are in the workforce. Despite that, the prevailing ideology continues to insist that women's place is subservient, in the home, caring for her husband, children, house and garden.

It was against this backdrop that Betty Friedan's book, *The Feminine Mystique*, was first published in 1963. Suddenly, a woman was stating publicly what most of us knew in our guts and some of us knew in our heads as well. We women were the victims of mass hypnosis, the victims of a huge hoax.

Women all over North America were silently suffering the effects of having been tied to our homes, our children and our husbands. If we were in the workforce, we were forced to carry a double workload, going to one job every morning only to return home to another in the evening caring for the needs of our families. In addition, we were made to feel guilty and inadequate; we were made to feel we were bad mothers, and lived with the fear that somehow we were robbing our husbands of their manhood.

If we were not in the paid workforce, we were made to feel inferior, incompetent and childlike.

The imperative to accept this state of affairs was so great that if women in any way resisted, consciously or otherwise, they were labelled unnatural, neurotic, abnormal, even pathological. Many were institutionalized in mental hospitals, some to be lobotomized if they persisted in their recalcitrant ways.

Looking back on the 50's and 60's, it can be said without much exaggeration that North American women were suffering from a form of mass psychosis, manipulated and brain-washed by experts, the educational system and the mass media. On the one hand, they were constantly being told they were the most modern, the most beautiful, the most privileged and the most free of all the women in the world. On the other hand, they were faced with the fact that they were free only to consume more and more products, to be sexual objects and to be

paid low wages for menial jobs. All over North America, women lay on the couches of male psychiatrists, only to be told that they suffered from "penis envy", a "masculinity complex" or at the very least to be told that they were rejecting or overprotective mothers.

PSYCHOANALYSIS,

developed by Freud at the end of the 19th century, was the cornerstone upon which many of the 20th century theories regarding "femininity" were based. Freud had brilliantly analyzed the personality structure of human beings in the context of 19th century capitalist social structure; out of his work came a methodology for understanding how the individual, through the unconscious, incorporates the prevailing ideology into her character structure. A rebel in his own time, he insisted on the basic sexuality of all human beings, male and female.

However, Freud did not have an historical understanding of human beings or society. As a result, he failed to see how the intra-psychic life of the individual corresponds to the social conditions into which she is born. Therefore, Freud projected the characteristics he saw in women and men of his particular epoch onto humans for all time. In this perspective, differences in basic character structure between men and women are seen as innate, and the social inequalities which accompany these differences, natural and inevitable.

WOMEN AND THERAPY

Freud's writings on women, though limited in number, had a profound affect on the development of theories of "femininity". By insisting on the equation of the feminine with passivity, by insisting that women were failed men and therefore inferior to men, Freud helped to provide the intellectual basis for the continuing devaluation of women. For Freud, penis envy was the organizing principle of femininity; the clitoris was an inferior penis to be discarded with the attainment of true womanhood (and the "vaginal orgasm"). He even addressed feminists in his writings, admonishing them for their refusal to accept their destinies, for resisting their very nature as women.

Feminists of the period were too busy trying to avoid the connection in the public mind between feminism and sexual libertinism to take up the radical aspects of Freud's theories. This role was left to Russian socialists after the Bolshevik revolution and Wilhelm Reich, a student of Freud's. It was Reich who developed a powerful technique of working with the body to release the sexual and creative energies blocked by the early years of socialization. For a period of time, Reich was active in the German Communist Party, organizing centres where workers could do therapy to break through the internalized strictures which prevented them from taking effective political action. Unfortunately, both these developments, one in Russia, the other in Germany, occurring at roughly the same time, failed to continue past the 30's.

In North America, psychoanalysis was robbed of its inherent radical nature. The emerging advertising industry of the 1920's used Freud's insights into the unconscious to initiate people, particularly women, into the era of mass consumption. The family was the basic unit of consumption, at the centre of which was the woman. Mass consumption required that women identify themselves first and foremost as housewives, mothers, homemakers, no matter what their role in the workforce.

The field of psychoanalysis itself took Freudian theory and squeezed the radicalism out of it. The neo-Freudians of the 40's and 50's were more concerned with establishing the impor-

tance of the ego in the development of the individual than in challenging Freud's notions about women. In their elaboration of theories of ego development, American psychoanalytic theorists left intact Freud's "biology is destiny" declaration, and in so doing further entrenched a sexist theory of women. It was the work which supported Freud's contentions about women which was promoted and even extolled, eventually entering the public consciousness through the educational system, the mass media and the advertising industry.

However, the very contradictions which produced the social and political protest of the 60's and 70's promoted a revolt of sorts in the field of psychotherapy. Theories which emphasized the emotive qualities of human beings and the need to grow and become more expressive were taken up in this period. The result was gestalt, primal therapy, transactional

analysis, bio-energetics, rolfing and many other methods of understanding and treating human pain. Many of these methods and theories were based on Reich's work, as well as the less known work of Freud.

Most of the proponents of these new theories rejected, at least in some measure, the model of therapy practiced until that time. They discarded the overt trappings of power, such as non-disclosure of the therapist's personal experience, separation of client and therapist by a couch or desk, the taboo against physical contact and the use of labelling jargon. These aspects of therapy were replaced by a friendly, warm and often literally embracing atmosphere. However, the proponents of these new therapy forms did not address the fact that the source of the alienation experienced by their clients was not to be found in the individual but in the nature of social organization.



They, like orthodox Freudians, denied the political nature of their work.

FEMINISM

as a political movement for social change re-emerged at this time as a result of the sharpening of the contradictions inherent in the position of women during the previous forty years. Many of the women who were the first to organize had been active in the movements of social protest and change of the 60's.

In these organizations women began to realize that we, like our sisters of a century ago, were struggling for the rights of others while we ourselves remained second class at both a political and social level. We began to realize that our essential marginality in these organizations for change was not accidental. Even in these movements we remained the victims of a sexism which was endemic to our society. We seemed to remain destined to service the needs of our male co-workers, to put aside our own needs for autonomy and self-expression and do the shit work which allowed the men to do the "important" work.

At this point, many women left these organizations to participate in establishing autonomous organizations which could and would directly address the issues of women's oppression and their struggle for liberation. Many discovered that the oppression they had experienced all their lives could not be overcome by simple political action. They needed to consciously address the nitty gritty elements of that oppression and how it had affected and limited them as individuals.

They formed consciousness-raising groups, the basic premise of which was the maxim that "the personal is politi-

cal". Consciousness-raising groups allowed women to express their anger, pain and frustration to one another without being put down as being irrelevant or hysterical because they were expressing feelings rather than ideas. They also encouraged women to talk about their personal lives and their feelings in a way which clarified the common experience of all women.

These groups were effective in giving women both emotional and political support; but despite this effectiveness, they could not deal with the long-term effects of social inequality based on sex, racial background and class. Many women discovered that consciousness-raising was only the beginning of an attempt to free themselves at a personal level. More and more turned to therapy for some solution.

Here they discovered that in many ways, despite the influence of the humanistic theories, therapy remained a tool for the social control of women. It still tried to fit women into the mold society had determined for them. As late as the 1970's, studies were done which showed that therapists, both male and female, overwhelmingly equated masculine traits with mature adulthood and feminine traits with pathology. The "real woman" was dependent, passive, nurturing, non-competitive, non-analytical, etc., etc. This was the same old view that the mass media had been feeding to the public since the 1920's.

What feminists entering therapy also saw was that a much higher percentage of women than men were in psychotherapy, that most of the therapists were men, and that the majority of training institutions were sexist to the core in their teaching of female psychology.

Feminist criticism of therapy mounted. The effect was to force many women who were training to be therapists and women therapists in the field to examine seriously their training and the work they were doing. Some began to incorporate a feminist analysis into their training and work. These therapists recognized that therapy was not in and of itself necessarily a tool for social control, but that it could also be used to confront and mitigate some of the worst effects of the internalization of social oppression which all of us experience in growing up in this society. These women call themselves feminist therapists.

THERAPY

of necessity, is an individualized process, not a collective one. And while it is true that therapy is a very political process, it cannot bring about social change. It is also clear, however, that movements for social change can be used by individuals to avoid looking at their own personal behaviour and thus can have the effect of reinforcing the distorted need for power nurtured in a society where many types of social inequality are institutionalized. The therapeutic process can provide an opportunity to deal with some of the more debilitating effects of the powerlessness and alienation experienced by women. Instead of being used against women, it can be used on our behalf to assist in the very necessary struggle each of us must carry on to transform our own consciousness and ourselves. Therapy cannot bring about social change, but it can raise the consciousness of individuals as to the social basis of their personal problems and in so doing free them to become politically involved.

PART II — THE PRACTICE OF FEMINIST THERAPY

What is feminist therapy? How is it different from traditional therapy? How does a feminist therapist function? Feminist therapy utilizes the analysis and principles of feminism in working with clients in a therapy relationship. Feminism recognizes the historical and present-day oppression of women as a group in a society in which men have the power. Feminist therapy helps

women to realize the ways in which they have internalized their oppression and to help them act upon the conditions which create their oppression.

Women have grown up with certain beliefs and attitudes about our roles and our possibilities which we learn from the people and institutions around us. These internalized messages may cause us to restrict our own

growth and potential and often lead to feelings of depression and powerlessness. Feminist therapy involves exploring this process with women, looking at how it affects each woman's life, and validating and accepting the anger which most women express after learning how society not only oppresses us but also teaches us to oppress ourselves.

WOMEN AND THERAPY

Feminist therapy has also developed out of the recent human potential movement and has many features in common with a humanist approach to therapy. These include offering clients warmth, support and nurturance in the therapeutic relationship as well as encouraging each woman to develop her own unique potential.

Traditional therapy can be any particular type of therapy although it often refers to Freudian or analytical therapy which is considered the most traditional. The basic differences between traditional and feminist therapy is in the therapist. According to Susan Sturdivant in her book *Therapy With Women: A Feminist Philosophy of Treatment*, traditional therapists are those "whose conceptualization of their patients' difficulties and their own therapeutic goals or clinical techniques has not been significantly altered or influenced by the past two decades of feminism".

Why do people go to therapy? What do they want from a therapist? Why would someone choose a feminist therapist? People seek help when they are in crisis or distress, when they feel out of control or when they recognize certain patterns in their lives they want to change. They feel that they can't cope on their own or make the kind of changes they want in their lives without some outside help. Individuals seeking our help as feminist therapists complain of feeling isolated or not belonging at home, on the job, and in many of their social environments. This social distancing breaks down a person's capacity to feel and be in touch with their senses and bodies, creating a sense of impotency which usually leads to self-blame or scapegoating of others.

The women we see as clients are not necessarily feminists — in fact, most would probably not define themselves as feminists when starting therapy. Should this be a goal of feminist therapy? In her paper "What Happens in Feminist Therapy?", Hannah Lerman provides a cogent answer to this question: "The goal is to help them become the best person they can be, within the limits of their personal circumstances and the patterns of society in general. If that means they need to become active feminists, fine; if not, fine, too."



Feminist therapists encourage and support people in questioning social and political structures and systems rather than accepting and adapting to them. We see changing these structures and systems as a positive solution and action in feminist therapy. Along with our clients we question traditional definitions of the family and sex roles. Feminist therapy also involves helping people to find a healthy lifestyle that fits for them and to look at different kinds of alternative lifestyles. We struggle with our clients to help them define who they are rather than accept society's definition of who they should be and what values they should have.

These are some of the qualities which feminist therapists have in common. However, the scope of feminist therapy is quite broad and therefore encompasses a variety of styles, approaches and skills. Not all feminist therapists operate in exactly the same way. The diversity within

feminist therapy is a reflection of the diversity found within the women's movement itself. The next section discusses some major aspects of feminist therapy and represents a model which we, as feminist therapists, try to live up to as much as possible.

POWER

is an element of every relationship: parent-child, teacher-student, male-female, therapist-client. One person in a relationship feels less powerful than the other. In traditional therapy, the model of health is the woman who is mystified by her oppression into thinking her problems are purely personal. The model for the therapeutic relationship is a patriarchal one in which the therapist has the power in much the same way as a father has power over his children in the traditional nuclear family. The traditional therapist learns

to cut off all feeling in himself and to manage or patronize feelings in the patient. Feminist therapy provides a model in which the therapist and client are seen as equals in struggle, insofar as this is possible in a capitalist society. We, as feminist therapists, try to reduce the personal power differential between therapist and client. Discovering ways to minimize and eventually eliminate the power differential is seen as part of the process.

Many of the practices of feminist therapy have been developed for this purpose: using first names, seeing clients in an informal setting and using sliding scale fees or bartering. We also try to equalize power in the therapy relationship by sharing our own personal experiences with clients, including those involving our own therapy. Personal disclosure on the part of the therapist helps to illustrate one of the major principles of feminist therapy to the client: personal experience is important and valid information to use in the struggle to grow and change.

In traditional therapy, all of these ways of equalizing the power differential would be seen as unprofessional or identifying with the patient. Maintaining a professional distance is the rule. Offer patients a coffee but don't sit too close to them. Give them a bus ticket but don't let them call you by your first name. Do a home visit and even stay for dinner but never answer any questions about your personal life. Accept a Christmas gift graciously but then joke afterwards with your colleagues about how the patient is treating you like the parent she is still trying to please.

In feminist therapy, we listen to the client's statements and accept her feelings in a non-judgemental way. Helping a client who lacks confidence to know and trust and validate her own intuition and experiences can often lead to her feeling more self-esteem and to take more risks in her life.

EVERY therapist offers a political view of the world to her clients. Her choice of words, her choice of what to focus on in therapy, what to stress, what to ignore: these are all examples of political acts. A feminist therapist makes her politics a self-conscious aspect of the

therapy she practices.

An important part of feminist therapy is consciousness-raising, using one of the basic principles of feminism — the personal is political. This means helping a woman relate the particular situation she finds herself in to the experiences of other women and to the position of women generally in our society. We try to help her see that women's individual problems have social as well as personal causes.

For example, a client may talk about feeling unable to cope with the pressures in her life and may feel that she is somehow inadequate and should be able to cope as she perceives other women are. When the therapist explores the woman's situation she may find that the client has a full time job outside her home, is responsible for house and child care when at home and her husband is complaining she's always too tired for sex at night. The client may need to see that her high expectations of herself are based on a view of women and their role which is oppressive but still held by most of our society. Other issues which directly add to the pressures she is feeling might be the lack of adequate daycare, guilt about being away from her children all day, lack of job opportunities, her husband's refusal to take any responsibility for house or child care, etc. All of these are political issues as well as personal ones, i.e. they relate not only to the client's individual life but to all women's lives in our society.

Connecting politics with therapy also means coming up with solutions and alternatives which might include political action among other possibilities. For example, a client involved in a difficult work situation might find that one solution is to become involved with her union. Or an incest survivor might become involved in a group which is developing a support group for incest victims.

In traditional therapy, the personal stays personal — the problems are considered to be either within the woman's psyche or within her family relationships. The therapeutic model presented to clients by a traditional therapist offers only individual solutions. What feminist therapy does is open up choices for women. Political

action or involvement is seen as a viable option but is not the solution for everyone.

SITUATIONS

women often find themselves in usually require more than therapy. A battered wife, for example, might also need medical attention, a temporary residence, child-care, legal advice, and vocational counselling. Women with physical problems might need a family doctor, fitness classes, a nutritional counsellor or a massage therapist. Some women might decide to become involved in some kind of political action and want to join a union, a political party or organization, or a feminist group.

Feminist therapists approach issues such as incest, rape and wife battering from a feminist perspective. This means seeing these kinds of assaults as a part of the violence against women which reinforces the power men have over women in our society. We make referrals to rape crisis centres, transition houses, support groups and other alternative feminist services for those clients who need them.

Some traditional therapists are unhelpful or even damaging to women who have been victims of violence. They may accept the myths that most people in our society do about such women. One incest survivor went to see a psychiatrist and slowly, painfully told her story for the first time. His first question when she finished was "What were you wearing at the time?" Another psychiatrist asked a rape victim if she had enjoyed the rape and did she have an orgasm.

Feminist therapy includes a holistic approach to people, recognizing that emotional stress can also have physical and spiritual effects. Stress can change our eating and sleeping patterns, cause hormone imbalances which could affect menstruation, or decrease sexual desire, among other things. Feminist therapists offer clients resources that take into account all aspects of a person's life. It might mean referring a client to a nutritional counsellor, a birth control clinic, a family doctor, a massage therapist, a yoga centre, or even another feminist therapist with different skills. We make available to our clients

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information on political and social organizations and events, support groups, workshops and self-help groups. This serves to connect clients with the feminist network and to offer political action as a solution for some women.

GROUPS

of women are now using the theories and practices of feminist therapy to explore their relationships and interactions with others or to get the support they need to make changes in their lives. Being in a feminist therapy group can be a very powerful learning experience for a woman. She may find that she no longer feels so alone, and isolated and guilty after joining a therapy group. The group experience and personal sharing cuts through the competition, mistrust and hatred which often occur between women in our society.

Consciousness-raising and some self-help and support groups are related to feminist therapy groups. Consciousness-raising or CR groups were developed in the 1960's during the initial stages of the current women's movement. They provided women with their first opportunity to explore personal experiences and feelings with other women and to discover their commonality. It was from this discovery that the "personal is political" insight was developed. Women began to develop a political feminist analysis from the sharing of experiences. Sometimes this also led to political action — demonstrations, organizing, the development of women's services and



often major personal changes. (For more on self-help groups, see *Seeking Help* in this issue.)

Some people might find it useful to belong to one such group instead of being in therapy. However there are

people who feel they need more and would choose to see a therapist either individually or in a group. Others might choose to see a therapist as well as belong to one or several support groups.

PART III — THE FEMINIST THERAPIST AT WORK

PRACTICING

feminist therapy in a society devoted to the preservation and accumulation of profit rather than the care of human needs is a challenge. As a feminist she knows that without societal change many of the problems her clients bring to her cannot be solved. She is also aware of the difficulty in creating and maintaining equal relationships in an environment where inequality is fos-

tered by class, age, sex and race prejudice.

A feminist therapist who chooses to practice in a traditional social work, mental health or hospital setting may be viewed as a traditional therapist by her employer, colleagues and clients. Since these settings are part of the community at large, employees are expected to support and maintain the cultural norms of the community. She

might find herself in a setting which opposes a woman's right to abortion on demand or would disagree with a lesbian mother's right to custody of her children or leaving her husband and children to be with her lesbian lover.

Regardless of how rooted she may be in a feminist analysis of the problems of the people she sees, there will be pressure to communicate her assessment and treatment plan to her

supervisor and professional colleagues in the accepted professional jargon of the agency, hospital or institution. She may find her descriptions of clients' behaviour translated in case conferences into professional jargon. She might hear her clients labelled as "controlling mother", "passive father", "seductive child".

The hierarchical structure of institutions rooted in the medical model creates social distance between professional groups and in turn between the professional and the client. A feminist therapist working in this environment will find it difficult to develop the rapport necessary to achieve a sense of equality in the therapy relationship. In view of the difficulties feminist therapists have encountered trying to practice in traditional settings, many have opted out of doing psychotherapy and joined the staff of one of the many women's services as a counsellor. While V.D. and birth control clinics, rape crisis centres, women's educational and employment services, hostels for battered women and their children, or feminist holistic health collectives do not offer therapy, the feminist therapist is likely to perceive the help offered for problems presented as more therapeutic than that available for the same problems in traditional settings.

The greatest drain on the energy of a feminist therapist who becomes a staff person with a woman's service agency is fighting for the survival of the service. Unfortunately they are frequently closed because they are seen as duplicating the services of a traditional agency, hospital or institution. However, clients presenting the same problem to these settings receive drastically different treatment.

ANOTHER

option for a feminist therapist who wants to practice psychotherapy is private practice. Here the primary drain on the therapist's energy will come from battling with inner demons which challenge her political stance as a feminist. When defining how a feminist therapist functions we mentioned that not all feminist therapists have exactly the same political analysis of women's oppression. Some of the

issues around which feminist therapists differ politically are: i) fee for service; ii) exchange of services with clients; iii) treating male clients; and iv) membership in a professional association.

The struggle for the feminist therapist around fee setting and collection is that, no matter what you do, you can only afford to see a limited number of women at a reduced fee or on an exchange of services basis. You and your bills have to be paid. A feminist therapist is not just sharing good vibes with her clients, but is sharing skills which she acquires through ongoing, intensive and expensive training. Also psychotherapy is very draining, and cannot be practiced forty hours a week. No one will become wealthy as a feminist therapist in private practice. Unfortunately the exchange of fees for services does mean that the majority of our clients are women who can afford to pay us.

The feminist view of money is that it is equated with power, that payment of a fee by one person to another in return for her skill as a helper creates a fundamental inequality in the relationship. However, this disparity in the private practice therapeutic relationship needs to be balanced out with the power a client gives up when they receive help from a government operated service. In the latter situation the client is assigned a therapist and cannot choose the mode of therapy she feels would best meet her needs. Also because of the policy of supervision in medical settings, she will usually have to agree to having information, shared with her therapist, shared with someone she has never met. The feminist therapist in private practice who wants to work with low income women, works on a contract basis in a traditional setting or with one of the women's services.

WHILE

the majority of our clients will always be female, most of us will be approached at some time in our practice by males wishing our help. Some feminist therapists have decided not to see male clients because they do not want to put their energy into nurturing males. Others of us have decided to do therapy with males who are in relationships with our female clients and want to work out an egalitarian relationship.

Some of us will only see these males in couple therapy, as a support to our female clients; others of us work with males individually and in groups focusing on raising their consciousness regarding the destructiveness of sexism on men and women. Those of us who choose to work with males do it feeling it is one way to have some impact for change on the larger patriarchal society. We find when we do it we have to be on our toes in confronting sexism whenever it arises in the context of the therapeutic relationship. Males who turn to us for help want to change, otherwise they would seek out a traditional male therapist to support them in further development of the male macho lifestyle.

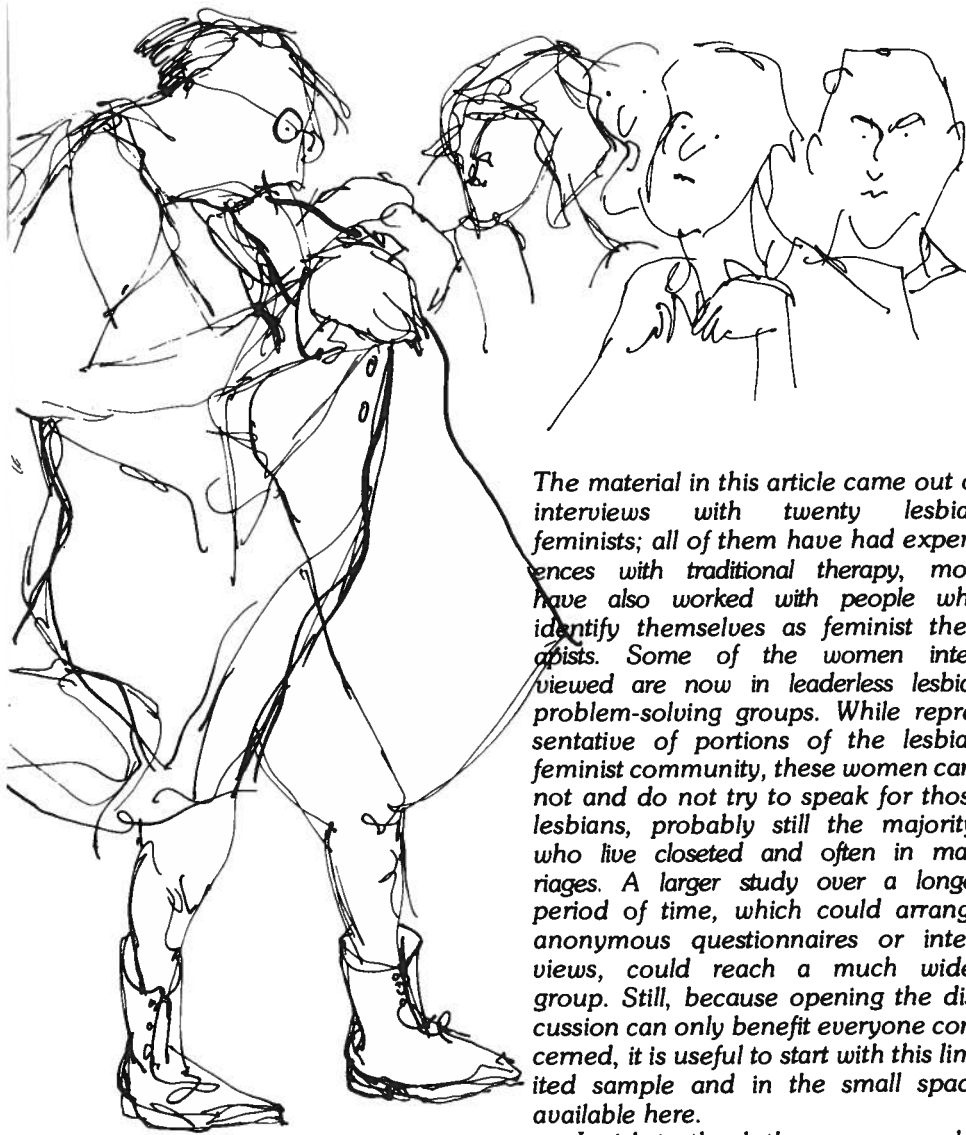
Depending on our feelings about professionalism we opt for or against membership in a professional association. Those of us who are members know that professional associations are designed to care for the interests of their members, not clients, and that incompetent and unskilled therapists do receive their protection. If licensing of psychotherapists is instituted, membership in professional associations will become mandatory, but will not necessarily guarantee better service to clients.

Professional associations do not provide the type of support some feminist therapists receive as members of support and study groups. These groups are experienced by the members as essential to survival in a milieu whose values are at odds with feminism.

If we could create an ideal society it would provide everyone with the warm nurturing support we give each other in these groups, coupled with honest confrontation which helps us mature into the people we want to be. In our groups we at times dream of participating in a community where everyone supportively works together to achieve common goals in a mutually satisfying way. An environment in which women and men together can safely risk being vulnerable and strong; where everyone is valued equally regardless of sex, race, age, class or position. Such a community would not need feminist therapists; we see ourselves in that community having time to fulfill the many creative fantasies we do not have time to pursue while practising therapy.

LESBIANS IN THERAPY

by Frances Rooney • graphics by Dawna Gallagher



The material in this article came out of interviews with twenty lesbian feminists; all of them have had experiences with traditional therapy, most have also worked with people who identify themselves as feminist therapists. Some of the women interviewed are now in leaderless lesbian problem-solving groups. While representative of portions of the lesbian feminist community, these women cannot and do not try to speak for those lesbians, probably still the majority, who live closeted and often in marriages. A larger study over a longer period of time, which could arrange anonymous questionnaires or interviews, could reach a much wider group. Still, because opening the discussion can only benefit everyone concerned, it is useful to start with this limited sample and in the small space available here.

I wish to thank those women who participated in the interviews for the article.

Lesbians enter therapy for the same reasons other people do: we can't cope with parts of our lives, we aren't satisfied with how we are coping with our lives, we feel powerless to change our lives, we feel oppressed by the world around us.

Some of the specific elements of our lives as a usually invisible, almost always despised minority add to those reasons. We often have unresolved issues to deal with concerning the men in our lives: neglectful or abusive fathers, rape in or out of marriage, claims that men make on our bodies simply because we are female, the stress of going from all-female home environments to mixed ones at work. There, men assume that we will take care of them in the many ways they are always taken care of, ways that have nothing to do with work and everything to do with their position of power in heterosexual situations. Our need to resolve these issues seems to be greater than the need of most heterosexual women — or it may be that, because we have removed ourselves as much as possible from those situations we are more in a position to resolve them.

We tend to be poorer than most people because we have no support, ever, from a male's earning power. Many of us are single parents. We pay the prices for that and experience the consequences of it. We can lose our jobs, our homes, our children, and in too many places and times, our lives, as punishment for the very thing that gives us the most nourishment and beauty — loving the person we do.

Lesbian Reveals Herself



The possibility of these losses lurks always with us. It influences everything we say, often dictating the things we do and do not dare to do — things like holding hands on the street or kissing a lover goodbye in an airport, or putting my real name on this article.

We often live in silence. Said one of the women I talked to, "I've just finished medical school. Three years of eating, sleeping, working, playing, laughing, crying with those people. And not one of them knows who I am. Not one knows that I'm as married as any of them to the person who made it possible to do what I've done. A couple have met her; they think she's my friend who shares the rent. It's enough to drive you crazy."

Most lesbians must fend off repeated unwanted attempts to connect them with a man. Many date, yes and fuck, in order to keep up that front. We have to pretend to family and friends and colleagues that nothing is wrong while a relationship falls apart, because we have never dared tell those people that a central relationship ever existed. We are members of a group who identify themselves to each other, always with fear, by an elaborate system of codes. Those who don't know the codes or who consider exposure so dangerous that they dare not ever connect with their own kind may spend their entire lives hiding — from the world and from themselves. The isolation is devastating.

And altogether too often, lesbians carry a hideous guilt. We loathe and despise ourselves because we find our own kind beautiful, because we cannot bear to subject ourselves and our

loved ones to a way of life we have all lived and have rejected. And of course with the guilt and fear goes anger: anger at the condescension and self-righteous judgements of those who know nothing of our way of life, and who consider it their God-given right to condemn us for not being just like them, to twist and cripple our lives because they are the majority and they rule.

The current wave of feminism and the human potential movement came of age at roughly the same time. Feminist therapy, child of both is influencing both (see articles on the roots and practice of feminist therapy). Lesbian feminists who have felt the need for therapy have, like other feminists, come to prefer those practitioners who share at least some of their assumptions. For example, traditional therapy tends, in fact if not always in theory, to assume that the client has full responsibility for and power over her own situation. But feminism traces women's feeling of oppression to . . . our oppression, social, economic and political.

Anger at that oppression is not, as Freud would have it, a denial of "natural" female masochism and a rebellion against the "natural" order; it is a legitimate anger at an illegitimate situation, a rebellion against a system carefully structured for the benefit of those who run it — men. The solution is not to learn to like the oppression; it is to learn, as much as necessary, to live with it. Traditionally, therapy has either

ignored lesbianism or treated it as a sickness. Therapists have, instead of accepting lesbianism as a starting point and a fact of a woman's life, rewarded lesbians for heterosexual behaviour and penalized us, with disapproval or drugs or hospitalization, for insisting that ours is a valid way of being. Feminist therapists work to overcome these prejudices.

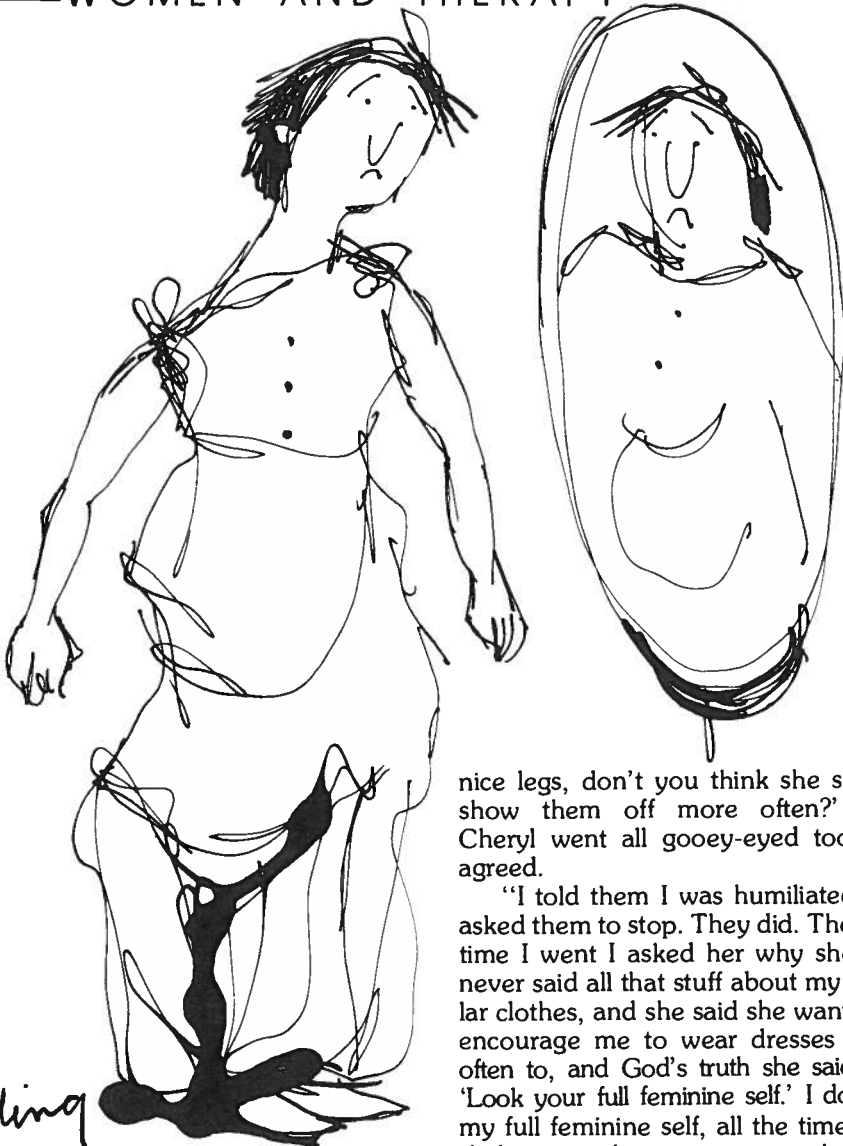
And because the feminist therapist is by definition outside the therapeutic establishment and female, the power imbalance between therapist and client can never be so pronounced and potentially dangerous as that between the traditional male therapist and his female clients.

It is tempting to assume that a therapist who is also a feminist and a lesbian will be most appropriate for a lesbian feminist client. That, of course, is a drastic oversimplification, taking into account only ideologies and not personal human differences. There are several factors to consider when choosing a therapist.

All of the women I spoke to had started out wanting a lesbian therapist. All had concluded that the therapist needn't be either a lesbian or a feminist or even, for some, a woman. Some thought it might even be easier to work with a man; a male therapist might try to convert a lesbian to heterosexuality, in which case it would be easy enough to walk out, but no male therapist will be personally challenged with the possibility of his own lesbianism. This is one of the major problems lesbians experience in therapy, and is often clouded and complex enough to remain hidden until serious damage has been done to the therapeutic relationship (more on that below).

The top priority, rather, is that the therapist be honest and direct, aware and sensitive to the entire person — to the person, not just to the sexual orientation.

As one woman told me, "I wore a dress one day, the first time in my two years of therapy with Janet. That alone should have told her something if she'd ever paid any attention to who I am. There I was, heels, nylons, the whole bit. I felt like a plucked chicken on stilts. If I'd wanted to be dressed like that it would have been different, but I had a company dinner to go to at the damn



*inding
yourself in a dress -
There was the dyke you
oved and admired?*

yacht club and had to meet the dress code. Janet knew all about that. I usually wear slacks and sweaters. I look quite acceptable all the time, and mostly I'm comfortable and reasonably content about what I wear. This day I showed up like that and squirming.

"Janet went all gooeey-eyed and drooly; she said how wonderful I looked and that I should wear dresses more often. She actually called another therapist in to look at me. I was humiliated. 'Look at her, doesn't she look wonderful in a dress, she has such

nice legs, don't you think she should show them off more often?' And Cheryl went all gooeey-eyed too and agreed.

"I told them I was humiliated and asked them to stop. They did. The next time I went I asked her why she had never said all that stuff about my regular clothes, and she said she wanted to encourage me to wear dresses more often to, and God's truth she said this, 'Look your full feminine self.' I do look my full feminine self, all the time, and she's so stuck in stereotypes that she had never seen it. I didn't go back, and I'm still furious. This is a woman who's brochure says she 'specializes in working with lesbian clients'. Not this lesbian client, she doesn't.

"How could she have seen so little of me in all that time? All I can figure out is that she thinks it's just fine if the only acknowledgements she gives my lesbianism is to not try to make me go back to men, that she thinks that that's all lesbianism is. How can she call herself a perceptive person or a feminist, let alone assume that she's able to work with lesbians?"

How indeed?

The therapist who works with lesbians must be aware of and willing to re-examine her assumptions, to learn and expand her concepts and definitions.

For example, one woman's therapist believed strongly in being open with everyone. She urged Marion to come out to her family, even though Marion felt it was courting disaster to do so. Marion tried to get the therapist to drop the topic, but she kept bringing it up. "Finally, more I think to get her to shut up than for any other reason, I told them. My mother cried for days; my father called me a pervert. He packed my suitcase and threw it down the stairs at me, saying he never wanted to see me again. That was four years ago. I've had a couple of hysterical phone calls from my mother since; nothing from my father. I sometimes write, but my letters usually come back. Thanks a lot, therapy."

Another walked out on her therapist when she tried to get her to admit her lesbianism to her husband. "I have three children under six. For the most part I trust Dick, but there are chances I can't take — especially at the bidding of someone who is very wise in some things but doesn't realize how ignorant she is in others."

The limitations on our lives are facts of those lives. We can in therapy lessen the crippling effects; we cannot ignore the reality. Therapists must be willing to acknowledge this.

Part of what this means is that lesbians in therapy must be willing to educate their therapists in matters particular to lesbian culture. To some extent every client does this: Italian women, rich women, poor women, Catholics, Protestants, Buddhists, atheists, leftists, rightists. Most of the people I spoke to are willing to take time out of the middle of a therapy session to provide information so that a therapist could understand a situation that might be very ordinary in any lesbian's life but foreign to the therapist's experience.

There was only one dissenting vote: one woman said, "I don't expect to hire a plumber and then have to tell him what tools to use and what to do with them." Replied another: "I'd tell him — for a reduced fee." The conclusion turned out: "I'd tell a plumber, or a therapist. Once. I don't expect any person to remember all the details of my life, but I don't want to have to tell a

therapist something important over and over. And I don't want a therapist to hear me say, 'This is important' and then decide, from her heterosexual security, 'This is minor.' If there are questions, fine, but we can't have our judgments discounted like that. Hell, that kind of treatment is a large part of why I'm in therapy in the first place."

The closer an issue is to sexuality, the more knowledgeable of the dynamics of lesbian relationships and the lesbian community lesbians want therapists to be. Several said they would not take a problem with a relationship to a straight woman. There were two main reasons for this: "If I'm having trouble with Sandra," one woman specified, "I don't want to have to explain how disastrous it could be to my morale to go to a dinner party with her. I don't want to have to explain that, because the community is so small, there could be two or three people there with whom we had been lovers, even though we're both anything but promiscuous, that everybody could easily know a lot about our problems already, that there might be someone there who, for whatever reason, would consider it a good time to approach one or the other of us. It all seems so obvious to us but might not be to an outsider, and if I'm upset, I want to deal with *that*, not with seating arrangements and the social chess game that this community can be."

Several women said that they have never found a therapist who was not a lesbian who genuinely accepted that lesbian relationships are real: as passionate, as committed, as complex and as devastating at the breakup as any others, that lesbians do not 'play' at love, do not mimic heterosexual marriages, do not settle for second best. The majority of people I spoke with, in fact, found that while therapists can accept that we might have minor affairs, the more serious the involvement, the less credence it is given. No woman needs a therapist who trivializes the most important things in her life.

Many women found that their therapists had at some point in the therapy questioned their own sexuality. Too often, the therapist tries to hide

the questioning from her client. She may grow distant or defensive — or both. When questioned as to whether anything is different or wrong, she denies it. The atmosphere of the therapy changes, and tension grows that distorts and can destroy the therapeutic relationship. Lesbian therapists do this a great deal less than heterosexual ones, probably because lesbianism is never chosen lightly, and anyone who does choose it has already been through an agonizing period of questioning that may have lasted most of a lifetime. For that reason, most lesbians are utterly and completely in sympathy with the sexual struggles and decisions of other people.

The most humane thing a therapist can do, and in many situations the most potentially productive one, is to admit to the struggle, whether or not she wishes to say anything more. That at least clears the air enough to continue the therapy in a reasonable manner.

So far, there has developed no specific lesbian therapy. There is, however, a growing tendency among lesbians to leave one-to-one therapy for leaderless lesbian groups. Toronto now has several, Vancouver some, and the demand is growing.

These groups usually consist of from six to twelve women who meet as frequently as once a week or as infrequently as once a month. The commitment is to participate without dominating, to grapple with the issues raised, and to support one another. There is also a pact that what happens in the group go no further.

One woman spoke for most of us: "I see my therapy in terms of myself as a child growing to an adult. At first I needed an authority figure, someone who would lead, direct, patronize me. Once my need to learn survival skills had been met, so had the need for that kind of person. Therapy became a way to enrich and expand my life, not a way to save it. My last therapist started to act very strangely at the end. Finally I asked her, 'Are your own sexual doubts interfering here?' and she said, 'I'm in charge here, I am the therapist, my life is not under examination' I walked out and found myself a lesbian

group where I could be an equal, someone with knowledge and capacity to think and valuable insights, someone with more of some kinds of information than other people, and less of some other kinds. I didn't need to be directed any more, and I damn well didn't want it."

It is because of feminist analysis and experience that women were able to challenge traditional therapy and create feminist therapy. It is because feminist therapy has been so successful that it is possible for women to form self-help groups that work. The therapist may be on her way to becoming a consultant for these groups. Groups do not give unqualified support to the individual, nor do they give her undivided attention. We all need both these things on occasion. There are advantages to belonging to a group whose members one sees socially. On the other hand, many of us have issues that are either clarified by an outsider's non-involvement or that we would just rather not talk about in front of people we see all the time. And there are some thorny issues that are either beyond a group's skills or that we think are beyond its skills.

All of the women I spoke with who are in leaderless groups mentioned these reasons for needing to consult a therapist, and for being very glad that feminist therapists are available. They also mentioned that they are unwilling to give up the power of the equal-among-equals situation of a group. What this implies for the therapeutic situation is a giving up of power, and a taking of power, to reach a mutual exchange. It means, in addition to a therapist's core of clients, a more sporadic clientele and less intense relationships. It may develop that groups will retain a therapist on an ongoing basis, as a company would a lawyer, or an individual would a dentist.

It's the difference between static/entrenched and dynamic/moving. And it looks as if the future of feminist therapy and lesbian involvement in it will be dynamic/moving/growing.

Frances Rooney, a Toronto freelance writer, has recently finished a book on Edith Watson, photographer, and a slide show on the sources of lesbian herstory.

WOMEN IN INSTITUTIONS

by The Feminist Therapy Support Group • graphics by Laila Gaidulis

Within our feminist therapy group, some of us have had experience as patients in psychiatric institutions, working as staff, or as relatives and close friends of psychiatric patients. All of us agree that hospitalization should only be used as a last resort. We do recognize that hospitalization is sometimes necessary. Perhaps other alternatives have been tried, or for women in smaller communities, there may be no other alternatives. There are people who become a danger to themselves or others, and people in great emotional pain which persists despite the support of family and friends. There are times when drugs are necessary for a person to become receptive to therapy. We do need places to go, but could these institutions not be more intimate, more humane, without drugging, coercion or restraints?

The key issue is social control.

It is when drugs, shock therapy and institutionalization are used as social control that we feel concerned. It is when we look at how these are used in relation to women that we become outraged: women consistently receive more than twice as many prescriptions for tranquilizers and other psychotropic drugs as men; twice as many women as men are in institutions; when patients go to a doctor for a problem such as backpain, men receive a pain-killer while women receive a tranquilizer; up to six times as many women as men suffer depression.

Within the traditional medical model, the mental patient is defined as "sick". It is the same model used for

physical illness where deviations from the ideal can be more easily measured (blood pressure, temperature, et cetera) resulting in predictable symptoms and a diagnosis. However, mental health is much more complex and differs dramatically according to culture, time and social context (as well as gender). Diagnosis is a subjective judgement, influenced by the bias of the professional and by the patient's character (e.g., submissive vs. assertive).

A survey of clinicians' attitudes in the early 1970's indicated that their ideal of a mentally healthy woman was submissive, dependent and supportive. The ideal for a mentally healthy *man* was to be independent, assertive, decisive and aggressive. And the ideal for a mentally healthy *person* was to be independent, assertive, decisive and aggressive. These are the characteristics considered necessary for success in the business and professional world. This puts women into an impossible double-bind — if she is a mentally healthy woman, she cannot be a mentally healthy *person*! Women are locked into a secondary position.

In the nineteenth century, if she rebelled against the feminine ideal, it was reasoned that, since the difference between her and a man was her reproductive organs which control the feminine personality, these must be malfunctioning and should be removed. It was in the late 1860's that physicians began to treat psychological "disorders" in women with surgery. Clitoridectomy was practised in North America until at least 1954. The devel-

opment of anesthesia in 1848 was a mixed blessing as hysterectomies became a treatment for rebellion. It is incredible to think that women continued to be castrated for psychological disorders until around 1946.

If a man thought that his wife or daughter was not behaving "appropriately", he could take her to a doctor to have her castrated and returned to him "tractable, orderly, industrious and cleanly".

Given the lack of antiseptic practices and imperfect anesthesia, it is no wonder that most women settled for a submissive role. For many women, this evolved into a decorative fragility since being delicate was considered feminine and appealing.

Next on the list after sexual surgery and psychoanalysis came tranquilizers; and now with the alarming increase in depression in women, antidepressants and shock therapy are filling the gap. Depression could be the modern expression of frustration equivalent to the hysteria of the 1800's.

Women are in the same double-bind as in the past despite their change in status. If they choose the role of wife-mother they may feel isolated and mindless, and possibly unaccepted by other women. They turn their anger and frustration against themselves until it becomes depression. If they assume both wife-mother role and a place in the workforce, they struggle to be "Superwomen", handling two jobs until they become exhausted. If they choose a career instead of marriage, they have abdicated the female role

thus facing society's disapproval. Depression is often defined as anger turned inwards.

The pressure for women to conform to the female stereotype is evidenced by the comparative statistics on tranquilizers, depression and institutionalization. Institutions are often a dumping ground for all the "misfits", from alcoholics to victims of abuse. Today's very effective substitute for the threat of sexual surgery is the threat of commitment to a mental institution.

The most terrifying moment of my life was when I was feeling depressed and my husband threatened to have me committed by my own therapist!

Once inside the institution it is extremely difficult to stand up against either the overt or the covert control. The most obvious control is the use of drugs and shock treatment, both actual and as a threat. Isolation, restraints, removal of privileges, forbidding patients to help one another, compulsory attendance at group therapy, force-feeding, undressing in front of others and lack of orientation when the patient arrives all serve as means of control. Equally powerful and incredibly undermining is the pervading condescension, sarcasm, silent treatment, disapproval, labelling, lack of humour and the excruciating boredom. Lack of access to one's own files, and refusal to tell the patient what medications are being given to her add to feelings of powerlessness.

As the women in our group worked on this article we became more and more frustrated, angry, and, yes, outraged. We felt disgust and helplessness at the unfairness and injustice of it all. It was easy to identify with the feelings a patient in an institution must have: betrayed, diminished, frightened for herself and others, trapped, then finally suspicious and cynical.

Despite these strong personal and professional concerns, hospitalization still is necessary at times and can be very helpful. The important thing is to get what you need while you are there.

In the following sections, we have put together some information which

will be useful in helping yourself or someone close to you get what is needed while being hospitalized.

Advocates

It is really important to have an assertive person whom you trust — a friend or relative or a member of your support group — act as your advocate. In choosing this advocate remember that a person who is attached to an agency or who has credentials recognized by the institution will have more power. This person can check out information about the hospital and staff, demand adequate treatment, ensure your rights are not violated, and help you make decisions or get information that you require to make decisions, for example, on the use of medication or ECT (electroconvulsive therapy or shock treatment).

The psychiatrist or other staff may not give information about your condition or proposed treatment to an advocate. This is partly due to rules about confidentiality which are meant to protect patients. Therefore, it is important that you clearly give consent, preferably written, to the staff person responsible for your treatment to share information with your advocate.

Be aware that you do run a risk when you use an advocate to help you negotiate with the mental health system. It is the same risk you take when you ask a lot of questions or ask for a second opinion or generally make a nuisance of yourself. Step out of line and you risk being labelled a "difficult patient" who is "resistant to treatment" and has "difficulty dealing with authority". This could also mean receiving some form of direct or indirect punishment — all the way from the withholding of privileges to the use of ECT. Insist on your rights and use your advocate, but be prepared for some negative reactions and make sure you have lots of support.

Types of Hospitals

There are various kinds of hospitals which provide psychiatric services: provincial mental health centres, hospitals for the criminally insane, psychiatric departments of general hospitals,

teaching hospitals, and private hospitals.

Provincial institutions are usually large, relatively impersonal places where many chronic patients end up. They may have good physical facilities — swimming pool, gym, etc. but provide little in the way of treatment except for medication and ECT. Patients are usually held and treated until considered "cured". Some general hospitals have psychiatric units for short-term patients (a 3 month limit in Ontario). Crisis units handle emergencies and provide follow-up as well. Private hospitals provide comfortable surroundings for those who can afford them.

Hospitals of all types differ in quality of staff, approach and treatment. There is also a definite class system among hospitals. Working class people tend to be admitted to provincial mental health centres; middle class people go to teaching hospitals, either general or psychiatric; and upper class people go to private hospitals. Even if they don't admit it, family doctors and psychiatrists take class into consideration when deciding where to refer a patient.

Structure

Like other large institutions, psychiatric hospitals have rigid hierarchical and bureaucratic structures. And like all hospitals, these structures are based on the medical model of functioning. What this means is that most of the decision-making power is in the hands of the psychiatrist. After the psychiatrist, in descending order of power, is the psychologist, social worker, nurse, occupational therapist, attendant and patient.

This structure also means that each professional has a very distinct role: the psychiatrist makes decisions about treatment and sometimes sees patients in individual therapy; the psychologist administers and interprets tests; the social worker sees spouses or family members for therapy. Nurses and paraprofessionals are the ones who carry out "treatment plans" and have the most contact with patients but have the least input into decisions regarding treatment.

WOMEN AND THERAPY

The ways in which hospitals are structured add to the feelings of powerlessness and lack of control that most psychiatric patients feel. The structure also reinforces the lesson that most patients quickly learn — to be a “good patient”, conform, behave, or else you will be punished.

Admission and Diagnosis

When admitted to hospital patients are assessed and diagnosed. That sounds simple enough but there are problems with the kind of labelling that goes with diagnosis. First, making a diagnosis is very subjective and depends on the particular doctor doing it. Second, a diagnosis can sometimes follow a person throughout her life and cause the person to feel that there is no way to escape it. Third, labels are often used as a secret language between professionals with no explanation given to the patient. Fourth, diagnoses are often related to class, sex and culture.

This last point is very important. Distinctions may be overt but often are more subtle. Many studies have shown that clinicians are often influenced by many factors when making a diagnosis. When identical written descriptions of two patients, one male and one female, were given to various clinicians, the female patient was more often diagnosed as disturbed than the male patient. Immigrant women are often diagnosed as suffering from culture shock when in fact there might be problems within her family or at work that are causing distress. Working class people are sometimes labelled differently than middle and upper class people. They also receive more physical treatments such as medication and ECT since they are patronizingly considered less “amenable” to verbal therapy.

Treatment

There is a lot of controversy about the causes of psychosis and therefore about how to treat it. In psychiatric hospitals the most common treatments are medication (chemotherapy), shock (electroconvulsive treatment), psychotherapy and rehabilitative therapies. Treatment plans may include indi-

vidual or group therapy, music, dance, arts and crafts therapy, life skills, etc.

Chemotherapy or medication is almost always prescribed for psychiatric patients. There are several types of drugs that are used depending on the diagnosis and the person's behaviour. The main types are: minor tranquilizers, sedatives, major tranquilizers, antidepressants and lithium carbonate. (See Healthwise)

Psychiatrist speaking to patient's parents, just after she had tried to commit suicide in her car, "She didn't think she was getting any treatment in here for these two weeks? Oh, she was getting medication all right, it was in her food."

Drugs are frequently used in large quantities in psychiatric institutions for behavioural control. They are usually given without complete information about temporary and permanent side effects to the patient. Even the nurses responsible for administering medication may not know all the effects of the drugs. Psychiatric patients have died as the result of being given too many different drugs or too much of a specific drug. If medication is prescribed for you, ask about dosage, side effects and how long you will be using it.

Alternatives to medication are

being explored including high dosages of vitamins and diet changes. Food allergies and hypoglycemia (low blood sugar) can cause many emotional and mental symptoms. Most mental health professionals don't accept such alternatives but you might find some therapist or doctors willing to work out such a treatment approach.

The use of ECT is even more controversial than the use of drugs in psychiatric institutions. It is apparent that drugs and ECT are often used indiscriminately and abusively — sometimes to control and/or punish “bad patients”.

After it was clear that I was not going to cooperate . . . e.g. not taking their pills, telling other patients that they should go home, making phone calls to friends on the outside asking them to get me out and shouting at the doctor, three people jumped on me and shoved me into a utility room where I was restrained and injected with a tranquilizing drug. They said 'maybe now you will take your pills'.

The side effects of both drugs and ECT can make you feel crazy and add to your “symptoms”. Both drugs and ECT are physical treatments which many psychiatrists feel more comfortable with as a result of their medical



training. Cutbacks in funding and in hospital beds cause financial pressures which lead to a quick turnover of patients and decreasing staff. Alternative methods of treatment are dismissed as research money goes into refining existing methods of treatment such as the development of more drugs by the drug companies.

Women as Psychiatric Patients

Although the above discussion of institutions applies to male and female patients, women are particularly oppressed as psychiatric patients. Women who are unhappy in their roles as wives and/or mothers, women who are lesbians, women who are struggling to define their lives for themselves are often labelled "sick" and committed to institutions by husbands, parents, children and friends. In hospital, a woman feels naked, stripped of her identity with no credibility, no privacy and no control over her life. She is constantly observed and her behaviour is always perceived as a symptom of her illness.

Sometimes, the process of being institutionalized can cause symptoms just as drugs and ECT do. The boredom and isolation are difficult to cope with and in many institutions there is little or no therapy available — only custodial care. The isolation is even more acutely felt by immigrant women who may feel alienated from such treatments as group therapy. Frequently, interpreters are not available.

It is understood by the patients that in order to get discharged you have to be docile, polite and compliant, in the assessment of the staff. This is the goal of the treatment. Therefore the very circumstances that triggered the woman's reaction and brought her into the institution in the first place are intensified and enforced. How then, if all attempts at assertiveness, independence and taking responsibility are actively discouraged, can an inmate develop the skills necessary for coping and survival in the outside world?

Alternatives

Since the absence of self-respect is a central issue in mental illness and its restoration the most important task of therapy, we believe everyone entering

institutional care needs to feel respected by the staff caring for them. If some staff members were ex-patients they might relate more easily with patients. Also, we would like to see the education of all mental health professionals include:

- personal therapy
- consciousness raising vis a vis women and mental illness
- training in equalizing the therapist-patient gap
- exposure to a variety of modes of psychotherapy to expand their expertise in perceiving and treating each person as an individual
- training in handling their own anger and other people's anger humanely

We recognize that well trained, caring therapists cannot do effective treatment in an oppressive environment. Therefore, we would like to see those needing residential treatment cared for in a warm, home-like setting. This setting would provide an environment in which each person had sufficient space for personal privacy and social interaction. There would be an opportunity and a space for people to recognize and vent their anger. Staff and residents would care for the physical space together, and co-operatively work out therapeutic activities designed to enhance each person's sense of self-esteem. The administrator of this setting would be personally accessible on a daily basis to residents and staff to clarify treatment procedures and mediate staff-resident conflicts.

The erection, equipping, staffing and operation of smaller homelike treatment units has been tried, at less cost per patient than our current larger institutions. However, as long as institutions exist, we recommend that each person admitted have a therapeutic advocate. To be effective an advocate requires the respect of the administrative and treatment staff. We feel ex-patients could be trained to be effective therapeutic advocates. Such a practice should lead to a decrease in use of drugs and custodial care, discontinuance of shock treatment, and an increase in reliance on psychotherapy.

Some of us who have been hospitalized feel it could have been prevented if we had a place to retreat for a few hours, a weekend, or longer. Our feminist therapy group would like to

see a women's holistic health centre in every community. We see this centre offering legal, medical, vocational, recreational and counselling resources. It would also have space for women to drop in for a few hours, or move into during a transition period in their lives. Connected to this centre would be businesses such as a restaurant and a health food store, which could also provide employment for women needing work.

This retreat could also house a support network of ex-psychiatric patients who would be available to make house calls and to help assess whether someone needed hospitalization. They would offer support to people in crisis, and to recently discharged patients. All this support work would involve family and friends.

We do not feel we are dreaming an impossible dream. We believe all of this is possible and necessary, and will happen as more and more people understand what mental illness is.



Thanks to the Women's Counselling, Referral and Education Centre in Toronto for use of their unpublished manuscript *Through the Therapy Maze*.

TRANQUILITY CAN KILL

by Linda Rauch Peregál • photos by Judy McClard

This interview is about one woman's withdrawal from addiction to Valium. It is her unique story, but it is not unusual.

Valium is a brand name. Its generic name is diazepam. Diazepam is one of the class of minor tranquilizers, mood-altering drugs which depress or slow down the body's responses by acting on the central nervous system.

A Saskatchewan study found that one in every seven people interviewed had received a prescription for diazepam during the previous 19 months. Studies consistently find that women receive twice the proportion of prescriptions for tranquilizers as do men. Women often receive tranquilizers for long periods of time and are often prescribed tranquilizers to cope with social, rather than medical, conditions.

The widespread use of Valium and similar drugs belies their physically addictive nature. Women taking tranquilizers have often been reassured that they are harmless. As recently as 1979, a U.S. government probe suggested that many physicians were still not aware of tranquilizers' addictive properties.

As you read this interview, you may wonder that Hoffman LaRoche, the manufacturer of Valium and the world's largest pharmaceutical firm, is able to make an estimated \$300 million profit from the sales of Valium each year. But Valium is not the only tranquilizer being misused: diazepam is also sold as Vivol and Novodipam; Librium and Novopoxide (chlor-diazepoxide), Ativan (lorazepam) and

Serax (oxazepam) are other minor tranquilizers.

A member of the Women's Therapy Study Support Group and Connie Clement of Women Healthsharing interviewed Linda Rauch Peregál in August, 1982.

Q. When and why did you first take Valium?

A. I began experiencing severe anxiety attacks when I was twenty-one. Looking back, I recognize that I was terrified of myself, of my existence. Everything was happening to me; my circumstances, the symptoms of anxiety I was experiencing, it seemed I had no choices. I finally went to a psychiatrist when I was twenty-three. He prescribed Valium saying I needed it to "take the edge off" the anxiety and panic attacks. Taking Valium became a part of my daily routine, beginning with a pill every three to four hours, usually four pills daily. He kept my prescription going for seven years.

Q. What does it feel like to take Valium?

A. Taking a Valium was like getting a fix. About fifteen minutes after taking a pill I would feel calm, terrifically relieved and secure. I was not afraid of anything.

Q. Were there any other physical symptoms? Any symptoms that caused you to worry about taking the Valium?

A. The Valium compounded all my original symptoms of panic, since it upsets the nervous system so badly. After the nervous system is arrested at a seemingly calm and depressed level, it gets jumpy when it needs another pill.

It wasn't until the last few years on Valium that I finally had a sense that something was seriously wrong with these pills. After one-and-a-half hours the effects had worn off. Between doses I became fidgety, my head would feel tight and I felt panic stricken.

I wasn't aware that anything was wrong for a long time. I didn't give a second thought to the fact that I was bumping into things — it wasn't that noticeable to me. I didn't realize that my bad memory had anything to do with Valium. By the seventh year I was always yawning, bumping into things and forgetting what I was saying in mid-sentence. It got to a point when crossing the street became a horrifying thing. Going anywhere at all was irrationally threatening.

That's how I lived for years, never in a million years believing it could be any different.

Q. How much did you understand about the drug and what it does?

A. I never thought of Valium as a drug. I was told by the psychiatrist that Valium was absolutely harmless, that it was about as potent and dangerous as Aspirin. I simply did not think. I could not afford to. The pills arrested the

panic and I was glad they did.

Even later, when I was at The Donwood Institute undergoing withdrawal, I could not believe this little yellow friend of mine that I had depended on at ail times for seven years of my life, was referred to as a "drug". Even during the most acutely hellish withdrawal I couldn't relate to that. Because *how* in the world could I have been so stupid!

Q. *During all the years you took Valium did you ever have trouble getting your prescription renewed?*

A. It was always easy to get. I had two prescriptions going at certain times, at different drugstores. One for nerves, and one for an inner ear infection.

However, when I was living in Denmark my last year with Paul, my husband, and my last year on Valium, they were almost impossible to get. After many refusals I went to the out-clinic of a hospital and begged for some, saying it was for my inner ear (which really did exist as a problem at the time). I called Canada to ask a friend to send me some Valium. I was counting the pills and rationing them until we got to England where obtaining a hundred at a time was no problem.

Q. *How did your friends and family react to your taking Valium all the time?*

A. My immediate family had no sense of how dangerous Valium was to me. My husband, I believe, attempted to show me what I was doing to myself, but I could not hear him. He felt he could do nothing. But truly, he did not have any idea what the reality was concerning addiction and withdrawal.

The same thing occurred with a couple of girlfriends who were very concerned and probably aware to some degree of what I was doing to myself. During the time I was addicted to Valium though, I needed and desired nothing from them. It was afterwards that I needed people, just their presence, not their advice or judgement. Just them.

Q. *What prompted you to take action to break your addiction? Was there any particular event?*

A. The concept of addiction did not exist in my mind. I knew I was emotionally addicted but didn't know I *could* be physically addicted. What got me to the Donwood were two friends. Their constant harping that my taking Valium was a serious issue aggravated me enough to finally give it a try.

Q. *Tell me about your withdrawal. What did you experience?*

A. My entire nervous system went berserk! Both my body and my mind. I felt like an exposed nerve. My senses were painfully and abnormally acute. My muscles twitched frantically, my body went haywire, my mind went through varying degrees of paranoia, terror, complete vacancy to the point of not being able to operate or think, at all.

I'll simply describe to you what symptoms I endured, although no explanation can truly describe this terror.

After about two days of not taking Valium I began to feel strange. Then it began. I could never really believe any of it was happening and I am amazed that any human being could survive such agony. It's difficult to remember the order of the symptoms and how they occurred. Even now as I tell you this, I do not feel with any impact this experience. A lot of my connections and feelings are deadened.

My stomach bloated up, way out of proportion and I had very bad diarrhea. That happened right away. Then my head felt like a hundred tons. I had to move it very slowly or else it would hurt like hell and the floor, ceiling, the walls and myself would spin wildly around.

My senses were so alive and exaggerated, very uncomfortably so. I wore sunglasses for over three months, at first simply because I could not stand any light; later I wore them to block out any and all reality. My hearing was acute — small sounds crashed through me and upset my entire system again and again. All voices were irritating and grating. I also smelled odours that were not there, and had the same experience with taste. Touch was an amazing sensation. Colours were unusually potent and clear.

I became obsessed with my hands.

They took on great proportion and changed shape constantly. The muscles in my face became loose and shapeless. My mouth just hung there.

I looked so sick, like an addict, like a derelict. Strung out of my mind. I was definitely strung out of my mind.

Inside of me, I shook like bloody hell. Electric shocks pierced through my body; I jerked about involuntarily. Outwardly, I had the shakes like somebody having severe withdrawal from alcohol. It was difficult to hold on to anything.

Then there were the hallucinations. Mostly I hallucinated objects already there. For example, my stuffed dog (the thing I clung to all those months) turned into a lamb. The plant in my room took on the appearance of my mother. Everywhere I looked I saw faces, but that did not frighten me. A lot of people began to look like babies — that was frightening. Their faces looked one-dimensional, as if the eyes were made of cardboard and would just fall out if they bent over.

Once I hallucinated something that wasn't there at all. I was terrified and begged the nurse to push my bed against the wall so that I could hang on to it. I saw a pattern of crystals, floating, suspended in the air, right in front of my bed, moving across the room from right to left, clear and sparkling. During that year I hung on to any omens I could find; I was desperate. I believed the crystals represented the ensuing brilliance and clarity with which I would see myself and the world.

Then there was what another patient called "the bee in my bonnet". It was a terrifying, loud buzzing sound at the top of my head. I dreaded that one.

There was a period of about two weeks during which the symptoms, the feeling of insanity and thoughts of suicide, subsided somewhat. That was after the first month of withdrawal and then came the worst.

Q. *Did you ever think about just turning around and taking Valium again?*

A. No, never. It never once occurred to me that it could make a difference. I *knew* it could not. I knew there was no place to retreat to, it just

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didn't work that way. No amount of Valium could have disguised what was happening.

Q. *Did the people around you understand what you were going through?*

A. Only sometimes. One day my brain stopped working. I simply couldn't think. Nothing. My brain was paralyzed and I was horrified. I asked another woman patient if she knew about this. She said she did and that it would go away. The doctors, you see, couldn't tell me anything about what was to be expected or for how long it would last.

The only way I could describe the constant underlying feeling I experienced was to call it "discomfort". I knew I could not communicate this hell to one single person. On top of everything I had to handle, people took offense at my belief that they did not and could not understand.

Q. *How long did your withdrawal take?*

A. It's difficult to say. My guess is that the strictly physical withdrawal took one year or so. It is so hard to determine because I was left in such an incapacitated and suicidal state. At some point, about nine months into withdrawal, I decided I had brain damage and that these experiences could not possibly be from withdrawal.

What was constant for a long time, for perhaps over a year and a half, was an emptiness which I feel is impossible to describe. A nothingness. A huge vacancy. Not as a concept but as an actual penetrating feeling. I was, but I could not feel. It was exasperating. I had no real sense of anything at all that had occurred before this nightmare began. I had no sense that I had been married for ten years. Nothing held meaning.

Q. *You underwent your withdrawal at a well-known addiction recovery institution. Can you tell me something about The Donwood Institute?*

A. The program at the Donwood is set up so that in-patients attend talks, videotaping, group therapy, discussions, etc. from 9:00 until 4:00 five days



of the week. Most patients were alcoholic and those coming off alcohol usually went through only a couple of days of physical withdrawal. The rest of the time for them was an educational experience. Families of patients attended a special program designed to educate them about ensuing difficulties the patient might have. Discussion groups were often led by ex-patients who could encourage others.

Q. *Did staff offer the kind of support you thought you needed at the time?*

A. If I stop to rationalize (which is my tendency) I can understand easily how people servicing this institution or any other find it impossible to be as supportive and compassionate as I would have expected or desired. Still, what is important is that in institutions the needs of patients are not fulfilled. The patient's job of survival and maintenance of sanity becomes a double job: learning how to ignore insensitivities and getting along in spite of this.

The thing that drives people nutty is



that when they are going through the worst times and feel they need understanding the most, this is usually the time it cannot be found. When I was most needy, most desperate, I was forced to learn to depend on and trust in myself. I could not expect to be understood. This was maddening at the time but helped me to grow later on.

Q. *What was missing during your stay at the Donwood?*

A. Almost nobody was there to confirm and acknowledge my suffering, to offer a warm and gentle hand, to say "Yes, I know what you are going through. It happened to me." I was able to do that very thing for a patient a year later and she knew from what I told her she would not feel this way indefinitely. Without this it was easy to believe I was permanently damaged and definitely crazy.

The one saving grace was the head psychologist at The Donwood Institute. I believe he has a lot to do with the fact that I am alive today. This man spent time and energy teaching me about myself, giving me perspective where I had none. He was equipped with wisdom that I could not acknowledge on a rational level, but which I sensed. My senses were the only thing I was relying on. This man worked with me for a long time. He was the one person in my life during this time who sat there with me, not in judgement, but in total

acceptance and confirmation. He cared and he acknowledged the hell in which I lived. He explained that what was happening was not arbitrary.

Q. *Did you ever run into professionals who didn't understand the addictive nature of Valium?*

A. Not at the Donwood, but before and after. The psychiatrist who first prescribed Valium to me told me I would get off it when I was ready! What a dangerous and irresponsible statement. One cannot become "ready" to go off Valium. When symptoms are repressed and ignored, as they are when taking Valium, they are not worked through and one is *never* ready for anything! Going off Valium is anything but a simple choice. During my seven years of taking Valium I did not grow emotionally. I dealt only with manifestations of my real problems and ended up with compounded and unrecognizable problems. My fears grew and I became trapped.

Some time after leaving Donwood I went to Mount Sinai Hospital as I was unable to take care of myself and realized I had to go into hospital. I waited several hours and finally saw a woman psychiatrist. She decided I must enter hospital and because there was no space there, she sent me with a note of referral across the street to Toronto General Hospital. There I was seen by an intern, male, thirtyish, who after listening to my story, told me there was no such thing as Valium withdrawal and proceeded to write out a prescription for Valium! That kind of thing can really make you feel crazy but I knew better, threw the prescription back at him and left. Because I talked coherently this doctor could not imagine that anything was really wrong with me or that I was suffering.

Q. *You were at the Donwood for nine weeks. Where did you go when you left? What kind of support did you have then?*

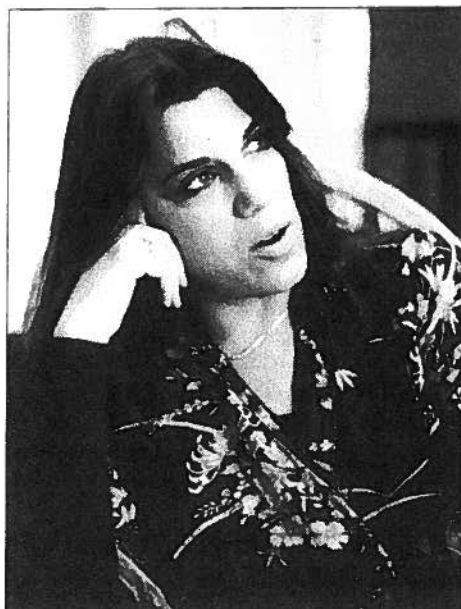
A. Following Donwood I returned to my apartment. All I did during this time was lie on my bed and struggle to survive.

Just recently I heard Jacob Timmerman tell of his imprisonment in Argentina during the coup in 1977. He

was tortured and interrogated for thirty months. He believed there were two things he could have done: to commit suicide or go completely mad. Instead, he remained passive and preserved all his strength in order to survive what seemed unsurvivable. He said there was not a thing in the world to believe in or hold on to. There was no feeling of time or space relative to anything. It wasn't as if tomorrow would be any different. My dilemma was the same. I had wished I did not have a choice, that instead my fate was determined and an end could be put to my misery. When Jacob Timmerman spoke his words in trying to explain his terror, I understood too well.

I could not be left alone for one minute during that time. Little things like doing the laundry or putting the garbage out were enormous accomplishments. Because my cousin, who was staying with me for some time, had to go to work very early in the morning, the Donwood had arranged for me to be there all day. I sat in a small office, squirming inside, not imagining I could last another minute, tying knots in wool and making macrame plant hangings and owls. I cried, I gritted my teeth and I prayed.

It was a draining time for those close to me. It is so hard for most people to acknowledge what is happening because it is difficult to face another person's suffering. People need to tell you it will be all right. It didn't seem to me that other people



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made any difference — nobody could do a thing, nobody could remove the agony. I am sure, though, if I had not had friends around me I could not have gone on trying and praying and relying on faith alone.

Q. *How did you feel once the physical symptoms of withdrawal were behind you?*

A. When all the withdrawal symptoms had ceased I was left a desolate, squirming creature in a world I never could have imagined existed. I had no idea how to endure this merciless pain and no relief was anywhere in sight or mind. I wanted so badly to terminate my life for such a long while but could not.

Q. *You are very much alive now. When did you decide you wanted to live?*

A. It was not really a decision. At first it came out of fear because it was suggested I have shock therapy when it seemed I could not help myself, when I could not find one little ounce of caring left in me.

Most of this time I had been lying on my bed, screaming silently, agonized, anesthetizing myself with food and writing my thought patterns down. At the time shock therapy was advised I began a new phase, a very upsetting and seemingly futile one. Instead of hiding in bed until late afternoon, I began to emerge in the early morning. I put on my jogging pants and went running. I ran, crying, feeling alone and insane and without care. I was minus my spirit and life force, completely mad and depressed as all hell.

During the next year or so I struggled. My idea was to do whatever I could to help myself in the long run. It sounds so simple. For a couple of weeks I would eat properly, go swimming, go for walks, function. I did volunteer work at a daycare centre and the Senior Adult Services. I didn't want to push myself but it was either that or being totally inside my head twenty four hours of the day and the things inside my head were twisted and destructive.

My mind worked triple time, telling me constantly why and how to go about helping myself, trying desper-

ately to believe anything might change a little at some magic point. It took so long for me to feel any change at all, and then it would last only ten minutes or so. I was trying to busy myself with meaningless preoccupations. Nothing helped though, nothing had meaning. I felt frustrated and defeated.

I made a positive decision that I wanted to live in December of 1981, seven months ago. This had to do with a kind of revelation I experienced, a knowledge I acquired through a struggle toward meaning and a need to find a reason to keep going. I felt, for the first time in my life, integrated and had a sense of vitality and excitement I could not deny. I understood with all my heart what it means to live, truly live. I had thought this would remain, this newfound freedom I gave myself. It did not. But that is when I began a new struggle that is common to women and men — it is a classic struggle — the one in which the only enemy preventing our peace of mind and sanity is the one that lurks inside of us.

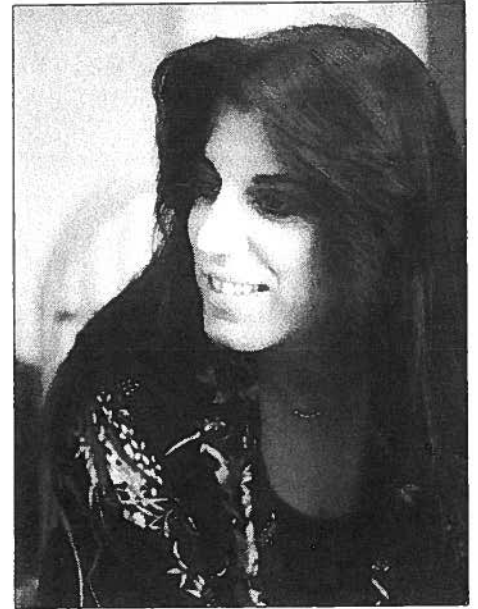
Q. *Can you share any understanding of yourself which has grown from your addiction and from your breakdown?*

A. It took me years to begin to understand that I never developed a core, so to speak. I had never designed a role for myself or had a focus. This whole idea and its implications is a long story but I understood that I needed to create a life, beginning from zero, from thin air. It's been very hard.

The struggle I experience now is to somehow dissolve the oppressor within me — the self-concepts, the ideals, the judgemental impositions with which I stunt my own growth and happiness, the self-inflicted prison. Knowing the mechanics of how I do this to myself does not change the habit. The change has to happen some other way.

Dr. Fritz Perls referred to the point at which one feels incapacitated and fearful of one's own emotions and experiences as "the impasse". Most people retreat from this point. This fear of the unknown, of one's own truth, of change and temporary insecurity can be used as a vehicle for health.

It is such a crazy thing when we are conscious of what we are doing, knowing it is the very thing that will not allow



us to breathe, to accept what we are and subsequently, to grow. At this point I have discovered what it feels like to emancipate myself from myself but mostly I experience still, the two parts of myself arguing; one for authenticity, the other denying it.

I understand that it is impossible to hide from myself without becoming sick. I have been forced, through this breakdown, to face myself and to learn about depending on myself. This kind of thing can feel crippling when it occurs suddenly and without choice but there simply is no other way to effectively live — everything else is a lie and an avoidance. It is the time when one finally goes it alone and when one learns that one's sense of self-worth does not and cannot depend on how someone else sees them. It is the beginning of everything creative and meaningful.

Q. *Out of all this pain is there anything you could say that you actually appreciate?*

A. I appreciate, rarely, but at certain times, how I fought and that I am a survivor. I survived. Now I am teaching myself how to live. I definitely would not go through it again. It cannot, could not, happen again.

Linda Rauch Peregall lives in Toronto and has recently been working as a counselor with assaulted women.

Reviews

Demystifying Therapy Reviewed by Annette Clough

In Our Own Hands, Sheila Ernst and Lucy Goodison, J.P. Tarcher Inc., Los Angeles, 1981. \$10.35 paper.

In Our Own Hands is the book I wish I had read six or seven years ago when I was trying to make sense of the therapy/anti-therapy argument. It is a manual on how to run a self-help group written by two women who have themselves had experience in self-help groups. It does not ignore the role of sexism, racism, classism, homophobia and capitalism in shaping our lives, our values, our self-concepts and our pain, as so many therapists and human potential movement types do. Nor does it underplay the complexity of our emotional lives and the ways in which our internalized oppression causes us to hurt ourselves and each other, as theorists and intellectuals often do. It shows how we can make it safe to explore our feelings and patterns of behaviour and situate them in an understanding of a culture which, to perpetuate itself, teaches us lies.

One of the most exciting aspects of the book for me is its critique of all the currently popular therapeutic options — gestalt, bio-energetics, psychodrama, transactional analysis, etc. They are explained clearly and the ways of using their techniques are discussed with many examples and some 140 exercises (which are indexed in the back of the book: you can easily find where the exercises are for, say, release of anger or exploring feelings about class) and their limits and dangers are well analysed. Awareness of women's oppression and the social causes of people's problems is lacking in the work of people like Perls and

Janov, although their theories and techniques can be useful for us. The authors have not thrown out the baby with the bathwater; they have pulled what is worthwhile for us from the mass of theory and technique of contemporary therapeutic work and given it back to us in a clear, readable form so that we can be our own and each other's therapists. Read the book even if you don't intend to be in a self-help group; it contains many insights and useful ideas that we can use in many situations. It is a radical book because it demystifies therapy and gives therapy's promise of ways towards a fuller life back to us, where it belongs.

Annette Clough works for the Vancouver Women's Health Collective. She is also involved in the Women's Self-Help Counselling Collective and Women Against Nuclear Technology in Vancouver. She was a member of the founding collective of the Women's Counselling Referral and Education Centre in Toronto.

A Manifesto for Feminist Therapy

Reviewed by Maeann Cameron Stevens

Therapy with Women: A Feminist Philosophy of Treatment, by Susan Sturdivant, Springer Publishing Co., New York, 1980

Therapy with Women guides the reader through the philosophical, historical, and theoretical underpinnings of feminist therapy to a fuller understanding of its origins, premises and

goals. Although heavily philosophical, the book never loses sight of the individual woman who seeks treatment. By her skillful blending of the general with the specific, the author provides a balanced and persuasive picture of feminist therapy.

Susan Sturdivant maintains that values and beliefs are an integral part of psychotherapy and that each therapist's value system largely reflects the value system of the culture from which it is derived. The therapist's own belief system interacts with that of the client to determine therapeutic process and outcome.

The author argues that since traditional psychotherapy is premised on sex-role criteria, it is thereby inadequate to meet women's needs or to relieve psychological distress. By contrast, a feminist philosophy of treatment "is consciously based on the female value system rather than the male, and specifically includes women in responding to basic human questions" (p. 17). Based on a feminist value system, her book examines such questions as the nature of human beings, the causes of psychological distress, interpretation of symptoms, and the nature and goals of the helping relationship.

The author cites the literature which reviews the feminist critique of traditional therapy and then describes features of feminist therapy which set it apart from other schools. The crux of her book is contained in Section Three where, drawing from feminist ideology, she articulates the value system of feminist therapy, the etiology of psychological distress and symptoms, the focus of therapeutic intervention, the role of the therapist, and goals of therapy. The author stresses that the female sex-role generates both internal (psychological) and external (sociocultural) emotional conflict for women. In broadening the context of conflict, she also redefines treatment to include both personal and social change. The symptoms of psychological distress and pathology are also reinterpreted to integrate the social and cultural factors with the personal. Political action is thus seen as an integral component of feminist therapy.

For therapy to be effective, the client must be brought "closer to a state of individually defined optimal functioning" (p. 162) in relating to her-

self, to others, and to her environment. This goal presupposes a set of attitudes and behaviours which nurture actualization of her human potential and the broadening of social roles. In its stress on the external as well as internal factors in pathology and treatment, feminist philosophy appears to be unique. Therapists of any persuasion would do well to examine and integrate the implications of this two-fold model with their women clients.

The book can be viewed as a manifesto for feminist therapy. As such, it espouses a feminist interpretation of history, of psychological distress, and of therapy goals. The author clearly articulates an alternative to traditional psychotherapy which will hold an appeal for many women. It remains for the client to inform herself of the subtle, and not so subtle, differences among the various schools of psychotherapy and to search out the approach which will most adequately meet her own needs.

Maeann Cameron Stevens is a psychologist/counsellor at Acadia University Counselling Centre. Her practice focuses on nonsexist individual and marital therapies, group instruction and consulting.

One Piece at a Time

Reviewed by Macha MacKay

The Down Comforter: How to Beat Depression and Pull Yourself Out of the Blues, by Juliene Berk, Avon Books, New York, 1980, \$2.95 paper.

"There is always something to be depressed about." Juliene Berk begins from this premise and then proceeds to tell us that we have a choice. If we wrap ourselves in "The Down Comforter" we may just learn some coping skills.

There are many books on the subject of depression. Some are written by experts in the field of psychology; others by lay persons who feel their experiences may be helpful to others. Berk takes the personal tack, although one has the feeling that she has consulted with professionals to provide that professional touch.

Part one suggests getting to know yourself and getting to know your depression. The symptoms and various levels are clearly outlined in a personal "talking to you" style. Part two suggests coping skills. This part provides many wise and helpful "nostrums", as Berk calls them, to aid

the sufferer. This is in essence the meat of the book. One gets the feeling that Berk knows what she is talking about and one is inclined to believe her views could help.

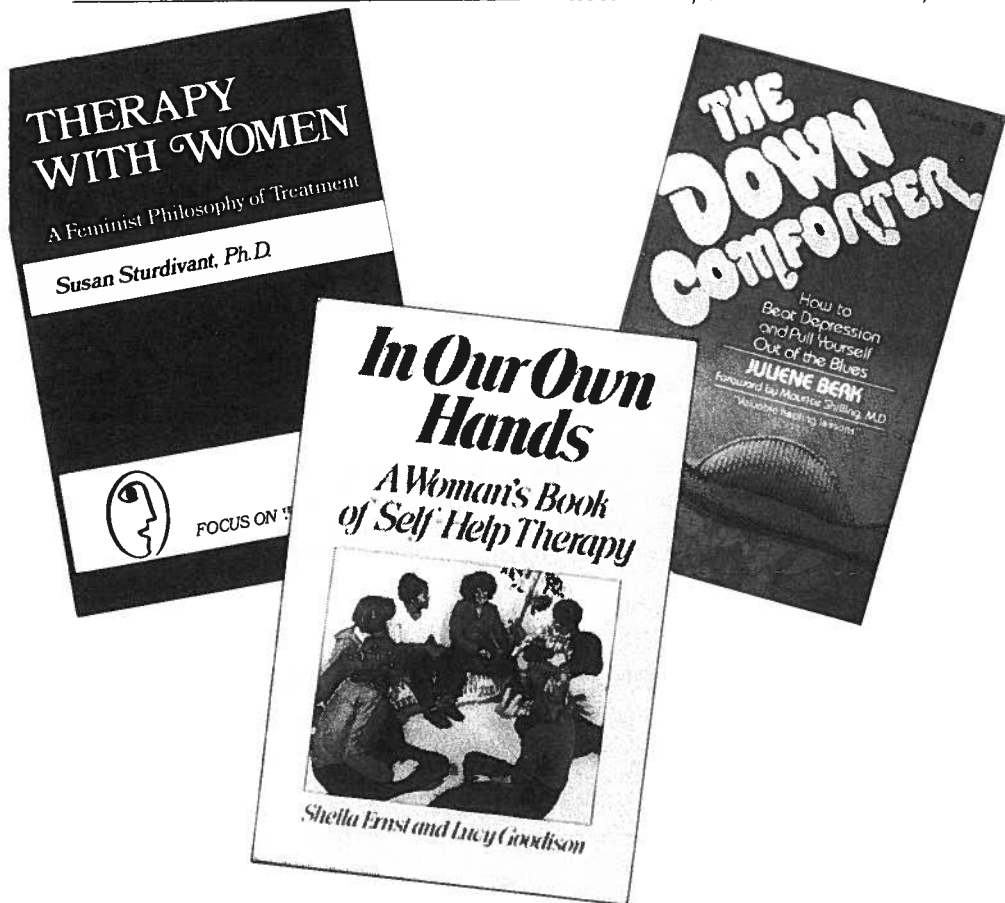
The final section is devoted to preventing depression. The helpful nostrums continue and are sound. One little line jumped out at me; it states, "dealing with things one by one — one piece at a time — is a first-rate coping device."

The book is logical, personal, filled with suggestions and with humour. Berk makes us feel that there is hope, that others have suffered as we do and that there is no shame involved only solid advice and HELP.

My only reservation about the book is a gut feeling that for many it would be too late. Once depression has a grip it would be very difficult to "read" your way out of it. Berk relies very much on the cognitive approach to therapy. She suggests analyzing, getting a grip on yourself, pulling out self-directed ploys for defeating the doldrums, short-term measures. All of the suggestions are good, sound advice. Unfortunately when one is in the middle of a depression no suggestions seem to work. Berk does acknowledge this and advises seeking professional help.

Read *The Down Comforter* and I am sure you will find some hidden truths. There is a lot of food for thought about self-concept and about anger. The book is very readable and full of good suggestions. Unfortunately there are few acknowledgements that depressed people often have a reality to be depressed about. Berk states, "the world does not change, we do." I believe sometimes we have to change the way the world is. Blaming the victim is not always the solution; there are social movements to help with the environment change as well.

Macha MacKay is a psychologist/counsellor at the Counselling Centre at Acadia University. She is also a board member of MATCH International, a non-governmental development program for women.



Regional Reports

BRITISH COLUMBIA

VICTORIA

**Susan Moger
Lorna Zaback**

Abortions in Jeopardy: Joe Borowski is preparing to challenge our already restrictive laws governing abortion and anti-abortion forces are rallying 'round. They are raising ever increasing funds and stacking hospital board elections. In many areas women's access to safe, legal abortion is already seriously limited.

In Victoria, after a difficult two and a half year battle, anti-abortionists have succeeded in disbanding the Therapeutic Abortion Committee at Victoria General Hospital. The Royal Jubilee Hospital picked up the slack and has been performing all of the therapeutic abortions for the area.

In the early part of next year Victoria General moves to larger quarters. Jim Nielsen, the Minister of Health, has announced his plan to move all obstetrics and gynaecology facilities out of the Royal Jubilee and into the new Victoria General. As a result of this move, Victoria General will be the only hospital where abortions can be performed. Given the current anti-abortion board at Victoria General, there is every reason to believe that come the New Year there will be no legal abortions available in the entire city of Victoria. Is this merely an innocent and practical move on the part of the Health Minister or is it part of a deliberate scheme to eliminate the availability of legal abortions in Victoria?

In response to this situation the Victoria chapter of CARAL is working on a brief proposing the establishment of an abortion and birth control clinic. This clinic would be outside the jurisdiction of hospital boards and would thus avoid the threat of board take-over by the right-to-life. The clinic will save money by not using the operating theatres and daycare facilities of a hospital. In addition, it will hope to ensure greater safety in the procedure by using local anesthetic.

Once the brief is finished, it will be presented to various community groups, city council, political parties and labour organizations for their endorsements. It will then be presented to the Minister of Health. CARAL would like to hear from anyone who has had experience in setting up or working in an abortion/birth control clinic. CARAL may be reached at Box 6282, Depot C, Victoria B.C. V8P 5L5.

To add fuel to the pro-choice fire in B.C., Dr. Henry Morgentaler is speaking in Vancouver and Victoria at the end of October.

VANCOUVER

Lorna Zaback

And Another New Health Collective: A group of women in Kelowna (in the Okanagan Valley of B.C.) is

working to set up a Women's Health Collective. They are starting to put together a directory of holistic health practitioners and services in the area and plan to pool their ideas and resources to provide women with greater access to holistic health techniques.

On the weekend of September 25 and 26, the Kelowna Women's Health Collective sponsored a series of workshops on women's health. The event was billed as a holistic health seminar; topics such as naturopathy and uses of local herbs were discussed. Two members of the Vancouver Women's Health Collective attended and spoke about collectivity, communications skills and the history of the Health Collective in Vancouver. Although still in its beginning stages, the Kelowna Women's Health Collective plans to meet together regularly. Their goals are to improve the quality of care that women receive from the healthcare system and to encourage women to take responsibility for their own healthcare.

With interest in women's health springing up in various areas of the province, the possibility of a British Columbia Women's Health Network just might be on the horizon.

ALBERTA

Ellen Seaman

Questionable Conduct: Is an Edmonton hospital subsidizing the activities of the right-to-life movement? At a public meeting in April featuring well-known right-lifer Bernard Nathanson, Dr. Philip Marcos, an Edmonton obstetrician, said that tape recordings of the meeting and copies of an anti-abortion slide show that had been presented at the meeting could be ordered through him. He suggested that these items be paid for through a donation to the Obstetrics and Gynaecology Department of the Hospital. This unusual arrangement could cause speculation as to who paid for the production of the materials in the first place. Is this a new method of Hospital fund-raising or is it simply reimbursement to the Hospital?

New Health Collective: A group of women in Calgary have formed the Calgary Women's Health Collective. Their goal is to develop printed resource material on women's health issues and sponsor a program of informal drop-ins and structured sessions. They are looking for helpful information from similar groups. We in Edmonton wish them every success.

MANITOBA

Lissa Donner

Breakthrough in Workers' Compensation: In a precedent setting decision, the Workers' Compensation Board of Manitoba has awarded a full pension to Shirley Warner, the victim of occupationally related cancer of the larynx.

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This decision is the first in which a "reverse onus" has been applied in a case of occupational illness. While acknowledging that there was no incontrovertible proof that Ms. Warner's exposure to cadmium fumes, in her work as a silver solderer, caused the cancer, the Board ruled in her favour. The decision was based upon the wording of Manitoba's Workers' Compensation Act which specified that "where the accident arises out of the employment, unless the contrary is proven, it shall be presumed that it occurred in the course of the employment."

Other important amendments made to the Workers' Compensation Act include:

- 1) coverage for workers in personal care homes, group homes and child care centres.
- 2) coverage for domestic workers employed more than 24 hours per week.
- 3) the establishment of a Workers' Advisors Program, funded by the Workers' Compensation Board, but reporting to the Minister responsible.
- 4) the opening of medical files of the Workers' Advisors, with the claimant's permission. This change was strenuously opposed by the Manitoba Medical Association who argued that the medical evidence and opinions submitted to the Board should remain privileged and not accessible to the claimant or her/his representative.

These legislative changes, and the application of the reverse onus rule are hopefully early indicators of future practice and mean that Manitoba workers can expect an even break at Workers' Compensation, at least until the next election.

SASKATCHEWAN Regina Healthsharing Inc.

Crisis in Reproductive Rights: Women's right to reproductive freedom remains a central issue on the Saskatchewan scene. While we retain the dubious honour of having the highest adolescent pregnancy rate in Canada, our new government is continuing to cut back preventive programs. The single provincial family planning coordinator has taken an educational leave and has not been replaced. The Board of Education has reduced its health education coordinator from full to part-time. The Women's Division, Department of Labour, is faced with serious staff reduction and its very existence is rumoured to be in serious jeopardy.

Meanwhile, both Moose Jaw and Prince Albert hospitals have, due to anti-choice pressures, been forced to stop all abortion services. Yorkton Union Hospital has lost its accreditation which means that they can no longer legally perform abortions. The government has removed four women from the Saskatoon University Hospital Board and appointed four men to replace them. Decisions regarding Moose Jaw and Prince Albert Hospitals lie with the Minister of Health who repeatedly publicizes his anti-abortion

bias, to the point of inviting the League for Life to apply for provincial funding.

A pro-choice coalition is forming in Regina and Saskatoon and it is hoped that a strong lobbying force will emerge. We will be looking to our sisters in all provinces for support, now and during the Borowski trial.

ONTARIO Toronto Women's Health Network

Successful Beginnings: Due to the questionable legal status of midwifery in Ontario, the Ontario Association of Midwives (OAM) decided to establish a defense fund to assist midwives who may have legal problems. A group of concerned women in Toronto has set up the Alternative Birth Collective (ABC) to campaign to develop support and to raise funds for the OAM.

The ABC kicked off its campaign with a highly successful and energetic children's benefit concert on October 3. ABC is proud to contribute a substantial amount from the proceeds of the concert to OAM's defense fund. Stay tuned for what's next in their activities — a dance and an educational series.

Abortion Coalition: The availability of safe legal abortions is being drastically eroded in Toronto, and in Ontario generally. Birth Control counsellor Michele Dore describes the situation as the worst it has been since abortions were made legal in 1969 — hospitals are tightening up, quotas are being reduced, the cost to the client is soaring and delays are forcing women to undergo saline rather than vacuum aspiration procedures. The fear is that things are only going to get worse.

In response to this situation and Dr. Morgentaler's repeated announcements that he will be opening an abortion clinic in Toronto this fall, representatives from various groups (women's, health, labour and others) have established the Ontario Coalition for Abortion Clinics (OCAC). The primary function of the Coalition is to inform the public about the need for free-standing abortion clinics and to build public support for the legalization and establishment of such clinics. OCAC can be contacted at Box 935, Station Q, Toronto Ont. M4T 2P1.

QUÉBEC

Clara Valverde

Depressed Anonymous: Self-help and mutual support are the focus of Depressed Anonymous, a Montréal centered group for those trying to deal with depression. The organization, which began three years ago, has expanded into 25 groups of 15 to 20 people who meet weekly, throughout the city and province, to discuss how they cope with depression. In its efforts to demystify depression,

Regional Reports

Depressed Anonymous stresses the importance of having its discussion groups led by lay people who themselves have experienced depression. Although many of the members of Depressed Anonymous are also in individual therapy, they feel that sharing their thoughts and fears in a group situation can play a vital role in coming to an understanding of depression.

Depressed Anonymous has a waiting list. They are in desperate need of people who can assist in leading the individual groups, both in Montréal and the rest of the province, and in either French or English. They can be reached at (514) 845-8653.

Parenthood (PP) of N.S. PCWC's unique *active* affiliate role with PP will be featured during CBC's 1982-83 "Access" program schedule, highlighting the educational work of PCWC's Irene Brennon. A new program for the Centre is a Battered Women's Information Service Project funded by the Secretary of State.

Incest Conference in Halifax: The Interagency Staff Development Group (ISDG) of the Halifax-Metro area has chosen incest as the topic for the second in a series of conferences planned for the immediate future. Following a highly successful conference in May on Women and Depression, the Incest Conference is aimed at frontline workers in social service, education, and medical professions. According to Carol Wambolt, conference chairperson, a primary goal is to broaden understanding of the issue by exploring social analysis of the problem. Another major conference objective is to identify areas of skill development needed by those who encounter incest situations in their daily work. ISDG is an affiliation of seventeen member groups that came together in response to a report from the Women's Counselling Collective (of Halifax) which identified gaps in social services available to Metro area women and their families. ISDG has two more conferences planned in this current series. Direct inquiries to: C. Wambolt, 1225 Barrington St., Halifax, N.S. B3J 1Y2; (902) 429-4063.

NOVA SCOTIA

**Susan Hower
Winnifred McCarthy**

Open House for PCWC: Pictou County Women's Centre celebrated a move to improved facilities in Stelleron this fall. Springing from a local women's group of the early 70's, PCWC developed under an International Women's Year grant in 1975 to provide a health, support, information centre and well women clinics. Today PCWC is affiliated with Prepared Childbirth of N.S. and Planned

Abortion Clinics

Plans are underway to open a free-standing abortion clinic in Toronto, with talk of eventual clinics in Winnipeg and other Canadian cities. (For more information, see Ontario Regional Report in this issue).

Your support is needed. Attorney General for Ontario, Roy McMurtry is threatening to prosecute any doctors operating such a clinic. Write to tell him what you think of this. Further, Minister of Health Larry Grossman needs to know that women want ready access to safe, medically insured abortions, which would be possible if he would legalize free-standing abortion clinics. Write the above, c/o Queen's Park, Toronto, M7A 2K5.

If you can make a financial contribution, many women will thank you. Send donations to:

OCAC
Box 935
Station Q
Toronto, Ont.
M4T 2P1

THE HAKOMI METHOD



**Non-Violent, Body-Centred
Psychotherapy Through
Inner Awareness**

Beg. March 2
1983

Abused
Women's Group

March 19-20
1983

Introductory
Workshop

April 18-24 1983

Professional
Training

Information: (Toronto)
Wendy Wildfong 977-0119
Jon Eisman 656-8150

MOUNT SAINT VINCENT UNIVERSITY

Canada's only women's university is asking one dollar from every woman throughout the country to support scholarships and bursaries for deserving women of all ages and to fund neglected areas of research into women's issues.

The university launched its first national fund-raising campaign four years ago. The goal was \$3.5 million and without the old boys network, it hasn't been easy. To date, \$2.5 million has been raised in pledges, many of which are contingent on whether or not the university can raise the rest during the next few months.

The first \$2.5 million had to go to much-needed facilities because the Mount is bursting at the seams with hundreds of mature women returning to full time study. A major disadvantage has been that the university, built by women for women at a time when women were not welcomed in such circles, has no endowment funds.

Mount St. Vincent needs your help. Be part of a network of Canadian women helping other women by sending your name and \$1. to Development Office, Mount Saint Vincent University, 166 Bedford Highway, Halifax, Nova Scotia, B3M 2J6.

Letters

We reserve the option to print letters to Healthsharing with minor editing for length, unless they are marked "not for publication".

Thank you, Amy

My emotional response to your story *For My Mother* (Fall, 1982) continues to flow within me. I only wish the words I want to say would flow . . .

Thank you — thank you for sharing such an intimate moment with me, with all of us. Alone in my room, I wept for me and my mother and for you and your mother and for all the love between daughters and mothers everywhere.

Somehow, now I don't feel as alone as I have these past ten years. Thanks, Amy, for sharing your story and your strength. I needed it.

Ren Duinker
Lakefield, Ontario

National Breast Screening Study

We were distressed to learn that Health and Welfare Canada included with Family Allowance cheques this past summer a flyer urging women aged 40 to 59 to "help themselves" and "women everywhere" by participating in a National Breast Screening Study.

The study, being conducted by the Cancer Institute, is designed to determine whether screening by mammography will reduce the number of deaths in Canada from breast cancer in women over 40. Mammography is the examination of the breasts by x-ray to detect lump formations before they can be felt by hand. There are problems with this approach to early detection.

As with other x-rays, the radiation used in mammography may damage breast cells and possibly cause cancer. This can

occur within a year or after many years. In 1977, the U.S. National Cancer Institute appointed three committees to study the effects of mammography. These studies confirmed concerns that repeated radiation exposure with mammography was probably causing more breast cancer than it was detecting. The committee published guidelines recommending that mammography screening be confined to women over 50, those with a mother or sister who had breast cancer and those with a previous history of breast cancer.

The risks of radiation are proportional to the amount of radiation absorbed into the body. Each country has established a regulated "safe" level. However, the actual "safety" of even these dosages is in dispute. Each single exposure carries with it the potential to mutate genes or cause cancer. The likelihood of danger increases with repeated exposure. The Health and Welfare flyer makes no mention of these dangers and does not say how, if at all, the study will take them into account in weighing the usefulness of the screening. We do not think five years' follow-up is enough to assess the long-term effects, even if a measure for this was built into the design, because the cancers precipitated by the radiation may not show up for twenty years.

We also question what the medical people involved propose to do when lumps are found. Mammography is not a reliable measure for distinguishing between malignant and benign growths. Benign cysts and lumps of various kinds form and are often reabsorbed into the surrounding body tissues. Some women have lump formations which enlarge

and reduce in cycle with their menstrual period. Sometimes lumps remain, harmless, in the same state for years. According to Hicks *et al* (1979), 38% of the women who are told, on the basis of a mammogram, that they do not have breast cancer, have it; 49% of those told that they do have breast cancer are told so incorrectly — they do not have it. Malignancy can only be confirmed by biopsy and we question the wisdom of biopsy for every beginning lump. If the follow-up to screening is to observe the development of the lump, watching for secondary symptoms, perhaps regular breast self-examination and attention to change is a safer, equally valuable approach. In any case, we think that women should know clearly the risks involved in this kind of study and the areas of controversy. As women, we need to be fully informed of the choices we make. We are critical of Health and Welfare Canada for appealing to women's sense of duty to help others and fear of breast cancer to get us to participate without giving a full picture of the risks we assume in doing so.

The Vancouver Women's Health Collective
Vancouver, British Columbia

Call for Films About Women

The National Film Board is coordinating screenings of films for departments in the Federal Women's Film Program. We are interested in knowing about films, video tapes and slide shows that are about women (women and work, women and health, etc.) If you have such a film, please send the technical information, a short description, plus distribution information to:

Ms. M. McEvoy, Federal Women's Program, 150 Kent St., Ottawa, Ontario K1A 0M9
Thank you very much.
Maureen McEvoy
Ottawa, Ontario

APOLOGY

To Sheryl Adam for spelling her name incorrectly in the by-line to *Cervical Cancer: The Facts* in our June issue.

Cervical Cancer

I'd like to congratulate Sheryl Adam on her very good article *Cervical Cancer: the Facts* (June, 1982). I found it to be well-written, clear and informative. I have some additional information on this subject which I would like to share with you and your readers.

There are two types of epithelium (lining cells) found on the cervix. The epithelium covering the external or vaginal surface of the cervix is called stratified squamous epithelium and is continuous with the same type of lining cells of the vagina. The lining cells of the cervical canal, however, are of a different variety called columnar epithelium. It is at the point where these two types of epithelium meet, the squamocolumnar junction, that most abnormal cell changes and, ultimately, cancer of the cervix occurs. It is thus important, when doing a PAP smear, to sample those cells at the squamocolumnar junction. In younger women, this junction may be readily evident on physical examination: the squamous cells give the cervix a shiny pinkish appearance, and the columnar cells look very red around the cervical os (the mouth or opening of the cervix). In the past, this redness was called cervical erosion, but is now known often to be normally protruding columnar cells of the cervical canal and called ectropion. As women get older, this junction moves up into the cervical canal and is not readily visible. Thus, a proper PAP smear in an older woman requires the use of a moistened cotton swab inserted into the mouth (os) of the cervix to reach the canal.

The position of this squamocolumnar junction, more externalized in younger women and increasingly internalized and therefore protected in older women, may relate to theories of the cause of cancer of the cervix. For instance, the increased risk of cervical cancer in women whose first intercourse is at early ages may be due to the unprotected presence of the squamocolumnar junction of

the cervix in the vagina, as it is, this junction which is more sensitive to external stimuli and where most abnormal cell changes occur. It appears that ages 15 to 20 are the susceptible period when first and subsequent intercourse predisposes to subsequent cancer. As a woman gets older, the junction is protected in the cervical canal and thus not exposed during sexual intercourse.

In addition, the epidemiological evidence has implicated not only early sexual exposure but also multiple partners as an important causative factor in cervical cancer. Thus there is the suspicion that an infective agent may be involved (e.g. the association with herpes simplex virus type 2). Perhaps the presence of the squamocolumnar junction in the vagina makes the cervix more vulnerable and susceptible to infection and cellular change in young women.

Ellen Buchman, M.D.
Toronto, Ontario

Networking

Two years ago, I wrote decrying my isolation from feminists concerned about women's health issues here in Cranbrook. I'm excited now to tell you that 15 women have organized a women's health collective here in Cranbrook recently. We came together to provide abortion referral and counselling when the local abortion committee changed and abortions were not available in this geographically isolated community. We have only just begun but feel good about the solidarity we are developing. We have plans to do workshops on many health issues after we have established several actions on the abortion issue. Your information will help us network with other similar groups. Keep up the good work. We appreciate it.

Darcy Russell
Cranbrook, British Columbia



Yes. Our graphics are great!

And original!

If you want to purchase art work you've seen in our magazine, please contact us. We will put you in touch with the illustrator.

Women Healthsharing

Resources

Listing of Women's Groups

This reference list groups general issue women's groups by province. Separate lists are provided for crisis centres, transition houses, periodicals, women's centres and government offices and programs. Readers are encouraged to send in information about new groups as well as revised information. This helpful guide can be obtained free from Women's Programme, Secretary of State, Ottawa, Ont., K1A 0M5.

Not A Love Story — A Discussion Guide

The National Film Board's 1981 film, *Not A Love Story: A Film About Pornography* is still being seen across the country despite regional censorship. The degree of intensity and the wide range of reactions to the film have not abated. Unfortunately, post-viewing discussions about the film and the issues it raises have sometimes been less than productive.

To help deal with this, the Vancouver Status of Women has produced a booklet and videotape. It aims to prepare group discussion leaders for the

kinds of issues and questions raised by the film's viewers. The kit has a definite feminist bias.

The videotape, *Pornography: A Women's Issue*, and the booklet, *Not A Love Story — A Discussion Guide* are available from the Vancouver Status of Women, 400A West 5th Ave., Vancouver, B.C. Costs: \$75.00 to purchase, a donation to borrow.

Quebec Commemorative Publication

Des Luttes et des Rires de Femmes was a feminist magazine from Montreal that folded for financial reasons in September 1981. The group of women who produced the magazine have recently released a special commemorative publication, *Sans Fluers ni Couronnes*. This retrospective contains writings on the political process around the production of *Des Luttes et des Rires* as well as reprints of noteworthy articles.

Copies of this "page from Québec feminist history" are available for \$6.00 from Librairie Les Mutantes, 161 Rue St. Jean, Québec, Que. G1R 1N4.

Midwifery Conference

The B.C. Association of Midwives is having its third conference February 18-20, 1983 in Vancouver, B.C. Program highlights include an update on the status of midwifery across Canada, discussion on certification issues, strategy planning and networking.

For more information write to the B.C. Association of Midwives, 1053 Douglas Cres., Vancouver, B.C. V6H 1V4.

Celibacy

The first issue of a new periodical, *The Celibate Woman: A Journal for Women Who Are Celibate or Considering this Liberating Way of Relating to Others* is now out. Editor Martha Allen welcomes articles, artwork, letters, experiences and ideas.

The journal is published irregularly. Cost: \$4.00 per issue. Available from 3306 Ross Place N.W., Washington, D.C., U.S.A. 20008.

Review of Canadian Abortion Policy

Dr. Larry Collins' article, *The Politics of Abortion: Trends in Canadian Fertility Policy*, is must reading for all of us in the pro-choice movement. Its historical perspective details the federal government's manoeuvring around the issue of abortion. Readers come away with a clearer picture of the inconsistencies and, at times, chaos in our abortion policy and some of the reasons for it.

The article appeared in the Spring 1982 issue of *Atlantis: A Women's Studies Journal*, Mount St. Vincent University, 166 Bedford Highway, Halifax, N.S. B3M 2J6. Subscriptions cost \$7 per year (2 issues).

The Menopause Story

This new film by Marilyn Belec (producer of *Taking Chances* and *Teen Mother*) is primarily a group discussion about menopause with women ages 42-71. Feminist therapist Judith Golden is featured.

The Menopause Story is 30 minutes long. The film can be rented (\$50.00) or purchased (\$525.00) from Mobius International, 175 King St. E. Toronto, Ont. M5A 1J4.

Resources on Women and Therapy

The following are books that the members of the Feminist Therapy Study/Support Group found most helpful in learning about therapy, mental illness and feminism.

Colette Dowling, *Cinderella Complex*, Summitt Books, New York, N.Y., 1981. Explores the struggle women have between wanting independence versus dependence by showing how women have been socialized to be taken care of.

Ann P. Hinton, Linda Sherby and Lynne Tenbusch, *Getting Free: Women & Psychotherapy*, Grove Press, New York, N.Y., 1982. Presents case studies on specific issues in women's lives — sexuality, anger, relationships with men.

Jean Baker Miller, M.D., *Towards a New Psychology of Women*, Beacon Press, Boston, Mass., 1977. Shows how women can come to grips with the fears and insecurities bred into them and how these feelings have been rationalized by traditional psychoanalysis.

Barbara Ehrenreich and Deirdre English, *For Her Own Good*, Anchor Press/Doubleday, Garden City, N.Y., 1979. Historical overview of how women's health of the last 150 years has been shaped by the so-called experts.

Additional Books:

Ann Kent Rush, *Getting Clear: Body Work for Women*, Random House, New York, N.Y., 1973

Hogie Wyckoff, *Love, Therapy and Politics*, Random House, New York, N.Y., 1979

Dorothy Smith and Sara David (ed.), *I'm Not Mad, I'm Angry*, Press Gang, Vancouver, B.C., 1975

Phyllis Chesler, *Women and Madness*, Doubleday, Garden City, N.Y., 1972

Ann Kent Rush and Anice Nander, *Feminism as Therapy*, Random House, New York, N.Y., 1979

Barbara Gordon, *I'm Dancing as Fast as I Can*, Harper & Row, New York, N.Y., 1979

Adrienne Rich, *Of Woman Born: Motherhood As Experience and Institution*, Bantam Books, New York, N.Y., 1977

Stanlee Phelps and Nancy Austin, *The Assertive Woman*, Impact Publishing Inc., San Luis Obispo, Cal., 1975

Jean Baker Miller (ed.), *Psychoanalysis & Women*, Penguin Books, New York, N.Y., 1973

Alexander Lowen and Leslie Lowen, *The Way To Vibrant Health: A Manual of Bioenergetic Exercises*, Harper & Row, New York, N.Y., 1977

Signe Hammer, *Daughters and Mothers, Mothers and Daughters*, New York Times Book Co., New York, N.Y., 1975

Susie Orbach, *Fat is a Feminist Issue*, Paddington Press, New York, N.Y., 1978

Natalie Woodman and Harry R. Lenon, *Counselling With Gay Men and Women: A Guide for Facilitating Positive Life-Styles*, Jossey-Bass Inc., San Francisco, Cal., 1980

Irene Claremont de Casillejo, *Knowing Women: A Feminine Psychology*, Harper & Row, New York, N.Y., 1974

Dru Scott, *How To Put More Time Into Your Life*, Rawson Wade Publishers, New York, N.Y., 1980

Dorothy Dinnerstein, *The Mermaid and The Minotaur*, Harper & Row, New York, N.Y., 1976

Elizabeth Wilson, *Women and the Welfare State*, Women's Press, Toronto, Ont. (Canadian distributor), 1977

Ann Kent Rush, *The Basic Back Book*, Moon Books and Summitt Books, Cal., 1979

Gerald Kogan (ed.), *Your Body Works: A Guide to Health, Energy and Balance*, And/Or Press, Berkeley, Cal., 1981

Irvin D. Yalom and Ginny Elkin, *Everyday Gets a Little Closer*, Basic Books, New York, N.Y., 1974

Dorothy Jongeward and Dru Scott, *Women As Winners*, Addison-Wesley Publishing Co., Don Mills, Ont., 1976

Virginia Satir, *Peoplemaking*, Science and Behavior Books, San Alto, Cal., 1972

Nancy Friday, *My Mother Myself*, Dell Publishing Co., New York, N.Y., 1977

Diane E. Russell, *The Politics of Rape*, Stein and Day, New York, N.Y., 1975

Marilyn Ferguson, *The Aquarian Conspiracy: Personal and Social Transformation in the 1980's*, J.P. Tarcher, Los Angeles, Cal., 1981