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LOST IN THE DIAGNOSIS:
INCEST SURVIVORS IN PSYCHIATRY

by

KATHLEEN WHIPP

A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfillment of
the requirements for the degree of

Master of Social Work

Department of Social Work

Carleton University
Ottawa, Ontario
April 29, 1991

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"LOST IN THE DIAGNOSIS: INCEST SURVIVORS IN PSYCHIATRY"

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in partial fulfilment of the requirements for
the degree of Master of Social Work

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ABSTRACT

This is a ground-breaking look at the psychiatric experiences and needs of the large proportion of women "psychiatric patients" who are, in fact, unidentified or unacknowledged sufferers from the trauma of incest. A whole new dimension is added to Rieker and Carmen's "victim to patient process": inadvertent revictimization by psychiatry itself.

During in-depth feminist interviews ten such women recount their experiences as "patients". Revictimization was found to be a common occurrence, so that psychiatry was often described as "crazy-making". Many traditional psychiatric attitudes and the diagnostic framework repeat aspects of the incest trauma and decontextualize women's strengths labelling them as weaknesses.

Participants' experiences with medication and survival mechanisms including "mania", suicide, self-injury and lying are detailed. The final chapter offers survivors' wisdom on what forms of support they actually need, such as control over their own process, and women's healing homes.

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Most all I wish to thank the women who shared their experiences of psychiatry so that others may benefit. Not all of them are represented here. One volunteer generously gave her story, and it was not until after, that I realized she didn't meet the criteria for "late disclosure/acknowledgement" of the abuse. Some have been clients in residential, hospital and sexual assault centre settings where I have worked, who cried out repeatedly for relief and understanding. Working on this project has indeed been a sacred trust.

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CHAPTER I
PRESENTATION OF THE PROBLEM

Introduction

i promised you i wouldn't tell
anyone
anything.
anything
to make you go away.
...and i kept my promise
by burying my childhood with
you.

buried so far down
it transformed itself...
...they didn't understand
where my pain was coming from--
i didn't understand
and thought i was crazy.

Tracy Nagurski

Self-help and counselling manuals for women survivors of childhood incest refer to fear of "going crazy" as a common reaction to the abuse. Nightmares, terrifying flashbacks, feelings of worthlessness, betrayal, and rage are muzzled first by perpetrators, and later by society at large. Women seeking relief and support thus find themselves in the impossible position of needing to be believed and understood, while caught in a "conspiracy of silence".¹ Incest survivors have had to transform, keep secret, or repress these memories.

Meanwhile, the most accessible mode of "treatment" in Canada is psychiatry, mandated to look for signs of "mental illness". When it comes to incest in particular, psychiatry as a profession has a long tradition of interpreting such

reports as "fantasy" (Glueck, 1963; Herman & Schatzow, 1987; Rosenfeld, 1979; Goodwin, 1985). In this milieu, typical post-traumatic responses to sexual victimization such as flashbacks, dissociation, addictions and inability to trust, if interpreted in isolation from the abuse, can easily be treated as merely "symptoms" of psychiatric conditions.

We are only beginning to identify and gather insight into the needs of women incest survivors who seek help from psychiatry. To date, we have no in-depth evaluation or even descriptions of psychiatric treatment from the perspective of incestuously abused "patients", themselves. However, Rieker and Carmen's (1986) "Victim to Patient Process", along with works by Herman and Schatzow (1987), Beck and van der Kolk (1987), Herman and van der Kolk (1987), and Bryer, Nelson, Miller and Krol (1987) offer insight into connections between abuse and "mental disorders", with implications for "treatment". Not the least of these is the potential for revictimization by psychiatry, itself.

Herman (1984) believes that changes are "percolating up from the rank and file of mental health professions", the majority of whom are women. They and a few women psychiatrists have "struggled hard--often with a lot of courage--to challenge their colleagues and question longstanding theories which everyone honored" (p. 8). It is no accident that it is primarily women in psychiatry who are risking loss of professional acceptance out of concern for survivors of

violence. The targets of sexual assault are primarily women and children, most often girl children, and the overwhelming majority of incest perpetrators (98.8%) are male (OACWI, 1990).

My experiences, which now include twelve years as a counsellor, a double field placement in out-patient psychiatry, and intensive work with women who were sexually abused, have raised many critical questions about psychiatric intervention. When I undertook this project I was especially curious about the large group of women who had been "patients" for years, and either had never directly disclosed that they were incest survivors, or had not been believed or encouraged to explore the abuse as a possible precipitant to their present "condition". I wondered how their experiences as "patients" under such circumstances had affected them. I noticed, too, that workers in psychiatry were unsure of how, and even if they should promote disclosure and exploration of incest with an acutely or chronically "disturbed patient".

This inquiry is also guided by my early academic/professional background in child development and mental health promotion, along with more recent exposure to feminism. Like Stanley and Wise (1983), I believe that "any state of consciousness is deeply rooted in particular sets of experiences" (p. 79). These perspectives have both enabled me to view "disturbed" behaviors of incestuously abused adults as survival responses, and inspired my interest in examining

psychiatric intervention for incest survivors through their experiences.

Research Question

The central question is "Since many women psychiatric 'patients' have either not disclosed their histories of incest, or have not been acknowledged by professionals as suffering from this trauma, what are their experiences with psychiatry under these conditions?" I have coined the term "late disclosure/acknowledgement" to label this common experience of incest survivors in psychiatry. In their own words, women were asked to tell their stories of involvement with the mental health system and to describe its impact upon their well-being, including what was and was not helpful in their healing from abuse.

The term "incest", unless otherwise noted, is defined broadly here in accordance with the experience of sexual assault survivor organizations. Not limited to blood relatives, the focus is on the traumatic effects of childhood sexual abuse committed by a more powerful person who betrays the child's trust (Ellenson, 1986). I use the term "survivor" primarily, rather than "victim", in order to emphasize these women's strengths and continual struggles for empowerment.

The literature review in Chapter Two includes discussion of the prevalence of incest survivors in psychiatry, long-term

psychiatrically relevant effects of incest, and our mental health system's capabilities for detection and understanding of survivors of violence, particularly incest, from a historical and feminist perspective.

Research findings have been divided into three chapters, based on themes that emerged as these women told their stories of psychiatry. Chapter Five is a summary of their experiences with traditional psychiatric approaches. These are further illuminated and contrasted in Chapter Six on difficult to understand behaviors of incest survivors in psychiatry, such as self-injury. Lastly, in Chapter Seven the ten participants share amazingly similar views on what they actually needed from counsellors during this period of their lives, leading to recommendations for major changes.

CHAPTER II

LITERATURE REVIEW

Underreporting, Prevalence and Disclosure

In 1896, after "the most laborious and detailed investigations" (p. 259), Freud claimed that all eighteen of his "patients" with "pure hysteria" and "hysteria combined with obsessions" revealed repressed memories of early sexual abuse.

Yet since that time, up to the present decade with the growth of the women's movement (see "conceptual framework"), there have been few reported cases of child sexual abuse both inside and outside psychiatry. These consisted primarily of court reports and spontaneous patient disclosures deemed credible by a few clinicians. As late as 1975, Freedman, Kaplan and Sadock in their major training text, Comprehensive Textbook of Psychiatry, quoted Weinberg's official estimate of the incidence of incest, one case per million population.

Underreporting

Recent surveys are increasingly finding incest far more prevalent than had been previously estimated both among women "psychiatric patients" and in the general population. Findings vary with differences in data collection that either facilitate or inhibit disclosure. Peters, Wyatt and Finklehor (1986) say experiences of child sexual abuse will not be reported in surveys if they are either (1) blocked and not

accessible to retrieval, (2) partially forgotten but not retrievable without the right prompting, (3) in memory but are not defined according to the terms used in survey questions, or (4) not volunteered due to embarrassment or to other conscious withholding.

To enhance recollection and openness of response, they recommend face-to-face interviews over self-administered questionnaires and telephone surveys, intensive training and screening of interviewers to ensure their comfort with the subject matter, and the use of multiple, specific questions with a variety of memory cues. Even so, for many incest survivors in psychiatry, memories of victimization surface only after long-term in-depth psychotherapy with alert and receptive counsellors.

When attempting to make comparisons of survey results, the reader must also note the lack of standardization in definitions used for incest. Childhood age limits, types of behaviors considered abusive, and other defining characteristics, such as use of force and age discrepancies between the perpetrator and the victim, all vary from study to study.

General Population Rates

For comparison, findings from large-scale nonclinical population surveys on sexual abuse of girls range from 6% (under 16) in research conducted by Burnam, to 62% (under 18) in Wyatt's survey (Peters, Wyatt & Finkelhor, 1986). Wyatt followed many of Peters et al's methodological guidelines, as

did Russell (1986) in her survey of 930 women of whom 54% disclosed histories of child sexual abuse. Russell found these two studies yield findings for all forms of sexual abuse, including non-contact, before the age of 18, that are "astonishingly similar" and "mutually validating", after recalculating her data to conform to Wyatt's sample aged 18-36 years.

Canadian figures from an anonymous questionnaire distributed in 210 communities are one in two females at some time in their lives fall prey to "unwanted sexual acts", with four in five of these incidents first occurring when they were children or youths (Badgley, 1984).

More particularly, incest, defined in surveys as sexual abuse by family members, was discovered by Russell among 19% of the 18-36 year old sample, while Wyatt's figure is 21%. Russell's larger sample of women aged 18 and older reported 16% incest prevalence overall. Four and one-half percent of the population surveyed were abused by their fathers.

Psychiatric Populations

After comparing Russell's interviewees with a group of women "psychiatric outpatients", Herman, Russell and Trocki (1986) emphasize that any similarities in prevalence rates among clinical and general population samples may be misleading. These two groups differed markedly in the types of histories judged most traumatic by the women in the community sample. For example, 75% of survivors who were

"outpatients" reported father-daughter incest versus a 28% rate amongst survivors in the nonclinical sample. Abuse was seven times as likely to be frankly violent in the clinical group, and more than two and a half times as likely to be of long duration.

In an attempt to compare psychotherapy and nonclinical groups for both prevalence and long-term effects, Briere and Runtz (1985a) conducted parallel surveys. They found 44% of 152 women community health centre clients admitted histories of child sexual abuse involving physical contact before age 15, to an intake worker, compared with a 15% questionnaire response by 278 women university students. While their general population figure was consistent with those found by Finkelhor and Russell, the high proportion of survivor clients represented a "newer finding". They hypothesize that the clinic's reputation, known for its services to victims of violence, might explain the high rate of reported child sexual abuse.

However, since then two more recent clinical surveys have produced similar results: 46% of chronically hospitalized "psychotic" women's records contained disclosures of childhood incest (Beck & van der Kolk, 1987), and 44% of women "inpatients" reported child sexual abuse before age 16 (Bryer et al, 1987). Both of these figures are conservative. In Beck and van der Kolk's study "the incest was typically reported in long-term psychotherapy to clinicians who were not looking for

it and who had no particular interest in finding it" (p.1476). Bryer et al found a positive relationship between the degree of abuse and severity of symptoms. They believe their

results probably underestimate the incidence of abuse because many of the disturbed potential subjects could not give informed consent or complete a self-report instrument...also suppression and repression of memories of these traumatic events may have been factors in some eligible subjects' choosing not to participate after reading a description of the study (p. 1429).

Herman and Schatzow (1987) found repressed memories to be common, even among women who sought help for incest abuse. The majority, 64% of referrals for their incest survivor's therapy group, did not have full recall of the abuse and reported some degree of amnesia. Twenty-eight percent came with severe memory defects.

The highest psychiatric prevalence figures to date are reported by Briere. He found 70% of "nonpsychotic" women presenting at a psychiatric emergency department disclosed histories of child sexual abuse when asked, compared to a control group rate of 6% disclosure, when women were not specifically questioned (Sellers, 1988).

Difficulties with Disclosure

Briere's study, along with others by Herman (1986) and Mills et al (1984) illustrate how influential clinicians can be in facilitating disclosures of incest. Usual psychiatric hospital procedures yield rates even lower than those in general population studies. Herman points to the "generally

low level of awareness of the prevalence and significance of violence, even among sophisticated clinicians" (p. 139). Most therapists also avoid discussion of incest abuse because of their own discomfort (Goodwin, 1985; Rubinelli, 1980; Benedek, 1984). Sgroi et al (1982) remark that they know of no other clinical situation in which the professional's "payoff" for denial equals or exceeds the client's.

Both Herman and Schatzow (1987) and Beck and van der Kolk (1987) went to great lengths to counter expected skepticism of colleagues, by seeking verification of reported incest from relatives. A surprising proportion of Herman and Schatzow's incest survivors' group (74%) were actually able to obtain confirmation that the abuse occurred, while 11% of members made no attempt to obtain corroborative evidence.

Breaking silence by obtaining such confirmation from within the family means survivors must weigh the many risks involved.² Bass and Davis (1988) in Courage to Heal, say that "secrecy...is the foundation of abusive family structures" (p. 133). One of the hundreds of survivors they interviewed put it this way:

What's hindered me the most is being so skilled at being silent. Incest has had so much to do with being silenced and silencing myself (p. 92).

Testimonies of survivors recount numerous obstacles that women have had to overcome in order to disclose their histories of abuse (Armstrong, 1978; Bass & Davis, 1988; Russell, 1986).³ Barriers to disclosure include protective

instincts well developed by survivors, whose past attempts to communicate their pain (in whatever roundabout ways that were available in their powerless situations) have been unnoticed, rebuffed and punished. Implicit or explicit threats by the abuser are always linked to breaking the silence. Disclosure often does bring on terrifying flashbacks of the abuse (Gelinas, 1983), so that survivors' fears of "going crazy" and "losing control" without ample supports are well-founded in experience.

Nevertheless there appears to be a consensus amongst incest pioneers in psychiatry that the burden of responsibility for asking about incest lies with the therapist (Herman, 1981).⁴ Not asking about past sexual abuse implicitly gives the survivor a message that it can't be discussed, say Bryer et al (1987).

Over and over we have heard the testimony of victims who longed for the opportunity to talk about their experiences with a helping person and who waited in vain to be asked (Herman, 1981, p.178).

To summarize, histories of incest victimization among women "psychiatric patients" are being uncovered more and more frequently by a few clinicians and researchers who are sensitive to the difficulties of disclosure. The latest studies reveal that 44% to 70% of female mental health populations have been incestuously abused as children. Yet, the frequency of repressed memories and correlation of abuse

with severity of symptoms mean many survivors are still not identified.

Low prevalence figures and difficulties with disclosure are not surprising given the perceptions of incest in psychiatry discussed in the section to follow on psychiatry's response to incest. Perhaps as important are the survival strategies needed by victims of incest to cope, not only with the abuse itself, but also with social attitudes.

Long-Term Effects of Incestuous Abuse

The vast majority of incest studies offer increasing evidence of deleterious effects on survivors' well-being, which often persist over long periods of time (Brier, 1984; Browne & Finkelhor, 1986; Herman & Shatzow, 1987). These will be summarized here as a basis for understanding incest survivors' needs for healing, and for examining psychiatry's responses.

Contemporary researchers have sought to document the harmfulness of incest by 1) describing the reluctance of "patients" to disclose and explore the abuse; and 2) designing retrospective surveys that include general population as well as clinical samples, and that test correlations between aspects of the abuse and severity of "symptoms".

We have had to rely on retrospective accounts, as secrecy has prevented long-term prospective studies to date; and data on short-term consequences in childhood is inadequate, since the effects may be identified years or even decades later (Russell, 1986). Even so, adult self-reports may be considered optimistic, because they measure only those long-term consequences recognized at that time by the women, themselves (Herman, Russell & Trocki, 1986; Bass & Davis, 1988).

Russell (1986) found half of women incest survivors in a community sample (not in shelters, institutions or group homes), recognized substantial long-lasting effects, and 27.2%

estimated that the abuse had had "a great effect" on their lives (Herman, Russell & Trocki, 1986).

Psychological impacts and behavioral manifestations of incest can be clearly understood as outcomes of what Finkelhor and Browne (1986) have identified, in their comprehensive survey of the literature, as the "traumagenic dynamics" of child sexual abuse: (1) traumatic sexualization, (2) stigmatization, (3) betrayal, and (4) powerlessness.

The trauma of incest is further compounded when it occurs with other forms of child abuse and neglect. Half of women "inpatients" who were sexually abused in childhood also reported early physical abuse, and their "psychiatric problems associated with child abuse appear[ed] to be more severe" (Bryer et al, 1987, p. 1429). Incest survivors are also, much more than women without such a history, vulnerable to further victimization (emotional, physical and/or sexual) in their adult years (Briere, 1984; Russell, 1986; Herman, 1981; Rosenzweig & Al-Zand, 1987).

Even so, a strong relationship between "abuse-related symptomatology" and perpetrator age, total number of abusers, use of force, father figure perpetrators, and duration of the abuse has been established in both general and clinical samples (Briere & Runtz, 1985a; Browne & Finkelhor, 1986).⁵ After comparing clinical and general population samples for these characteristics, Herman, Russell and Trocki (1986)

conclude "victims who become patients usually are those who have suffered the most severe early traumas" (p. 1296).

Coping Strategies or "Symptoms"

The following discussion of psychiatric "symptoms" does not negate my preference, along with that of some authors (Bass & Davis, 1988; Blume, 1990; Bryer et al, 1987; Esper, 1986; Rieker & Carmen, 1986) to stress the original and ongoing survival functions of these thoughts, feelings and behaviors.

Gelinas (1983) describes how incest survivors tend to seek psychiatric treatment without disclosing the early sexual abuse, showing instead a "disguised presentation".⁶ Along with other clinicians, (Blake-White & Kline, 1985; Bryer et al, 1987; Donaldson & Gardner, 1985; Goodwin, 1985; Herman, Russell & Trocki, 1986; Briere & Puntz, 1985a), she discovered beneath more observable "symptoms", a "chronic traumatic neurosis", or "post-traumatic stress syndrome", consisting of flashbacks of the abuse, impulsivity, confusion, hypervigilance, dissociated states, and nightmares. Flashbacks, intense reexperiencing of trauma, are accompanied by painful emotions, and can easily be mistaken as "psychotic decompensation", says Gelinas.

Similarly, Ellenson (1985; 1986) uncovered "masked symptoms" in all survivors he assessed. Fearing they will be considered "crazy", they avoid sharing recurring "thought content disturbances" and "perceptual disturbances" arising

out of the abuse. He found that not only do clients rarely volunteer histories of incest, but they even more rarely reveal the presence of these "symptoms", regardless of whether a history of incest has been revealed.⁷ Each of these "symptoms" can be understood as a memory of the original trauma and/or a protective coping strategy for the survivor or her child (see Appendix A).

Gelinas, Blake-White and Kline, and Bryer et al say that if this "traumatic neurosis" is not treated, secondary elaborations or more indirect paths are developed in order to deal with the distress.⁸ Herman and Schatzow (1987) say these same behaviors are also a last resort for women who suffered frankly violent or sadistic sexual abuse, and are neither able to utilize massive repression nor to depend on dissociation and isolation of affect. What they refer to as "maladaptive" coping strategies range from serious depression and suicidal ideation, free-floating anxiety, somatization, panic attacks and phobias, angry outbursts, impulsive risk-taking and substance abuse, to even more severe and confusing "symptoms", such as suicide attempts and "possibly psychotic" states.

The ability to dissociate or psychologically flee from an unbearable experience, is a skill that many children develop to deal with incestuous abuse. Briere and Runtz (1985a) have recently pioneered empirical documentation of dissociation as a long-term effect of child sexual abuse involving contact.⁹

Only a few clinicians have recognized how, depending on the severity of the child's experience of abuse and her difficulties in finding support, a fantasy world of safety may grow in importance for her survival. One woman explains in The Courage to Heal:

Mental hospitals were more like a respite for me because they got me away from my family...I had no control of my life whatsoever. I was in this body, but it was like I was this puppet, and everybody else pulled the strings. I had to get sick to get away. I just kept going further in my head, so I wouldn't have to deal with reality at all (Bass & Davis, 1988, p. 48).

"Inpatient" survivors of physical and/or sexual abuse had more "possibly psychotic or psychotic-like acute symptoms", and were given pharmacological treatment more often than those who did not disclose victimization (Bryer et al, 1987). Abused psychiatric "patients" also experienced longer stays in hospitals (Mills, Rieker & Carmen, 1985).

Among "chronically hospitalized psychotic" women, those who disclosed incest in long-term therapy had a much higher proportion of suspected organicity (75% versus 9%), substance abuse (58% versus 18%), major medical problems (50% versus 9%), "sexual delusions" (41% versus none), and histories of depressive "symptoms" (91% versus 36%) (Beck & van der Kolk, 1987).

Depression is the most frequently reported long-term effect of incest (McLaughlin, 1987; Finkelhor & Browne, 1986). Suicide may seem like the only way out when pain is overwhelming. In two different counselling intake surveys, Briere

and Runtz (1985a; 1985b) were told of at least one past suicide attempt by 51% and 55% of women survivors of child sexual abuse versus 34% and 23% of other clients.

Self-injury, more common among incest survivors (Sellers, 1988), is one way to make visible, and/or to find relief from the pressure they feel inside. It can also serve to gain control of pain, cope with self-blame, and express anger. For some women who have become numb in order to survive, it can be a means of regaining feeling.

After reviewing the research on anxiety (evidenced by nightmares, anxiety attacks and difficulty sleeping), Finkelhor and Brown (1986) conclude that this long-term effect of child sexual abuse has been widely confirmed in both quantitative studies and clinical observations.

Imbalances in interpersonal relationships were observed by Gelinas (1983) to be the reason that most women incest survivors originally sought "treatment". Patterns characterizing their early years affected later attempts to form healthy intimate attachments. Often lacking sufficient self-esteem, positive role models, and trust in their own instincts necessary to minimize involvements with potentially abusive partners, survivors of incest are more likely to be victimized by battering and rape in marriage (Briere, 1984; Russell, 1986). Briere (1984) found 48% of survivors in clinical intake interviews reported fear of men (versus 15% of nonvictims) and 12% shared their fear of women (versus 4%).

Several clinicians have also noticed that survivors often fear, and many actually discover that their daughters are being sexually abused by these same partners (McLaughlin, 1987; Gelinas, 1983). Bass & Davis (1988) interviewed survivors who revealed distressing thoughts of hurting their own children, and a few who acted out these feelings, before they became actively engaged in healing.

A backlog of anger was noted in 44% of clinical articles on incest survivors (McLaughlin, 1987). More than twice as many of the women who had been sexually abused in childhood said they had "trouble controlling their tempers", as those who had not (Briere, 1984).

Feelings of isolation, and a sense of being branded, marked or stigmatized by the abuse, were shared by all of Herman's (1981) clinical group of father-daughter incest survivors, and 73% of Courtois' (1979) community sample of former incest victims. Sixty-four percent of Briere's sexually abused respondents shared strong feelings of isolation.

McLaughlin (1987) found sexual problems cited in 74% of the mental health literature on incest. For example, Meiselman (1978) in a clinical sample, and Courtois (1979) in a general population survey, discovered around four-fifths of incest survivors reporting problems in sexual functioning.¹⁰

Additionally, empirical evidence now supports connections between childhood incestuous abuse and prostitution,

addictions to alcohol and drugs, and compulsive eating patterns developed to escape from, and gain control over aftereffects of the trauma (Browne & Finkelhor, 1987). McLaughlin (1987) cites other effects noted by clinicians including confusion (in 44% of articles), and somatic complaints, such as headaches, backaches, abdominal pain, and gynecological problems (in 32% of the literature). The most comprehensive clinical reference to date, Secret Survivors, contains an "after-effects checklist" of 34 different categories of characteristics common to survivors of incest (Blume, 1990).

Child sexual abuse in the long run, then, can be so pervasive that

it permeates everything: your sense of self, your intimate relationships, your sexuality, your parenting, your worklife, even your sanity. Everywhere you look, you see its effects (Bass & Davis, 1988, p. 33).

Psychiatry's Response to Incest Then and Now

In order to understand the experience of being a late disclosed/acknowledged incest survivor in psychiatry, "treatment" assumptions and practices must be examined for both incest abuse that has, and has not been identified. The remainder of this review of the literature recalls psychiatry's views of incest historically, identifies many hidden or unacknowledged incest survivors by the "diagnoses" they are given, examines some implications for survivors in this system of "diagnosis" and "treatment", highlights recent pioneering work of incest experts in the field, and raises issues identified by survivors themselves.

Freud and Psychoanalysis

Far from being a "pure science", contemporary psychiatry is strongly influenced by dominant beliefs and values. Because incest abuse has been kept a secret in patriarchal societies, psychiatric theories have developed without recognition of the prevalence and impact of sexual victimization.

Freud appears to be the first, in 1896, to believe in the truth of adult survivors' memories, and to clearly link early incest victimization with psychological "symptoms".¹¹ His paper, "Aetiology of Hysteria", met with reactions of "disavowal and disgust" from colleagues (Masson, 1985). The medical climate at the time was characterized by concerns for

the "unjustly" accused abuser, and the preponderance of "simulated" reports of sexual attacks, from children who lie for attention, greed, revenge or "to give themselves over to debauchery" (p. 44), acting out their "evil instincts" and "evil passions". Stories of rape were also suspect, especially coming from "hysterics", who supposedly had "genital hallucinations" resulting from their "illness" and also "invented mendacious stories with the sole purpose of attracting attention to themselves and [in an attempt] to make themselves interesting" (p. 46).

After several years of being considered a "crackpot" (Cole, 1982), Freud only gained a following when he began to retract his evidence of incest trauma. He constructed elaborate theories to explain how these disclosures were actually "phantasies which my patients made up" (Masson, 1985 p. 11).¹² Rather than traumatic victimization of the child by the parent, Freud blamed the child's "infantile sexual yearnings" for the parent of the opposite sex and "innate aggressive impulses" against parents (Oedipus complex). Psychoanalysis, and its denial of the reality of most such disclosures, dominated psychiatric thinking from the 1920's to the mid-sixties (Cole, 1982).¹³

Only a few psychiatric clinicians such as Ferenczi (1932), Litin et al (1956), Glueck (1963), Molner and Cameron (1975), Peters (1976), Rosenfeld (1979), and Shengold (1979)

have questioned some aspects of Freud's revised incest theory, until recently.

Early Incest Studies

Lukianowicz (1972) found a scarcity of references on overt incest and remarked that, in comparison with anthropological sources, the psychiatric literature was not as extensive as "might be expected". Most of the few clinicians, who actually wrote about adult-child incest, applied existing misogynist psychological and medical models to what was still considered a rare event. Lukianowicz divided psychiatric theories of aetiology into physio-pathological (popular among French authors), and analytic schools.

The analytic view essentially extends Freudian fantasies into actions. An incestuous father is described as only attempting to return to his "true" love, i.e. his mother. Meanwhile the primary culprits are daughters and mothers, as indicated by titles of analytic articles listed in Lukianowicz's references: "Penis envy and incest" (1940), "Incest as revenge against the preoedipal mother" (1955), and "Incest--the revenge motive" (1959).

Daughters are acting out "pregenital anger" and "dependency wishes" (Lukianowicz, 1972), "death wishes" against the mother (Sloane & Karpinsky, 1942), and the "oedipal wish" (Kaufman et al, 1954). These girls in particular are said to possess unconscious "sex urges" (Bender & Blau, 1937) and an "abnormal craving" for sexual excitation,

while feigning "protestations of innocence" (Sloane & Karpinsky, 1942).¹⁴ Bender and Blau's descriptions of the various cases invariably consist of the child-as-actor, i.e. "soliciting men" and "visiting men for sexual relations". The perpetrator is described as the victim's "sex object" and her "means of gratification" (Bender & Blau, 1937), who assumed responsibility for the girl's desires by being the aggressor (Sloane & Karpinsky, 1942).

A third similar, but more recent model is the family systems perspective described by Gutheil and Avery (1977), Lustig (1956), Lukianowicz (1972), Henderson (1983), and Kaufman et al (1954) in which the daughter and father are using a "tension-reducing defense", serving to maintain the integrity of the family unit, which the mother has either physically or emotionally "abandoned". In this model there is unanimity that the "mother is pivotal" (Gutheil & Avery, 1977). She has unconsciously "given permission" for incest, by supposedly "setting up" a situation where it could occur (Kaufman et al, 1954), such as having another baby or developing some new interest outside the home.¹⁵

Lukianowicz (1972) claims development of a new socio-cultural interpretation of his data. However, he too works from patriarchal assumptions.¹⁶ While innovative in exposing the reality of incest, these few early articles, to varying degrees, ignore power differences between perpetrator and victim. They pay little or no attention to the responsibility

of the perpetrator, labeling child abuse a "relationship", and consistently assigning initiative to the victim and her mother.¹⁷

In addition, dominance of psychoanalytic practice during this period means that much of treatment focused on therapists', rather than "patients'" own interpretations. The "real" meaning of a "patient's" story is deduced by the clinician, and her disagreement is interpreted as "resistance" (Cole, 1982; Gutheil & Avery, 1977).

Contemporary Views

In spite of an explosion of knowledge about adult survivors of incest within alternative settings during the last decade, psychiatry continues to be heavily influenced by patriarchal and Freudian thinking. Contemporary psychiatrists report that their own training background did not include information on sexual assault, specifically cautioned students to disbelieve patient reports of incest, and failed to acknowledge the relevance of child abuse (Herman, 1984; van der Kolk, 1987).¹⁸ Many recent textbooks still exclusively view adult memories of incest as "fantasy".

Earlier-mentioned analytic and family systems perspectives dominate discussions about children who present with evidence of overt incest (Stafford-Clark & Smith, 1978; Nicholi, 1978; Henderson, 1975; Saddock, 1980, 1985). Both Henderson (1975; 1983), and Renshaw (1982), recognized incest

experts in the field of psychiatry, are good examples of such contemporary wisdom.

Henderson is the incest authority for the 1975, 1980 and 1985 editions of the Comprehensive Textbook of Psychiatry, and author of "Is Incest Harmful?" (1983). He argues that "the alleged victim" often willingly "participates" in the incestuous "relationship" with her father. According to Henderson, the "intense personal pain" the woman shares with the clinician was, in part, her "motive" for partaking in the incest, rather than a consequence of victimization. He questions whether incest, like masturbation, is "necessarily pathogenic at all", and asserts that in some cases it may be beneficial (1983).¹⁹

Renshaw's Incest: Understanding and Treatment (1982), is the first, and only such book written specifically for psychiatrists. She too does not see incest as abuse, but rather inappropriate sexualization of "affection", a "sexual learning disorder", or another kind of "love", which has been condemned in society. The child is called an "incest partner". She argues that damaging effects of the incest, itself, have been exaggerated, and the panic on discovery can be much more traumatic.

Renshaw's main contribution is in the area of professional self-awareness and self-care. She also addresses professional avoidance and emotional reactions that interfere with "noncondemnatory listening", and frank discussion.²⁰

However, her format for detailed psychiatric evaluation focuses on the supposed sexual mechanics of the incest "relationship", e.g. "consanguineous consensual heterosexual noncoital adult-child pedophilic incest", which obscure and divert attention from survivors' personal experiences of pain and powerlessness.

Renshaw and Henderson both subscribe to a family systems perspective.²¹ These two clinicians restrict the trauma of incest to social disapproval, and seem unaware of the trauma-genic dynamics of powerlessness, betrayal and traumatic sexualization. Clinicians who consult these highly-regarded references run the risk of revictimizing the survivor by either overlooking these dynamics, or inadvertantly repeating them in the therapeutic relationship.

Sexual Abuse by Therapists

Perhaps the most blatant form of revictimization of incest survivors in psychiatry is sexual abuse by clinicians. Penfold (1987) emphasizes that harmful sexualized conduct of therapists can be seen as widespread in that it occurs on a continuum, from comments or flirtatious behavior that reinforce womens' prescribed role in society as sex objects to actual molestation. Incest survivors are particularly attuned to these behaviors.²²

The potential for sexual exploitation by psychiatrists arises easily, says Penfold, with the "medical mystique", patient-therapist power differentials, culturally determined

patterns of behavior for men and women, psychiatric traditions of "blaming and scapegoating women", and the "cloud of protectionism" around sexual misconduct of therapists.

The American Psychiatric Association's "Principles and Medical Ethics" do state explicitly that sexual activity with a patient is unethical. Yet, a survey of members on "sexual contact with patients" revealed 65% of respondents had counselled clients immediately after sexual "involvement" with their previous therapists, the majority of whom were psychiatrists (Gartrel et al, 1986; Gartrel & Herman, 1986).^{23,24} Only 8% of abuses were reported to professional or other authorities, even though 87% of these subsequent therapists saw them as "always harmful".

This problem has either been omitted from discussion or downplayed by most incest experts in psychiatry.²⁵ Typically, the latest edition of Comprehensive Textbook of Psychiatry makes no mention of sexual involvement with "patients", with the exception of a few comments about the patient's "erotic transference", says Penfold.²⁶ However, works by Rosenzweig and Al-Zand (1987) and Herman (1981) clearly state this danger. As well, the College of Physicians and Surgeons of Ontario has organized a Task Force on Sexual Abuse of Patients, with a report due in fall 1991.

Psychiatric "Diagnoses"

Even though women "psychiatric patients" are frequently survivors of incestuous abuse, they have not, for the most part, been recognized as such. Smith (1975) says "psychiatry deals with the disjunctions between how women are supposed to feel and respond in their situation and how women actually do feel and respond" (p.5). Behaviors and feelings that "don't make sense" to the physician become "symptoms" of individual "sickness". Since recognition of the frequency of histories of victimization among women, and "making sense" of its effects, have not been standard psychiatric practice, survivors' coping strategies and signs of stress have been routinely inserted into a framework of "mental disorders".

Intervention styles may vary to some degree, but North American psychiatry is uniform in its reliance on the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders. Criteria in the latest edition, DSM-III-R (APA, 1987), and its predecessors enable practitioners to "diagnose, communicate about, study, and treat the various mental disorders" (p.vii). With repeated usage, each of these "diagnoses" has become reified and specialized, obscuring the fact that it is merely a construct continually undergoing revision, and that even "specialists" disagree amongst themselves about causation and effective "treatment" (see "'borderline personality disorder'").

In practice, the DSM-III-R has become the language of psychiatry. Cole (1982) cautions "instead of the patient being perceived as a person experiencing certain symptoms, she may be perceived primarily in terms of her illness" (p. 67). The power differential between "patient" and physician promotes dominance of professional perceptions. This differential may be compounded for a late disclosed/acknowledged survivor, whose sense of identity is shaky, having repeatedly been forced to accommodate to the judgements of others since the abuse (see "conceptual framework").

Options within the DSM-III-R

The Diagnostic and Statistical Manual of Mental Disorders (DSM) uses a "multiaxial system" with the first three categories, or axes, constituting the "official diagnostic assessment".

Axis I	Clinical Syndromes and V Codes
Axis II	Developmental Disorders and Personality Disorders
Axis III	Physical Disorders and Conditions
Axis IV	Severity of Psychosocial Stressors
Axis V	Global Assessment of Functioning.

Williams (1981) claims that the DSM-III "represents APA's acknowledgment of the importance of a holistic approach to mental illness" (p. 102). However, relevant psycho-social stressors are only seen as supplementary, and must have occurred "in the year preceding the current evaluation" (APA, 1987, p. 3). Past child abuse which results in adult distress does not meet this criteria, and therefore is not considered

relevant. Similarly, the strengths of people who suffer from "mental disorders" are "emphasized" by assessing "global functioning" at the highest level attained only in the last year.

The emphasis, in fact, is on "disorders", not "normal" human responses to trauma. Stressors are noted only if they have contributed to, or exacerbated, a recurring, already existing, or new "mental disorder". As well, the severity of a current stressor is determined by the physician's assessment of how that situation would affect the "average person" with similar sociocultural values. If a "vulnerability to stress exists, it will be frequently due to a mental disorder that is coded on Axis I or II" (APA, 1987, p. 34).

A physician who, after evaluating an incest survivor, tenaciously believes that her many distressing "symptoms" are normal responses to the abuse, could choose one of the "V Codes", "conditions not attributable to a mental disorder that are a focus of attention or treatment", e.g. "V61.10 Marital Problem...apparently not due to a mental disorder" (p. 203). However, he still has a legal responsibility to identify and record "suicidal gestures", and is expected to describe distressing feelings and patterns of behavior, not as effects or coping strategies, but as "symptoms". A woman with a particular pattern of "symptoms" must have a "disorder". This distinction is important to this analysis and will be developed further in the "conceptual framework".

Not only does the DSM determine "treatment", but it also has "prognostic value" (Williams, 1981). Prognosis is the psychiatrist's assessment of a particular "patient's" prospects for recovery. Gelinas (1983) says misdiagnosed incest survivors both receive treatment that is "inappropriate", and "prognoses which were usually not as hopeful as a more accurate evaluation would have implied" (p. 327). An unacknowledged adult survivor of child sexual abuse will be "treated" in a milieu of either professional optimism or pessimism, depending on a "diagnosis" that both emphasizes pathology, and compares her stresses and strengths with an "average person" during the limited time frame of only the last year.

Common "Diagnoses"

Although the literature is sparse in this area, high incidences of childhood incest have recently been identified among women with several psychiatric diagnoses:

"borderline personality disorder": 86% by Bryer et al (1987), and 75% by Stone (1981);

"alcohol dependence": 75% by Rohsenow et al (1986), and 40-50% by Evans and Schaefer (1980) and Benward and Densen-Gerber (1975);

"eating disorders": 5 out of 6 by Sloan and Leichner (1986), and around two-thirds of clients by Oppenheimer et al (1984);

and "multiple personality disorder", 97% by Putnam (1986).

Although 46% of "chronic psychotic" women patients in Beck and van der Kolk's study had disclosed incest abuse at some point to their various therapists, no differences were found in "diagnoses" between this group and those who had not mentioned such a history. Most survivors were "diagnosed" as "schizophrenic", and the others as having "schizoaffective disorder", "major recurrent depression", "paranoia", "bipolar disorder", and "borderline personality disorder".

Diagnoses of "psychoses", including "schizophrenia" and "bipolar disorder", have also been mentioned in the incest literature by Gelinas (1983), Bryer et al (1987), Summit (1982), and Glueck (1963).²⁷

In 1979 Rosenfeld had "diagnosed" his women "patients" who later shared their incest backgrounds with "hysterical character disorder" (now labeled "histrionic personality disorder") or "hysterical neurosis". Links between incest and

other "diagnoses" have also been noted, including "panic disorders" (Davies, 1979), and "dependent personality disorder" (Britcher, 1986). In addition, a literature review of fifty articles and books by McLaughlin (1987) found high agreement among therapists (74%) that depression is an indicator of childhood incest. More recent use of the "diagnosis" of "post-traumatic stress disorder" by some clinicians, who are more informed about the effects of incest, will be looked at in a later section.

Diagnostic categories in psychiatry contain much overlap. For example, several authors note frequent concurrent diagnoses and overlapping criteria for "borderline personality disorder" and "histrionic personality", "antisocial personality", "affective", "schizotypal", "schizophrenic", "anxiety", "organic" or "multiple personality" "disorders" (Herman & van der Kolk, 1987; Kaplan & Sadock, 1985; Links & Steiner, 1988). Because the "diagnosis" "multiple personality disorder" ("MPD") is only recently gaining acceptance, Putnam (1985) discovered most such "patients have been misdiagnosed as having depression, borderline or sociopathic [now called 'antisocial'] personality disorder, or schizophrenia" (p. 71). Furthermore, an average of 6.8 years had elapsed between their first assessment and their being "diagnosed accurately" with "MPD".

"Borderline Personality Disorder"

In order to examine psychiatric treatment strategies, "borderline personality disorder" ("BPD") has been selected (see Appendix B). "BPD" is a common "diagnosis" for women, and in the most recent survey 86% of these women "inpatients" disclosed histories of incest (Bryer et al, 1987). Women who are labeled "borderline" are viewed as not suffering from trauma, but from inherited biological dysfunction and/or from inadequate early mothering (Waldinger, 1987). In their critique of the literature on "BPD", Herman and van der Kolk found that the role of actual parental abuse had never been systematically investigated. Disclosure of a history of child abuse "tends to be discounted or dismissed as part of the patient's self-serving distortion of reality" (p. 114).²⁸

"Symptoms" of "BPD" are very similar to those of "chronic post-traumatic stress disorder" ("PTSD") (see Appendix C). After making a detailed comparison between these two "diagnoses", Herman and van der Kolk conclude

the most significant descriptive discrepancy...is the absence in the criteria for borderline personality disorder of a recognizable stressor in the patient's history (p. 115).

Women survivors of incest who receive this diagnosis will, more often than not, be treated as "borderlines" without recognition of the connection between the trauma and their attempts to survive.

The "BPD" literature is replete with differing definitions, and contradictory theories of etiology and "treatment"

(Kaplan & Saddock, 1985). Tarnopolsky and Berelowitz (1987), after reviewing the recent literature, "caution against the complacent reification of the diagnosis, as research in new-- and some old--issues is clearly needed" (p. 733).

It is no wonder that Dawson (1988) says the primary goal of treatment with "BPD" should be "to do no harm". Indeed, "borderlines" are infamous in the psychiatric community for their "worst behaviors", "insatiable" demands on therapists, difficulties with forming trusting therapeutic relationships, and their high treatment failure rate (Blum & Marziali, 1988; Links & Steiner, 1988; Tucker et al, 1987). Waldinger and Gunderson's (1984) study of 790 "BPD" "patients" revealed that only one-third completed therapy, and out of this group only 10% were evaluated as having a "successful outcome".²⁹

In their review of "psychopharmacologic management" of "BPD" Links and Steiner (1988) found "at least half" of these "patients" who are hospitalized or "treated" at university medical centres receive medication, even though "solid scientific evidence" on the effectiveness of current practices is "still lacking".

Briere (1984) hypothesizes that the absence of recognition of child sexual abuse in the backgrounds of so many of these women may explain why such "cases 'rarely get better'".

Meanwhile, "BPD" therapists are cautioned to have readily available support for themselves, as this "disorder" is "fraught with real pain and anger for patient and therapist

alike" (Kaplan & Sadock, 1985, p. 981). Mainstream practitioners may easily mistake a survivor's anger at her abuse, and at a treatment setting that does not understand her, as merely formidable manifestations of her "disorder".

Dawson (1988) believes "much of the worst behavior of borderline patients" to be a "direct result of the interactional process between patient and physician or institution" (p. 372).

If a self harmful act occurs within your therapeutic relationship...you must consider the possibility that your therapeutic relationship with the client is provoking her self-destructive behavior (p. 373).

Yet, he too falls short of helping a woman to "make sense" of the life experiences that lie behind her self-destructive behavior. In order to communicate that a woman "patient" is healthy, competent, intelligent, responsible, likeable, and adult, Dawson advises clinicians to ignore and disqualify suicidal threats and gestures. "Borderlines" are "managed", with a "limit-setting 'holding environment'" controlled by therapists (Dawson, 1988; Kaplan & Saddock, 1985; Links, 1988).

With these limitations and inaccuracies in psychiatry's diagnostic system, combined with historical psychiatric perspectives on incest, late disclosed or acknowledged survivors are likely to be repeatedly pathologized, discounted and controlled in the "treatment" setting.

"Post-traumatic Stress Disorder"

Several incest pioneers in psychiatry are concerned about "misdiagnosis".³⁰ When a history of traumatic abuse is detected, the one existing diagnostic option rising in popularity is "post-traumatic stress disorder" or "PTSD" (Briere & Runtz, 1985; Bryer et al, 1987; Donaldson & Gardner, 1985; Herman & van der Kolk, 1987; Lindberg & Distad, 1985).

"PTSD" is a radical departure from prevailing concepts of "mental illness". While other psychiatric "disorders" supposedly develop out of a person's individual psychological and biological make-up (Andreasen, 1985), "PTSD" may arise out of a past traumatic experience that would be "markedly distressing" to anyone. "Psychophysiological changes" are conceptualized as "trauma induced". Some researchers value "PTSD" as an opportunity to understand the "biological concomitants of psychological symptoms", a way of bridging the split between proponents of these two major streams in psychiatry today (Herman & van der Kolk, 1987; van der Kolk, 1987).

This may be one reason "post-traumatic stress disorder" has been called a "fad or misdiagnosis" (Lindberg & Distadt, 1985). Yet, "PTSD" is well accepted amongst psychiatrists working with sufferers of wartime trauma in veterans' hospitals. Britcher (1986) reported that 86% of women sexual assault survivors, when referred to one military medical centre, received this diagnosis.

Herman & van der Kolk (1987) believe that validation and integration of the traumatic memories, as prescribed for "PTSD", are "preconditions" for "development of improved affect tolerance, impulse control, and defensive organization", as well as "an integrated self-identity and the capacity for appropriate relationships with others" (p. 119). However, this process may be overwhelming for some survivors.³¹

Psychiatric "treatment" of other diagnoses focuses more on relief of symptoms and behavioral change. "PTSD" raises a challenging chicken-and-egg question in "treatment" planning: whether to first concentrate on changes in survivors' problematic coping strategies, or to focus more on "making sense" of these difficulties through memory retrieval.

Careful attention should be paid to ensuring safety, through social and therapeutic supports, and women need to have "the greatest possible control" over this process, including timing and pacing, say Herman and Schatzow (1987). Are most psychiatric facilities capable of providing such an atmosphere?

Trimble (1985) criticizes the DSM-III for limiting the types of events that precipitate this diagnosis to those outside the range of usual human experience. He notes that work-related and automobile accidents are not unusual occurrences, but are nonetheless capable of producing "PTSD" symptoms. Sexual and physical abuse of women and children are

also common traumatic occurrences in our society, yet are overlooked in most discussions of "PTSD".³²

Even if these forms of victimization were accepted as "PTSD" producing events, the long-term nature of adult survivors' "symptoms" are not viewed in traditional psychiatric literature as normal. Post-trauma responses become a "disorder" if they last for more than a month. Furthermore, "the more chronic the symptoms, the worse the prognosis" (Andreasen, 1985, p. 923).³³ Chronicity is defined as having a latent onset of more than 6 months, or having symptoms that last for 6 months or more.

Esper (1986) points out that the vast majority of rape survivors experience "PTSD" "symptoms" long past the chronicity limit. Those women who experienced a "rapid recovery" (in less than 6 months) had a "greater ability to use defense mechanisms such as repression and denial" (p. 53). She argues that the supposedly pathological reactions to trauma described in the DSM-III for "post-traumatic stress disorder" should be seen as normal adjustment strategies that allow, rather than inhibit, healthy psychological functioning.

The traumatic event, according to the DSM-III, also takes a greater toll when victimization occurs in childhood, because coping mechanisms are not fully developed; and when the stressor is of human design (APA, 1980), especially deliberate human design (Ochberg, 1984). "PTSD" prognoses for incest survivors, who often lack extensive support systems, are

further "worsened" by "the possibility of receiving compensation or other forms of secondary gain" such as "increased attention or sympathy, and the satisfaction of dependency needs" (Andreasen, 1985, p. 920).³⁴

Within the psychiatric diagnostic framework, even "PTSD" does not appear to embrace a growth-oriented, long-term model of healing from incest abuse (Bass & Davis, 1988; Burrows, 1987). This human process is reduced to a "disorder" with a "poor prognosis", implying incurability. Nonetheless, it seems as if, out of the existing options within the DSM-III, "PTSD" most "makes sense" of survivors' experiences.

Meanwhile, both Briere and Runtz (1987) and Finkelhor (1987) question whether the "PTSD" syndrome explains all child sexual abuse-related "symptomatology". Briere (1984), Renshaw (1982), Rosenzweig and Al-Zand (1987) and Blume (1990) advocate the addition of a "post-sexual abuse" or "post-incest" "syndrome" category to the DSM-IV. Both Blume's "after-effects checklist" and Briere's survey results offer clear indicators for counsellors.

A review of the literature on psychiatry's treatment of incest survivors supports Van der Kolk's (1987) criticism of the profession for its "relative neglect" of the whole issue of psychological trauma, in both biological and psychodynamic streams of intervention. The tremendous potential for inadvertent revictimization and questions of how best to meet

the needs of late disclosed/acknowledged incest survivors who are in psychiatry still need to be addressed.

Views of Incest Survivors in Psychiatry

"Extensive qualitative investigations" are now necessary "to advance clinical understanding of the 'victim to patient' links" say Bryer, Nelson, Miller and Kroll (1987, p. 1430), and survivors' experiences as "patients" in psychiatry must be part of this research.

Autobiographical accounts and interviews with incest survivors have been written primarily to reach others and offer hopes of living a normal life (Armstrong, 1978; Butler, 1978; Brady, 1981; Vale Allen, 1984; Fraser, 1987). Because experiences in psychiatry have been excluded in nearly all of these works, late disclosed/acknowledged survivors have had to continue carrying the double stigma of "incest victim" and "psychiatric patient". In addition, survivors in psychiatry have not been given a voice because of the severity of their distress. In choosing her interviewees from newspaper ad responses, Armstrong explains, "selection was dictated by the fact that I was in no way equipped to push where I sensed deep and threatening wounds" (p. 267).

Herman and Hirschman's landmark study of 40 women "outpatients" is closest to this investigation (Herman, 1981). However, her interviews too, were with "a relatively healthy group" of survivors of father-daughter incest. They focused on their experiences of abuse and its aftermath, with some discussion of the psychiatric counselling they had received. Burrows (1987) interviewed 18 women survivors with a variety

of counselling experiences about helpful and not helpful attitudes in therapists.³⁵ At least three had been "psychiatric patients".

Brief autobiographies that disclose involvement with psychiatry have been written by Muench (1986), Ruskin (1984), and Stewart and Allen (1984). Danica's (1988) memoirs detail her traumatic history of incest, child prostitution and pornography, and subsequent revictimization by psychiatrists. She then embarks on her own healing journey of ten years "being crazy" with her pain. Bass and Davis' (1988) comprehensive manual, based on interviews with survivors about their healing processes, includes only a few sketches of experiences with psychiatry. All of these women described supportive family/and or friends as vital to their healing (Bass & Davis, 1988; Danica, 1988). Yet, of the many survivors who related histories of extreme abuse with severe consequences (such as multiple suicide attempts), none credit psychiatry with playing such an essential role.

The sad truth is that great numbers of women in psychiatric institutions do not have adequate friendship/family supports, that might enable them to handle the recurring crises and intrusions of traumatic memories that often accompany disclosure. A key question that emerged in a recent workshop I attended on women and psychiatry is "to what extent and in what capacity can the mental health system meet

a survivor's needs for social support, if it is not otherwise available?"

An important mental health issue for clinicians as well as survivors is how available should, and can a therapist be outside of regular appointments, to a woman who is having terrifying flashbacks and suicidal or self-destructive impulses? What about the usual alternative, instructions to "go to emergency" if an "outpatient" survivor needs support after hours?³⁶ One woman describes the healing potential in having a lay counsellor available on a 24 hour basis.

I got off my [anti-psychotic] medication. I took the gamble that if I lost it and had a psychotic break, Judith would be there for me...And it worked (Bass & Davis, 1988, p. 429).

Yet, for another woman, "the traditional model of the therapist-parent caring for the client-child" is "frightening and degrading", negating one's "adult competence and strengths" (Burrows, 1987, p. 59).

Samantha Ruskin (1984) and Johanna Stuart (Stuart & Allen, 1984) each worked with only one effective therapist out of several in psychiatry. These counsellors were distinguished by their human caring as fellow human beings and their unconditional faith during suicidal and self-destructive periods. We do not know what measures these two therapists took to establish boundaries during these times.³⁷ Heidi Muench (1986) also required a "therapeutic process that allows me to feel competent and equal while providing support" (p. 27).

On the other hand, many of the women in Burrows' research originally had "expectations of being passively or 'magically' cured by a medical authority or fairy godmother", and one woman "expressed grief and anger at having to invest actively in her own recovery process" (p. 58).

One survivor interviewed by Burrows identified a tendency in her succession of therapists to do "power trips". Danica also describes how her psychiatrist "threatened" her with committal if she would not talk. The justification of coercion "for the 'patient's' own good", says Burrows, can "replicate the experience of abuse in childhood" (p. 58).

Herman (1981) believes that when a woman senses replication of this dynamic in therapy, "the healthiest response...is to become enraged with the therapist" (p. 186). What reactions have occurred when a woman unleashes rage in psychiatric settings? We need to hear more about these issues from survivors themselves.

Women who have been abused are "extremely sensitive to any reaction of withdrawal...and can detect the therapist's discomfort from even very subtle cues" (Herman, 1981, p. 184). Both Burrows (1987) and Herman cited survivors' negative experiences with male therapists who get aroused or frightened, and subtly blame the victim out of identification with the abuser. They also complained about female therapists who distance or over-empathize with the hurt and helpless child. Women therapists, according to Herman, may project

their own outrage onto the client, and persuade her to express anger when she wants to focus on her abuser's positive qualities.

To what degree does a therapist need to have worked on her own issues of child abuse, given that healing can be a long-term process, and many memories are repressed? Herman says that once a woman therapist has "mastered her own tendency to overidentify with the victim", the "natural tendency to identify...becomes an advantage" in forming a "successful working alliance" (p. 184). A survivor in Burrows' study said it was "really important" that her lay counsellor, had "been there". "She believed me and it had happened to her and she talked about that" (p. 60).

The male therapist has a "potentially more destructive" tendency to overcome in his identification with the abuser, says Herman. He may continually seek to exonerate the offender, fail to validate her angry feelings, and "focus on the sexual aspects of the relationship", ignoring the most important "issues of protection and caretaking" (p. 185).

Burrows notes that four of the survivors she interviewed saw work on sexuality "as a last and in some cases optional stage in a 15-20 year recovery program". For them, "having a sense of self, a reason to live", along with "seeing victim patterns, learning to say no and set limits comes first" (p. 59).

Most survivors were not allowed to tell anyone or to say "no" to protect themselves. Danica (1988) had to "make things up" in order to appease her psychiatrist who was not receptive to her history of incest. Adaptive survival strategies of concealment (Goodwin, 1985; Shengold, 1979) and compulsive lying (Bass & Davis, 1988) create credibility problems, says Goodwin (1985). At the same time, the possibility of revictimization in disbelieving a survivor who risks sharing her truth, may result in not only a sense of betrayal, but also may increase her need to further rely on dissociative mechanisms (Goodwin, 1985). When is it helpful or not helpful to believe survivors with such "diagnoses" as "multiple personality disorder", "schizophrenia", "bipolar disorder", "borderline personality disorder" or "antisocial personality disorder"?

Therapists Rosenzweig and Al-Zand (1987) advocate consistent and sensitive confrontation of "defences". Herman (1981) believes the therapist must recognize and discuss a survivor's "resistances to therapy [shame, hopelessness, fear of betrayal in intimate relationships], which result from her experience of incest" (p. 189). Survivor Johanna Stuart appreciates how her therapist "soothed and harassed" her towards self-respect.

However, "confrontation, shattering survival skills, before there is trust [and] self-esteem" was listed as one of "therapists' worst blunders" by Burrows' respondents (p. 62).

Is confrontation in conflict with Bass & Davis' admonitions to counsellors: "validate your client's coping behaviors", "refrain from discounting the survivor or judging her to be wrong about herself", and "she's the expert" (p. 346)?

There appears to be agreement among survivors interviewed in these few accounts and studies that healing is a slow process, and intensive work on repressed memories comes later in counselling (Burrows, 1987; Bass & Davis, 1988). Samantha Ruskin, for example says her "wall" of protection "must be taken down as it was built, one stone at a time" (p. 312).

Yet, the tremendous impact of emotional work for survivors in psychiatry is expressed by a woman who describes herself as "psychotically depressed" for most of the first 25 years of her life (Bass & Davis, 1988; p. 427).

When I got access to my feelings, the psychotic episodes dropped down a whole lot. Some kind of pressure was released.

We are lacking information from clinicians and survivors in psychiatry on what needs to happen before a woman is ready to do intensive work involving memory retrieval. For example, how much stability does she need in her life? Can medications and/or electroshock be helpful before, or during abreaction?

According to Bass and Davis (1988), drugs offer temporary feelings of relief, protection and control, yet they may block healing by cutting off feelings. Prolonged use of "medications" can also harm the body and impact on all aspects of a survivor's life. Two respondents in Burrows' study found the

"dozen or so" psychiatrists they interviewed in search of affordable support, were "unreceptive...to the need to do real work, rather than repress pain and traumatic memories with drugs and interpretations" (p. 61). Danica (1988) tells how her psychiatrist and husband together controlled her with "pills", so that she would "be nice" to her husband and "have sex". "They are both pleased...I would have to take the pills for a long time, maybe always" (p. 79).

In The Courage to Heal only a few survivors mentioned their various experiences with psychiatric medications.

I couldn't get off my couch [on that medication]. I was like a cucumber or the head of a cauliflower. I got so depressed...[I was] thinking razorblades (p. 384).

She put me on Tofranil...and I felt really weird. She said to me "You're starting to have feelings!" ...and my life really started to change (p. 427).

By spring I knew I was getting very close [to remembering]. The anxiety attacks were overwhelming again. A psychiatrist friend suggested I go back on antidepressants and I said, "No, I'm not going to put this to sleep again. If I do it's going to kill me" (p. 451).

The effects and risks of "electroconvulsive therapy" have been hotly debated in general, yet we do not know how women with histories of incest abuse have fared. After electroshock, Glueck (1963) notes disclosures of incest, while Herman (1981) mentions one survivor who then denied her previous disclosure. Two women interviewed by Burrows told how fears of medication, institutionalization and shock therapy prevented them from opening up about their problems.

We need to hear from late disclosed/acknowledged survivors about their experiences with the pathological orientation of psychiatry. To what extent is the conceptualization and "treatment" of a survivor as suffering from a specific psychiatric "illness" accurate and/or useful in her recovery? Both Herman (1981) and Blake-White and Kline (1985) believe awareness of and focus on the incest abuse is essential to healing.

However, one woman (Bass & Davis, 1988) who diagnosed herself as "agoraphobic", was able to overcome much of her fear with behavioral therapy, before she remembered the sexual abuse she suffered as a child.

It had taken a year and a half of healing for me to have the strength to remember. Remembering the molestation and connecting it to the agoraphobia didn't suddenly cure me, but it did allow me to know it wasn't all coming out of the blue (p. 385).

Johanna Stuart and Linda Allen found their common condition of "anorexia" made them feel they were "sisters".

Yet, for another woman who was diagnosed as "psychotic" for 25 years, the powerful revelation in an alternative setting that she had done the "right thing" in order to survive as a child, enabled her to realize "I'm not crazy anymore" (Bass & Davis 1988). Her words are almost identical to those of a survivor in Burrows' study, after seeing a lay counsellor: she "made me feel that something had really happened to me and I was not crazy" (p. 60).

Burrow's respondents needed to understand the "altered state experiences so frightening to them", that they were "not crazy but...responding normally to abnormal life experiences" (p. 61). Psychiatric hospitalization, along with use of drugs and electroshock, while intended as "treatment", confer the stigma and model of "mental illness" on late disclosed/acknowledged survivors. Can hospitalization provide a safe place for healing?

Until now, we've had many questions and only some clues as to the needs of late disclosed/acknowledged incest survivors in psychiatry. A piece of research that was really missing was a systematic in-depth inquiry into the psychiatric experiences of this group of women.

CHAPTER III

CONCEPTUAL FRAMEWORK

This investigation is inspired by feminist analyses of the violence against women and child sexual abuse. Feminist research and practice has shown that women incest survivors often enter a "victim to patient process" (Rieker & Carmen, 1986), and may then be revictimized by the agencies that claim to help them. These under-standings have been developed primarily by, and as a result of, the work of feminists determined to lift the "veil of secrecy" over incest and other forms of violence against women and children (Herman, 1984). They have gained some legitimacy in psychiatry as a result of psychiatric trauma studies since World War II, and research in such fields as social work and victimology.

The women's movement has played two prominent roles in increasing our understanding of incest survivors in psychiatry. First, in the consciousness-raising groups of the sixties and seventies, sexual victimization of women and girls by men was revealed to be a common experience, and this gave women the courage to speak out.³⁸ Secondly, feminism with its slogan, "the personal is political" (Levine, 1982) has offered an analysis of society and its institutions that recognizes how they impact on the lives of women.

The exclusion of women from the production and control of "knowledge" in man's culture, has been investigated by Smith (1975; 1978; 1979).³⁹ In her extensive analyses of

professionalism and psychiatry, she shows how myths of objectivity, neutrality, and professional expertise obscure and perpetuate women's oppression.⁴⁰ Psychiatric "treatment" is in fact shaped by western ideologies, such as "individualism", in which the problem and solution are located within the individual (Penfold and Walker, 1983). As a result, the existence and tremendous impact of oppressive gender norms, such as those which enable sexual abuse of women and children, remain hidden.

Similarly, "the myth of value-free psychotherapy" prevents clinicians from understanding the effects of inequality on psychological development (Reiker & Carmen, 1984).⁴¹ Traditional psychiatric biases also minimize women's strengths.⁴²

The "Victim to Patient Process"

Reiker and Carmen (1986) say

the damage to the self that many victims experience is a result not only of the abuse but also of the need to repress and deny the trauma in order to survive (p. 369).

Several other therapists have described how the incestuously abused child has had to accommodate to the world of adults on whom she depends (Goodwin, 1985; Miller, 1984; Summit, 1983; Bowlby, 1979; Rosenfeld et al, 1980; Shengold, 1963).

These children are isolated and disconfirmed by societal myths regarding families and sexual assault.

Parents' actions toward their children [are] regarded exclusively as loving and beneficial and

...children [are] denied the right to protest (Miller, 1984, p. 160).

Herman (1985) says if and

when secrecy fails, the explicit justifications of sexual assault begin...These are the same as the common rationalizations that one hears from the perpetrators who get caught. The first is that sexual assault did no harm...Underlying this is a real failure to distinguish between coercive and consensual sex...The second group of rationalizations puts the blame on someone other than the offender--usually the victim (p. 4).

According to Rieker and Carmen's model, the "victim to patient process", these ongoing patterns in family and social relationships bring about "profound disconfirmation" of the survivor's reality, resulting in fragmentation of her identity. They theorize that "some, but not all victims" develop "mental illness" because of their

attempts to accommodate or adjust to the judgments that others make about the abuse. The common features of this accommodation are 1) denying the abuse, 2) altering the affective responses to the abuse, and 3) changing the meaning of the abuse or, as we define it, the disconfirmation and transformation of abuse (p. 360).

In order to reduce feelings of vulnerability and helplessness, the child must learn to deny her own feelings, perceptions and self-worth. Either her parent, on whom she depends for survival is dangerous and bad, or she must be. If she assumes responsibility for the abuse, she is able, at least temporarily, to restore an "illusion of control" over her own well-being. Her other option is to "redefine and minimize the event, thereby protecting a view of the world that is just and orderly" (p. 363).⁴³

To restructure her reality, she must dissociate from her feelings and those experiences "that tend to overwhelm" her capacities to adapt. If the situation is prolonged, survivors may develop a "lifelong dread" of feelings. As well, incestuously abused children are trained to gratify the needs of adults and are unable to maintain ties to others without sacrificing their own needs and sense of self-as-separate, making it difficult to trust their innate self-protective mechanisms. These coping strategies can easily be misinterpreted by professionals. Summit (1982) cautions that

the splitting of self-perception and the need to restructure contradictory relationships, mechanisms that are necessary survival skills of the child entrapped in incest, may be treated as indicators of intractable mental illness (p. 129).

Van der Kolk (1987), too, warns clinicians of painful consequences possible for late disclosed/acknowledged incest survivors. He shares the case of a survivor of psychological trauma after five years of "intermittent psychosis and dramatic deterioration".

If she had not met a therapist who was able to understand the meaning of her symptoms and who wanted to know how she became who she was, she would have ended up another chronic patient whose tales never got told (p. 188).

When a survivor's words and actions "don't make sense" (Smith, 1975) to the "treatment team", and are determined to be pathological, she has "little alternative but to feel crazy" (Penfold & Walker, 1983, p. 55). Esper (1986) found all the women in her sample of 25 rape survivors "felt 'crazy'

because they had been told that they were crazy" (p. 54). Schaeff (1985) believes "it is very difficult for men to understand how fragile our trust in our perception is" (p. 70). By labeling women "sick, bad, crazy, ugly or incompetent", our institutions "make women back off from their own perceptions" thus keeping them "in their place".

According to the testimonies of some incest survivors in the last chapter, the turning point in therapy was when they realized they were not "crazy". Miller (1984) says a survivor must reexperience her rage, not as meaningless, but as a response to cruelty. These women are not only survivors of incest, but are also

victims of a society that...will not permit them to be angry and insist on their right to their own bodies. They are expected to internalize their angry feelings and accept the fate adult males hand them (Butler, 1978, p. 37).

The institution of psychiatry may perpetuate internalization of angry feelings by the very structure of the "treatment" milieu. Psychiatric control measures for angry "patients", may include medication, electroshock and removal of normal areas of personal freedom. In addition, choices of clothing, activities, and liberty to come and go are converted into earned "privileges", echoing the powerlessness of survivors' abusive home situations.

Revictimization in Psychiatry

Without training in working with survivors, mental health workers are not only likely to mistake symptoms. According to Rieker and Carmen

the psychotherapy situation can become a destructive repetition of the trauma, in which the patient is again disconfirmed and left alone with his or her pain (p. 368).

The literature review above provides many examples of ways that mainstream psychiatric "treatment" (whether a survivor discloses or not) may give crazy-making messages that are strikingly similar to those originally received by the incestuously abused child, and highlighted in the "victim to patient process": "it didn't happen"; "it happened but it wasn't important"; "it happened but you provoked it"; and "it happened but it wasn't abusive".

Apparently, this possibility has received almost no attention in psychiatry until recently. Exceptions are a largely-ignored work by Ferenczi, who in 1932 blamed "professional hypocrisy" and repetition of childhood patterns of victimization with the analyst, for failure to earn an incest survivor's trust; and Litin et al (1956) who admitted

in years past [incest] patients were lost or driven into psychosis by our failure to believe them because of our conviction that much of their accounts must be fantasy (p. 43).

English common law traditions of disbelief, blame and lack of concern for victims, predominant since the 11th century, shape North American attitudes."

Recently, different components of revictimization by society and "helping" agencies have been named: "forced silence...[a] second trauma of enormous importance" (Lister, 1982); "second injury" to victims of crime by health care providers (Symonds, 1980); and "the second assault" from public attitudes toward rape (Williams & Holmes, 1981).

Berdek (1984) describes how Lister's "forced silence" necessitates a trade-off that replicates the abuse for late disclosed/acknowledged incest survivors in psychiatry. The survivor promises "unwillingly and unwittingly" she "won't tell" the therapist (who wants to avoid dealing with incest) in exchange for his/her "empathy, rapport, [and] gratification of dependency needs". A survivor of incest may have difficulty in consciously recognizing this subtle form of revictimization. Shengold (1979) explains how the survivor's needs to hang onto the "promise of the good and loving parent", (this time the therapist) is fueled by her desperate to avoid overwhelming feelings of abandonment and annihilation.

Symonds' (1980) "second injury" refers to revictimization of crime victims in health care settings. He believes revictimization is experienced because of survivors' heightened sensitivity to the behaviors and attitudes of others, combined with the profound revision of attitudes and values that occur after trauma. He discounts the validity of their discomfort with professional distance as "victim misperception", and

cautions fellow clinicians to "avoid becoming [survivors'] unwitting scapegoats". Yet, at the same time practitioners are urged to prevent revictimization by communicating that the survivor did nothing wrong, restoring power by asking permission during procedures, and being receptive, not defensive.

On the other hand, Krell (1984) clearly details how psychiatrists minimize and deny terrible traumas in order to distance and protect themselves. He also describes the revictimization inherent in psychiatry's use of inappropriate terminology, the labeling of "pathological", "essentially logical, sane consequences of an insane experience". While his work is with holocaust survivors, the issues are similar to those with survivors of incest.

Similar to Finkelhor and Browne's (1986) "traumagenic dynamic" of "stigmatization", the common experience of a "second assault" on victims of rape has been documented by Williams and Holmes (1981).⁴⁵ The term refers to victim-blaming judgements and attitudes which may be "unwittingly perpetrated", yet are "equally devastating in [their] impact". Esper (1986) claims that "non-empathic" attitudes in society cause as much suffering as the original trauma of rape.

Not only are survivors of incest often blamed by society for the initial victimization, but psychiatric explanations, that pathologize women's behaviors without contextualizing them, lead practitioners to also hold survivors responsible

for their experiences of revictimization. Russell (1986) says that many women who are reabused in adult life are "smart enough not to disclose such experiences because they know they will be held responsible for them" by psychiatry (p. 172).

If the "victim-to-patient process" truly describes how survivors develop the "symptoms" of "mental illness", and if various aspects of this same process are duplicated in psychiatry, then it is imperative that research be done to not only evaluate what is helpful and not helpful for survivors, but to also examine whether psychiatry, itself, can be "crazy-making".

CHAPTER IV

RESEARCH PROCESS

In this exploratory investigation, ten participants in incest support groups and/or feminist counselling looked back on their experiences of psychiatry. The purpose was to systematically examine, through feminist methods of intensive unstructured interviewing, how psychiatry has affected these women, from their own perspectives. Feminist research is based on the principle that "the way people talk about their lives is of significance, that the language they use and the connections they make reveal the world they see and in which they act" (Gilligan, 1982, p. 2).⁴⁶

Preliminary Dialogue

In order to make this research as useful as possible, I conducted preliminary interviews in early 1987 with sixteen professionals inside and outside psychiatry who were experienced in sexual abuse counselling. Four individuals and one group of women, who were both incest survivors and "psychiatric patients", were also approached.

These preliminary interviews revealed important issues for incest survivors in psychiatry, and validated both of my hunches: 1) that the number of survivors among "patient" populations was great, and 2) that there were indeed real dangers of revictimization in the psychiatric system. At the same time however, especially in conversations with survivors,

the complexity of their needs became evident, and I realized that I must take great care to avoid oversimplification, and to probe as deeply as possible for an understanding of their experiences.

Research Question

The central question is "Since many women psychiatric 'patients' have either not disclosed their histories of incest, or have not been acknowledged by professionals as suffering from this trauma, what are their experiences with psychiatry under these conditions?" Each woman was asked to explore in her own words the various methods of psychiatric "treatment" she received, what fit and did not fit her needs during her healing process. I also asked her to describe the process of becoming/being a psychiatric patient, and how this felt at different points along her journey. At the end of the interview, each woman was asked if she had a message for other survivors seeking psychiatric help, and a separate message for professionals working with women in her situation (see Interview Guide, Appendix E).

Method

Because there are, to my knowledge, no previous investigations of this particular research question, this is an exploratory study, utilizing qualitative methods. The ten participants thus had maximum freedom to share their

experiences, producing a rich body of data from which to highlight areas requiring further research with a more representative sample.

This inquiry employed feminist intensive interviewing as described by Oakley (1981). The "primary orientation is towards the validation of women's subjective experience as women and as people" (p. 30). She addresses the dilemma feminist researchers encounter in attempting to use traditional in depth iterative interviewing techniques, which contain a "lack of fit" between the "ideal interview" in theory ("objectivity, detachment, hierarchy and 'science'"), and practice (comfort, rapport, mutual trust, cooperation, commitment). Feminist research recognizes that there is "no intimacy without reciprocity", and the potentially valuable role of women's relationship skills in creation of such an optimum interview climate.⁴⁷

Participant Selection

The following criteria were chosen for the ten interviewees

- experience as a "psychiatric patient" for at least one year (in total) before the incest abuse was disclosed and/or acknowledged by a therapist as an important antecedent to her "condition" and became a focus in counselling;
- experience with at least one other form of psychiatric "treatment" besides counselling, that has been developed within the medical model, such as medication, hospitalization, and/or "electroconvulsive therapy" (ECT);
- incest survivor, self-defined in having participated in a survivors' support group and/or feminist counselling for the abuse;

Late disclosure/acknowledgement

The numbers of hidden incest survivors in psychiatry at present far outweigh those who are recognized and "treated" for the abuse (Herman, 1986; Mills et al, 1984; Sellers, 1988). However, it would be both difficult to locate, and irresponsible to interview women who have not had the opportunity to focus on the abuse in counselling. In order to find out about incest survivors' experiences of being "patients", who are "diagnosed" with, and "treated" for "mental illness", the minimum criteria of "patient" status for at least one year before disclosure and/or therapist acknowledgement of the abuse was selected after consultation with incest counsellors. While the accounts of necessity were retrospective, seven out of the ten women continued to have some dealings with psychiatry during the time lapse between interviews.

Experience with the medical model

It is the medical model that distinguishes psychiatry from other avenues of healing from incest. The literature revealed many areas within this model that require survivors' evaluation, including the diagnostic framework, medication, ECT, and hospitalization.

Group experience and/or feminist counselling

The therapeutic effectiveness of support groups for incest survivors has been well documented (Bergart, 1986;

Blake-White & Kline, 1985; Herman & Schatzow, 1984,1987; Gordy, 1983).⁴⁸ Group experience can provide a reference point for women as they consider what was and was not helpful in psychiatry.⁴⁹ In addition, survivors' support groups contradict the crazy-making messages described in the "victim to patient process".⁵⁰ Chance: that interviewees had experienced some empowerment and were learning to trust their own perceptions and feelings were consequently increased.⁵¹

During the initial phase of participant selection, I had originally required survivor support group membership. However, several feminist counsellor contacts had clients who had not been in such groups, but wanted to share their stories of psychiatry. Because feminist counselling has many of the same goals as group experiences, such as validation and empowerment, I decided to include four interviewees who were healing with one-on-one feminist support.⁵²

Recruitment

The first six women were recruited through a letter passed out at meetings of incest survivors' support groups by counsellor contacts made during the preliminary dialogue stage. The last four responded to a revised version of the letter (see Appendix D), which required either feminist counselling or group membership, and was circulated to feminist counsellors who specialized in work with survivors.

Because of the double stigma carried by incest survivors who have been, or still are "psychiatric patients", as well as

the potential of bringing up distressing memories, the utmost care was taken to ensure confidentiality and respect for participants' needs to carefully think through their decisions to take part in the project. The letter was given out with the clear understanding that if a woman was interested in volunteering, she would phone me. During the call I would describe the purpose and format of the project, answer her questions and, in order to make the process more meaningful and safer for her, I would invite her recommendations. No woman was interviewed without my first inquiring about her present access to a counsellor, should she need support after the interview.

The Women Who Participated

Due to space limitations of this thesis, I was unable to incorporate even edited versions of the interviews. Thus the courage, creativity and wisdom of each woman, as she struggled to find the healing resources she needed, can not be given adequate recognition. I regret as well that a well-rounded biography, celebrating aspects of her life other than her psychiatric history, could not be included. The following sketches offer some context for each woman's remarks that do appear in the findings chapters. Pseudo-nyms were chosen by the participants, and identifying details are omitted to ensure confidentiality.

Bernadette

Bernadette works in public health and is a spiritual artist. She is a pillar in a support network of strong women. Her father sexually violated her from the ages of 2 1/2 to 15 years, and has continued to threaten her with sexual abuse in adulthood. Her experiences with psychiatry total about six years, beginning in her early 20's (1968) with a private psychiatrist, who told her she imagined the abuse. She was hospitalized twice for four to six week periods, the first time for sodium pentathol and electroshock treatments, and the second for a drug overdose. She had a positive two year experience with an outpatient social worker, and a frustrating relationship with another private psychiatrist in 1986. None of them were willing to deal with the incest abuse. Not only that, but an intern and her GP sexually abused her. Bernadette's healing has been assisted by a bioenergetics therapist, women's groups (including an incest survivors' program), and a feminist counsellor who specializes in sexual abuse.

Chris

A talented artist who has had to support herself primarily by driving buses, cabs and a "bunch of shit jobs", Chris is presently taking time out for her healing. Her memories of incest revolve primarily around traumatic experiences with her male cousins and her uncle. She has also

been trying to piece together very early memories of abuse before she was adopted.

Her psychiatric experiences begin in 1978 when she was a teenager, with three hospital admissions for depression, lasting from six to eight weeks each. She could no longer cope with the emotional abuse at home and both emotional and physical abuse suffered routinely from fellow high school students. Chris also saw a psychiatric social worker for two years, a psychiatrist for a year, and took part in addictions recovery programs, all without recognition of the impact of the sexual abuse. She has been prescribed lithium, antidepressants, and minor tranquilizers, but is now drug-free. Only recently, after counselling with another social worker, joining an incest survivors' group, and in the last month a peer counselling organization, has she been able to make clear connections between her battles with panic attacks, "mania" and depression, and her memories of violation. She is enthusiastic about her newly found abilities to accept herself and express her emotions freely.

Essie

Essie is a musical and spiritual woman, happily married, and runs a family day care in her home. She describes herself as a "fighter", and has become very active in Narcotics Anonymous (NA) as a sponsor and outreach volunteer. She says that people who knew her two years ago, before her alcohol and drug recovery, and subsequent period of intensive healing from

abuse, say "Holy shit, you're not the same person at all!" She now remembers sexual abuse from her father starting at age three, along with multiple abuses throughout her life, including institutionalization as "emotionally disturbed" from ages four to 11, sexual abuse by strangers and foster families during childhood, sexual abuse by several male relatives when she attempted to reunite with her family in adolescence, and two marriages to violent men.

Essie's experiences with psychiatry on and off total approximately 12 years. In her late teens, from 1967 to 1970, she was hospitalized three times. She spent nine terrifying months of her last stay in an "incurables" ward of a large psychiatric hospital. Essie has battled suicidal feelings for most of her life. She has also suffered with bouts of cancer.

Until she met a woman psychiatrist in addictions treatment who shared that she too was a survivor, Essie had never disclosed the incest. Since then, the "last 20 months have been like a miracle", as she has worked hard on her addictions recovery in NA, and on her incest healing with a holistic feminist counsellor who is also a survivor. During the first interview, Essie was not taking any medication, and wanted to avoid dealing with psychiatry in future. At this writing, after losing her holistic counsellor, and experiencing a subsequent "manic" episode, she has decided to go back on lithium prescribed for "bipolar disorder".

Helen

Helen is an administrator and a counsellor with women survivors of sexual abuse. Beginning at the age of five, she was forced by her uncle to endure incest for five years. When she told her parents at the end of this period, she was taken to the family doctor and prescribed tranquilizers, the beginning of a long-term pattern of medicating her pain. Helen was also raped and almost killed by a stranger in her mid-twenties.

Her first contact with psychiatry was during hospitalization for ulcers in her early 20's. She later sought help for her drinking problem from a private psychiatrist, whom she saw for three years. For the first time since childhood, she disclosed the incest, but was told her problem was the fact that she was a lesbian. This precipitated a painful period of identity questioning, with two additional psychiatrists and three years in group therapy. She was given "totally ridiculous" quantities of Valium and antidepressants during this time. In the end, the other group members helped her to realize that it was ok to be a lesbian. Yet, it was not until later that Helen, suspecting that the sexual abuse was the primary source of her pain, joined a survivors' support group and discovered "This is it!" She was able to leave behind the drugs and alcohol. Helen says it was like night and day. She believes she accomplished in one year

with a feminist program, what she never could in 12 years with psychiatry.

Isabel

Isabel is an alternative helping professional, a leader in community organizations and a very spiritual person. She is also a single mother of four children. Her memories of sexual and physical abuse to date involve her mother (beginning at 18 months) and her bus driver (at 5 years), although she is aware that there is more to remember and strongly suspects her father. The birth of her second child brought on frightening impulses that led her to seek help from a pastoral counsellor. Isabel later worked with two psychoanalysts, beginning in 1986 and 1988. She did not feel safe enough with either of them to experience remembering. She carefully chose other resources, a hypnotherapist and a "shaman-healer-witch" for memory retrieval and catharsis.

Since 1985 she experienced three hospitalizations of two to three weeks each. She has tried a number of medications through the years and struggles with suicidal feelings, bulimia and self-injurious behavior. At the time of the first interview Isabel belonged to an incest survivors' support group, and was attempting to work through differences she had with her analyst. In a brief follow-up interview by telephone, she was pleased that she had "fired" her psychiatrist, and after a lot of searching, her "supports are in place". These supports, with whom she has arranged a team meeting,

include a psychologist specializing in child sexual abuse, her GP for medication, a spiritual director, and a social worker to help with practical matters.

Janus

Janus is a single mother of two grown sons. She is actively volunteering in several social service organizations, as she waits for surgery and vocational rehabilitation. She had worked primarily as a mental retardation counsellor over the last 15 years, until injuries forced retirement. Janus remembers sexual abuse as a child by a boarder and a neighbor, physical and emotional abuse by her family, along with two relationships with sexually and physically abusive men. Over a two year period in the mid-seventies she was also sexually abused by psychiatric orderlies while she was a "patient".

Her experiences with psychiatry date from 1970 to the present, with periods of intensive work and hospitalizations during a series of three year-long depressions (five in all). Suicidal feelings have continued to haunt her, and she feels this is due to a lack of appropriate services. Her story focuses primarily on an eight year (in total) therapeutic relationship with an analyst, with whom she recently attempted unsuccessfully to work through an impasse. She has been active in Adult Children of Alcoholics and more recently joined an incest survivors' support group. At this time she is taking antidepressants and looking for a therapist who can provide an intensive and safe healing environment.

Jill

Dedicated to creating and providing services for women, Jill is also a single mother of two grown children. She clearly remembers several years of sexual abuse by a male neighbor who was part of her extended family, and who also gave her "one of the first positive family experiences I'd had". In 1980 job stress and sleep deprivation precipitated the first of six "manic" episodes that brought her involuntarily into a psychiatric hospital. She was seen on an outpatient basis by a psychiatrist for the year following the first incident. In her search to understand these crises, she has been able to rally support and advocacy from her circle of women friends, reducing her hospital stays from 1 1/2 weeks to two days. While she makes some connections between her mood swings and early deprivation and abuse, she is striving to find out if there is any evidence of an organic illness. Jill is attempting to moderate her moods with regular sleep patterns, and has refused ongoing medication.

Lise

Married and a mother of two young children, Lise switched two years ago from office jobs to a full-time university program in counselling. She also sees herself as a "fighter", and wants to devote her life to working with survivors of abuse. Lise only recently uncovered memories that "half [her] family" had been abusing her from the time she was five years old.

She was prescribed valium at the age of 13, but didn't begin her psychiatric experiences until the birth of her second child. In a quest to understand her problem with bed-wetting, she was referred to a neurologist. Unlike most survivors when they first get counselling, she suspected there might be a connection between the enuresis and an abusive nightmare. One year later memories emerged and she was diagnosed with "multiple personality disorder", and spent much of the next two years in and out of several psychiatric wards recovering from repeated suicide attempts. She was given antidepressants and major tranquilizers. At one point she was kept in hospital for intensive regression therapy under hypnosis, and found it was "too much". Lise credits her recovery to her own hard work and the support of a feminist therapist from a sexual assault centre, who was enlisted by her psychiatrist to join him in a team approach. Both clinicians were very available to her during times of crisis. She feels she was "one of the lucky few" who got the support she needed.

Louise

Louise has two children and has worked outside the home as a researcher in universities and with the government. She was first sent to a psychiatrist (six months) and psychiatric hospital (one week) at the age of 14, for depression and headaches, after the death of her grandfather who molested her. She never told anyone about the abuse until her early

twenties when she confided in her husband. She did not tell the university counsellor she was seeing at that time. A few years later she brought up the issue in marriage counselling, and later still with a psychologist. While offering a few practical ideas, both of these therapists did not understand the depth of her need to focus on healing specifically from the incest. As a new mother she was suicidal, and ended up in a psychiatric ward of a general hospital for two and a half weeks. Once again the importance and the process of healing from incest was not recognized, and she left the system feeling that she did not belong there. Louise believes that natural childbirth and the incest survivors' support group she recently joined have been powerful experiences enabling her to feel like a whole person.

Sarah

Sarah is a married health care professional who leads an active life outside her job with many hobbies and a keen interest in the environment. She was repeatedly sexually abused by a male family member, but has only recently remembered this. In 1976 she first approached psychiatry in her early 20's for depression. During the next two years she had 15 admissions to a general hospital psychiatric ward and one short stay at a psychiatric hospital for self-injurious behavior. She continued with outpatient psychologists from 1978 to the present. After a lot of drug therapy and several diagnoses, Sarah no longer takes medication and does not

identify with a particular diagnosis. She disclosed the incest under hypnosis before she was ready to deal with it, and never returned to that therapist. A year ago she began seeing a feminist psychologist who asked her about child sexual abuse. Sarah says they covered more ground in this one year than in all the previous years of psychiatry combined. She dreams about working in the future with teens who have similar problems.

Interviews

In keeping with feminist principles, I have attempted to minimize the power differential between interviewer and interviewee by 1) inviting collaboration; 2) offering flexibility around our meeting place, and assistance (e.g. child care, transportation costs); 3) maintaining a conversational atmosphere which included judicious use of self-disclosure and/or interviewer's receptivity to requests for information (Aisenberg, 1988; Oakley, 1981; Kieffer, 1981); 4) giving interviewees control over their own data; and 5) maximizing benefits to these women who have generously volunteered their time, hospitality, and input.

For the participant, the interview provided an opportunity to reflect, to be validated, and to make further sense of her life. Most of the women hoped that their sharing of experiences in psychiatry would empower and reduce the isolation of other survivors, as well as inform helping professionals.

I was able to reciprocate by providing information when requested, and by communicating similarities in the perceptions and experiences of the various participants. Two interviewees had experienced family tragedies in the interim period between the first and second interviews, and I was able to provide a listening and caring ear during the follow-up exchange. Even after the second interview, a few participants were so enthusiastic about the project that they kept me informed of their experiences with new healing resources.

The interview process involved taping relatively unstructured accounts, from two to four hours in length (her preference) providing maximum freedom for each woman to tell her story in her own way. Before she started, I asked her to fill out a "face sheet" (Appendix E), listing her psychiatric experiences including dates, hospitals and therapists. She could then refer to this time line as she described her journey in chronological order (as much as she could without interrupting her flow). Most interviewees also listed other counselling experiences on this sheet, and shared what was and was not helpful during these encounters. Toward the end, I scanned a list of questions arising from the literature (see "interview guide" Appendix E), in order to introduce missed topic areas for possible comment. This guide also enabled me to hold a mental picture of general areas of inquiry, and questions that could be used informally as probes.

The technique of requesting that each participant describe her experiences in chronological order was borrowed from Kieffer (1981). While researching the experience of "empowerment", he found that a chronological description illuminated not only the factors, but also the process involved. Similarly, it was hoped the impact of psychiatry on incest survivors could be described in order of occurrence, so that as much as possible, their lived experiences of becoming and being "psychiatric patients" could be approximated.

Follow-up Interviews

After the first round of interviews were transcribed, each woman received a copy. Further involvement in the project was entirely voluntary. Participants were then encouraged to review the transcripts for accuracy, provide additional information about their experiences during that period, and furnish an update if they desired (several of the follow-ups occurred nearly a year after the initial interview). A second meeting was held with two participants, six women took part in telephone follow-ups, one interviewee replied by mail, and one said she had nothing to add.

From the researcher's perspective, the follow-up interviews aided in 1) clarification and elaboration of data, 2) prompting of further recollection, and 3) inquiry about possible aspects of their experience that had been described by other participants. An unexpected insight into the processes of further dependence upon, or greater independence

from the psychiatric system was gained from conducting the second interview nearly a year later. In some cases, differing circumstances such as increasing validation and empowerment, or loss of a therapist affected participants' overall views on psychiatry during this interim period.

Data Analysis

As in Kieffer's methodology, thematic analysis consisted of a process of identification of themes, beginning with many topic areas in each woman's own words, then moving toward consolidation into more and more general themes that were applicable to more than one woman's experience. Differences in participants' stories were used as counterpoints.

Data analysis consisted firstly of doing my own meticulous transcribing, as soon as possible after each interview. Most of these women were both candid and often passionate in their sharings, and my novice typing skills required that I listen to their words over and over. Twelve years working as a counsellor prior to the project further enhanced my ability to recall body language and emotional tone, so the interviews came alive for me every time I reread them.

Secondly, each participant's unique themes were noted in the margins, with no limit on numbers. Quotes containing these themes were then grouped by listing the woman's name, key words, and page references on a master list. As the process continued for each interview, similar comments were

inserted in the thematic categories. Later these groupings were consolidated into broader categories.

Thereafter, the follow-up interviews were scheduled for additional input and clarification, along with solicitation of comments on topics mentioned by other women. As in the initial meeting, each woman was encouraged to focus primarily on aspects of her psychiatric experience that were important to her. The informal nature of these interviews precluded rigorous questioning.

Before drafting the findings, four copies were made of each interview, so that three could be used for cutting and grouping the quotes according to the themes in the master list. As these groupings were spread out and reread, currents of similarity and variance emerged. I was amazed at the number of comments from different women that echoed and reinforced each other.

My initial intention was to provide an opportunity for participants to come together to review the findings. However, the idea was dropped when more than half the women said they wanted to maintain their anonymity. After writing up the findings in a first draft, I compared them to questions addressed previously in the literature review.

Although a multitude of themes emerged from the shared experiences of these women, I chose to report on topics that are most immediately useful to counsellors and other survivors. Chapter Five is a summary of encounters with

traditional psychiatric interventions: women's many and varied experiences of revictimization, along with the impact and relevancy of the diagnostic framework, medications and ECT for survivors. Chapter Six offers meanings behind and suggestions regarding certain survival behaviors that are difficult to understand. In Chapter Seven this group of survivors describe what kinds of overall support they felt they actually needed during the time they were "patients" in psychiatry.

CHAPTER V
WOMEN'S EXPERIENCES WITH
TRADITIONAL PSYCHIATRIC INTERVENTION

I have to say I'm filled with sadness when I think about the hospital...because it was time wasted, on my part, and on their part...The majority of them really thought they were helping, so that's why I'm sad. And it was time wasted in a life as well. That's why it's important that there's a change in it (Sarah).

While some of the psychiatric experiences reported by this group of incest survivors were positive, many traditional attitudes and methods were experienced at best as a waste of time, and at worst as revictimization. Although the criteria for interviewees included a period of at least one year in psychiatry before the incest became a focus, most women spent many years as a "patient" before receiving what they considered to be appropriate support: "half my life" (Isabel), "fourteen years" (Sarah), and "twelve years" (Helen). After twenty years in and out of psychiatry, Janus reviewed her latest, and relatively most effective psychiatrist: "I put in an awful lot of time in and so did he, using the wrong techniques". Essie spent much of her life after age four as a "psychiatric patient". Yet, it was not until two years ago, when she worked with a psychiatrist who was a survivor herself, that she felt safe enough to disclose the years of incest abuse.

This chapter first examines experiences of revictimization from traditional psychiatric attitudes. It then looks

at survivors' experiences with the diagnostic framework, medications and electroconvulsive therapy (ECT).

Revictimization from Traditional Psychiatric Attitudes

Powerlessness, silence, sexual abuse and blame not only engulfed these children, but as teens and adults, the very system that they approached for help inadvertantly betrayed them by repeating these and other "traumagenic dynamics", such as those outlined by Finkelhor & Browne (1986) and Rieker & Carmen (1986) in previous chapters. Since examples of revictimization are interspersed throughout the findings, my purpose here is to detail the most prominent themes emerging from the interviews.

Powerlessness

I had no control over what was going to happen to me, which really is the most frustrating thing as a patient. You are totally out of control about what happens to you, and yet, that's the very thing you're striving to gain, a little bit more control (Sarah).

You want to be able to tell them, "You fucked me around", but they all think they're right. You have so little power, and so little control, that you can't affect them at all (Helen).

The theme of psychiatric power over "patients" was mentioned repeatedly as damaging for these women. Most often this dynamic was subtle, as with Helen's analyst.

Everything was on her terms, all the time...I looked at her as this ideal...but she was bringing me closer and closer to what I didn't want to do.

Chris talks about how a psychiatrist's insistence, "If you do as I say, then you'll be fine", suggested that she was "not for real". "It was 'daddy knows best'...the same garbage that I heard from my abusers."

Isabel felt "impotent" because she was not allowed to share her expertise with her analyst. Janus asked many times for her diagnosis, and Jill repeatedly requested to see her psychiatrist's notes, both to no avail. "I have a sense of him wanting to maintain a one-up-manship, and this was his way of doing it...[with] these secret little writing notes."

Lise and Jill share the impression of being "treated like a child", in hospital. Says Lise, it's "like you're a five year old...they don't think you can think for yourself". Sarah "did not trust them, oh gosh I didn't trust them, 'cause I figured they're so much in control, they take all the power away from you".

"You're like puppets in their hands and that's it", explains Lise. Many, like Sarah, recall being threatened, "'Do you want me to call the orderlies in?'" Jill found "If you don't do this, this will happen...You can't be resistant to these suggestions, otherwise they certainly can make it hell".

For Isabel it felt "so cruel" that hospital staff wouldn't get her meals when she was afraid to leave her room, and Lise was forced to eat in the same room as the men in addictions treatment. "I was so afraid of the guys, most of

them looked quite tough and menacing to me." This repeatedly brought on flashbacks of her perpetrators, and resulted in forced injections because she became "out of control". "I didn't want to go and eat when I knew every time I'd be there, I'd be given a needle." Consequently, like Lise, all of these women submitted to their "caregivers". "I was really afraid of that man, and I thought if I don't do what he tells me when I'm in here alone with him, I'm going to be here for years."

Jill and several other women recall particular clinicians who were "really nasty", with the power that they had. Chris and Janus both were both "interrogated" and techniques were used to "make [them] angry". Janus met with a psychologist who "screamed abuse" at her, and Lise had one psychiatrist who "had a voice that could scare anybody". This psychiatrist ran a floor with "army type" nurses. "They all want you to submit yourself. You feel like you're a slave with them, and I just wanted to die." After she then attempted suicide in the hospital, this psychiatrist asked to speak to her. With fears of long-term committal, Lise "apologized" for trying to take her own life.

She put me on a one to one...you had to remain in your room...you weren't allowed to speak to anybody ...when she didn't see the resistance...she was really nice with me.

Three interviewees relate their terror at being locked in solitary rooms, and six share times when they felt threatened with long-term psychiatric hospital committal. This became one of Sarah, Lise and Essie's "greatest fears". Janus's

psychiatrist told her "You don't want to be in the loony bin...I could send you". Sarah was informed

If I really want to be crazy, then he would send me to the psych hospital, and my craziness would find a home there...When they told me I was going, I flipped out...That would be the one and only time I could say I lost touch with reality...I felt so abandoned... This is it...they're going to put me in a back ward.

When she was released, they sent her back to her abusive home with the "rule" that if she self-injured again, she had to return to psychiatric hospital. Similarly, Essie remembers being told she was

"certified for life...This is the end of the road for you"...Do you know how many times psychiatrists told me, "You're a hopeless case. You'll never be well"?

Silenced

As with all of the other nine women interviewed, Helen learned quickly that "there are certain things that you can't say, and you just know that". She was told, as were three other respondents, when she brought up her history of incest, "That's not the issue". Janus's analyst

did not want to deal with the experience of abuse, nor with the emotions that are a fall-out from it...Finally I said, "I get the feeling that you don't want me to talk about it anymore", and he said, "Yeah, good decision, let's not talk about this anymore"...This is when he started falling asleep...Whenever I...get invalidated or get subtle messages not to talk, I shut down. I go into a shock state.

Sarah's opinion of doctors is unequivocal, "They never listen". Isabel, Essie, and Janus attempted to get their

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feelings out in psychiatric institutions, but soon realized "it's not ok to do this stuff", "no venting allowed", when "they silenced me". Four women were completely ignored as inpatients, spending from one to two weeks without seeing their treating psychiatrist.

Half the interviewees, like Sarah, say their feelings and behavior were minimized. "One thing that I found very detrimental was the minimizing of my physical self-harming." Isabel felt "demeaned" by her inpatient psychiatrist's comment that "abuse isn't everything". Helen was "silenced" and stopped seeing one therapist after he minimized her feelings during a crisis call, with "'You're gonna be fine, don't worry about it'".

Suicidal feelings were also downplayed by hospital staff. When Isabel said during a hospital stay that she was still afraid of suiciding, she was told "'Oh, but not with four children'". Janus was suicidal, but the emergency physician, "told me to go away, that he had some really sick people to see".

The detached approach to psychotherapy followed by psychoanalysts and some other clinicians was experienced as "cold", "very bleak, very alone", "painful, painful", repeating the childhood trauma for those women who encountered this approach. Isabel has spent "hours and hours" pondering over her analyst's lack of empathy after she injured her knee. "This may be a reenactment of my childhood...my father was

also distant and cold." She was never able to share memories of abuse with either of her analysts. "I can't give him my feelings...I mean how can I do that to someone who...I guess there's not the closeness and comfort".

Janus became "even more out of touch" with herself when she worked with a psychiatric resident who used a tape recorder, and gave "no feedback...no structure". "I felt like a bad patient, and I started feeling crazier and crazier." Her analyst's standard textbook phrases, like "'What does that mean to you? ", in response to painful disclosures of abuse, enraged Helen. "Fuck off! I'll lay you down and fuck you and then stick a spike in your leg, and you tell me what that does for you!"

Bernadette believes unequivocally that "Freudians are not good for survivors". She remembers telling her psychiatrist

"Look, my father did things to me, and I'd like to explore it. It makes me feel bad." And he says, "Oh no, it's just your imagination...It didn't really happen".

Janus criticizes her analyst for making her

aware of the very depths of my personality, the unconscious feelings, memories without really elucidating it...He never did discriminate between reality [and fantasy]. In fact, he accused me at one time, 'All you're going to focus on is the reality?'"

Isabel's analyst was "not necessarily a believer" in her memories. "'Whether it's real or fantasy, it doesn't matter. That's what you're believing now, that's fine'...[but] it's important that I have someone who believes."

For Helen, "the most horrendous thing" was the

mother-blaming. Every one of the psychiatrists, the very first thing that they wanted to know about was your relationship to your mother...not the relationship with your father...My mother was dying, and I wanted to be close to my mother.

Janus, too, was frustrated that "all we concentrated on was my mother. Whenever I'd try to widen it, he would bring me back to that." She says, "He wanted me to think that men were all right...I could never talk about my father."

Sarah and Jill both found their psychiatrists siding with their husbands and invalidating their perceptions, "to me that was demoralizing", "I never had any affirmation of my point of view".

Sexually Abused by Male Caregivers

In a previous chapter, Penfold (1987) describes a continuum of sexual abuse by therapists that begins with reinforcement of "women's status in society as a sex object". At the far end of this continuum, three women in this study were actually molested and/or raped by male caregivers. Bernadette's GP started his abuse by telling "dirty jokes" around her and asking her to do typing. He later

decided to try hypnosis to bring back memories... But I think it was turning him on. I sensed it in my hypnotic state, because you're super aware. It almost felt like he was masturbating.

When she told her GP about being held by her new bioenergetics therapist, he raped her. "It was like a recreation of my father's stuff...victim scenes."

Essie was routinely molested while she was on the "incurables" ward in hospital by orderlies giving her

the free feel and the free poke on the way by. Disgusting, you know it was absolutely. I wasn't insane when I went in there, but I fuckin' was when I came out.

Janus was repeatedly raped and later harassed by three orderlies, one from a medical ward and two in a psychiatric hospital. Her situation warns of the danger of not being believed or taken seriously if a woman reports sexual abuse on a psychiatric ward. Once when she was attacked, Janus tried to defend herself, but the orderly

called for help. I was this "crazy lady", and "she was hallucinating", and "she tried to attack me". I felt really guilty...I just withdrew and tried to be as good a patient as I could.

Janus later "demanded" her psychiatrist "do something" about these orderlies, who were also preying on other women patients, but "he started saying, 'This happens all the time'". Similarly, when Bernadette told her psychiatrist about an intern who had molested her after "shock treatments" and later attempted rape in a washroom, "he just dismissed it" and said, "'Oh, he does that to everybody'".

If these women's experiences are at all representative, such sexist attitudes are common among psychiatrists. Lise found many clinicians believe that incest is "a sexual thing. When a doctor says to you 'You made love, you're cured', come on, give me a break!" Sarah's psychiatrist

thought that my problem with sex was that I wasn't getting enough of it...The reason they felt my

boyfriend really split up with me was because I was a virgin...that I was frigid...and he found another girl...[I now realize] the problem was that he found another girl, it was the betrayal.

Four women mention the hurt they felt when they received sexist messages from therapists that they had to be thin to be valued.

Two interviewees were revictimized by heterosexist attitudes. Helen identified herself as a lesbian to her analyst, who continually tried "to encourage me to see myself with men as positive, or something I really wanted inside, but wouldn't let myself go". During the years she saw this psychiatrist, the doctor attempted to convince Helen that her sexual orientation was a pathological outcome of the incest. "Everybody's telling me that I'm not a lesbian, and I feel like a lesbian, and I'm going crazy here." Chris was criticized by a psychiatrist for her lesbian style of dress and told she had a "bad body image".

Blamed

Three women share instances of being held responsible for the incest by their Freudian-trained psychiatrists. Lise was told "If you'd stop thinking about sex, you'd be fine". Bernadette's analyst told her, "You must admit you had a special relationship with your father, and it was pleasant, some pleasant things". Helen's psychiatrist thought

penis envy was the problem. She asked me to describe my feelings about a penis, what I was afraid of. This came after one attempt to talk about my shame at remembering pleasure with my abuser.

Janus's long-time analyst accused her of "splitting" and "projecting", but when she read up on psychoanalytic theory to understand his terms, he then accused her "of being intellectual and using the theory. It was crazy-making."

Sarah mentions discrepancies in the way male and female psychiatric "patients" are treated.

If the man flipped out...poor guy, he must have been really upset. If a woman flipped out, it was because she was being dramatic, she was seeking attention, she was trying to manipulate.

This double standard was perpetuated by attitudes of male therapists with a

macho image that "we have to protect you from yourself"...That was the worst possible thing they could have done...They think all of this behavior is "bad girl behavior"...It was just an extension of what I'd always done all my life...at home...If you're a "good girl", you're not going to get into trouble. But that's what was making me sick. What I was doing was contributing to my own illness.

On one occasion when Janus was in hospital, and she had what she realizes today was a "memory flashback", she accidentally broke things. She was "treated like a crazy, psychotic" on the one hand, and "bad, in full control and manipulating" on the other. "I got punished for it, charged with mischief, certified and shipped."

After Bernadette attempted suicide, her psychiatrist told her brother, "I don't want anything to do with her if she is going to pull that kind of stunt". Janus got the message from her psychiatrist that she was a "bad patient" if she went to the hospital when she was suicidal. "He was losing money, and

he never knew whether I was going to walk in the door or not".

In repetition of a childhood with abusive caretakers, whose needs superseded their own, these women were often disappointed and revictimized when they reached out for safety and nurturing from psychiatric personnel.

Survivors' Responses to the Diagnostic Framework

Chapter Two featured a critique of the diagnostic framework of psychiatry, how it pathologizes, rather than "makes sense" of the aftereffects of abuse. "Patients" are seen as "sick", psychiatrically "disabled" rather than whole. Examination of particular common diagnoses, especially "borderline personality disorder" reveals the psychiatrist-as-expert's attention to be on "managing" "symptoms" and problems, rather than empowerment. What were these women's experiences? Interviewees who share some appreciation of their diagnoses agree with Essie, that the label was better than "not knowing". All of these women wanted to "know what's wrong" with them. "At least there was a name for it" (Essie), "rather than...just thinking I was crazy" (Lise).

Janus was never told her diagnosis, even though she repeatedly asked. While she was in so much pain that she suspected she was "schizophrenic", Janus actually feared staff would "kick [her] out", during her first stay as a psychiatric "inpatient". "'Cause I was a fraud. There was nothing wrong with me." Lise agrees that having a label in hospital makes

you "feel better that you're there...it sort of gives you permission to be sick". Sarah's experience was similar.

I had a sickness. It wasn't my fault, so I couldn't help it, and all the people who were rejecting me because I was running around cutting myself would have to say, "Oh the poor girl, she's sick"...as long as I was popping pills...I had a medical problem.

Having spent so much of her life in institutions, Essie was "used to labels". Isabel says she likes labels because "they give me something to look up at the medical library. A place to go from". Sarah and Janus were also avid researchers. They spent hours attempting to fit into the psychiatric framework, in Janus's case, "to get a sense of control over what was happening to me".

Sarah was terrified of "punishment" for remembering and breaking the silence around incest. "The whole family, everybody, wants to believe I'm sick." She "clung" to her second diagnosis of "manic depressive psychosis".

Creative types...bohemian...a lot of greats had it...I knew there was something else...It meant I didn't have to face what was really wrong.

Later, she tried to accept her revised diagnosis of "borderline personality disorder". Years of accommodating to the judgements of others for survival made it easy for her and Essie to fit their diagnoses. Sarah felt

like a chameleon...when they said "Be a crazy person", I was a crazy person. "Ok, now you're depressed", oh yeah, I'm depressed...When they told me I was schizophrenic, I could be schizophrenic.

Essie also found

If you're diagnosed as insane, you tend to play the role...[You're given] a list of behavior modes... "This is what happens when you're schizophrenic." You've got the friggin blueprint. So you can take that and make yourself believe, you know?

Lise and Sarah describe how incest survivors' unmet needs for connection and recognition make them susceptible to psychiatry's requests for participation in research and presentations. Lise worries about other women with "multiple personality disorder" ("MPD"), who don't have the kind of feminist support she had, being able to move beyond the diagnosis, if their therapist "keeps you there" for his studies and educational purposes. She believes some women are "still there" because they "have nothing" and receive some identity and nurturing as an "MPD". Sarah was "sort of coerced" into speaking to an auditorium full of psychiatric professionals.

It was an ego thing for me...boy, didn't I get the pats on the back. "What a good girl you are. We're so proud of you. You've accepted your illness, and you've come a long way...You're our star pupil"... This wonderful doctor figured out I was a "borderline personality disorder". He "cured" me, so it was really a feather in his cap...But then of course I didn't get any better...We were feeling good about a falsity.

Both Lise and Essie fought their diagnoses, striving to reframe them as survival mechanisms. Their struggles are detailed in the sections on dissociation and "mania" respectively. Lise explains how "sometimes you feel you're

just crazy. So you accept the label". Essie, in the first interview said

I don't believe you can label anybody. You put someone in a bottle when you do that...they were trying to categorize..."Now that we know that's what it is, ok, now we can fix it." It's not that easy at all...We are...a combination of many things ...That doesn't make us sick people. It just makes us people that have things to deal with.

However, her opinion had changed at follow-up, when she lost the holistic counsellor who had been providing alternatives to medication. Her GP and two psychiatrists stressed the need for lithium because she had "bipolar disorder".

Chris, who has feminist counselling support, had to see a psychiatrist recently so that she could qualify for a disability pension while she is healing. He diagnosed her with "bipolar disorder" and "panic disorder", stressing that she should lose weight and take medication.

Even a year and a half ago, I would have gotten into all this self-doubt about buying into a lot of the garbage he was telling me.

For most interviewees, the disadvantages of psychiatric labeling appeared to far outweigh the advantages. Several talked about their difficulties with the stigma of "mental illness". Louise had to change her identity. "Now I was a psychiatric patient...and I didn't like it...I felt like a specimen, that I was a type." Having the diagnosis of "MPD", for Lise "proved I was no good...that's it, my life was over". Likewise for Sarah, the label "schizophrenia was like a death sentence, you were going to spend the rest of your life

crazy". Isabel was adamant she would "never use the psychiatric hospital", only a psychiatric ward of a general hospital. "I don't see myself as someone who's going to be in the revolving door...I mean it's so contrary to being in harmony with the universe."

Lise believes she received no family support during her hospital stays because of the "damn stigma" and their "fear of mental hospitals". She attempted suicide because she feared her husband would leave her after discovering she had a "mental disease".

I was in this mental hospital, so I was just "crazy". The more I got in the hospital, in and out, the more proof to them I was "crazy". You end up being totally alone.

Essie, who spent time on a "back ward", said survival in the psychiatric system, "getting along", requires being "one of them". "When I was locked up for the first nine months, the environment alone makes you one of them."

Sarah recalls how psychiatric staff, instead of attempting to make sense of her behaviors, interpreted them in the light of her current diagnosis. When she cried after receiving a gift, instead of learning that Sarah's tears arose from her disbelief that her friend could "care that much", a nurse came to her and said, "'Do you know what schizophrenia is?'...letting me know that...crying over a gift was abnormal". Chris saw a psychiatrist, who diagnosed her as

"manic-depressive"...after half an hour...Whenever I'd go and see him, he would just sort of say, "Have you been taking your meds? Did you get your

blood test?"...He was like a brick wall... Emotionally I was trying to tell him what was happening to me. He had already stuck his label on it and didn't want to consider anything else.

In her account of hospitalization in the section on self-injury, Sarah describes her progressive loss of self-worth as she was increasingly labeled "schitzzy" and "dangerous". Late-disclosed/acknowledged incest survivors often receive many diagnoses over the course of their involvement with psychiatry, and this was the case for at least four of these women. "It doesn't make me feel good, I've had lots of labels" (Bernadette), "a thousand diagnoses" (Isabel).

Essie's first childhood diagnosis at the age of four was "emotionally disturbed". Later she was told she had a "sleep disorder" and a "seizure disorder". Both she and Sarah were labeled "schizophrenic" at one point in their lives. After the initial shock of being told she was suffering from "paranoid schizophrenia", Sarah says,

I started to think being crazy is not all that bad. People...can't expect much from you...and you can get away with behavior that other poeple certainly would never even dream. I think there's a lot of power in knowing people are frightened of you.

One of the most common diagnoses received by this group was "borderline personality disorder". In accordance with the literature summarized earlier, this label was experienced by participants as painful, rather than healing. Bernadette attempted to appeal the "borderline" diagnosis, combined with "schizoid tendencies", which was made by an intern during

intake for an "eating disorders" program. Two of Isabel's diagnoses were

"Schizoaffective disorder" and "borderline personality disorder". These were "difficult to treat" and said I had to be "managed". Showing my feelings was "acting out", negative.

Sarah was "really embarrassed" when she read about her last diagnosis of "borderline personality disorder".

These women who cut themselves, and they're manipulative, and they're not very good in relationships...I am one of these awful people ...What they're saying is I'm not capable of looking after myself...What I'm doing is meaningless...I am bad. You're a bad person.

She says "the most damaging thing about my experience with psychiatry" was the "treatment" for this "disorder".

I didn't ever feel that they were helping me, they were sort of managing me. I felt like how they manage cattle, before they send them away. In this chute, out that chute. Don't let them get too hyper because they're dangerous.

In the section on depression and suicide, Janus describes how standard procedures for "managing" threats of suicide by women with "borderline personality disorder" actually precipitated her decision to follow through in desperation with an overdose.

Other diagnoses explored in depth in the interviews include "depression", "bipolar disorder", "panic disorder" and "multiple personality disorder". These accounts follow in the chapter on difficult to understand behaviors.

Isabel was the only woman interviewed who received the diagnosis of "post-traumatic stress disorder" ("PTSD"), the

emerging diagnostic trend for identified incest survivors in psychiatry. She says that "PTSD", in comparison with previous "negative" labels "is so comforting to me, because it comes with compassion, the hurt has to be expressed".

Louise prefers the label "survivor". "I'm beginning to accept myself more because I've got this label. It's more me than 'neurotic, immature', and I will probably depend on it for awhile."

Experiences with Medications

With that label goes a bottle of pills (Essie).

What I hated the most was the drugging (Lise).

I think all they did was delay the inevitable. The inevitable knowledge that had to come...because it focused our attention on the diagnosis, and consequently medication that was associated with the diagnosis. It got rid of anxiety on the outside, but I don't think...the anxiety really went away...yet on the outside you look pretty darn good. You're not causing anybody any problems (Sarah).

With a few exceptions, medications taken over an extended period are not considered helpful by this group of women. Drug "side effects" also added to their discomfort and confusion. Three interviewees share some relatively positive experiences, but they, too, continue to seek alternative resources that would enable them to heal without drugs.

In the short term, several women appreciate medication for crisis intervention, including the relief of being able to sleep. It is not within the scope of this thesis to offer detailed accounts of experiences with particular drugs.

However, some comments will be shared regarding the broad categories of antidepressants, minor tranquilizers, and neuroleptics (antipsychotics). Lithium is discussed in the section on "mania".

Of the seven women prescribed antidepressants, only one of them finds this group of drugs personally useful, and the range of troublesome side-effects is well described. For example, Isabel had difficulties with weight gain and fatigue. Certain antidepressants made Chris and Janus, who took them in combination with perphenazine (a neuroleptic), feel "worse", exacerbating insomnia and panic, rather than alleviating them. However Janus, convinced she has a truly biological depression, was taking a different type of antidepressant at the time of the last interview. She attributes her satisfaction over the last five months to her new psychiatrist, who has the "interest, knowledge, and doesn't make assumptions", required to find the right medications for her.

At least half the participants in this study were prescribed minor tranquilizers. Janus regrets not being given information when she "begged for Valium" during a crisis, and later went through "a major crisis withdrawing" from the drug. She says minor tranquilizers are "habit-forming and dangerous". Helen found them useful for sleep, but "walked around numb...I didn't wash. I didn't care about my clothes. You can't even function half the time". Chris believes these drugs, used on a one-time basis, help break her cycle of

panic, until she is able to learn other ways to release pent up feelings and calm herself.

Antipsychotic drugs were heavily criticized by all interviewees who had taken them, with two exceptions. Jill found the right dosage of haloperidol could break her "manic" cycle, but she disagreed with involuntary injections. In order to fulfill her role as a single mother of four children, Isabel was using perphenazine to handle intrusive memories without self-injuring or becoming suicidal. However, the accompanying risk of tardive dyskinesia, a neurological side effect that is permanent, has motivated her to look for alternative methods of healing and less harmful medications.

Lise, Sarah, Essie and Bernadette recall frightening experiences when they were injected with neuroleptics: "like putting a child in her room...proof you are a bad person", "terrible...a chemical straitjacket", "paralyzing from the face, drooling, you can't speak", "bang bang bang with the hypos", "to shut me up, like a zombie". Because the "awful awful feeling" of being sedated with a antipsychotics is "too much", Lise feels that when a "patient" is "out of control", it is

better to put her in a straightjacket, or tie her in bed, and staying with her...calmed down and talked some sense, or even hugged. I think if someone had come to me and said, "I just want to hug you", I think it would have worked a hell of a lot better than a shot.

Prevention appears to be the most effective solution for "out of control" behavior. In the section on dissociation

Lise explains how her "acting out" ceased once she had a counsellor she trusted. Six women offered examples of when they "acted out" in anger and/or terror, in response to revictimization by psychiatric staff. "He caused this out of control way I was in", says Lise, describing one psychiatrist who repeatedly intimidated her, and then gave her injections when she responded by losing control.

Medications are criticized for inhibiting the very self-expression that is necessary for the process of healing from abuse. Lise talks about society's suppression of feelings, "Don't cry, don't cry", and doctors' tendencies to "plunk a few pills in you". This exacerbates incest survivors' difficulties with overcoming their fears of expressing feelings. Lise asks "How can I know myself if I can't get in touch with myself, if I'm always drugged up?" She still doesn't remember much of her "treatment" for "MPD" because she was "so drugged...it's vague...like I'm still in vapours". Sarah found

that dozey drugged feeling doesn't allow one to think, to have a memory...The person doesn't have the energy or the wherewithal, or maybe even the desire to express the feeling.

When Essie was in a psychiatric hospital it was

drugs to wake up, drugs to keep you calm, drugs to keep you going, drugs to put you to sleep, drugs to get you going...and they check your mouth. If you won't open your mouth, they rip your mouth open.

Lise also complains, "They put you on medication you don't want to be put on". Only Chris, when she was a teenager, and

Louise, when she was pregnant, recall having spent time on a psychiatric ward without medication.

Chris, Lise and Isabel stress the importance of choice, and information about "side effects" in decisions regarding medication. Lise also cautions physicians to be careful with suicidal "patients". "The more [pills] they gave me, the more it gave me a chance to kill myself, whenever I was going through a rough time."

Experiences with Electroconvulsive Therapy (ECT)

Bottom line, it's terrible (Essie).

Of the three participants who experienced ECT or "shock", none recommended it for other survivors. Essie remembers before treatments feeling like a "lamb led to slaughter". Both she and Sarah recall being painfully disoriented afterward, "That was when I hurt myself the worst" (Sarah).

They all suffered permanent memory loss, and this was especially crushing for Essie, who, after thirty-six "treatments" tells how she lost her "music. I played classical music for a long time, and I was very very good...Well today I can't. They zapped that."

Bernadette says she received

a whole series...enough to just obliterate me off the planet...I apparently had an IQ of about 130. I had a photographic memory, and now I can't remember anything like that.

Even though Sarah had a shorter series of twelve "treatments", she too has "lost a lot of permanent memory".

Although ECT relieved her anxiety in the short term, by "wiping out the memories that were starting to surface", Sarah still had to face her abuse down the road.

I don't think it's a good treatment, although my parents were thrilled, because...I seemed really good after that...But in actual fact, the only reason I pulled up my socks is because I met a fellow whom I'm now married to...that would be twelve years ago, and in the last five years I started having problems again.

Can Psychiatry Be Crazy-Making?

Overall, traditional patriarchal "treatment", that operates on the premise of psychiatrist-as-the-expert, employing methods of social control in order to manage "patients'" behavior, and to suppress their memories on an ongoing basis, was experienced by this group of survivors as a denial of self, frightening and "crazy-making". Obvious examples include Lise's dissociations into violent and suicidal states, and Sarah's one "psychotic" reaction when they were inadvertently reabused by controlling psychiatrists.

Consequently, participants were prevented from forming trusting relationships with such clinicians, and had to resort to "playing along" with the system for self-protection. Typical is Sarah's memory of her "macho" physician requiring "good girl" behavior, the very thing, she says, that was "making [her] sick" all her life.

Much of participants' precious time and energy was spent adapting to their disempowered positions and the psychiatric system's perception of them: "The message that I got was that

I was crazy, I'd always been" (Lise). When the often overwhelming aftereffects of child sexual abuse combine with societal messages to women that they are "sick", "bad", and "crazy", survivors of incest are particularly likely to fear that they must indeed be "crazy". Psychiatry confirms these doubts with its diagnostic framework, along with the aforementioned traditional attitudes that revictimize women survivors.

In the next chapter, participants explain how they had to develop difficult to understand strategies, in order to survive these aspects of the psychiatric system, as well as the abuse in childhood. Emphasis in the findings to follow, however, is on the women's awareness of what forms of support they actually needed at this time in their lives.

CHAPTER VI

DIFFICULT TO UNDERSTAND BEHAVIORS

No matter how unusual or strange or disturbing to you as a therapist the person you're working with is, it's important to always remember that this is a person who's had the strength and the fortitude to survive. This is someone with intelligence, and with dignity, which may not be readily evident to you, but it's there somewhere. I think the person should be treated first and foremost with respect...and with compassion and care (Chris).

Keep in the back of your mind that this person is a victim of really really unpleasant circumstances. And the pain she's showing is just as confusing and just as upsetting and unsettling for her as it is for people to observe (Sarah).

The following topics are grouped as "difficult to understand" behaviors rather than "symptoms" or "diagnoses" because the women I interviewed, for the most part, stressed the normalcy of these aftereffects of abuse. The medical model's focus on "mental illness" and reliance on the pharmaceutical industry have obscured the relationship of these painful states of mind to their origins in trauma, as strategies of survival.

Because they have been taken from the context of women's lives and labeled by psychiatry as "pathology", and because they are manifestations of the pain of the abuse, they elicit feelings of fear, helplessness, and anger in caretakers, as well as in "patients," who are affirmed in their fears that they are truly "crazy". Socially constructed psychiatric "diagnoses" also fragment and compartmentalize survivors'

experiences, when in fact, each survivor may have relied on many of these strategies.

"Mania"

Of the ten women I interviewed, three volunteered that they worried at times they may have been "manic", "on a high". Four others recalled being formally diagnosed with "manic-depression" or "bipolar disorder". However, for Sarah, this resulted from her attempt at the time to fit into the diagnosis.

Essie, Jill, and Chris in describing their "manic episodes", shared strikingly similar accounts of experiencing powerlessness and/or memories pushing up, inability to sleep for many nights in succession, incessant needs to talk, and the mounting high with terror of the impending crash. Essie describes "the down after the high". It's "so low you can't see up...everything turns inside out and upside down...I'm afraid I'll take my life". Chris talks about "struggling to stay in denial about [these memories] because I didn't think I could deal with them," and Essie calls it "running mode--running from feelings". Fears of death propelled Jill, Chris and Essie to psychically spiral upward. Child sexual abuse is often experienced as life-threatening.

Chris recently remembered oral sexual abuse while very young, suffocating, violent, and fearing annihilation. She talks about the adrenalin, the normal "fight or flight"

response to memories of such a threat, which she believes fuels her cycle of many sleepless nights and resulting altered state of consciousness. Now, when memories come, she is working hard to "ride them through" and "discharge" the emotions through the peer counselling techniques and community of re-evaluation counselling.⁵³

As her skills and safety increase, she is striving to have "emotions all the time", rather than keeping her inner child "walled...in someplace inside". She believes that her last "manic episode" was a "really necessary part of my getting to where I am now", because "I was doing a second childhood in a major way". When her holistic doctor/therapist asked her to think of what was "good" about that period, she remembered

I could see things like when I was a little kid. Seeing the sunlight come through a leaf a certain way was mystical and beautiful beyond words...most of my life since I was a kid, I couldn't see anything beautiful in the world. I've remembered good things from my childhood...I got into this whole spiritual trip.

Essie too remembers her abuse happening when she was "very very young...the trauma...was enough that it took all my capacities to survive...something got drained". During treatment for addictions she was prescribed lithium. About 18 months before the first interview, she began seeing a holistic feminist counsellor and quit taking lithium "cold turkey". Essie reports progressing "leaps and bounds" in her healing over that period. However, she recently has resumed taking

lithium since her counsellor retired. She says her new GP, who works with addictions, had her "scared" in their first session, after Essie told her she'd been previously diagnosed with "bipolar disorder".

"Oh my god," she said, "And you're not on medication? The relapse potential with somebody that's manic-depressive ..." She tried to get me in that day to see a shrink to get me back on lithium... they might have had me...but no, I spoke to [my counsellor], and I've done much meditation on it, and I don't need that.

However, months later when she lost her counsellor, she had another "manic episode".

It lasted six long weeks...at [an NA] meeting I lost it, saying "I want out, I just want to die". The floodgates opened, and I couldn't control the tears. Others told me to go to the doctor. She was really good. She gave me something to help me sleep, and we agreed I'd come back in a week...I came in and I was worse than before, so she sent me to the hospital.

The psychiatrist she met there convinced her

"You are destroying the quality of your life by not taking lithium. Are you beating yourself with the only thing left?" Am I denying myself the pleasure? He hit it right on the button. The swings are physically debilitating, exhausting...I just want to be normal. Over the last five weeks I'm back to the land of the living. My life is manageable...I thank my higher power for providing these pills.

While Essie was working with the holistic counsellor on abuse issues for the year prior to this time, she was very hopeful of being able to heal without medications.

I do not want to become drug dependent again...they don't realize I now have learned to say something when I'm fucked up...when I go high she talks me

through it, and we do, I do, what I have to do... I've had too many drugs in my life...I'd much rather do it from the inside...You can keep putting chemicals in your body, but it doesn't solve...all you need is grounding.

She describes what she means by "grounding".

When the manic cycle starts, I can't sleep, and it's a different not sleeping from my usual pattern. I know what's coming and my mind is racing...grounding is what I need, with nature, the soil, the earth and putting my hands into it. Meditation, colours, crystals, teas, I pull out as many as I need...I would call [my counsellor] as a last resort. It took a long time to be able to call. Here I am, totally fucked up. She knew me, so she knew what I needed, what grounded me. "Go put your hands in the flower pot." She'd say "You're sane, you're not crazy."

In the first interview Jill believed "that there may be an organic problem" at the root of her "manic episodes". However in a follow-up telephone interview, she said she is still "striving to find out if there is any evidence of an organic mental illness". This was just after reading Kate Millett's book, The Loony Bin Trip (1990), about her experiences with this diagnosis. Jill now feels more "hopeful". Having herself been traumatized by six involuntary committals in psychiatry when she was "manic", Jill says she was heartened by Millett's view that this diagnosis "'is established upon behavioral grounds...and...impressionistic evidence'(p. 311), and is not sufficient cause to be involuntarily incarcerated, drugged, and denied the right to refuse treatment".

While a volunteer counsellor for other survivors of sexual abuse, Jill herself has not received extensive

counselling in this area. She remembers reading the Courage to Heal before one of her bouts of "mania" and says it "set the wheels turning with too many memories" but doesn't remember what those were now. She believes "emotional deprivation" might also be linked to her "mania".

The precipitating events she has identified have been job related. "I was either doing too much, self-imposed, or frantically trying to crawl out of apathy." Her first two "episodes" involved "having to work in unsafe conditions". On one occasion she was cornered by her supervisor, who had asked her to commit fraud on their employer's behalf. He threatened, "'Frightened rats bite back. If you tell on him, you'll be in big trouble'".

With the support of friends and by listening to her own sense of what works, Jill has been able to reduce her hospital stays from a week and a half to two days. She has found the right dosage of halperidol to induce 20 hours of sleep, and then be able to go home, although she would prefer such an arrangement with an outpatient nurse. Prevention appears to be the key for her.

If the quality of my sleep has not been good...I know, ok, this weekend I've got to get some sleep. Everything else has to be put aside, and to hell with the laundry.

Depression and Suicide

When she first "hit bottom", Essie realized "you have to heal or you're going to die, because literally what you do is you die inside." Both she and Bernadette say that when they finally received appropriate help they had almost lost their "spark". Bernadette describes herself as "like a zombie... this big hole in me that ached...was empty...this nothingness", and Isabel says, "I was nothing". Essie too, talks about "a huge hole", while Louise refers to being "in that pit for such a long time".

Every woman except one described herself as "depressed" when she first became involved with psychiatry. Seven of them shared feeling depressed in their teens, "very very shy", full of fears, and "going for days without speaking". Four of them attempted suicide during this early period. Essie made two attempts, "The only option that I ever had was to die."

Continual childhood brainwashing that they were "dirty", "rotten", "worthless", and "undeserving" combined in their adult years with later experiences of victimization and powerlessness. Such feelings are intensified by triggered memories of the incest that may or may not be conscious at the time. Sarah recalls during sexual relations

I would see something that would, I think now, spark a memory, and the next thing I'd know, the next day, I'd be looking at 52 292's and saying "It's time to get out of this. Something is wrong. I can't go on...my whole life is starting to disintegrate again. What's happening?"

Repeated unsuccessful attempts to better their situations brought on feelings of fear, anger and hopelessness. Isabel, Lise, Janus and Louise, the four mothers of young children in the study, all became suicidal as they felt out of control and unable to care for their children.

I'd cry and cry and cry, and this little toddler would come and put her hand on my lap and say, "Don't cry mommy". How do you feel having that happening to you? (Lise)

When Janus, a single mother, found out her children were being abused in their foster home while she was working and healing she "felt like I was in a box...like I was collapsing. I knew I couldn't do my plans to keep the kids at home and continue working". In desperation, Janus warned her psychiatrist two weeks in a row that she was "'very suicidal...I don't think I can control it. Please put me in hospital.'"

However, in response, like many of these women, Janus encountered stigma, powerlessness and revictimization from psychiatry itself, which often precipitated rather than prevented suicide. Her psychiatrist followed standard "treatment" procedures for "borderline personality disorder".

He would say, "I don't see any signs. I'm not going to do that. I'll see you next week". I felt terrible...like I couldn't tell anybody anymore. It was inevitable. The second week I tried and he said "I'll see you next week." And I said, "The hell with you! This weekend I'm going to 'kill myself'...I really thought about whether I would do this...[and] I just collapsed...and took an overdose...The message loud and clear I was getting was "It's ok to do that".

Nine of the ten respondents describe experiences of feeling more depressed after seeing their psychiatrists whom they had hoped were there to help, but instead ignored, pathologized and talked down to them. In many instances these feelings led to suicide attempts.

Bernadette took a drug overdose when her psychiatrist didn't believe her disclosures of father-daughter incest.

I tried to bring it up a few times and he would just ignore it. It was like I was talking to a wall...it made me feel like I was crazy...He said "I don't know what to do with you", and I said, "Well I'm really depressed, and I don't know what to do either", so I overdosed.

Helen "swallowed a bottle of Valium" when her psychiatrist did not listen to her feelings of vulnerability with a man, who reminded her of "a lech" in her therapy group. Instead, the doctor applied Freudian thinking and suggested that she had a "hidden crush on him".

I felt violated. No safe place. I dreamed about him, my uncle [who had abused me], and the shame and humiliation at not being validated.

Janus attempted suicide in a dissociated state when she reached for aspirin for pain and "really bad" bleeding from her IUD. She links the "impulse" with seeing her psychiatrist just after a skating accident looking "hurt and vulnerable...I had to see her as invincible and in control...and seeing her that afternoon really shocked me". Psychiatrists who present themselves as powerful experts set up such potential for disillusionment.

Sarah recalls being labeled as "manipulative" while she spent time as a psychiatric "inpatient".

That put a lot more emphasis on suicide as being the way out, because what that meant was they don't want to help me, because they think I'm a jerk. Therefore, if I can't get help, which is really why I'm here, I might as well be dead. Actually, I think they pushed me closer to suicide than anything.

"To this day," says Essie about her psychiatrist who was monitoring her lithium for "bipolar disorder", and conducting psychological tests for depression, "he doesn't know what my major issues are about". She couldn't tell him about her history of abuse and the fact that she was receiving alternative counselling. While painful memories were emerging with her holistic therapist, Essie's "depression score" was "below suicidal". Meanwhile, the psychiatrist was "very worried" about her, and told her "'Look, if things don't change, you're going to have to become an inpatient'". She decided "fuck the psychiatrist", and withdrew from her medications "cold turkey", in order to discontinue seeing him.

With repeated psychiatric counselling, Lise soon came to think of herself as a "crazy" mother, and attempted to repress as much as she could, so that "it didn't show". She overdosed when she feared her husband would leave her and take the children, because she was "mentally ill" with "multiple personality disorder". At another point, "one of my 'personalities' decided to hang herself" when she discovered she was

hospitalized on a ward with a psychiatrist who was known to be physically and emotionally abusive.

After several suicide attempts while Lise was dissociated, her dedicated psychiatrist decided to hospitalize her. His plan was to hypnotically induce non-stop regression in order to bring up all the memories. After four weeks, it was clear this "treatment" had backfired, because Lise had no control over the process, and the "suicide attempts were getting worse and worse". The overall lack of control over her healing, and "degrading" treatment in psychiatry made Lise "so damn angry".

I'd been two years with [my psychiatrist] and things weren't going that well. I got to a point where I didn't want to fight any more. I just had had it. And what for?

Her repeated suicide attempts did not abate until she developed a relationship with a feminist counsellor, who saw her as a whole person with dreams and strengths. The counsellor surprised Lise when she asked, just as she was just coming out of intensive care,

"What's your biggest dream?...What would make you the happiest"...I thought she was so crazy...[but] I said, "going back to school"...To me that was a turning point...it was something to hold onto...because every time I'd get really really low, I'd think about it and laugh.

Louise also found this kind of affirmation and focus on her interests and goals brought her out of depression.

Six of the respondents believe that suicide was a request for help, the only "way out" of their painful circumstances.

Sarah did not need to go that far. She found that depression itself was "a good way out. You don't eat, you don't sleep, you don't talk to anybody, you just lay there like a bump on a log."

On the other hand, Lise believed she had to resort to suicide. With all the memories bombarding her, she was not able to rest, and she needed a chance to heal without hurting her children.

I couldn't just call [my psychiatrist] and say, "Listen, I need some time off, get me into the hospital". The only way was suicide attempts...It got that bad that one "personality" would try and kill herself...All I wanted was not to have to do housework, but you can't say that.

Lise's suicidal "personality" phoned a crisis line "to say I was definitely going to die". The fact that she phoned was a signal that there may have been some ambivalence. Isabel was also serious about suicide, although she hopefully left her empty pill bottle on the kitchen counter. Only because a friend came by, triggering the realization that "some people care about me", did Isabel decide to go to the hospital for help.

Chris and Louise wanted to stay at the hospital when they were suicidal. Louise recalls thinking when she first went in, "I felt saved". Bernadette believes "some people need protection, and others don't. Ground privileges should be done on an individual basis". She is angry because she was refused "privileges" unnecessarily for days. "I was treated like I didn't exist."

In the section on "a safe place" Isabel, Sarah and Lise detail the kind of non-institutional environment that they believe would promote healing and prevent suicide. Isabel, like Lise, envisages one function would be to "handle my drugs" so she would not be so tempted to overdose. Lise is convinced that if there had been a healing place where she could have gone, without the stigma of psychiatry, with "someone to talk to", "I don't think there would have been so many suicide attempts".

Similarly, Louise was heartened when a private counsellor told her on the telephone in response to her suicidal plea, "You've already done the most important thing. You've recognized you need help". Chris and Bernadette are enthusiastic about the rapid progress they made with emotional release work as a tool for overcoming depression. Bernadette's bioenergetics therapist told her that in a year and a half, seeing him every second week, "I did about five years work". And after only a month of emotional "discharge" with re-evaluation counselling, Chris finds her "self-esteem is increasing in leaps and bounds".

Anxiety and Fears

"Panic attacks" and "tremendous anxiety" are frequently mentioned by four participants, and four share debilitating fears. From childhood Bernadette recalls being afraid to talk on the phone and not being able to "pee in other bathrooms",

while Sarah carried secret fears of vomiting and of "murdering people". In her early twenties, Louise avoided a career because she "was terrified of becoming a grown-up. Going out to work really scared me". During this same period of her life, Chris

started getting anxiety attacks, lots of them, in a major way. I didn't know what they were...and I thought I was going to die...[or] I must be going really nuts.

After two years of struggling with these fears, Chris saw a psychiatric social worker who had "done a lot of work with people with panic attacks". She learned to say to herself, "This is a known thing", and to give herself "permission to have it, then they're not as intense, and the cycle doesn't last as long".

Both she and Sarah emphasized the importance of understanding and normalizing the origins of their fears as memories of the abuse. It is "such a relief" to Sarah to understand her fear of vomiting as a "pseudomemory" after "all these times...I was seeing psychologists and other people, and nobody seemed to be able to put a finger on it. Now it doesn't bother me."

Even though Chris learned some behavioral techniques for calming herself from traditional psychiatry, she believes "it would have been much easier", and the panic attacks wouldn't have gone on "as long", if someone had told her earlier "that a lot of survivors...get panic attacks... from having memories or body memories".

Before this realization, as is common, the fears get "worse and worse and worse". Sarah eventually became

petrified to leave the house, because I knew that if I went, I was always feeling sick. Of course, the more you think about being sick, the more you feel sick.

As for Chris, her fear of dying while in a panicked state also led to a fear of going out of the house, and later "being terrified even when I was home all the time". She learned in feminist counselling that panic is a "valid" response to memories, and no longer attacks herself when the feeling arises.

There's nothing wrong with it... 'cause I had a lot of shame and guilt around the fact that I couldn't go out... I felt like I was no longer in control of any of my life, and that I was stupid... [I was] truly isolated... this sense that... this can only happen to me, and it's my fault, which is the same mentality around the abuse, right?

Now she experiences "panic attacks"

not nearly as much. I'm mobile. I mostly just try and ride them through... and if you start cohesively and determinedly looking for your triggers... you can... alter them and make them no longer as volatile. Rather than having the world closing in on you... you can start broadening your horizons.

Janus, Sarah, Helen and Lise relate their fears and "panic attacks" to recent or current situations of powerlessness and emotional isolation. Janus started having them "just after I'd left my husband. The day I left he almost killed me." Apart from this example, all of the precipitating incidents that she and the others mention consist of inappropriate or abusive intervention in psychiatry. Janus talked

about having "major panic attacks...[that lasted] sometimes three hours, sometimes 48 hours", during the four months she took part in "non-directive therapy", using a tape recorder with no feedback from the psychiatrist.

Later, she "was having enormous panic and rage attacks" towards the end of a long period of escalating sexual and emotional abuse by two orderlies, who started assaulting her while she was in the hospital. Her psychiatrist "didn't pay any attention" to her early disclosure of their abuse, and later "encouraged" her to "not be so sexually promiscuous". This same psychiatrist years later fell asleep regularly in their sessions. Janus confronted him and said she "couldn't take this" the first two times, and "the third time I ran out in a panic, and it was five blocks down the street before I came to".

Lise mentions panicking once after her first and only fifteen minutes of hospital group therapy, and another time when she found out she was going to be placed on the floor of an abusive psychiatrist. Sarah recalls feeling "paranoid" about the one-way mirror at a meeting with ten inpatient staff who wanted to "meet" her.

Both Helen and Lise found that over the time they saw psychiatrists exclusively, they became "afraid of everything". Says Helen,

My fears just seemed to get more exaggerated. I was afraid of the dark, I was afraid of noise. I could not watch anything on TV that had anything to do with beatings or blood or anything like that.

Afraid of snakes, I mean it was just, the fears were ridiculous, so I'd take more drugs. Then it got to the point where I was afraid to go to work...if...I was going to be one or two minutes late...so I started taking a lot of sick time off.

When asked if the medications did anything for her, Helen said, "They put me to sleep when I wanted to go to sleep, and that's what I used them for, basically". She was given various benzodiazapines and antidepressants. It was not until she received support from a feminist sexual assault program that she "absolutely went off the pills".

The issue of drug treatment for "anxiety attacks" and "phobias" also came up with Chris and Janus. While Chris had her first panics when she was using alcohol and drugs, they intensified once she was "detoxed". She believes various antidepressants (including imipramine and prosac) didn't help, but made her feel "stoned," more "panicky," "really weird," and "scared". During the first interview, she said she believed medication could be helpful in an emergency to "stop the panic cycle when it gets really out of hand", but in our follow-up conversation, she was receiving non-drug support to "discharge" the emotions behind the panic.

When Janus first went for help she was also prescribed Elavil (an antidepressant combined with a neuroleptic for "anxiety and depression") after separating from her violent husband, while trying to finish the term in university and caring for two children. "I stopped taking the medication just after Christmas. I didn't want any more of it...it was

making me worse." However, she reports at our follow-up interview that she is taking another antidepressant, imipramine, with good results.

Dissociation and "Multiple Personality"

Five women talk about dissociation, the feeling of separating from or feeling separated within themselves in order to escape threatening circumstances. Some remember the particular incidents when they felt dissociated from their bodies, or were aware of internal dialogues. Isabel describes dissociating when in terror.

It was very strange hearing [my friend] talking to [my doctor]. I'd hear her saying "If she starts to talk again, talk".

Another time when she was beginning a course of antidepressants, she was lying on an acupuncture table after a treatment. "I couldn't move...I was outside, it was cold out, and I was quite aware that I had left my body." When she self-injured, "it was all very dissociative" as she watched herself and thought "why are you doing this?"

Janus describes two suicide attempts when she "didn't realize until after I'd done it what I was going to do". Chris recalls going "right into autopilot" and hitting her date when he "ditched" her at the graduation dance. She and Lise both talk about "a wall" inside.

I think we all fragment to some degree. I walled in my little kid and my teenager and all different pieces of myself that I'm now trying to reclaim.

Essie and Sarah describe their internal quarrels.

That's me, fighting with myself, little Essie and big Essie. Little Essie was the one that suffered ...that survived...I have to make her believe that it's ok now. This will never happen again.

Both times Sarah disclosed the incest, the first being under hypnosis, she experienced "one part of me is saying, don't say yes, say no". When she said "yes" before she was ready, she "was out of there like a flash, and I never went back". Sarah sometimes felt like a "wimp". Other times when she self-injured, she struggled with "this strong component of my personality that would have done more damage". She also talked about her

ego state that's like a street kid...I was eating candies and throwing the wrappers, just showing total disrespect, for [the psychiatrist], for everything, for psychiatry. There were sides of me that had a sort of cynical laughter, like "This guy's a real asshole". So there were so many different responses. That really confused me...I felt like a chameleon.

At the end of the spectrum of dissociation, are acts performed without any conscious awareness. When she was institutionalized in childhood, Essie remembers using books as an excuse to completely

leave...just go off into my little world...I didn't even have to read...They'd call me and call me, and I wouldn't hear, and when I did come back and realize somebody was calling me, I'd say, "Well, I was reading".

Lise was able to completely forget a first interview with a psychiatrist when "the room was quite dark and I didn't like it. I psychologically left the place". To this day, she has

no memory of the many times when one of her "personalities" (which she has requested to be in quotation marks) attempted to suicide when she did not feel safe.

Essie and Lise were the only two women who were diagnosed with 'MPD' or "multiple personality disorder". "I laughed at that one", says Essie, "because I had about fourteen of them that I practiced quite regularly, and I put on a show for them at that point". After she had been committed to a chronic ward in a psychiatric hospital, she wanted to give the psychiatric team "something wrong" so they wouldn't dig into what was really hurting.

On the other hand, Lise spent much of the interview recounting her struggle to free herself from this diagnosis with its stigma, and its implied pathology and disability.

I have memory loss. I had all the symptoms, if you want, but does it need to be labeled like this? It has nothing to do with psychiatry, with a mental disease...they think there's something organic. I don't think so. I think that "MPD" is a response to stress. I don't disbelieve it, I just disbelieve the fact that it has to be treated in psychiatry, unless you're totally out of control. Unless you could kill yourself or kill somebody else, fine. After awhile, once this is stabilized, you don't need that anymore.

Lise says she did benefit from an "MPD" support group and involvement with their projects, because they gave her an opportunity to use her skills towards realizing her dream of going back to university. Once she started school, she said, "I could not relate to 'MPD' anymore, especially if the women weren't getting any better".

I look at others who are still [dealing with psychiatry], and they've got nothing...I guess if I were in their shoes, I wouldn't mind still being an "MPD" and still have all my "personalities". At least I'm not alone...you get all this attention. It makes you feel special...But it's also so sad that these people will probably be with psychiatrists for most of their lives...Some of them have been in there for so long, they don't know how to get out of there.

In Chapter Seven, Lise stresses the importance of feminist counselling in her healing, with its emphasis on her strengths, the normalizing of her survival strategies, and going for her dreams.

The way I see it ["MPD"] was a defense mechanism...that I used because there was too much pain...It was not a pathology. Whether I did or didn't have "personalities" I will never know...Whether there was a Mary or Ann or Jim, if I wanted to believe that they were there, that's fine, because that's how I needed to cope with things. That's how I survived. Maybe if I hadn't had that, maybe I would have been a prostitute, maybe I would have been dead at 15 years old.

Lise has found that because she has developed "enough confidence" in herself, she can now "take responsibility" for her actions.

If I'm having a fight with my husband, I can either fight with him and deal with it, being Lise, or I can just retreat and take no responsibility at all and just let a "personality". But if I do that, I also know what's going to happen...I won't be in control anymore, and it's going to be a mess. So I've got a choice here.

Now that she understands that the ability to dissociate is available to her, Lise says,

If I were walking on the street, and I was attacked, I was raped, Mary, or whatever "personality" I had before, would be back and would work with it. Until the next day when Lise would be strong enough to say, "Ok, I need help now,

because this is back"...I'd need some kind of coping mechanism, and this is the one I know best, so you're damn right I'm gonna use it. But what would be different now is that I would be conscious about it and I could get help faster.

In the section to follow on "support in remembering" Lise speaks about the necessity of processing her memories of abuse and the accompanying emotions. However, her four week hospital experience of intensive hypnotic regression, without her control, was traumatic.

One "personality" wanted to get out and kill the people who have done this to me...and I would end up being tied down in my bed...and as soon as he was tied down, another "personality" surfaced. That "personality" could not be tied down because ...in the past...she had been tied down to be abused...I had someone with me constantly. I couldn't do anything by myself.

She believes that psychiatry "might be a good thing" if "you need to do a lot of regressing in order to bring the memories to the surface". However, in her case, this was done "too fast. And being drugged up also, because they had no choice. It was a total out of control situation, which was brought on by them."

On the other hand, Lise found that once she had a secure relationship with her sexual assault counsellor, she was able to stop taking medication.

I still had 'MPD' the way they saw it, but I was no worse because I wasn't under medication. Once we had someone we trusted, the out of control acting out that was going on before, wasn't going on.

Lise found as well, that a tough or distant parental approach "didn't work". She benefitted from having nursing

staff and sexual assault counsellors communicate lovingly and use "safe touch" (see section to follow) with her inner child when she was "out".

I had other nurses who would come under the bed with me, with a doll or something, and just stay there. [The nurse would] act like she was also five years old, and finally take me out of there.

Self-Injury

What I wanted to do was get out of this mess. I didn't know how to do it...if I just show them how bad I feel, maybe somebody can do something for me...I kept thinking this isn't enough, it's not enough, I'm not doing enough damage to myself (Sarah).

Although Sarah was the only woman who shares in depth her struggles with self-injury, she was not alone. Isabel also found herself dissociating and "cutting" habitually, "When I realized it hurt to cut, I figured I was making progress". Five other respondents share incidents of self-harm. Head-banging was mentioned by Chris and Bernadette. Lise's hands were "all open" as an abused teenager from biting them in a dissociated state. During her period of regression under hypnosis in hospital, she awakened after one of her "personalities" had beaten her. When these women self-injured, suicidal feelings may have been present, but this was not the intent, with the exception of Helen and Essie, who disclosed that they had "slashed" their wrists. Bernadette and Janus had "terrible fantasies" and fears of self-mutilation and slashing, but did not act on them. Essie has battled cancer

in areas of her body related to the abuse. "When your body manifests major big time, it's time to do the work...[it says] ok baby, this is it, we're taking you out of here if you don't do something...I went on [as usual] for three more years after my body manifested".

Isabel, Bernadette and Sarah made connections between their use of, or control over food and self-injury. Sarah says anorexia and bulimia, as well as cutting and burning may be the "only way to speak the unspeakable". Like Bernadette, six other women shared histories of massive weight gain for "soothing, nurturing and protection". Isabel and Sarah talk about the need to learn to "like our bodies". Along with Chris and Lise, Bernadette found therapists oppressive who "harped on how big I was".

Heavy drinking accompanied many of Sarah and Isabel's "cutting" sessions, while alcohol and drugs were primary methods of coping for Esie, Chris and Helen. All of these strategies arose out of situations in which they were being silenced, invalidated, abandoned and disempowered, accompanied by the unprocessed memories of earlier abuse. Because more has been written about healing from alcohol and drug problems, and the struggles with food were not divulged in any detail by respondents in this study, this section focuses primarily on Sarah's experiences with cutting.

I never really wanted to do that, but I thought maybe if they could see in, they would see what I'm talking about...I couldn't say the words, because

the punishment for speaking would have been almost death, itself, you see...So it was very hard to say anything.

Until she worked with a feminist psychologist, Sarah was not really heard for fourteen years in psychiatry. Isabel also found that even though her psychiatrist was "quite interested" in her cutting, and consulted his colleagues, "no one at that time was making the connection between cutting and abuse". She had to make her own connections, and seek support from a sexual assault group, and most recently, a feminist psychologist. Sarah looks back on her self-harming with sadness.

But of course, it never did do much good, and I'm scarred enough that people ask. It seems to me it was such a futile thing, and yet it's the only thing that kept me alive. I'm sure about that, it was a survival-type maneuver. I would have suicided for sure. The cutting was my way of keeping alive.

When Sarah knew that the hospital staff interpreted her cutting as suicidal, rather than "communicative", it set in motion those feelings that she wasn't "doing enough damage" to be heard. After discharge, she'd start cutting again when alone. "I'd reach a point where I felt I was losing control...One side of me...would very much like to just slash to bone." She then would run out of the apartment to stop herself, "this mad woman with blood on her arms and hands", and end up being picked up by the police and taken into the hospital again.

Her experience was a vicious circle, spiraling downward. Hospital staff, upon release, would ask her to "make a

contract" to not harm herself. If she thought she would harm herself, she was to come back. But these staff were not, as Sarah had hoped, "pleased" that she "was well enough" to honor the contract.

There was no question in my mind...that they were very disappointed in me for coming back...a lot of confusing messages...[the majority of staff] found me "manipulative", a "spoiled brat", "demanding", and they did not like me. They treated my self-injurious behavior as "manipulative" and they would try and belittle that, make it seem like it was less, which would then be computed by my mind to mean I'm not doing a good enough job.

So when she went home again, she "was worse than before I went in". Soon, most of her admissions were "after really losing self-control".

I'd usually be drunk...and I'd be admitted to the emergency ward...and you could see the doctor, oh god, here she is again. And they'd be calling me "schitzzy" to my face..."We don't want you damaging anything", and being stitched without a local...The general consensus was, "We've got a loony toons here, and the sooner she's out of our hair the better". It contributed...I was really going down the tubes.

Self-injury became habitual when she

got to a point where I really enjoyed cutting myself, and bleeding was becoming very significant. It was really important to me. So having them ask me to stop was asking me to do something I really couldn't do or didn't want to do.

Eventually, she did inflict a "life-threatening wound". Sarah stopped self-injuring when she met her future husband. "Life started to improve for me, and he was a very patient, understanding guy...I didn't want another stint in the hospital. I didn't want to be harming myself..."

Sarah advises psychiatric staff to "not minimize the pain and suffering...[or] be afraid that someone's taking them, trying to take advantage of their better nature". It's important to look underneath the self-mutilation, and assume a woman has been abused, to not "put a bandage over something that has to be aired". She says it takes patience, "because it can be so frustrating to lose somebody". Hospitalization is only appropriate if "there's a real problem with uncontrolled self-destructiveness". A hospital can be a "bit of a safe place" because "it wasn't easy to do it there".

Many times Sarah says all she needed was to be with people, to talk to somebody and to be away from the isolation of her room where she engaged in self-injury. Sarah believes medications get in the way of healing, but Isabel found they "allowed" her to work on memories without self-injuring.

Some nurses, says Sarah, were "compassionate...they accepted me for whatever I was doing...I think at some level they understood that it wasn't really a game I was playing". She sums up her idea of appropriate intervention.

Instead of worrying about whether my behavior was good or bad, let me have my behavior..."Ok, you need to cut yourself, because it's very important for you. However it's damaging to yourself...So why don't we work on something you can try, don't have to do it, but you can try it as a replacement for cutting yourself, and see how that works"...I betcha I might have even quit sooner. I think I might have.

Lying and Keeping Secrets

"There's a lot of learning to keep secrets"

(Isabel).

Seven in ten women mentioned situations where they lied or consciously withheld information from psychiatric staff. Louise's sentiments are representative. When she was an inpatient, she did not disclose a previous suicide attempt.

My instinct for self-preservation took over and I decided to withhold a few things about myself. I felt it was them and me. I didn't feel we were working together at that place.

Past experience with psychiatry, and/or a particular staff member taught these women to be very cautious about what they shared. Sarah gave three examples where she attempted to avoid committal or mistreatment by staff. "They were pretty dangerous...as long as I played along with them I'd be ok."

Essie lied for protection from her violent father, her husband who made death threats, and from involuntary hospitalization. In the past, her wishes had seldom been respected in psychiatry. After a teenage suicide attempt by slashing and drug overdose, her doctor refused to honor her request to not send her home to her abusive family. As a result, she decided to not disclose the overdose. "I figured, if I don't die this way, I'll fuckin' die when the pills get into me." When she was hospitalized years later for brutal wife assault, Essie remembers, "I wouldn't give any information". Both her husband and psychiatry were threatening.

I couldn't say anything, because he would have killed me...and...I always have the very very terrible fear, that if they ever got a hold of me again, I would never get out.

Normal aftereffects of incest are often hidden by survivors in psychiatry to avoid being labeled as "crazy" and treated as such. Sarah did not disclose her fears of committing homicide, because she didn't want to end up in a psychiatric penitentiary. When asked if she'd hallucinated, Bernadette says "Of course I do, but I wasn't going to tell them that." Essie and Isabel describe similar moments of panic in an emergency ward, attempting to "be cool, don't let him know how fucked up you really are," and worrying "if my body shakes too much, they're going to think there's something really wrong with me". Lise had to lie to cover up her memory blackouts. "This is very painful because you're never sure if you're sane or insane". She was afraid she might have had an early case of Alzheimer's disease.

Self-preservation was also the incentive in a different respect for Helen, Essie and Sarah when they faked symptoms and stories to keep psychiatrists away from their deepest pain.

I went into this room and I was surrounded by eight interns...hitting me with these questions. I felt really intimidated, but I also felt that I needed to answer. I didn't want to tell them anything about me, so what happened was I started lying through my teeth...I exaggerated everything...I freaked them all out, and that was, I guess, my intention. I was angry at them, angry at me, angry

at not knowing what the fuck's going on. So after that they decided that I needed to be institutionalized (Helen).

Essie described how she was "feeding psychiatrists information that they wanted", when she faked "multiple personality disorder".

They wanted something to be wrong with me, so I gave it to them. And I thought if I give this, and you work with this, then you'll leave the rest of me alone. You won't pick my brain.

Similarly, Sarah who had not yet consciously remembered the incest abuse "tried to fit the manic-depressive psychosis diagnosis". She says

I thought what I was doing was trying to convince them, but really, I was trying to convince myself, because I did so much want it to be something that I wouldn't have to be ashamed of.

Helen and Lise both withheld some of their truths because they needed to be supported and validated in psychiatric settings that would otherwise not provide these. Lise knew that if she told her doctor her suicide attempts came out of a need to "have someone to talk to", and all she wanted was to "not have to do housework", they would "definitely think you're crazy". Helen began again to exaggerate the traumas in her life after she was humiliated in a group therapy program. Her intent was to "give people the shock treatment", because

nobody around me, including myself, was looking at what had happened to me as a serious incident. So therefore, how could I make people know that I was really hurting?

She found psychiatrists' distant responses perpetuated her need to emphasize her pain. A therapy group in which the

participants "identified" with her and felt "compassion" enabled her to once again feel safe telling the truth.

Helen offers insight for counsellors looking for meaningful connection with women who feel a need to lie. She points out how all her stories were "partially true".

For instance, when they asked me about sex, they asked me what was my younger life like, when did I start going out with boys...? I was very angry at the time and and I said, "What do you mean, dating, going out with boys? I was fucking guys when I was five years old!" So I exaggerated everything, but I sort of remembered my uncle and the things he used to do to me between the ages of five and ten...and expanded on it.

Male therapists were experienced as not safe for sharing matters related to sexual abuse, the body and sexuality by Essie, Lise and Isabel. Such therapeutic alliances may replicate the incest dynamic of "forced silence" described earlier by Lister (1982), in which nurturing and dependency needs are gratified at the survivor's expense, when the trade-off is that she won't talk about the abuse. If a woman has broached the subject with a male psychiatrist and receives a sexist reply, she is once again disconfirmed in her feelings and perceptions.

These women's experiences with traditional psychiatric responses to their difficult to understand behaviors further illustrate the potential for exacerbation of the very anxiety, depression, self-injury and other painful "symptoms" that psychiatry is supposed to alleviate. Participants' wisdom about the meanings behind such behaviors and what kinds of

assistance they need, will hopefully encourage therapists to respect that each survivor is truly an expert when it comes to her own healing. Survivor-appropriate support described by interviewees is outlined in the next chapter.

CHAPTER VII

WHAT INCEST SURVIVORS IN PSYCHIATRY SAY THEY NEED

As they relate their experiences with psychiatry, all of these women repeatedly emphasize that their healing processes could have been much shorter and less painful, if they had received the kinds of assistance they felt they needed. While each woman's journey is unique, and the timing of certain needs for support will differ considerably, the following themes emerge with amazing regularity.

Validation: Help Make Sense of My Pain

"I didn't have enough trust in my own perceptions" (Janus).

"We're not crazy, christ! We're far from it" (Lise).

Every woman shares her struggle to understand why she was in such pain, and her susceptibility to believing that there was something wrong with her. To be "validated", "heard", "believed", and "accepted" was experienced as powerful and necessary.

This group of women have been bombarded with messages that they "shouldn't exist", "don't belong to the human race", "are not worth anything", and are somehow "responsible" for the abuse they have suffered, and the wound that has resulted. Self-blame is a survival strategy reported by all of the respondents. "If it's [the perpetrator's] fault, then you can't change it...I didn't realize until I came into recovery, that it wasn't my fault...This was abuse" (Essie).

As they worked through their experiences they learned they are not "dirty", "bad", "wrong", "manipulative", "repulsive", "a freak", "a slut", "a doormat", "undeserving", "no good", "dangerous", "a trouble-maker", "antisocial", or "crazy". "Now I can see I wasn't bad for behaving the way I did. It was a way of surviving" (Louise).

Panic attacks, self-injury, and the many other aftereffects of abuse need to be understood. When they approached psychiatry, nine of the ten women either did not remember being abused, or did not relate this trauma to their pain. Bernadette "kept trying to find out why [she] was depressed". The same with Louise, "I didn't connect my depression with the abuse, at that time. I just felt like a horrible rotten person. The abuse hadn't happened for a while, because my abuser had died...and was incapacitated by strokes." Chris says "I blocked this stuff around the incest. At that point I had no concept of it being anything even remotely weird, so I didn't talk about it."

Early in her journey, Janus' life was "a nightmare day and night...like going into freefall...nothing made any sense to me". When her psychiatrist "started to make a lot of sense, [she] began to really look forward to [the sessions] and build trust in him". Jill's quest has been to understand her "manic" episodes. When she approached therapy, she was looking for hope. "I wanted to know why does it happen to me, and what it was all about."

Sarah's self-injury was in part an attempt to make sense of her pain. "If they could see in, maybe they would see what I'm talking about". Now that she understands the origin of her fear of vomiting, "it doesn't bother me". Helen found a feminist program for incest survivors was "an eye-opener" for her.

Lise was the only woman who, at first, even suspected a connection between abuse and her distress. She told her neurologist, "I think I've got a dream of abuse...I don't know what this means, because...I don't think I've been abused... Could the enuresis have something to do with that dream?"

A few women emphasize the importance of the therapist being knowledgeable about incest and asking the right questions. Isabel was relieved to find someone specializing in the area of sexual abuse. "When we talked on the phone, it was like, this woman knows, and I felt so comfortable with her." She also found "You need someone to say, 'That [memory] was real'. As much as I know it was real, I need to be reminded about that." Sarah says when her feminist psychologist first inquired about incest, she had been thinking,

There really is something going on here, and I don't know what it is. She asked me, and it was like, oh thank god somebody finally asked the question. I said "yes" but another part of me's going, "You can't say yes to this, you don't have any proof of it. You've no reason to even think it. Why are you saying yes?"

She believes that is "when I really started to improve. I think she did in a year what nobody really did for 14. Because she knew the answer". Louise recommends that therapists

ask questions, even if a woman hasn't disclosed... Say "Is there anything that happened to you in your past that you found difficult, or were there any people around you that did things to you that you didn't like, and you weren't able to ask for help?"

Three women state that questioning should be "gentle". Essie needed a combination of her therapist's self-disclosure and "no pushing, prodding, prying...If I cared to share it, it would be ok". Both Isabel and Louise recommend therapists be on the look-out for abuse.

It's almost having to assume that it did happen...I think that women and men who've got a lot of problems as adults probably had something bad happen to them as kids. Who knows what it was and maybe it was sexual abuse (Louise).

Sarah suggested "a bug in the ear" with "breathing space...Let the individual know that other women who do cut themselves are incest survivors".

Janus was disappointed in therapy when her psychiatrist no longer brought up the abuse after the first interview. "I kept hoping he would be more explicit...saying...'This often happens, did this happen to you?' so I wouldn't feel like a freak."

See Me as Whole and Encourage My Dreams

At the same time as one is working to "make sense" of the pain, Chris and Lise found it essential to nurture their self-esteem. "I'm trying to struggle to have some kind of self-image, and go, 'I am worth this. I am worth the work it's taking me to get sober" (Chris). When Lise's psychiatrist gave her positive feedback

I didn't believe him, 'cause my self-esteem was too damn low...But once I started believing it...nothing was going to stop me.

Both Chris and Essie found affirmations helpful. One aspect of her peer counselling process that has been powerful for Chris is built-in "affirmative feedback".

Several women talked about the importance of being seen as a "whole" person. While Lise believes the diagnosis of "MPD" had some validity, she emphasized

But to me I had other things. I had a family, I had myself...And I could like this self...[women need] therapy which would enable them to see that they have themselves, and to see that they could do something. Even though they lost half their lives, they can still get the other half, and have a good life with it.

Helen had one psychiatrist who stood out because "He treated me not as a patient...but as someone who's interesting...so I started to feel really good". Louise discovered that for her, natural childbirth was "so much more healing than psychiatry".

This was the first time that I felt that I was doing something that any woman could do. That I was really a woman, and there was no holding back. I was being completely honest. I vocalized as much

as I wanted to, and I pushed when I felt like I wanted to and there were no images of the past there.

Chris, with the help of her holistic GP, was able to identify music as her "touchstone".

I'm good at this...I created this even when I was in incredible pain...this is a very strong and affirmative thing in me. He said, "When you get into your self-doubt stuff, think about that. Make that be the first thing you go for." And it's worked!

There are no pat formulas for self-worth. Helen cautions therapists,

Instead of encouraging me to do the things that you do the way that you do them, you should encourage me to find out who I am, based on my likes and dislikes, not yours! I got into doing feminist work, and started doing stuff out in the community, and it just went like, in one year's time, it was like night and day!

For Lise, the "turning point" came after a suicide attempt, when a feminist counsellor asked her "What's your biggest dream?"

Finally someone believed that I had the intelligence to have someone say "You can do it". But somehow being honest. You could feel it was real. The hard hard therapy's gone and done...And even today I still have this feeling inside me that I can do everything. If I ever work with survivors, I'm going to instill the dream in them if they don't have one.

Essie's counsellor gave her the image of the child within that she will grow, and she will become tall, and fair, and her arms will reach out for everything that's in the world for her.

Practical Skills/Present Concerns

Eight women talk about the need for "guidance", or "tools" for survival. Lise, who used to dissociate easily under stress says

I think when you get enough confidence in yourself, value yourself enough, have dared to change the behaviors, and realized...the new behaviors work better than the old ones, you don't need them...you just need a good person to help you learn new things.

Louise found her survivors' group was an opportunity to hear "other people's stories and what they've done". Practical information was sought by various respondents for handling difficulties with food, panic, "mania", revictimization, making friends, assertiveness, child care, career development, and relaxation. Two women found relaxation training and self-nurturing strategies like hot baths enabled them to sleep and "come down" from the memories. Two others benefited from assertiveness training.

The more I started to think for myself...and the more I thought that people weren't rejecting me [for asserting myself], ho ho! Watch out world!
(Lise)

Respecting a woman's own priorities and timing appear to be crucial. Sarah was urged to make friends, but

for me making friends was agony...It's not something at that time that I wanted to do. So you're asking me to do something that I don't really have the tools to do the job.

Chris had a counsellor for incest but

she didn't seem to know a whole lot about panic. I was needing to address the survivor stuff, but not

yet. I think I wasn't in a space where I was willing to admit that the stuff with my cousins still had an effect on me...and the panic was a major issue at that point.

Louise and Bernadette benefited greatly from developing their interests and working towards quality of life in the present. But the inability of counsellors to support them in healing the past inevitably brought on reoccurrences of their depressions. Bernadette told one therapist who believed that dwelling on the past caused more damage, "I disagree. I'm having far too many feelings about it yet, to just pretend it's not there...I have to have these feelings".

Control Over My Life, Including My Healing

All ten women stressed the need to regain control over their lives after the years of abuse. Six respondents specifically caution survivors to "shop around" for a therapist. Sarah's message is typical:

Trust your intuition...Your mind, your heart tells you the person is right or wrong. If it's not right, feel that you're worth enough to get out of it...the person you choose makes a big difference.

Essie, Isabel and Helen talk about how "you know yourself better than anyone", and believe in the potential for "healing ourselves" if we are willing to do the hard work, and have accurate information and choices. Isabel says

No matter how much of a wreck I was...I guess I have a belief that people know on some level how to help themselves, or what area to go in.

She advises therapists to

validate that the client knows how to heal and follow her lead...if [something] is that important to me, even though we don't know the background, then you defer to me.

Similarly, Lise tells counsellors to "be flexible... feminist therapy's good, but it's not necessarily for everyone".

She emphasizes the importance of looking "at the pros and cons of doing something...was it really something that I wanted to do?"

Several women have clear memories of particular counsellors who were respectful, and treated them "more on an equal footing", "almost like a peer".

There doesn't have to be that pedestal, that one-up-man, where "I know better than you", even though I haven't experienced a goddamn clue of what you're talking about (Bernadette).

"We should be treated as adults, not as 'sick' persons" (Lise).

Three women remember recent short psychiatric hospital stays that were somewhat positive, in that they were left alone to do what they themselves felt they needed to do. With the help of friends, Jill was able to "ward off all the other things that happen in the hospital, so that I can be left alone to sleep, and then get out". She learned that it helped to bring in her own pillow and take a teddy bear. Isabel also lined up a friend to accompany her, and they "were able to say that we knew what part of the problem was". She brought in her own copy of The Courage to Heal, and "had a nurse who knew

the book, and was quite happy for me to read the writing exercises to her". Lise says she was

lucky in the sense that they never forced me [at one hospital] to go into group therapy, or occupational therapy. I'm a reader, I always had six or seven books there, and I'd write down poetry, or I'd write, simply write. So they saw that I...didn't need the other stuff.

Body Privacy and Safe Touch

Five women share intimately their simultaneous fears of unsafe touch and longings for nurturing physical closeness. As with other aspects of healing, the key for them was to have control. Sarah, who had repressed memories of the sexual abuse, "didn't like being near people. I saw people's bodies, I never knew where their bodies ended and mine began". Both she and Bernadette had only experienced touch that was sexual. "There's always a trick, so being hugged isn't safe", and "I'd never been held without ulterior motives".

Isabel had a positive experience with a male nurse after she told him "it was really hard to be touched...because of abuse".

He was very skilled at knowing to stand three feet away, and say, "I'm going to take your pulse. This is how I'm going to do it. I will touch you with these two fingers only...I need to explain this to you. Can I sit beside you, so you can read it?"

She refused to take off all her clothes in emergency, because she felt "I'm disappearing on my own. I don't need this to disappear me more".

When Sarah heard that some therapists tell their clients, "I'm available for safe touch", she said, "Oh, what a relief. I wish someone had said that to me". Several women talked about the importance of touch in healing the "child within", as a "grief process" (Janus). A therapist must not be "afraid to touch, or afraid to be a child herself" because "you're not going to be able to reach a part of that survivor that needs to be reached", says Lise. Isabel remembers one pastoral counsellor as "the best" because, among other things, "safe touch came naturally", and after much searching she has finally found a social worker who "gives hugs, and I can bring my doll". Lise had one therapist,

all she did was hug me for an hour. But at that time, that's what I needed. There are so many needs that haven't been met in the survivor, that while she's reliving and while she's letting go of her control, and letting herself feel, she has to be able to feel some other things.

Survivors know when they are ready, especially if they do not feel pressured. Bernadette explains that "it took a while for me to be ready to be held...when she did I said, 'I can't feel you and I want to'. I stayed in her arms and I cried and cried."

Isabel and Bernadette had therapists who were well-intentioned, but imposed their own agendas of physical contact.

He used to pick me up and rock me...I would sit there like a stone...I knew there was something missing...I would be so nervous that he was doing this...just so afraid of being touched...in that

intimate caring way. It's easy for me to touch friends, when I initiate, I keep my power (Isabel).

During Bernadette's first visit with a bioenergetics therapist, she told him about her history of sexual abuse by her father. He then asked her if she would like to be held.

And I said, "sure". I thought holy shit! He did the bioenergetics where you sit and you just lean against him...I went into shock, not at the time...something happened inside me...I felt safe touch for the first time in my life...and I didn't know it would be such a shock to my psyche...I wouldn't recommend holding in the first session, because I was in shock for three days. A slower pace would have been better.

Support in Remembering

The "shock" to Bernadette's psyche, that came when she was held, was a "flashback", the process of remembering the abuse. Everyone I interviewed shared her struggles with remembering, and several women detailed ways that counsellors attempted to help them work through these memories. Lise talks about "that tunnel that was so damn dark".

You have to face the abuse, face to face, dead on. You've got to see how much it hurt, how much you've missed, because you need to grieve over it, and you can't grieve over something you don't know.

Bernadette and Isabel describe the intense part of this process.

I went into a very deep...inner journey, the dark...I thought I was dying. I was literally in the deepest mental anguish I'd experienced in my life. And it was worse than any of the depressions I'd had...It was like being hung on a meat hook and held. I was just hanging in a void, in the most intense pain. It was like my therapist had hit a

place where all this pain was coming in. And that's when all the incest stuff started coming (Bernadette).

There was a lot of vocalizing, it was very loud. I never do that. And lots and lots of grieving and crying...That was very good although I would only want to do it with someone who was real skilled at cleaning up all the junk that comes out (Isabel).

They both sought out experienced healers, a bioenergetics therapist and a "shaman" or "witch", who were able to help them remember through bodywork, and to make the experience manageable.

While Bernadette was helped to remember through visualization in which she "had the control", Sarah and Lise both had frightening experiences when they were hypnotized without feeling in charge. Lise's four weeks of "regression" in the hospital was

the worst time in my life...if he kept doing it I would die...I was to be encouraged to act out and to regress as much as possible. Just remembering it and talking about it brings an ill feeling, because...there's so much a person can take...The suicide attempts [in hospital] were getting worse and worse...too many memories coming out too fast.

Her psychiatrist

thought that if, in a very secure place, I was allowed to work as much out as I could, there would be less acting out...there might be a chance we would get over the worst of the memories faster... His idea wasn't bad at the time, but I'm glad he changed his mind because I don't think I would have made it sometimes.

It is the lack of permission to pace her own memories to which Lise objects, not the actual process of regression. She believes that, until other options are created (see "a safe

place")), a hospital stay for this purpose would only be helpful if the "doctor is willing to work with someone else" like a sexual assault counsellor.

Essie also emphasizes her need to be in charge of the pacing of memory retrieval, "I would be dead if all the memories had been there at once". A few women talked about the psyche's natural ability to "take a break", "shut down", "like a broken film" that prevents the feared total loss of control.

As well, the first memories are often the easiest to handle. Sarah for years only consciously recalled a "show and tell" episode with her brother. "What I did was I put all of whatever happened to me into that episode." Isabel said she has recently been "harassed" by another "Black memory. It may be my father. I'm still not ready to deal with it."

Through experience, Essie found that "stuffing" memories that are pushing up could sometimes be "worse...than if I had been dealing with what I should have been dealing with". Sarah, along with Lise, found "we all have excellent control at keeping things down" but at certain points, "it just starts to happen...and that's really scary".

Several women say the pain was so intense and so prolonged that they wanted to give up. For Essie, "the work [was] hell". After a particularly devastating memory, she told her counsellor, "I can't do this healing shit any more...fuck you all, I'm gone". She found the counsellor's

response, acknowledging her "choice", and asking if Essie really wanted to give up all that she had accomplished thus far, brought her back. "I wouldn't give anybody the goddamn satisfaction of quitting." She shares how it often takes her months before she is ready to process another memory.

I'm afraid to let it go...[that] there will be nothing left. All I could remember was painful. I need to hold onto it for that length of time to really learn that it is time to let go of it, that I can live without it.

What helped was a visualization of a flower that her counsellor offered.

When you clear all that shit out, the seed starts to grow, and sends out all these little arms and fills your whole body and your head opens up and this beautiful...I just love it...When the going gets tough...I keep saying "grow grow grow".

She is now finding it easier to handle memories with experience.

It gets so scary before you deal with it, and it's never quite as bad as what you think it is before. You get so apprehensive and the pain is so great, and once you let it go, it's like whooo, thank god I did that...The relief...that calm that comes after.

Early in the healing process, all of the women interviewed experienced distressing feelings, such as depression and anxiety, that could only later on be identified as memories of abuse. Janus remembers "the feelings come first". That's why a counsellor needs to

be open and not judge, and patient, and to listen well...the key to validating the person, so these "irrational" emotions can become memories, and then worked through.

Chris remembers when she reached a certain level of detoxification from alcohol and drugs, "This stuff started shooting up out of me, and I'm going, what is this? I don't want to know...body memories...and not knowing what that was".

The process of remembering involves expression of emotions that were held in for survival during the abuse and thereafter. Typically, this group of women found the prospect of reexperiencing these feelings "an enormous wrestle" (Isabel), as frightening as remembering the pain of the abuse, itself.

It scares the hell out of you...we were raised not to feel anything, so once you start feeling something, it's so strange. I think that with incest survivors, that's the worst thing...to leave control of your feelings and just let them out...there were so many feelings and so so overwhelming...I'm afraid I'm going to die if I cry. So you need to have someone who's going to say, "Go ahead, it's ok. I can handle it and and you can cry. You're not going to die, 'cause I'm going to be here to protect you". In the long run you have to face all the feelings that you denied.
(Lise)

Essie now reaps the rewards of reclaiming her tears. "You see something beautiful, I see babies, I see animals, I cry at everything. It feels nice to do that."

While counsellors may urge incest survivors to "let the feelings out", there are practical constraints in women's lives that deserve recognition. Lise found "You get out of the office and you're still feeling...then you get home and you're overwhelmed...and you've got nobody to talk to." Fellow workers, partners and/or children are likely to be

alarmed and misinterpret expression of old emotions. It may be difficult, if not impossible to concentrate on responsibilities. Isabel, a single mother of four children has used prescription drugs (see "experiences with medications") in order to

have the courage to look at my memories without feeling totally bummed out and suicidal...I can live life without being totally in the abuse all the time. This is good for my kids.

Lise remembers crying

all day, and my husband would come home...and I didn't feel like smiling. There were times where I would have cried day in and day out...There were times when I wanted to be in my bedroom and just smash the walls until I'd pass out. I couldn't do that. It's not acceptable...you don't want to answer questions.

A Safe Place

Along with several other women who were interviewed, Lise believes, "Women who relive the incest need a place to go...and not be caught in the psychiatric world". "When I'm dealing with stuff I'm afraid of", says Essie, "I've always used [my counsellor's] place as a safe place. I go there in my mind, because...nobody in the whole world can find me there, and I'm safe".

Isabel, Louise, Janus and Lise, all mothers of preschool children during this period of their lives, talk about the need for actual time out in a safe environment. At one point, says Isabel "I couldn't cope. I couldn't talk". During her first breakdown, she was not able to

cook meals. I didn't do laundry...I couldn't look after [my little one]...I remember saying to my ex-husband, "If I could count on you, if I could just ask from you for six months, like every time I needed to be held, or hugged or cuddled, that you would come and do that, no questions asked, just be totally giving, whenever I asked, whatever I need in that area, that things would work out for me". And he said he couldn't do that.

When Louise was in crisis, she needed "to withdraw to a safe place" to retreat and wait.

You're just in that pit for such a long time and and you don't know how to climb out...I've been lucky somebody's been there to help when I needed it...I just hope I never have to be hospitalized again.

Lise, who was abused by many perpetrators over a long duration needed a concentrated period of time for her healing. She found, however, that "the psychiatric hospital is not the right place. It should be done in comfortable surroundings, not an institution." She believes that when you are

dealing with memories you cannot bother with housework, raising children, taking care of a budget...You need to be with yourself, alone, with somebody supporting you, naturally...You should be allowed to cry...to scream...to act out, and do that for three weeks, a month, six months, however long it needs to be done. If there had been a place I could have gone to, a women's shelter, with survivors, and a therapist there, someone who would have respected the fact that I needed a rest. I needed to work things out. If you need to take a year for yourself...it's not much, because you know that after that year, you can give them all of what they're going to need for the next 20 years. One of my greatest dreams would be to win a million dollars and open a place like that, myself.

Isabel also "envisions wonderful healing centres, where women like us can go...and there would be sistership". Such a healing house could help many women, says Lise, including

those who only need a short time out. It's important to have the freedom to come and go. Janus agrees, suggesting "the least restrictive environment", allowing women "the dignity of risk". Lise explains,

If a crisis comes up and she needs a couple of days on her own, she has this place she can go to... [then] go back to work if she wants...she's got the option. She can work on it at a faster pace if she wants, because she knows there's some support.

A few women had some positive things to say about staying in the hospital. When she sought refuge from an abusive home situation, teenaged Chris was admitted as a voluntary patient and was not given medication. "At that point staying in the hospital seemed safer and preferable to staying at home." Isabel feels that taking a friend along, and the fact that "there was some consciousness about abuse" made her hospital experiences "at times... very helpful".

Sarah says when she felt out of control with self-injury, hospitalization was needed. During those times the "hospital was a bit of a safe place", "a haven", where she was able to revert "to childhood". Having them "feed you...bathe you... watch you all the time...in some ways it can be very comforting". Sarah found she had to pay a price, however, if she was not a "good girl" (see Chapter Five).

At other times Sarah, like Jill and Isabel, explains that she simply "needed to talk to somebody". She laments that "there isn't really a place to go. A home for women. That would be better than probably anything." In Sarah's view,

this home should not be targeted for only sexual assault survivors, "because I didn't think that was my problem". Lise suggests "It could even be a drop-in centre...I need a hug tonight. Right now...just to feel that it's ok."

In Jill's case "my process is very dependent upon having an understanding, supportive group of women around me that are able to understand what I sometimes go through". She feels her ideal situation, if she again escalates into "mania", would be to have "an outpatient nurse to administer and monitor me through a day or two of drug therapy, so that I can get 20 hours sleep, and that's it". Likewise, Lise believes "there should be a doctor available, in case it gets out of control" to provide medication.

Community: Women Friends, Groups, Spirituality and Negotiating the System

If I'd had the resources to make friends and start relationships, I probably would have been able to go to a good friend. I didn't have that at the time (Sarah).

After years of emotional isolation, so necessary to survive incest, four women speak at length about the growing importance in their lives of a supportive community of women friends. Mutual aid groups provided the beginnings of these networks for some survivors. Bernadette participated in a series of women's workshops, and later joined a support group for survivors of incest.

I was terrified of women like you wouldn't believe! Now I love them...it's like they are my sisters, and the more of them that I have and connect with, the better. Because they're teaching me and I'm teaching them, and that's what it's all about.

When Helen connected with a feminist sexual assault center, she says, "I did some heavy duty work for one year straight and absolutely went off the pills, off the drugs, off the booze and everything". In one year's time she moved from using the crisis line to volunteering, and later working for the organization. Essie's healing has revolved around her spiritual relationship with "earth mother" and the community of Narcotics Anonymous. She now sponsors new members, and speaks about her recovery and NA to people with addictions.

Survivors' Support Groups

Among the ten women interviewed, the six who attended survivors' groups, like Bernadette, sought out this avenue of healing and were enthusiastic about the benefits. Isabel says "I knew that I needed a group", as did Louise, "to talk with other people who've been through it, not just a therapist". Isabel is "surprised how important" the group became to her, but finds "in itself, the group isn't quite enough...you don't get the one-on-one". On the other hand, Helen and Louise believe "groups are the answer", and being with a group of survivors "has been the most helpful thing".

Essie and Sarah, who were both pressured to attend survivors' groups by their therapists, had strong negative feelings about groups. When she was in treatment for addic-

tions and disclosed the incest for the first time, Essie then reluctantly attended three group sessions at the facility. Her response to the psychiatrist's "suggestion" was

Don't be fucking taking me anywhere where anybody knows that this has happened...it was too new for me. It was too scary. These women and their anger was woaaah, because I hadn't hit the anger stage yet...it was just unreal...like my words coming out of their mouths...I was totally overwhelmed that I'd ever told anybody, let alone that.

Sarah is "supposed" to be entering a group soon. After bad experiences with hospital group therapy, "I don't know how to set boundaries", she says "it's this feeling that I'm being thrown into" such a decision that "is really causing me difficulty". "If I were in a group," she says, I'd be happy to sit further away from everybody else...and then in time I would move in". She also senses intuitively that "If you are not having memories, you might have memories, more of abuse", and she does not feel ready.

Spirituality

From the beginning, Isabel sought out counsellors who included a spiritual perspective, a pastoral counsellor when she was a Christian, and more recently a "shaman-healer-witch" for deep memory release work. Essie's therapist used herbal and other forms of alternative healing like visualization and crystals. "We do it the spiritual way...nature is one of my greatest healing fields...I just sit and fill myself." Although interviewees in general revealed little about their spiritual persuasions, it is noteworthy that four of them

mentioned the important role in their healing of the burgeoning women's spirituality movement.

Negotiating the System

Respondents who faced psychiatric hospitalization often found, as in Jill's case, that many "staff have no awareness" of the needs of incest survivors. The initiative and creativity of these women are evident as they attempted to negotiate for appropriate services from the system. In their dealings with the hospital, three interviewees brought friends with them, and five women located professional counsellors who supported their rights and explained the needs of survivors to the psychiatrist.

Isabel's message to other women using psychiatric services includes "take a buddy". She brought friends for hospital admissions and hypnosis sessions. Essie was glad her "sixth sense" told her "take somebody with you" when she was almost hospitalized against her wishes. After her first admission, in which she was denied contact with family and came out black and blue from forced injections, Jill planned to have her friends accompany her to the hospital during a "manic" episode. They

lectured nurses and doctors about allowing me to have what I need, and it was ok...I was not anywhere near as brutalized. I didn't have bruises that time. They were allowed to stay around...It was a protected stay and it felt a lot better, and I certainly came down a lot faster.

Three women developed trusting relationships with social workers who gave them candid information about the psychiatric system, for example which psychiatrist, if any, was competent in working with survivors, and how to "play the game" in order to maximize chances of getting what they needed.

Lise, Janus, and Essie also benefited from advocacy by four particular physicians, who are remembered as helpful for talking to them "like an intelligent person about how to survive in the system", "protecting" and "sticking up" for them. "All of a sudden it was like, oh, I got a little respect" (Essie). However, the physician's ability to intervene was affected by his status. When Lise's inpatient psychiatrist was emotionally abusive and forced injections after she reacted by dissociating, her outpatient psychiatrist stood by helplessly as a resident and advised her to "'tell them what they want to hear'". He was later able to assert authority when he graduated and became her primary physician.

A team approach enabled Lise to work through much of her healing in a dramatically short period of time, even though she had many abusers in childhood. Her support came from volunteers and staff of a sexual assault centre in addition to her psychiatrist.

Even though their ways of working with me were different from one person to the other, everyone worked with my well-being at hand. And that to me was extraordinary, because I don't think I'd be out of it, even now.

While she has been attempting to organize a healing team for herself for some time, Isabel has only now been able to locate appropriate resources. For her these include a psychologist able to do memory work, a social worker for hugs and practical help, a physician for medication, a spiritual director, and occasional use of a crisis line. She hopes to be involved in a support group for survivors who self-injure in the near future. Sarah's message to survivors includes looking for a "group type arrangement", in other words "a clinical psychologist who has a social worker who's...able to help a little bit more outside the office". Chris's social worker "is really good", because she helped with panic attacks, and recommended she get a counsellor and join a group specifically for incest.

Finding a Good Therapist

"I have spent half my life" looking for an appropriate therapist, says Isabel, and after a series of unsatisfactory counselling relationships, she's finally getting resources. Lise and Essie call themselves "lucky" to have found counsellors who responded to their needs. Because this happened for Lise soon after she remembered the abuse, she was assisted in moving into a full life in only two short years.

I so much wish that every incest survivor could have the two therapists I had, or two similar therapists. I'm sure there are many good ones, but so hard to find.

Essie believes she "never would have dealt with any of [the abuse] had those special women not been put there" for her.

She and Sarah tell survivors to "be very careful about whom you choose". In the beginning of their involvement with psychiatry, seven participants did not know what to look for, and inadvertently placed their trust in particular psychiatrists because of their status. Five women spent years with unsuitable therapists before they trusted their own perceptions enough to be able to look elsewhere.

In the course of describing their experiences with psychiatry and other forms of counselling, certain therapist qualities were mentioned repeatedly as essential: honesty and working on her/his own issues; teachable; listens, believes and cares; consistent, patient and trustworthy; and knows his/her own limits. These complement the counsellor's ability to honor the aforementioned needs of survivors: to make sense of the pain; see them as whole and encourage their dreams; work on present concerns; to have control over their own healing; privacy and safe touch; support in remembering; and building community.

Honest and Works on His/Her Own Issues

Six of the ten women, like Helen, mentioned the importance of a therapist working on his or her "own process". Words used to describe such a counsellor include "down to earth", "a normal person", "genuine", "personable, a person", and "a whole person...not to have to divide his professional

from his non-professional side". "If you're phoney [survivors] can spot it in a second" (Bernadette).

Her therapist's self-disclosure of incest helped Essie by both redefining the problem as abuse (not her own "innate badness") and creating safety for her to share. Chris also finds "another survivor" the "best" counsellor. "There's that feeling of dealing with a peer, which is so crucial in terms of trust." For Sarah, a counsellor must either be a "survivor herself, or someone who specializes in the area". She stresses the need for comfort with the effects of abuse, including self-injury.

I would tell anyone who wants to work in psychiatry that if they have any problems at all with sexual abuse, emotional abuse, physical abuse, if they've got any hang-ups about it, and they suspect the person has this problem, then don't even stay on the case. Get the hell off it, and get somebody who can deal with it. Because I think that's what did damage to me, people who couldn't cope with it, themselves, so they made it into something it wasn't.

Communicates Her/His Boundaries

Half of the respondents pointed out the benefits of a counsellor setting clear limits with them. Like Sarah, who was not aware of her boundaries, Janus says she "had no sense of limits" when she first started working with her psychiatrist. Lise found one psychiatrist's ability to share his limitations made her

feel like he had confidence in me, that I was capable of understanding what he was telling me ...He didn't try to play god with me. He didn't

think he was this super human being who could do everything. So for that I can thank him.

Bernadette also admired and trusted her social worker, when she told her "'I don't know how to help you'" with the incest. "She at least could say that...and we stayed friends." In contrast, Helen felt hurt by her psychiatrist, who

over-stepped her boundaries in a couple of ways...one minute she'd be very professional, and another minute she wouldn't, but when she wasn't, it was only when she needed something. I got very confused about that.

On the other hand, Isabel found her analyst went "overboard" on boundaries.

Like I asked him, "Do you have children?" in the context of, I was making all these lunches, and the house is such a mess. You know, do you know what it's like when you have children? And he wouldn't answer...I felt degraded by it.

Listens with Acceptance and Caring

"A good therapist believes what you're saying and cares about what you're saying", according to Bernadette. Six women give examples similar to the one above where they needed human caring and connection, not distance. "You have to be able to hear what someone is saying. And not just from the head, but from the gut", explains Helen. This includes the ability to accept women's expressions of anger, say Janus, Lise, and Helen.

Sarah dealt with only two psychiatrists who seemed to understand that she was somehow abused and treated her with kindness. She and Bernadette both remember some nurses who

were "compassionate...very helpful and they accepted me", and "very nurturing...[would] answer my questions...really caring".

Consistent, Trustworthy, and Patient

When you're a survivor, you have to have consistency. You have to have someone that the caring doesn't stop when you walk out the door, and then resumes at [her] convenience...you need someone dedicated...not to carry you, but to be there (Essie).

This policy on the part of her counsellor over the past year enabled Essie to have "ultimate trust in her". Lise's psychiatrist was exceptional in that he came to see her in the hospital "every day...even though he was not allowed to see me for therapy". When she was home, her feminist counsellor returned her calls by special arrangement with a 24 hour crisis line.

I was never put on hold...sometimes I'd call her at one or two o'clock in the morning, and I had a gun to my head and she had to diffuse this before I shot, and we'd speak for five or six hours on the phone...I needed it so much that I was selfish...I wouldn't want to talk to anyone else...there had to be one person in my life that would be present and that I knew that I could count on...I don't know if all survivors are like this, but I think we can drain someone real fast.

Similarly, when she needed crisis telephone counselling, Isabel said during our first interview that she hadn't "phoned and just talked to anybody". Her group leaders gave her their home telephone numbers. She later was able to use the crisis lines more easily even though she said she still finds "it hard not knowing who I'm talking to". Helen also felt safe

with one psychiatrist who was "accessible...I could phone him at home". She was "really upset" with another psychiatrist who encouraged her to call, but later "cut that off real quick...nothing was consistent with her".

Essie explains how a counselling relationship with a woman who has survived incest is "very sacred".

Be gentle...[you] have been given a gift, because the watching of the growth and of the rebirth... when someone shares that with you, it means that person trusts you and believes in you and you can never break that. It would really do great damage to the person in the healing process...most of us have such a hard time with trust issues.

"When you've learned early" that you can't trust, according to Isabel, the counsellor "needs to be a lot more accommodating of how hard it is".

Patience is essential in the experience of six interviewees, because building trust and learning to express feelings "take a while" (Bernadette). Even though Lise "thought he was safe...it took almost a year before the wall came down" with her psychiatrist. Janus remembers how important it was that her psychiatrist "wouldn't give up" on her and "wouldn't let go". Sarah empathizes with counsellors who get frustrated with self-injury, "especially when all your training is to make people well". She too advises them to "have a little patience".

Teachable

Lise was the only woman interviewed who had a predominantly positive account of a psychiatrist who played a major

role in her healing. Not only was he able to admit that he hadn't dealt with incest before and was burning out, "'You're too much for just one person'", but he also "recommended" a feminist counsellor from a sexual assault program. Because he was teachable, Lise and her feminist counsellor were eventually able to "keep him in line" around power and gender issues. For example, when she was being emotionally abused in hospital by another physician, this psychiatrist acted immediately upon the advice of Lise's feminist counsellor to "get her out of there". Through feminist counselling Lise discovered she could also be assertive with her psychiatrist. "In the end I could tell him whatever I felt like, and he would take it. I think he learned a lot from me."

Her sexual assault counsellor also learned from Lise.

She didn't know about this defense mechanism called "MPD"...she could make her views from having a "case" in front of her and saying, "Do I want to call this a pathology or is this not just what I see?"

Isabel had a somewhat positive exchange with an analyst who didn't realize she was abused while they were working together, but was able to admit after termination,

"If I had known what we know now". I went back and we talked over our relationship...It was nice to do that...so I feel at least he learned something, and so it was at my expense.

Janus also remembers when her psychiatrist later admitted she was right about his remark being "sadistic...That's when it started to open up...we're trying to save this impasse".

Bernadette, Janus and Isabel experienced frustration in attempts to teach psychiatrists in sessions, as well as after the counselling had been terminated. When Bernadette gave her therapist information on incest, and later asked her if she had read it, the doctor replied, "'Oh, some of it'". Visibly upset, Bernadette implored, "I'm really teaching you things here. I'm teaching you what this is about". When the psychiatrist responded with an inference that the incest was consensual, Bernadette was angry, "Oh Jesus, I don't need this!"

While Isabel has brought up some of her angry feelings towards past therapists in counselling sessions, she wants to somehow go back with other issues that she is not yet "ready to risk". Half of the women interviewed either had made attempts to teach their psychiatrists and/or had elaborate fantasies of doing so. Lise wants to go back to "all the psychiatric wards I've been on" to tell them, "Whether we adopt any kind of defense mechanism, we're far from being crazy". Once she gets her degree in counselling with all her "marks and percentages" she plans to "send a copy...and I'm going to say 'no thanks to you guys!'"

Since she has found while working alongside medical students that "they're not very open-minded", Sarah says if she "had the guts" she would

stand up in front of a medical class and say "Look, these are the things to look for. This sort of stuff happens!...You can't put this stuff under the mat... and if you're going to treat somebody who

comes in slashing themselves like they're a 'manipulator', or they're a 'personality disorder', and not really face the fact that they are probably trying to tell you something, you're gonna waste their time, your time and a lot of money"...And I don't think any of them are prepared to hear it, maybe 1%, I give them, maybe that amount.

She finds the conservative attitudes in upcoming medical students as well as seasoned professionals "distressing". "It's depressing", because in order to meet survivors' needs, "it would require a whole different way of thinking". Helen did go back to one psychiatrist who had listened more than the others.

I wanted to let her know just how their system was such a rip-off. Not only, it was costly, and it took so friggin' long to get anything done or to make any headway with that system...when you can find it, for me, I found it [at the sexual assault program] in a year! And I worked at that system for 12 years!...I wanted them to know what they had done, so I dumped it all on Dr. X.

All of these women are concerned, like Louise, that psychiatry as a profession needs to "assimilate our experience". Sarah pleads, "For god's sake, open your eyes". Helen, who also works as a sexual assault counsellor, says psychiatrists "need correct information...and they should get it from survivors".

In order to understand it all, they're going to have to look at socialization, they're going to have to look at the whole picture. Not just "treat" a survivor, but where does it come from? They're going to have to re-evaluate themselves and their industry.

"Don't Go to Psychiatry"

Eight out of ten women recommend that other incest survivors stay away from psychiatry: "I wish I'd never gone to psychiatry" (Janus); "I didn't feel it was the right place for me" (Louise); "It's a punishment...It does nothing to boost your self-esteem" (Lise); "Psychiatrists had nothing that I could use" (Helen); and "Don't go to your typical professional psychiatrist whose main aim is to diagnose and cure" (Sarah). Lise goes so far as to say that the hospital

is the worst place to be. Psychiatric hospitals are full of male doctors...and women doctors don't always know how to deal with [incest]...In all the hospitals that I've seen, I've only met one woman doctor who was very nice...she's young and she's very good.

Janus and Bernadette concur respectively: "It's only recently that some psychiatrists, most of whom are female, and most of them feel psychiatry doesn't work, are validating these experiences" of violence against women and children; and "only a small percentage of [psychiatric] experiences are good. The staff are not schooled and not interested in learning about incest."

Although Janus is currently taking antidepressants, she thinks "We've got to stop using the medical model for most of these". Sarah agrees that "from a medical point of view" psychiatry did not do "a lot of good". Says Janus

There is no answer to being suicidal in the hospital. It's not a solution. It doesn't help in the least...There's nothing in hospital except

medications...They've failed at having any supportive community...The theories don't make any sense.

She calls the hospital a "bureaucratized routine, where paperwork is the first priority".

Toward the end of the interview Lise realized that since she has left psychiatry, she has been carrying

some anger...because I know there are other women right now who are going through something similar. It's an anger that I'm out, and some of them are in there. And they're not as lucky.

Criticism of the system appears to vary in intensity between women who are currently receiving psychiatric services, and those who are not. This could, in part, be explained by the appropriateness of particular psychiatric services for them. In other words, women who are benefiting are still using a particular medication. However, this same attitudinal shift occurred within each woman, herself, when she was in a different position with regards to psychiatry. Perhaps it is a crucial survival mechanism to view positively any support one is currently dependent upon in order to feel safe in that relationship. Even so, Isabel and Essie, the two participants who did not specifically rule out psychiatry, were cautious. Isabel agrees with others in the study that her few positive experiences in hospital were "so unusual". Essie could speak for the whole group of participants when she says to survivors who are considering psychiatric help, "Be very careful...Be very very careful, and don't let anyone tell you what you're feeling".

In spite of the tremendous institutional obstacles and the lack of appropriate resources, it is indeed to the credit of all of these women, that they found the strength to persevere, and given any opportunity, that they struggled to define, and often create what they needed for their healing.

CHAPTER VIII

CONCLUSIONS

Since the "conspiracy of silence" around incest has been exposed by feminists, a handful of researchers in psychiatry have received disclosures from the 44% to 70% of women patients who were able to remember and felt safe enough to reveal this childhood trauma. Although this study examines the psychiatric experiences of only ten women incest survivors, many collectively held criticisms and requirements for support emerged from the interviews. These warrant careful consideration by counsellors both inside and outside psychiatry for their applicability to other survivors.

Participants' many similarities in experience and identified needs are especially remarkable in that they had different "diagnoses", were at widely divergent places in their healing at the time of the interviews, and had been given feminist counselling in a variety of settings. Their individual situations and views also merit attention as examples of how each woman could have potentially provided her therapist valuable instruction about her unique needs, if only she were heard.

These women all felt that most of their experiences with psychiatry were frustrating and, to varying degrees a waste of precious time that could have been spent leading a more empowered life. Their stories also confirm the question that arose in the literature review, of whether psychiatry itself

can be crazy-making. Three major aspects of traditional psychiatric practice hold this potential. The first is the "mental illness" paradigm, that fed into and confirmed participants' fears that they were truly "crazy", and reinforced similar messages from perpetrators and society as a whole.

The second is repetition of the "traumagenic dynamics" of child sexual abuse: "traumatic sexualization, stigmatization, betrayal and powerlessness" (Finkelhor & Browne, 1986). The third is repetition of the "victim to patient process," whereby survivors once again are required to deny their own perceptions and feelings in order to fit in, leading to "profound disconfirmation" of their realities (Rieker & Carmen, 1986). The testimonies of survivors in this study add a whole new dimension to the "victim to patient process", its continuation throughout psychiatric "treatment".

In all three of these aspects, traditional psychiatry decontextualizes women's behaviour, interpreting adaptive survival responses (strengths) as pathology (weakness). Such women deserve recognition for their remarkable strengths in having survived under the most adverse of conditions, not "treatment" that inflicts further damage. Chapters Five and Six offer numerous examples of what psychiatry would consider "crazy" behaviours that were actually responses, rather than antecedents to psychiatric interventions.

According to this group of women, the potential for revictimization in the psychiatric setting is more likely to be a common occurrence. Their accounts and calls for appropriate support concur with my own experience as a feminist counsellor. I have spent much time in sessions assisting women in their struggles to rebuild their capacities to trust and their senses of self after years of psychiatric mis-"treatment".

Ironically, while psychiatry, according to these women, is one of the least appropriate counselling alternatives for incest survivors, it is presently the most available in Canada because it is paid for by government health care plans. To consistently meet some of the needs of the many late disclosed/acknowledged incest survivors who will continue to knock on psychiatry's doors for help, the system will have to make major changes. Psychiatry must place a much greater emphasis on education of staff, particularly physicians, about the prevalence of violence against women and children, its effects, and what survivors require for healing.

This work must be done from a feminist perspective, in other words, we need to hear over and over from survivors, themselves. This serves a two-fold purpose: it breaks the silence and empowers survivors, as well as providing accurate information about their needs. Without a feminist perspective, there is the constant danger that a little information will be used to sell a system of care that is

still entrenched in a patriarchal, diagnostic and psycho-analytic framework that not only does not "fit", but also carries much potential for revictimization. Clinicians and support staff who have some training can still inadvertently reabuse survivors, both because of the often subtle dynamics of revictimization, and because the very paradigm of "mental illness" channels helpers' perceptions towards invalidation of competency, sanity and ability to attain healthy functioning.

These women went to psychiatry with hopes of finding a "safe place" for healing, government funded counselling, medication to help them cope, and essential resources such as disability pensions. However, apart from knowledge about medication, the psychiatric system has less expertise and is much more expensive to operate in comparison to sexual assault centres, transition houses, and other mutual aid and community based options.

We must provide ample government dollars for less expensive and more empowering alternatives such as feminist counselling, sexual assault centres and safe healing homes for women. While the majority of respondents in this study claim feminist counselling can free a survivor from dependence on psychiatry in one or two years, even after she has spent half her life in the system, such a healing relationship requires consistent counsellor availability over this period. Sexual assault counsellors who work with this group of women should have ample time allocated for crisis intervention and regular

contact. As well, staffing at healing homes should be available for one-on-one support during the "emergency stage" of remembering. Survivors must be able to determine their own needs in these facilities, and there should be no pressure to "move on" until a woman is ready. The experiences of these women also raise questions for future research on whether appropriate supports that enable survivors' healing, might negate or reduce long-term needs for medication. Many survivors would benefit from hearing from a larger sample of women with "mania" and/or recurrent debilitating depression who have found alternatives that provide relief over long periods of time.

Primary prevention must also be a priority. This means increased funding for preventative educational programs that confront sexist attitudes in our society at all levels. Sexism is only one face of the "power-over" function of patriarchy, however, and as long as there is a widely held belief that some people are worth more than others, many will be disrespected, invalidated and abused.⁵⁴

In the meantime, for those incest survivors presently in psychiatry, these ten women who have shared their wisdom offer much hope for healing and empowerment, if only a survivor is given the opportunity to be understood and supported in ways that fit for her.

NOTES

1. Conspiracy of Silence is Sandra Butler's (1978) expose of childhood incestuous assault, "underreported and unacknowledged" by helping professionals.

2. Both general population and psychiatric studies have not routinely asked survivors if and whom they may have told about the abuse. In Russell's (1986) community survey 51% of women spontaneously mentioned whether or not they had ever told someone prior to the survey. Only 17% of this group disclosed at the time of the first incident or soon afterward. Ten percent told someone at a later point. Only 2% reported the abuse to the police, and of these 4 cases, only one was convicted.

3. These include "needing to be 'normal'", as it is common for survivors to feel "painfully different", "bad", or that others will consider them "crazy"; fear of losing control, reexperiencing the pain and actually going "crazy"; fear of authority figures; shame and self-blame; taboos around discussion of sex; doubting their memories; wanting to protect family members; fear of retaliation by the abuser; difficulty trusting after numerous betrayals; fear that no one will listen; fear of criticism; and the necessary process of working through ambivalence about telling someone.

4. In one survey, survivors most frequently answered that they disclosed when 1) they thought they would feel better by doing so, 2) someone encouraged them to tell a counsellor, and/or 3) when counsellors asked them directly (Josephson, 1985).

5. Other factors, such as the age of onset and type of sex act, yield ambiguous outcomes. Since repressed memories are more frequent when children are abused at earlier ages (Herman & Schatzow, 1987), this may account for inconsistencies regarding age of onset. With regards to particular sex acts, Bass and Davis (1988) caution that societal and clinical judgements alleging that penetration is more severe than other forms of abuse, contributes to minimization of a woman's experience. "Violation is determined by your experience as a child--your body, your feelings, your spirit. The precise physical acts are not always the most damaging aspects of the abuse".

6. In Gelinas' (1983) experience, most women first request counselling for relationship difficulties, or any of the "secondary elaborations" of the trauma, such as depression. "Psychiatric symptoms" are often triggered by a developmental milestone that reminds a survivor of the trauma, such as marriage, a job promotion, or her child reaching the age of onset of the survivor's own abuse.

7. In keeping with Gelinas' (1983) and Ellenson's (1985) contentions that most survivors fear sharing any experiences that could be interpreted as symptoms of insanity, Finkelhor and Browne's (1986) comprehensive review of empirical studies on child sexual abuse effects makes no reference to respondent reports of "mental illness", or even "flashbacks". While long-term effects such as low self-esteem earned a whole section in their book, they only mention "flashbacks" once, on a chart listing possible outcomes of traumatic sexualization. McLaurin (1987) found only 26% of the fifty clinical articles she reviewed had mentioned "flashbacks". However, 60% of clinicians noted "severe disorders", such as "psychotic-like rages" and "severe anxiety disorders with outbursts of physical violence".

8. It is understandable that many survivors in psychiatry suffer from "secondary elaborations". Only a few of Blake-White and Kline's group members had previously worked on their incest victimization, even though almost all had received counselling from mental health services.

9. Dissociation was described in clinical admission questionnaires (Briere and Runtz, 1985a) as "spaciness" (42% versus 22% rates among nonsurvivors), "out of body experiences" (21% versus 8%), and "feeling that things are unreal" (33% versus 11%). Their parallel student survey also found higher scores of dissociation among survivors.

10. While most empirical studies have found significantly greater distress around sexuality amongst survivors, Finkelhor and Browne (1986) say results are not consistent. However, the studies they cite as contradictory involve unmarried young women (average age 19) in one, and in the other, a comparison group of "seductive" versus "incestuous" fathers. The second study by Herman (1981) viewed "seductive" behavior by fathers on a continuum of abuse with incest, and found similar disclosures of sexual difficulties among both groups of daughters.

11. Freud learned of the reality of brutal physical and sexual abuse of children by caretakers from Tardieu, who in the 1850's had conducted demonstrations and wrote legal medical papers and texts regarding autopsies of child victims in the Paris morgue. Although Tardieu was dean of the Faculty of Medicine at the University of Paris, and president of the Paris Academy of Medicine, his shocking evidence appears to have been ignored and denied by the rest of the psychiatric community (Masson, 1985).

12. In the "Aetiology of Hysteria" Freud attempted to counter skepticism from colleagues by painstakingly describing his clients' responses to retrieval of repressed memories, "violent sensations, of which they are ashamed and which they try to conceal".

He avoids implicating men, particularly fathers, in "Aetiology of Hysteria", referring instead to "more numerous cases [than those abuses by strangers]...in which some adult looking after the child--a nursery maid or governess or tutor, or, unhappily all too often, a close relative..."(1896). However, in a private letter to Fliess in 1897, he says "'in all cases, the father [emphasis in the original], not excluding my own, had to be accused of being perverse'". In order to give weight to the Oedipus Complex in later years, when he retracts his seduction theory, he says of supposed imagined childhood sexual experiences, "with female patients the part of seducer was almost always the father".(Masson, 1985)

It appears that Emma Eckstein's flashbacks of Satanic cult abuse are among the first to be interpreted as fantasies by Freud. Freud links these "scenes" with statements of the accused during witch-burning times. "'Why are their confessions under torture so like the communications made by my patients in psychological treatment?'"(Masson, 1985)

13. In a 1981 correspondence with Masson (1985), Anna Freud writes, "keeping up the seduction theory would mean to abandon the Oedipus complex, and with it the whole importance of phantasy life, conscious or unconscious phantasy. In fact, I think there would have been no psychoanalysis afterwards".

14. Bender and Blau (1937), along with other clinicians including Freud, credit Abraham (1907) for his insights into "child sexuality". Abraham asserts that some children are constitutionally predisposed to sexual trauma, and initiate such activity, which they "rationalize" with "excuses of fear of physical harm, or the enticement of gifts".

15. Kaufman et al (1954) briefly mention that all incestuous fathers studied "deserted their children at some time", and showed evidence of "general irresponsibility" in the occupational sphere. Yet, mothers and grandmothers are discussed at length and held much more accountable. They are described as "masochistic", "choosing men who would desert them", "controlling, cold and extremely hostile women".

Daughters are also incriminated, since they "accept their father's sexual advances". Pavenstedt (1954) cautions against foster home placement of the daughter, as this could be a "setup so reminiscent of the one in which she only recently reigned and was dethroned". She supposedly experiences very powerful "repetition compulsion" and will "attempt to seduce the foster father".

In one case Guthcil and Avery accuse both daughters and mother of banding together in denial of the "mother's failure", "resorting to a 'sexist' defense... deploring [instead] father's failure to provide the care".

16. Lukianowicz (1972) differs with his peers in observing that incestuous fathers commonly exhibit aggressive behavior, and that this practice does not appear to be considered deviant. Yet, he is unable to hold perpetrators accountable, because they are "'oversexed'" with "poor inhibitions and intolerant wives". Because daughters usually spoke of their fathers' behavior as "'normal'", he concludes that "at least some of the girls might have played an active part in the initiation of the incestuous relations and that not all of them were only 'innocent victims'".

He also observes a "condoning attitude on the part of the mothers", noting that only two of 26 reported their husbands to the police. Even these two mothers who pressed charges are implicated, for playing "the role of a martyred victim who had been abused by her husband".

17. Survivors are negatively labeled "brazen", "selfish" and "self-indulgent" (Bender & Blau, 1937; Sloane & Karpinsky, 1942). Along with exhibiting "fundamental incorrigibility", they are described as "weak", "flirtatious" (Bender & Blau, 1937); "prudish" and "inflexible", having "jealous disposition" (Sloane & Karpinsky, 1942); "masochistic", with "secondary sex characteristics precociously developed". supposedly it was "the sexuality of these girls [that] led to the arrest and incarceration of the father" (Kaufman et al, 1954).

18. Until recently, many psychiatric textbooks contained no mention whatsoever of incest (Noyes & Kolb, 1963; Forrest, 1973). An exception is Redlich and Freedman (1966), who emphasize "the noxious factor is not the traumatic sexual experience", it is "faulty child-rearing practices in general".

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19. Henderson also hypothesizes "hysterical patients", may have "acted on incestuous sexual object choices in childhood" as a result of their disorder, and "borderlines" are more likely to become involved in incest since "their major conflicts are with dependency and trust".

Henderson also proposes, as his predecessors have implied, that the harmfulness of incest noted by clinicians is "solely a consequence of the shame and guilt...on violating a taboo".

When he is quoted by Saddock (1980; 1985), we are not told whether "impairments" predispose daughters to incest or follow. Yet interruption of incest, rather than the abuse, itself, is clearly presented as harmful.

Some of Saddock's (1985) own comments appear contradictory. She says "incest may be viewed as child abuse" and mentions symptoms of abuse in children such as genital irritations, abdominal pain, separation anxiety, phobias, nightmares and school problems.

20. Professional avoidance of incest, according to Renshaw (1982), consists of the following:

textbook denial	absence from DSM I,II,
restricted research	III
"lack of time"	lack of follow-up
avoiding learning to take	ignoring
incest history	feeling overwhelmed,
trivializing effects	anxious, inadequate
referring case	withdrawal
refusing to see	closing case
covering up	misperceiving
disbelieving	denying incidence
trivializing effects	burnout

21. In Renshaw's (1982) list of ten "important clinical questions", five revolve around concern for maintenance of the family. Only one considers victimization: "Is any member exploited or harmed?"

Some examples of Henderson's continuing stance of victim and mother blame in the latest edition of Comprehensive Textbook of Psychiatry (Saddock, 1985) include: mothers "frustrate their husbands sexually", and "encourage" their daughter's "sexual partnership with father", while vicariously gratifying their own childhood incestuous wishes in doing so; daughters only disclose the incest for revenge "evoked by perceived withdrawal of the father's attention". They assume a passive role in the "relationship" in order to avoid guilt, stemming from "violation of the incest taboo" and "hostile

impulses toward the mother".

22. Survivors interviewed by Burrows (1987) commonly feared, and some shared experiences of sexual abuse by male therapists. Russell (1986) reports 53% of incest survivors in her general population survey also shared at least one incident of an "unwanted sexual advance by an authority figure such as a doctor, teacher, employer, minister, therapist or policeman."

23. "Sexual contact" was defined as "any contact which was intended to arouse or satisfy sexual desire in the psychiatrist, patient or both."

24. Gartrel and Herman (1986) caution that the 6.4% figure for those psychiatrists who acknowledged sexual contact with their own patients is a conservative estimate. This is likely, given the number of abuses reported by fellow practitioners, the low (26%) survey response rate, and the unwillingness of the American Psychiatric Association (APA) to sponsor the survey. After a three year "involved struggle" on the part of these feminist researchers with their organization to gain APA sponsorship, it was refused on the grounds that "it might damage the credibility of the psychiatric profession".

25. Renshaw (1982) lists "attraction" as a possible "personal and professional reaction" to incest and points out some of the "complex behaviors" that form "guises of attraction". Yet "exploitation" is listed under "non-sexual reactions" along with "attention", "affection", and "gaining special status, treats, money, privileges, protection", most of which appear to be referring to survivors' behaviors. Sexual exploitation by the therapist does not appear to be an issue.

26. Penfold also cites an article about treatment "hazards" with "multiple personality patients" in which Watkins and Watkins (1984) describe how "seductive behavior" of the "patient" can stimulate counter-transference reactions in the therapist. No mention is made of therapist responsibility in initiation, and discussion of consequences is limited to effects on the therapist's reputation.

27. Similarly, in "Battered or Schizophrenic? Psychological Tests Can't Tell", Rosewater, (1988) discovered that battered women have the same MMPI (psychological test) profile as do "patients" "diagnosed" with "chronic schizophrenia". Paranoia, a common "symptom" of "schizophrenia", is supposedly a "clinical measure of fearfulness without basis". Battered

women, like incest survivors, have a good reason to be fearful. Her additional observation that the level of fearfulness rises in correlation to the frequency of battering indicates that the violence causes the paranoia.

28. Herman and van der Kolk (1987) cite two well-known BPD experts, Gunderson and Kernberg, who both have observed frequent disclosures of childhood victimization, but either do not believe them or do not see them as relevant.

29. Wallinger and Gunderson (1984) conducted retrospective assessments of the outcome of individual long-term psychodynamic therapy.

30. Gelinas (1983) and Rosenzweig and Al-Zand (1987) describe differences between many survivors and other women with "borderline personality disorder". However, these points of difference are often contradictory. Both Briere (1984) and Herman and van der Kolk (1987) argue that survivors qualify for the diagnosis of BPD, but dispute current wisdom on BPD etiology and intervention.

31. "The breakthrough of previously repressed traumatic memories is accompanied by powerful affect and marked, though temporary, ego disorganization. Patients may become extremely symptomatic during this process, with severe anxiety, feelings of despair, and impulses toward self-destructive behavior. Often patients approach the task...with a fantasy that a single overwhelming and cathartic experience will result either in total annihilation or total cure. The danger then arises that the breakthrough of repressed memories will be experienced merely as a reenactment of abuse, with the therapist in the role of the tormentor." (Herman & Schatzow, 1987)

32. While the latest (1985) edition of The Comprehensive Textbook of Psychiatry now includes rape and accidents in the home as antecedents to "PTSD", it makes no mention of the more "private", "family" crimes of child physical and incest abuse and wife assault.

33. Some patients with repressed memories might be expected to fare better, according to Andreasen (1985), if they are treated as details surface. Delayed but brief "PTSD" cases, "if treated early...usually respond well to brief supportive or insight-oriented psychotherapy." However, late disclosed or acknowledged adult survivors of incest abuse in psychiatry, according to this prediction, may be given a very poor prognosis, indeed.

34. Modern openness toward the reality of psychological distress as an outcome of traumatic experiences is haunted by the old ghost of "compensation neurosis". Debate over psychological vs. organic causation of psychiatric symptoms arose out of the issue of monetary compensation for injuries. Earlier in this century, psychological causation was restricted to "malingering", and a common label for post-traumatic stress symptoms was "compensation neurosis" (Trimble, 1985).

35. Burrows organized survivors' responses around Stein's (1984) framework for therapists' attitudes: "1) power and authority; 2) sexual-erotic; 3) caretaker (mother-child); 4) wounded healer; and 5) spiritual midwife". The women's experiences produced a sixth category, "mentor-role model".

36. Like Herman and Schatzow (1987), Rosenzweig and Al-Zand (1987) describe their "patients" often seeing the therapist as "the abuser who...stirs up hitherto unconscious conflict surrounding the abuse...leaving the patient to deal with the ensuing emotions and symptoms between therapy sessions".

37. Rosenzweig and Al-Zand (1987) emphasize the necessity of "consistent, firm and repeated establishment of the inter-personal boundaries" in counselling survivors. Because they come from families where there were few if any boundaries, survivors "continually test" boundaries in therapy, and the resulting frustration "produces rage and often reports of worsening symptoms as the patient experiences rejection and responds by acting out in the form of self-injury or angry distancing behavior".

38. The overwhelming majority of incest perpetrators are male (98.8%) according to a national survey commissioned by the Canadian government (Badgley, 1984).

39. In explaining her rationale for writing Women's Reality, Schaef (1985) explains how the "white male system", which dominates society, is like a haze of smog that is difficult to sense when one is in the centre of the city, but can be clearly seen from an adjacent mountain top. Myths such as "the white male system is the only thing that exists", and that it "knows and understands everything" have prevented women's experiences from being heard. Another myth, according to Schaef, is "that it is possible to be totally logical, rational and objective".

40. Smith (1975) locates psychiatry as part of the ruling apparatus, in its dominance of the mental health hierarchy, with control of research, diagnosis and treatment, program administration, government policy, etc.

41. Without extensive value clarification skills, say Rieker and Carmen (1984), physicians will continue to evaluate "manipulative", "seductive" and other indirect communications as pathological. A feminist analysis reveals these same behaviors to be culturally prescribed strategies for women, in the absence of self-determining options.

42. Stiver (1985), along with Miller (1976), Gilligan (1982), and Surrey (1984), notes "the extent to which women are seen as lacking and defective when evaluated according to masculine models of personality theory and developmental psychology. These models fail to recognize the unique qualities of female development and experience".

43. Several authors suggest that Lerner's notion of the "just world", also leads to victim blame. This is the popular misconception that people get what they deserve and deserve what they get (Gulotta & Neuberger, 1983; Janoff-Bulman & Frieze, 1983; Wortman, 1983). Feminist counsellors attempt to remove the guilt and self-blame society inflicts on sexual assault survivors while validating their perceptions and feelings. Some stress the importance of specifically telling a survivor "it was not your fault", while others (Schaeff, 1985) believe a woman will feel her perceptions invalidated once again unless she is encouraged to feel her self-blame, explore it, and realize through this process that she did what she could at the time to escape further victimization.

44. Ochberg (Salisan, 1980), along with Rich and Stenzel (1980) points to the judicial system's emphasis on the rights of the accused within a "competitive society which stresses winning and losing". There are tendencies "to disparage and even despise the loser, the victim, and to isolate and in fact to deny that there are problems".

45. Finkelhor and Browne's (1986) "traumagenic dynamics" summarize the extensive empirical literature to date on the initial and long term effects of child sexual abuse, itself: (1) traumatic sexualization, (2) stigmatization, (3) betrayal, and (4) powerlessness. I believe psychiatric intervention needs to be examined regarding its emphasis on healing or replicating these traumagenic dynamics. For example, in the case of late disclosed/acknowledged survivors who are "diagnosed" with "borderline personality disorder" (described previously), prescribed "treatment" may repeat dynamics of

stigmatization (both as a "borderline" and in not receiving encouragement to explore the abuse), powerlessness (over her "treatment" in the hands of BPD "experts") and betrayal (when she is not believed or understood).

46. Collective experiences of women are being recorded in efforts to build a "new psychology of women" (Miller, 1976; Greenspan, 1983; Schaef, 1985; Stiver, 1985; Surrey, 1985).

47. Says Oakley (1981) "the mythology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data production [is] replaced by the recognition that personal involvement is more than a dangerous bias - it is the condition under which people come to know each other and to admit others into their lives".

48. "Women who have considered themselves hopelessly [mentally] ill through years of conventional therapy often discover redeeming self-worth and self-confidence after only a few months of contact with other survivors within a specialized incest treatment program" (Summit, 1982).

Benefits for late disclosed/acknowledged survivors, according to Herman (1981) include "diminishing of the patient role, for group members give to each other and become each other's therapists". Self-help groups in particular "foster a sense of health and competence, because participants do not identify themselves as patients in need of treatment". As well, they "may offer a safer and more therapeutic environment" than "the traditional mental health system" that carries a "high risk of insensitive or destructive treatment".

49. Clients are only able to evaluate a service in comparison with other similar experiences, in accordance with their expectations, and in relation to what they are accustomed (what they believe is "normal") (Rees & Wallace, 1982).

50. These groups provide a safe place where validation of a woman's perceptions is the norm, rather than the "disconfirmation and transformation of abuse" involved in the "victim to patient process" (Rieker & Carmen, 1986). In a talk on "group work" Heney (1989) summarized the "rights of survivors" essential to healing, identified by feminists: 1) to break silence, 2) to control and direct their own recovery, and 3) to be recognized as a survivor, not a victim.

51. Summit (1982) explains how only the experience of a "secure environment that is full of consistent, noncontingent acceptance and caring" will allow many survivors to abandon accommodation mechanisms such as splitting of reality, altered

consciousness, self-blame, and labeling oneself as crazy and not worth caring for.

52. Webster (1988) describes "feminist therapy" as "questioning the power relationships inherent in any therapy process and calling for new ways to provide an egalitarian experience in therapy which might facilitate learning about women's experiences, rather than telling women what their experience should be".

53. Re-evaluation counselling is an international peer counselling network that focuses on emotional release with the aim of freeing oneself from past distress experiences. Their newsletter, Present Time is available at 719 Second Ave. North, Seattle, Wash. 98109

54. Starhawk (1987), a feminist healer, says "Power-over comes from the consciousness I have termed estrangement: the view of the world as made up of atomized, nonliving parts, mechanically interacting, valued not for what they inherently are but only in relation to some outside standard...We are so accustomed to power-over, so steeped in its language and its implicit threats, that we often become aware of its functioning only when we see its extreme manifestations.

Appendix A

**INCEST SURVIVORS'
"PERCEPTUAL DISTURBANCES"**

Ellenson's (1985) "predictive syndrome" evolved during three years of relatively unstructured "mental status examinations", which probed for signs of posttraumatic stress, after noticing similarities in self-reports from clients in long-term therapy. It includes the following:

Thought Content Disturbances

- 1) recurring nightmares with such content as catastrophes, scenes of chase, death or violence involving the client, children or family;
- 2) recurring and unsettling obsessions of harming or feeling that someone else is harming one's children;
- 3) dissociation from one's child or one's past, as if they belonged to a total stranger;
- 4) persistent phobias of being alone or in less defensible situations;

Perceptual Disturbances

- 1) recurring illusions of an evil entity in the home or entering oneself;
- 2) recurring auditory hallucinations of a child or someone crying or calling, intruder sounds, and booming sounds;
- 3) recurring visual hallucinations of movement "out to the corner of the eye", furtive shadows, or a looming shadowy figure;
- 4) recurring tactile hallucinations, from being lightly touched to physically pushed or thrown down.

These symptoms are predictive if they have occurred two or more times per month, and the client has either: any combination of seven; five, including at least one perceptual disturbance; or two perceptual disturbance symptoms.

Appendix B

"BORDERLINE PERSONALITY DISORDER"

The DSM-III-R Desk Reference (APA, 1987) offers the following guidelines for a psychiatric diagnosis of "borderline personality disorder":

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

- (1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation
- (2) impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5].)
- (3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only more than a few days
- (4) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights
- (5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior
- (6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values
- (7) chronic feelings of emptiness or boredom
- (8) frantic efforts to avoid real or imagined abandonment (do not include suicidal or self-mutilating behavior covered in [5]).

Appendix C

"PGST-TRAUMATIC STRESS DISORDER"

In the DSM-III-R (APA, 1987), "post-traumatic stress disorder" includes the following criteria:

Persistent reexperiencing of the traumatic event in at least one of the following ways:

- 1) recurrent and intrusive distressing recollections
- 2) recurrent distressing dreams of the event
- 3) sudden acting out or feeling as if the traumatic event were recurring
- 4) intensive psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic

Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness, indicated by at least three of the following:

- 1) efforts to avoid thoughts or feelings associated with the trauma
- 2) efforts to avoid activities or situations that arouse recollections of the trauma
- 3) inability to recall an important aspect of the trauma
- 4) markedly diminished interests in significant activities
- 5) feeling of detachment or estrangement from others
- 6) restricted range of affect, e.g., unable to have loving feelings
- 7) sense of a foreshortened future

Persistent symptoms of increased arousal as indicated by at least two of the following:

- 1) difficulty falling or staying asleep
- 2) irritability or outbursts of anger
- 3) difficulty concentrating
- 4) hypervigilance
- 5) exaggerated startle response
- 6) physiological reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event

Duration of the disturbance of at least one month.

Appendix D

LETTER OF RECRUITMENT

Dear Survivor,

If you both 1) graduated from a survivors' group or saw a feminist counsellor, and 2) previously sought help from a psychiatric facility, your help is needed. Because the issue of incest has only recently been looked at, most professionals in psychiatry know very little about survivors who look to mental health services for relief.

I plan to interview ten women about their experiences as "patients" for a long period of time before the abuse became a focus of counselling (either in or outside psychiatry). The interview will provide an opportunity for you to tell your story, in your own way, with the intent of documenting your lived experience as an incest survivor in psychiatry. In sharing your story, it is hoped that you will personally gain from further reflection on this period of your life, as well as share with others what was helpful and what was not helpful for you at different points in your healing.

If you:

- were a patient in psychiatry for at least one year (in total) before the incest became a focus in counselling and
- experienced other psychiatric treatment besides counselling, such as medication, hospitalization, shock treatment, etc and
- graduated from a survivor's group or worked with a feminist counsellor at a later date and
- you might be willing to participate in a face-to-face interview with me,

give me a call. I will answer any questions or listen to any concerns you might have about volunteering. My plan is to make this a learning experience for us both, and your suggestions will be included. Your participation will be kept confidential.

Thank you for your consideration.

Sincerely,

Kathleen Whipp
School of Social Work

Appendix E

FACE SHEET

Dates of
Interviews: _____

Name: _____ Phone: _____ Yr. Born: _____

Address: _____

Experiences with psychiatry,
approximate dates:

(from-to)	inpat/outpat.	therapist/hosp.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When partially/fully disclosed the incest abuse in psychiatry:

When asked about abuse: _____

When acknowledged, and became counselling focus: _____

When entered, graduated from support group? _____

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

INTERVIEW GUIDE

Preparation

- Remembering some experiences with psychiatry may be upsetting. Do you have support you can call on, if you need to?

- I encourage you to share only what you are comfortable with sharing. Let me know if you want the tape recorder turned off at any point. Does anything come to mind that would be helpful right now to make it as comfortable and safe as you would like?

- My purpose is to help you tell your story of experiences with psychiatry, and to explore what fit/did not fit your needs during your healing process, and why. I am also interested in understanding the process of becoming/being a psychiatric patient, and how this felt for you at different points along your journey.

Areas of Information and Sample Probes:

1. Would you begin by describing what was happening in your life at the time of your first experience with psychiatry?

Probes:

- How did you see yourself, and your difficulties?
- At that time, did you remember being sexually abused?
- If you did, did you make any connections at that time between the abuse and your reasons for seeking help?
- Friendship, family, and other supports?
- What made you decide to get psychiatric help?

2. Tell me about your first experience with psychiatry.

Probes:

- Do you remember what you were expecting?
- What did you hope would happen?
- Did you have an opportunity to shop around? What did you find?
- What took place, and what was your response?

3. Can you describe the setting?

Probes:

- How did you feel in that environment?

4. Can you remember the first person you talked to? Who next?
Probes:
 - What sense did you have about the role that person was playing, his/her attitudes toward you.
 - How was that for you?
5. When your history was taken, were you asked about child sexual abuse?
Probes:
 - How did you feel?
 - What message did you receive?
 - Before you approached psychiatry, had you disclosed the abuse to anyone? What was that like?
6. What were you told about your condition? Do you know what diagnoses you were given?
Probes:
 - How were they determined and explained to you?
 - What was that like for you?
 - What impact have these diagnoses had on your life?
 - After disclosure and after the abuse became a focus, what diagnoses were you given?
7. Can you tell me about the counselling you received?
Probes:
 - How did you find this therapist?
 - Can you describe how the counselling went, ie. style of therapist and your response, different activities inside or outside the session that took place or were suggested.
 - What was helpful/not helpful for you?
 - Who determined what was discussed, timing etc?
 - When you showed anger, what response did you get and how did you feel?
 - Stages of healing: what were you ready for, and what happened?
 - Do you remember any confrontations and what these felt like at the time, and later on.
 - How available was your therapist outside appointments? How was this for you and and what did you do in emergencies?
 - What attitudes did your therapist seem to have about women, sex, sexual abuse, power etc. that you particularly remember, and what was your response?
- 8a. What medications were you given, and what were they like?

- b. Describe your experiences with shock therapy.
Probes:
-How was the decision made, and how did you feel about it?
-What effects did the medications/ECT treatments have?
-When, and in what ways did you find them helpful, not helpful?
9. If you were hospitalized, tell me what you remember about the experience.
Probes:
-Who's decision was it, and what were your feelings at the time?
-What was your experience with the routines, restrictions, team approach, other patients, activities etc?
-How did you feel about yourself before, during and after each admission? What was helpful/not helpful, and why?
10. Did you have any other forms of therapy, eg. group, day hospital, OT, hypnosis, psychological testing, biofeedback, social work, family or marital therapy during your initial psychiatric experience?
Probes:
-How were these for you?
-How did you feel about yourself before, during and after?
11. Can you tell me about all the other experiences you have had, as they occurred?
12. Would you describe the time you first told someone in psychiatry about the abuse?
Probes:
-If this was not your first attempt, either inside or outside psychiatry, can you also share these other experiences?
-What made this time different from other counselling sessions?
-What was the therapist's response, and how did you feel?
-What do you need to trust a therapist?
-Do you think a therapist should ask about incest, or wait for survivors to disclose when they are ready?
-What was life like after disclosure?
13. What did you need in order to work on repressed memories?
Probes:
-Can you describe how this work was for you?

14. Did you ever experience inappropriate sexual behavior from psychiatric staff?
Probes:
 - e.g. flirtation, leers, embarrassing jokes or gestures, molestation, propositions, or rapes?
 - how did you handle the situation, and what happened after that?
 - what effects did this have on you?
16. Are there any aspects of therapy that you saw one way at the time, and differently now?
17. Did you ever have opportunities to talk with other patients about your past incest abuse? If so, what was that like?
18. Are you presently using psychiatric services, on medication etc.? How is that now?
19. What would you like to tell therapists and other staff in psychiatry about meeting the needs of women who are survivors.
20. Do you have a message for helping professionals or volunteers as a whole?
21. Do you have a message for other survivors considering psychiatric help, or presently receiving these services?
22. What has this interview been like for you?

Appendix F

LETTER OF CONSENT

I, _____, hereby agree to participate in the study being conducted by Kathleen Whipp of Carleton University School of Social Work. I am aware this research will examine my experiences with psychiatry.

I understand that participation in the study will involve:

- two, and maybe three interviews. The first will be taped, and will last two to three hours. The second will take approximately one hour. A third interview may be necessary to ensure that my experience is reflected as accurately as possible.

- my involvement in reading over the transcript, and offering clarification, additional memories, and my ideas of themes that seem to stand out.

Tapes will be offered to me or destroyed. Names and other identifying details will be omitted from the completed work.

While there are no anticipated risks involved in this study, I understand that I may withdraw from participating at any time.

Signature _____ Date _____

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