Toward Dignity and Survival for Female Psychiatric Patients

By Barbara Holmberg and Marion Beauregard

Although Canadian statistics suggest that women are less likely than men to be admitted to public inpatient psychiatric facilities, women are more likely than men to use psychiatric services in the outpatient and private sectors.[1] This should not discount the sizable numbers of women who currently are admitted to provincial psychiatric hospitals.[2] First of all, we want to introduce you to some of the reasons why women are vulnerable to abuse in psychiatric facilities and then we will offer a variety of individual and collective strategies for changing this serious situation.

Phyllis Chesler[3] was one of the first modern writers to describe the abuse of women in psychiatric institutions. Then, Dorothy Smith and Sara David[4] presented the stories of abuse of Canadian women by the psychiatric establishment in *I'm Not Mad, I'm Angry*. More recently, the work of CHASTEN,[5] Temi Firsten,[6] the Task Force on Sexual Abuse of Patients formed by the Ontario College of Physicians and Surgeons,[7] and a number of consumer groups have demonstrated that women continue to experience abuse as part of their treatment by the psychiatric system. The pervasive power disparity between men and women is exacerbated by illness and emotional distress, leaving many women vulnerable to abuse at the very time when they need protection, succour and healing. Women are admitted to psychiatric facilities for counselling, for a rest, for refuge, for meds, but they don't come to be abused and revictimized.

Some professionals are finally beginning to recognize the fact that large numbers of women who seek services in the mental health system are survivors of physical, sexual and emotional abuse in their past and present relationships. Surrey, Swett, Michaels and Levin[8] found the rate of female outpatients reporting a history of sexual or physical abuse or both to be 64 percent. Other research has produced similar findings. Firsten and others[9] have demonstrated that this abuse is given little or no attention during the assessment and treatment process of malestream services. This neglect of a legitimate mental health concern is really another form of revictimization.

There are a number of basic facts about women that contribute to the vulnerability of women in general:

- Women are different than men, with different experiences, different needs, and different reactions to everything from medications to anger.
- Women are an oppressed group-economically, socially, politically, etc. Their choices are limited even more if they belong to another minority group.
- Almost every woman has been a victim of abuse.
- Traditional psychological theory teaches that women's behaviour is abnormal, crazy, irrational.

These four facts put all women at a disadvantage. Step inside a psychiatric facility and women become even more disadvantaged, powerless and vulnerable to abuse. The medical model decrees that the clinical team, especially the doctor, knows what is best for the patient. Do doctors really believe that women have the right to informed consent and to refuse treatment? When a woman says "No thank you" to drugs or electroconvulsive therapy, is this respected or is her next of kin (her husband, father, son) asked to make the decision for her?

So what passes through an incest survivor's mind as male staff members strap her spread-eagled to a mattress? Or as she is stripped of her street clothes upon entrance to seclusion and forced to wear a hospital gown that barely covers her? How does a women who already has paranoid symptoms feel when she is placed on a mixed ward where she must sleep across a hall from strange men, protected only by curtains? What happens to a woman using a pay phone in a dark alcove separated by heavy fire doors from the nursing station? Women patients feel vulnerable because they are. They exhibit justified paranoia. Male patients, visitors, staff, and professionals are all the potential abusers.

The nature of psychiatric hospitals is to bring "disordered" behaviour under control. This is done primarily with drugs which leave patients sleepy, sedated, less alert, unaware of danger signals, detached (it's not really me that is walking down this hall), euphoric (I can take on the world). Passivity and compliance are the earmarks of the model patient. Therefore the very treatment they get places them at greater risk of assault in the hospital as other patients see them as an easy mark for any number of scams from sexual favours to free cigarettes.

The outcome of institutional life with all its rules and procedures leaves patients with little control over their lives and no power to change it. Can a woman really exercise informed consent in an atmosphere where she has to negotiate for her own clothes, her makeup, more sanitary pads and permission to phone her children? Personal privilege levels, voluntary and involuntary legal status and judgements of incompetence all remove the individual woman's feeling of control over her body and her life.

Collective Strategies

There is a definite need for more gender sensitivity from staff and mental health professionals. Psychology of Women and Family Violence courses should be mandatory, not optional or "frills" courses, in the training of mental health professionals in colleges and universities. Current staff need encouragement and leadership to attend workshops that address gender issues in mental health from a feminist perspective.

Consumers and ex-patients should be consulted by institutions regarding the redesign of policies and procedures and to sensitize staff as to what is is like to be mentally ill. They know what treatments feel like abuse and why. The voices of consumers are integral to the process of improving patient rights.

Hospitals which provide high-risk environments that foster abuse should be open to civil suits and penalized by loss of accreditation. A process similar to the Safety Audit that METRAC [10] developed for safety on city streets should be added to the accreditation criteria and improvements made to the physical environment. As Firsten noted[11] women are more at risk of being assaulted in a psychiatric hospital than they are of dying there in a fire. Simples changes such as moving phones to visible places, improving lighting, closing doors on bedrooms and bathrooms, putting in mirrors, and making nursing stations more accessible are such measures.

Institutions should be held responsible for educating all current staff about the ethics of care and boundaries, especially as to how to flag inappropriate activity and report it. Women's complaints should not be invalidated due to their status as patients. An understanding of the impact of abuse can lead to the prevention of actions that revictimize women. Physical restraint, seclusion rooms and loss of one's clothes can have blatant similarities to the abuse suffered by women at the hands of abusive parents, pimps and husbands. Treating all women as victims of prior abuse is a start. As Temi Firsten [12] points out in her article, "Violence in the Lives of Women on Psych Wards," few women are asked about their history of abuse, while asking about hallucination is common.

Persons who are known to threaten, abuse or take advantage of patients should be given restricted access to patients. This may include assaultive husbands, patients who offer incentives for sexual favours, and even staff who are suspected of abusive remarks. Professional misconduct investigations should be implemented in the case of staff: they should be removed immediately from all patient contact.

Alternative, non-degrading and non-threatening measures should be developed and promoted for the use of "cooling out" volatile and self-abusing patients. This may require additional staff and more communication with patients.

Measures should be taken to promote the dignity of psychiatric patients. Allowing personal clothing, privacy, personal contacts and choice of therapist act to re-establish normality.

Some consumers feel that hospitalizing women in psychiatric facilities has such a high potential for damaging them that it should be avoided altogether. They would prefer a community "safe house" much like a birthing centre or transition house where women are helping women in the healing model rather than the treatment model. It would take a feminist rather than a medical orientation, relying on personal power instead of Dr-God power. The focus would be providing help under the women's control. Some might want medication and a psychiatrist; others a spiritual leader or meditation. In safe surroundings with appropriate precautions, a full range of emotions could be expressed from rage and self-hate to joy and tenderness. Staff would be available 24 hours a day to listen, validate and support. If a woman wanted to scrub floors or walk around the block at 3 am, she could and she would not be handed a sleeping pill. She could wear her own clothes, shower whenever the shower was free, and shut the door when she wanted to be alone.

Such a home-like environment would treat residents as guests, not patients, and encourage them to regain control over their lives. Such centres are currently being developed for sexual abuse survivors[13] and schizophrenics [14] but they require a complete rethinking of the mental health system, consultation with consumers, and input from others who work with people in crisis.

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Personal Strategies toward Consumer Education and Empowerment

All women need to understand that if something does not feel right or if they don't understand, they can ask questions. They can ask doctors about side effects and treatment options and they should be given answers. If someone threatens them, (patient, staff or outside visitor) they have the right to be protected from that person. All women should know their rights as patients, especially that sexual activity is not permitted in hospitals or private practices between patients and staff or professionals under any circumstances. This is not treatment; this is abuse of power. Information about professional bodies that accept complaints needs to be available and women need encouragement to use it with some assurance that their psychiatric history will not invalidate complaints. Assertiveness training would be helpful in providing individual women with the tools to say "no" and to take back control over their bodies and their health care.

Survivors are needed in the "expert" roles of program planners, peer counsellors and policy evaluators to help to prevent abuse. Mental health professionals who will listen to their recommendations and implement changes give them an opportunity to find a new value in life instead of the stigma and disdain that have burdened them in the past. This promotes mental health in the very group that can benefit most. Such ex-patients can play an important role in assuring that the psychiatric facilities that exist become more consumer-friendly, especially toward

women.

In conclusion, the vulnerability of female patients in psychiatric facilities needs to be addressed. The chapters of violence in their lives need to be resolved not perpetuated by the mental health system. A collective effort of consumers and professionals that takes into account the individual needs of women may be unattainable within our present mental health system if the power differential is not fundamentally changed.

[1] Women and Mental Health Committee, C.M.H.A., *Women and Mental Health in Canada: Strategies for Change* (Toronto: C.M.H.A., 1987); C. D'Arcy and J. A. Schmitz, "Sex Differences in the Utilization of Health Services for Psychiatric Problems in Saskatchewan," *Canadian Journal of Psychiatry* 24 (1979): 19-27.

[2] Ontario Ministry of Health (1990).

[3] Phyllis Chesler, *Women and Madness* (New York: Doubleday, 1972).

[4] D. Smith and S. David, eds., *I'm Not Mad, I'm Angry* (Vancouver: Press Gang, 1975).

[5] CHASTEN is the Canadian Health Alliance to Stop Sexual Exploitation Now.

[6] Temi Firsten, "An Exploration of the Role of Physical and Sexual Abuse for Psychiatrically Institutionalized Women," Ontario Women's Directorate (1990).

[7] *Report of the Task Force on Sexual Abuse of Patients*, Ontario College of Physicians and Surgeons (1991).

[8] J. Surrey *et al.*, "Reported History of Physical and Sexual Abuse and Severity of Symptomatology in Women Psychiatric Outpatients," *American Journal of Orthopsychiatry* 60.3 (1990); S. Rose *et al.*, "Undetected Abuse Among Intensive Case Management Clients," *Hospital and Community Psychiatry* 42.5; B. Hoffman and B. Toner, "The Prevalence of Spousal Abuse in Psychiatric Inpatients: A preliminary study," *Canadian Journal of Community Mental Health* 7.2; E. Carmen *et al.*, "Victims of Violence and Psychiatric Illness," *American Journal of Psychiatry* 141.3.

[9] Firsten, *op. cit.*

[10] METRAC Safety Audit Kit (Toronto: METRAC).

[11] Firsten, presentation at Queen Street Mental Health Centre, Toronto (November 1990).

[12] Firsten, "Violence in the Lives of Women on Psych Wards," *Canadian Woman Studies / les cahiers de la femme* 11.4 (Summer 1991): 45-48.

[13] Danica House, Toronto.

[14] L. R. Mosher and L. Burti, *Community Mental Health Practice* (New York: Norton, 1989).