

# Notes for Feminist Theorists on

by *Lilith Finkler*

*Sous forme de discours prononcé par l'auteure, le présent article examine les droits des femmes en thérapie psychiatrique plus particulièrement lorsqu'il s'agit de parler et d'analyser la nature de leurs expériences. L'auteure discute de la façon dont les "experts" qui ne font pas partie de ces groupes s'approprient les expériences de ces femmes et comment, par conséquent, leurs opinions sont imposées à ces groupes.*

## Part 1

When I was originally approached to present on this panel, I understood that all the other participants would be psychiatric survivors. I discovered only inadvertently, two days before this conference began, that the title, composition, and direction of this session had been changed! While I welcome the new roster of participants, a more wide ranging phenomenon needs to be addressed.

One of the speakers was informed that self-identified psychiatric survivors would be speaking strictly experientially. As the theoretical analyst, she would speak last. Who assumed that those who live a particular oppression are unable to theorize its existence? Are women unable to engage in feminist theory? Should lesbians not analyze heterosexism? Or is it that psychiatricized women, in particular, are inadequately prepared for the intellectual rigour of an academic milieu?

When presenting at an academic conference, an unspoken requirement exists to identify one's credentials, one's previous publications and current status in the academic world. I suggest that presenters identify their connection to the group they purport to study. Do they belong to the group in question? Are they active members of a community that may stand in opposition to the group they study? Anthropologists studying First Nations people is a good example of this phenomenon.

The politics of appropriation are such that a privileged few manage to determine subjects of study and gain recognition as "experts" on a community outside their own. This process becomes particularly insidious when so-called "progressive" individuals claim to be allies of an oppressed group and in so doing, constantly speak on their behalf. This disempowers the people directly affected by a particular experience, since they have less "credibility" and less access to privilege.

These relations of power revealed themselves at this conference when a non-identified survivor was asked to lend her "objective voice" to the survivor experience. Once again, psychiatricized women were being defined by the authoritative articulations of others.

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## *If the women's movement is to the lives of psychiatricized women at the margins of,*

These same dynamics are evident within the context of the so-called "therapeutic relationship" where an admission of suicidal feelings can lead to involuntary committal in a psychiatric ward. Psychiatrists, social workers, and feminist therapists are unsafe for women with psychiatric histories.<sup>1</sup> Yet, not surprisingly, it is precisely these professionals that claim an understanding of our experiences! It is utterly enraging!

## Part 2

This article articulates the realities of psychiatricized women from a survivor perspective. Psychiatry is a "woman's" issue because women comprise 40 per cent of those admitted to provincial psychiatric institutions (Ministry of Health). Class-stratified health care delivery in Ontario determines that poor women and women of colour are more likely to see a psychiatrist since their services are free. White middle-class women can often afford the exorbitant fees charged by so-called "feminist therapists" and avoid some of the more blatant abuses.

While we refer to ourselves as "psychiatric survivors" or "ex-psychiatric inmates," we who mourned our freedom and who heard the sharp clang of locked doors are commonly referred to as "mentally ill." This term connotes a biological reality designed to reinforce the medical model. An "illness" is a physiological problem. Cancer, brain tumours, epilepsy are "illnesses." There are x-rays and blood tests which confirm or deny their existence. Some argue that "schizophrenia" is also biologically based, claiming that an insufficient amount of dopamine in the brain results in "mental instability."

Biology has been used to justify the oppression of many peoples. Doctors once theorized that women had floating wombs which moved up to their abdomens. This resulted in "hysteria." Black people were characterized as having a smaller brain circumference which limited their intellectual abilities. People with developmental disabilities were warehoused in large institutions in rural areas in order to prevent the "contagion of feeble-mindedness." It is not surprising that individuals whose behaviour does not adhere to social norms receive a biological

# the Lives of Psychiatrized Women

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explanation for the basis of their oppression. There is no such thing as “mental illness.” Rather, there exists psychological stress and intense emotional suffering caused by one’s social and political location.

Psychiatry, as a form of social control, reinforces the marginalization of various oppressed groups. One has only to peruse versions of the Diagnostic and Statistical Manual commonly known as “DSM-III-R” to view the extent to which women, persons of various colours, and persons with different disabilities have been labelled. Refugees, often survivors of torture in their countries of origin, allegedly suffer from “post-traumatic stress disorder.” There is no analysis of the racism and ethnocentrism that many refugees face upon arrival into Canada, nor the ways in which the refugee determination process itself contributes to the psychological stress facing exiled peoples.

Native people who drink excessively are labelled as having “psychoactive substance use disorders.” The DSM-III-R does note that “There is a higher incidence of inhalant use among minority youth living in depressed areas,” but neglects to explain why. Psychiatrists, typically content to focus on the individual, rarely acknowledge the impact of residential schools, the systematic removal of Native children from their families and their placement into white adoptive homes. Broken treaties, the mass sterilization of Native women, the outlawing of spiritual practices all remain invisible in the medical understanding of human behaviour.

Enslaved blacks in the last century who wished to escape their owners were labelled as suffering from “drapetomania.” During the late 1950s, white psychiatrists suggested that blacks engaged in the civil rights movement were more prone to “mental illness” as the process of desegregation was “anxiety-producing” and led to ambiguities in their social status. Diagnostic practices and psychiatric labelling processes effectively reinforce white supremacy as well as patriarchal power structures.

Therefore, I oppose the introduction of “battered women’s syndrome” as a legal defence. Women battered by their husbands are not suffering from a psychiatric malady, but rather from a prevalent expression of patriarchal power. Using psychiatric

terminology to defend a woman in court reinforces the medical model, and the oppression of many other peoples.

Unfortunately, many feminist theoreticians conceive of “woman” as a female individual who is non-disabled. The dangers inherent in the labelling process are trivialized or ignored altogether.

If the women’s movement is to adequately reflect our perspective, the lives of psychiatrized women must be central to, rather than at the margins of, feminist discourse. Activists demanding an end to “violence against women” refer specifically to wife assault, rape, and incest. Some engage in research exploring sexual abuse of female survivors of the psychiatric system. However, the presumed universality of the definition of “violence against women” ignores the brutality of the hospital setting. Four point restraints, chlorpromazine, and electroshock are all patriarchal weapons.

Feminist definitions of “violence” must also incorporate the day to day realities of psychiatrized women. Many women with psychiatric histories reside in boarding homes. They live two or three to a room without a lock on their doors. Less fortunate individuals live on the street, staying in hotels or hostels for short periods of time. These women are vulnerable not only to their male partners but to the systemic violence of the state.

The lives of psychiatrized women must also be considered when feminist theory is being formulated. As Jenny Morris says, the invisibility of women with disabilities is particularly evident when contemplating the politics of caring. Since women are conditioned to nurture, and inevitably assume responsibility for those persons with disabilities in their families, feminists ideologues argue, persons with psychiatric disabilities should be institutionalized to liberate the individual female of her unpaid and unrecognized labour.<sup>2</sup> This intellectual paradigm does not construct “woman” as anything other than emotionally independent. What if the person being cared for is also female? What if there are no other means to provide for her on-going care? Does the loss of control that the psychiatrized woman experiences when institutionalized merit the financial gains that the caregiver enjoys when she is relieved of her duties? Who decides? Is not the right to control one’s own body a feminist demand as much as equal pay for work of equal value? Why are feminist demands considered appropriate for only some women?

Who should care for women who experience extreme emotional and/or psychological stress? An institutional setting does not relieve the pain. It exacerbates an already difficult situation. Forced drugging and electroshock, traditional treatments of choice, also cause physical disabilities. Forty per cent of indi-

viduals who receive neuroleptic drugs as a long term form of "treatment" develop tardive dyskinesia (qtd in Breggen, 74), which consists of involuntary muscle movements, drooling, etc. According to many survivors, electroshock results in both short and long term memory loss.

### Part 3

The literature of feminists in general does not consider women with psychiatric histories as part of their theoretical paradigm. Moreover, it is rare to discover a thoughtful approach to our lives in the body of knowledge referred to as feminist jurisprudence. Organizations such as Legal Education Action Fund (LEAF) and the Advocacy Resource Centre for the Handicapped (ARCH) focus on charter litigation. Most litigation affecting women with psychiatric histories occurs not in the courts but at administrative tribunals. These tribunals act as formal interpreters of statutory laws pertaining to particular pieces of legislation.

The Social Assistance Review Board (SARB), for example, makes decisions with regards to the General Welfare Act and the Family Benefits Act. The Psychiatric Review Boards make decisions regarding the Mental Health Act. Individual women, currently incarcerated in a psychiatric ward, are unlikely to employ charter litigation to secure their release. The process is lengthy, expensive, and provides no guarantee of freedom.

This is not to completely decry the use of the charter, but rather to challenge the notion of its centrality as a vehicle for legal social change. For example, Section Fourteen of the General Welfare Act and Section Ten of the Family Benefits Act provide for the appointment of a trustee, should a social assistance recipient be deemed incompetent to manage their own financial affairs. Unlike the statutory provisions under the Mental Health Act, which require an examination by a medical practitioner and the right of appeal, the decision to appoint a trustee is made by a worker without right of appeal. One could use the charter to challenge this statute. However, in my own experience before SARB, cases of this nature are settled on an individual basis in order to avoid precisely this situation.

If the courts are to provide a forum for the assertion of our rights, psychiatrized women themselves must determine the directions of such efforts. It is all too dangerous for legal practitioners to identify a case with "good facts" and proceed without the guidance of those affected.

I, myself, was guilty of this. When I began working at the legal clinic, I assumed that my clients would all require representation at review board hearings. I prepared students for such situations. To my surprise, a significant minority requested admission to the psychiatric wards I had once wished to escape! To poor women, hungry and homeless, a warm bed and three meals a day were a welcome change from the dreariness of the street. As a result of my experiences, I now prepare students to negotiate with psychiatrists as well as argue cases against them.

Clearly, psychiatric survivors are no more homogeneous than any other grouping. Our views of the world, our perspective on law, are affected by our location. As psychiatric survivors, our understanding of what constitutes a "survivor" must be expanded to include women who remain in the back wards of provincial hospitals, those on psychiatric drugs, and those women attached

to the electrodes of a shock machine. If the woman remains alive despite those forces acting against her, she is a survivor.

As feminist activists and academics, we must re-examine our notions of the universal female. The word "woman" must mean all of us; we must recreate both the theory and practice of feminism so that it incorporates the images and interests of all of us.

*This article was originally presented at the panel on psychiatrized women at the CRIAW conference in November 1992.*

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<sup>1</sup>The author contacted approximately 25 feminist therapists. Each one insisted that if a client was a "danger to self or others" they would consider involuntary committal to a psychiatric institution.

<sup>2</sup>See for example, the discussion of the institutionalization of women in the book, *Review of the Situation of Women in Canada*, National Action Committee on the Status of Women, 1993.

### References

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