



For Her Own Good
Emotional Resiliency
After Abuse

Discussion Guide



Ontario Association of Interval & Transition Houses

ACKNOWLEDGEMENTS

I would like to extend a special thank you to the women who agreed to be interviewed for this film who despite their own struggles chose to share their personal stories in the hopes of helping other women:

Leona Keesic - Northern Ontario (Leona`s daughter is Charity Keesic)

Rhonda Skene - Southern Ontario

Cheryl Smith - Southern Ontario

Opal Sparks - Southern Ontario

Robin Taylor - Northern Ontario

Nancy Wallace - Central Ontario

I deeply appreciate all the support I had on this project. Thank you to all the folks who contributed their time and effort.

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Thank you to The Ontario Women`s Directorate for their support.

This DVD and Guide were created as a tool to support the work of women in the feminist anti-violence sector. The objective is largely aimed at supporting women who are new to the work, but it also offers those of who have been around for a while, an opportunity to reflect and ground ourselves in what we know.

There are many pathways and perspectives on the issue of mental health and violence against women. I would like to thank OAITH for giving me an opportunity to contribute to this important discussion.

Margaret Alexander – Project Coordinator/Developer

ABOUT OAITH

OAITH is a provincial coalition founded by women's shelter advocates in 1977. Membership includes primarily first stage emergency shelters for abused women and their children, as well as some second stage housing programs and community-based women's service organizations. The association works with member agencies to educate and promote change in all areas that abused women and their children identify as important to their freedom from violence.

OAITH operates from an integrated, feminist, anti-racist/anti-oppression perspective on violence against women. We recognize that violence and abuse against women and children occurs as a result of unequal power and status of women and children in society. We also recognize that all racism and oppression of women is a form of violence.

We are committed to:

- Removing barriers to equality for all women and children
- Ensuring the voices and experiences of all abused women are heard when working for social change
- Increasing awareness through education, public advocacy and empowerment for OAITH member agencies
- Assisting shelters in offering support and services to women
- Offering training of to OAITH member shelters
- Working with our equity-seeking allies in the community to end all forms of violence and oppression of women



Ontario Association of Interval & Transition Houses

Filmmaker Susan Tiihonen

Susan Tiihonen is artist, activist and queer mom. She is a graduate of the Film Production Program at Confederation and the Assaulted Women and Children's Counsellor Advocate Program at George Brown College. After thinking she had left "the industry" (the film production world) for women's advocacy work, she found herself marrying two of her passions, movie making and women's issues, in the creation of *For Her Own Good: Emotional Resiliency After Abuse*. When not making movies, she can be found running after her toddler Silas.

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Margaret has been an activist and educator in the women's anti-violence movement for over 16 years. She has worked in both women's shelter and rape crisis services, developing programming that provided support and advocacy to women who had experienced violence, as well as delivering anti-oppression training to frontline shelter workers all over the province. She is also a teacher at George Brown College in the Assaulted Women and Children's Counsellor/Advocate Program.

Margaret has authored a number of training publications including: *Intimate Partner Violence and the Workplace, Supporting Survivors, Supporting Employment: A Workshop for Career Development Practitioners, An Integrated Anti-Oppression Framework for Reviewing and Developing Policy: A Toolkit for Community Service Organizations, Initiating Support for Female Victims of Human Trafficking in Toronto: Findings & Recommendations Report, and Training for Change: An Integrated Anti-Oppression Framework.*

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INTRODUCTION

The film *For Her Own Good: Emotional Resiliency after Abuse* shares the stories of six women who have experienced violence and oppression in their lives and have as a result grappled with the emotional effects of those experiences. The women describe their struggles in being heard and supported by a number of community supports and institutions and tell us how they were able to cope with the distress of these experiences. By identifying some of the systemic issues and what needs to change, these women use their own narrative to advocate for other women. It was our pleasure to meet and learn from these powerful advocates and to work with them on this project.

This film and its accompanying discussion guide have been created primarily for feminist anti-violence workers located in women abuse shelters and second stage organizations. However, both the film and the guide can be useful to community service practitioners from any sector who desire to do feminist, anti-oppressive work with women who have experienced violence.

Feminist anti-violence workers in Ontario have experienced a great deal of pressure to conform to “legitimized” ways of working with women, who have experienced violence. The message conveyed both directly and indirectly is that our work with women lacks clinical distance, that, as advocates, we are too subjective - in short, not “professional”. Our struggle is to resist that framing of our work.

This material was developed in order to support our essential resistance to the pressure to comply with others’ definitions and framing of our work. The film and accompanying guide aim to ground our work in feminist praxis — that is the combination of feminist thought and practice. Our work is personal but it is also political, as such it is much more valuable to many women than are systems that dismiss women’s voices and pathologize their experiences.

There are many opinions and perspectives about how to work with women who experience emotional distress and problems as a result of violence and oppression. This film and guide are offered as a contribution to the larger discussion.

PREAMBLE

Feminist Anti-Violence Work

There are many ways that people understand feminism and a variety of beliefs about why sexism exists and how to address it. The theories do overlap on several issues, one being that people identified as female, as a group, have been relegated to subordinate status in society. Oppression is not about who people are — it is about how society sees people and assigns value to them based on what they see. A system of oppression operates by categorizing people into groups and then marginalizing and devaluing groups through the creation of a social hierarchy¹. How people are categorized into groups and which groups are privileged changes according to time and space, in accordance with the dominant culture and established norms.

Therefore, there is a framework that guides feminist anti-violence work:

- Violence is rooted in, and enabled by, systemic and social oppression
- People who identify as female, and all things deemed feminine, are devalued in our society
- Inseparable from her gender identity are all the other identities occupied by women; some of which are also devalued in society
- All people who identify as female are at risk of violence; however, a woman's vulnerability to violence is directly related to the marginalized identities she occupies
- Feminist anti-violence work involves both supporting women who have experienced violence, and advocating for social justice; therefore, a gendered anti-oppression analysis is a requirement of this work

¹ The size and nature of this guide limit the discussion of the complexities of interwoven and multi-layered manifestations of oppression and privilege, identity and power to an assumed reader understanding of the intersections of oppression in women's lives and how violence will manifest differently for different women.

Violence Against Women²

Violence, as a tool of oppression and a way to maintain subordinate status, has a unique way of occurring and affecting women's lives. Although women as a group do not experience oppression in the exact same ways, a gendered analysis of violence includes understanding that gender roles and female identity, in addition to other social identities, has a direct bearing on a woman's vulnerability to violence, how violence will happen, and the barriers she will face in attempting to live in a world where she will experience violence and oppression.

This way of framing violence against women is directly related to how feminist anti-violence workers do their work. We understand violence to be an issue of equality and social justice. We see ourselves as women working with other women who live in the world alongside us. This framework necessitates seeing our role as ally, advocate, and activist — different from social worker. Our work is to support women who have experienced violence; our strength and expertise come from understanding and recognizing ourselves to be part of the group that we support. The feminist goal is to end violence against women, yet the reality is it has not ended and as women we continue to experience it every day.

Feminist anti-violence workers understand our lives to be the same as the women who access our services. We work with other women knowing we have common experiences of violence and oppression. We understand the impacts, the effects, and how to survive the lived reality of being marginalized people. This does not mean to imply that feminist anti-violence workers do not recognize the power differentials between women, such as the class differences between worker and service user, or the racism issues that exist between white woman and racialized woman. However, we seek to address these issues by identifying and acknowledging our places of power and privilege, and challenging ourselves to engage in self-reflection. We examine the ways oppression affects the relationships we have with other women, including women accessing our services, and put an understanding of oppression, power, and social hierarchies at the center of our work.

Historically, it is women who organized themselves around creating safe places for women and bringing the issue of violence against women out of the private sphere and into the public. This awareness raising was, and is, an important first step in our struggle. To have the public realize that this situation was not limited to some individuals; it was not random nor was it a few "bad" or "sick" men who were doing bad things. Instead, women struggled through lobby and protest to have violence against women recognized as an insidious social problem in our communities.

² I use the term "woman" with an inclusive intent to refer to all those who identify as female. The term violence against women indicates violence and oppression based on this socially constructed category.

The result has been a great deal of change in social policy across all sectors and systems in the way that violence against women is addressed. It has also resulted in a great deal of backlash against feminist practice.

Changes in Anti-Violence Work

One of the ways that we are experiencing this backlash is the consistent undermining and devaluing of our feminist anti-violence work by government, other sectors and systems. Evidence of this backlash includes: a lack of appropriate funding for our organizations; excessive monitoring of our services and budgets, risk management and hierarchical business models imposed on organizations; the co-opting and changing of the language we have used to discuss our work; and the relegation of our services to subordinate status by justice, health and the mainstream social service network.

This backlash has impacted the ways in which feminist anti-violence organizations are working today. The pressures to conform to mainstream practice in our work with women, the cuts to programs experienced across most social justice and community-based programs, and heightened business monitoring have led to feminist anti-violence workers gradually adopting more conformist methods of operating our programs.

Cuts to our services have left organizations trying to meet the needs of diverse women with minimal staff. Cuts to the social safety net in Ontario have left women more disenfranchised and marginalized and in need of our services; thereby placing a bigger demand on services and staff who are already struggling with a greater variety of pressures (Social Planning Network of Ontario, 2010). For example: in many shelters there is only one person on a shift who is responsible for all the women and children in the house, the crisis line, and anyone who comes to the door. There may also be one outreach worker who is responsible for working with hundreds of women in the community and one organization responsible for responding to an extremely large geographical region with a range of diverse needs (Tutty, 2006).

In response to the requests for adequate funding, government and other sources of subsidies and supports have insisted that organizations should limit who they serve and how. Feminist anti-violence organizations' funding contracts dictate in what ways we support women, who we work with, and for how long. Feminist organizations are pushed into partnerships with oppressive systems and expected to "work with them" which often means become like them.

This is problematic for feminist organizations on several levels. The first is that the language of "work with them" and "partnership" implies a level of equity that does not exist. Child protection, legal and policing, health and medical systems are all vastly bureaucratic, legis-

lated systems with enormous budgets and staffing levels while feminist anti-violence organizations are relatively small, autonomous agencies with equally small budgets. There is no equality of influence or power in this relationship. Partnerships should be reciprocal, with give and take that leads to a better whole. Similar to other types of partnerships, there should be an equal sharing of resources, effort, compromise and influence.

The second way in which this notion of “partnership” is problematic is that the systems we are directed to partner with are institutional systems. While many individuals within the these systems can be allies in our work with women, as community activists and women’s advocates, we are in conflict with these institutions; part of our work is to challenge and critique their policies and practices. It is extremely difficult for feminist anti-violence workers to challenge and critique these large systems that hold many more resources, power, and influence than we do when we are pressured to engage in partnership with them. The result is that our work as women’s advocates is often subsumed by a larger, competing agenda, placing us in a difficult position of complicity in the oppressive practices that we oppose.

Given this ongoing pressure, it is increasingly vital that feminist anti-violence workers consistently apply a feminist anti-oppression analysis in all of our work, in our partnerships with institutions, and when analyzing social policy - asking questions that include:

- *In what ways does this policy benefit women?*
- *In what ways does this oppress women further?*
- *Which women benefit by this decision?*
- *How does this decision or policy support the goal of social justice and equality?*
- *Does this policy understand and acknowledge our role as advocate and support our work?*

Part of Community

Our approach reflects a desire to build and maintain community. Our roots are firmly embedded in community. Our organizations began in community; were organized by communities of women in response to needs identified by the community. The purpose was to reduce isolation, share resources and survive experiences of violence and oppression by supporting each other. Therefore, women’s organizations are about much more than service delivery, and indeed more than advocacy and social justice activism.

Recognizing that violence and oppression flourishes when people are isolated from each other, feminist anti-violence organizations deliberately aspire to become a place where women feel they belong and that it belongs to them. Not a part of the service system, but a part of the community of women, whereby building community is a source of strength, support and a foundation for action.

MENTAL HEALTH AND VIOLENCE AGAINST WOMEN

Over the years there has been a change in the language used to describe the focus of psychiatry; from mental illness to mental health. On the surface, this linguistic difference indicates a shift in focus from a disease and deficit model to a more client-based model that focuses on prevention and recovery (Walker, 2006). In reality, the change in language may reflect a desire to change and perhaps illuminate a direction for change; however, the mental health model still functions as an entrenched model of disease and deficit.

Historically, medical science has been used to justify oppressive and violent treatment of certain groups of people. The medical science institution in conjunction with religious institutions defined normalcy, stratified belonging, and set social norms for behaviour that were communicated to the general public through the popular media of the day. In this way, socially constructed norms continue to define 'truth'.

In the past century there have been significant changes in the medical establishment, such as: women are now doctors, illnesses have new names and/or new treatments, and the rules around scientific experiments have changed, to name a few. The partnership between medical science and religion has also changed in that medical science is now partnered with corporate concerns. However, what hasn't changed is that medical science still sets standards of normalcy that creates limitations on human experience and functions as a form of social control.

Feminists have a long history of questioning and challenging the medical establishment on policies and practices that concern women and their health. However, there is still a great deal of work to be done. Women continue to be negatively affected by medical science; with racialized and Indigenous women most at risk of continued violence including forced sterilization and as subjects of medical experimentation and clinical drug trials (Ahmed & Bell, 2009; Washington, 2006; Smith, 2005).

More and more, women's natural life events like: menstruation, pregnancy and childbirth, and menopause, are being redefined as medical events (Mintzes, 2010). Examples of this include pre-menstrual syndrome. This notion is particularly problematic for several reasons, the least of which being that a pharmaceutical intervention is regularly recommended as treatment. Our media sells images about lifestyles; privileging the white, middle class, heterosexual, thin, able-bodied and youthful. The messages about women that are firmly entrenched and reinforced in society are insidious. The "perfect woman" image involves acceptable looks, behaviours, thoughts and feelings, which often require pharmaceuticals (or surgery) to maintain. Powerfully marketed by pharmaceutical corporations, psychotropic medications are made popular by the notion that our behaviours, thoughts and feelings do not fit society's definition of "normal".

The medicalization of social realities, including women's experiences of violence and oppression through the lens of mental health/illness has always been of great concern to the feminist movement. There are several areas with regards to this framework which should continue to concern feminist anti-violence workers.

Medicalizing Violence Against Women

One danger of viewing violence against women through a health framework is that it takes the focus away from the need for societal change and equality. It individualizes the problem of violence, poverty, systemic and societal oppression. A great deal of time, money, attention and energy is focused on identifying behaviours that women may engage in to survive their lived experience as illness and then eradicating these behaviours. The societal crisis is framed as a concern with the growing number of "sick" women, and how we fix this crisis is to create more numerous and improved medical interventions. This takes attention off the cause: that women are experiencing violence in staggering numbers and that gendered oppression, violence, and the threat of violence is in fact quite a common experience for all women.

The broader social crisis that often becomes invisible is the increased dismantling of a social safety network that supports a good quality of life for all citizens through income supports, education, jobs, housing, childcare and other resources of the community. The encroachment of human rights and freedoms of citizens, the monitoring and controlling of certain populations of people, environmental destruction on a global scale, and the superseding of human interests by corporate and financial interests are all affecting the condition and position of women worldwide. These issues are of great concern to feminist anti-violence activists yet our organizing efforts are often mired by an increasingly narrow service delivery focus.

Another critical consequence of the health framework is that it perpetuates the idea that men who use violence to control women are not doing so by choice, but because of mental illness. A recent example is the "sexsomnia" defense in rape cases (CTV News, 2008). Feminist anti-violence workers and other women's rights activists have spent many years battling the societal notion that men who are abusive are ill and, therefore, require medical intervention to cure them. We believe that in most cases violence is a conscious choice, grounded in a sense of entitlement, that is supported by a patriarchal society and that maintains the subordinate status of women and other marginalized groups. The issue of violence against women is rarely a medical issue and the fix is not medication and therapy.

Mental Health and Deficiency

According to statistics, 36% of women in Ontario are diagnosed with mental disorders (Canadian Mental Health Association, 1999). Once diagnosed with a “mental illness,” women are often stigmatized by their family and community. Women become defined by the label and treated as though they have something wrong with them that requires medical intervention — often pharmaceutical. On the other hand, while a medical label can lead to stigmatization, it can also be the only way to get adequate supports. One example of this is the difference between Ontario Works rates, which are not enough to live on, and the Ontario Disability Support Program (ODSP) which enables survival, although is still not adequate.

This structure is an example of how a mental health framework is supported when it may be a woman’s only option for eking out an existence. This is not to suggest that people are pretending to be sick to get ODSP (an assessment riddled with many arbitrary hurdles). Unfortunately, far too many women whose behaviour, depending on the health professional, the context and the timing, has been medicalized and for whom gainful employment or access to education is limited.

The medicalized framework of violence is based on notions of “normalcy”. The range of experiences classified as normal are experiences that are usual in the lives of the dominant group in society; usually white, heterosexual, able-bodied, upper middle class men (Burstow, 2003). The idea of “normal” is a social construct. It is a word heavily laden with racism, sexism, classism, and other oppressive beliefs.

Women who have experienced violence and oppression have a pretty clear sense of reality and adopt behaviours that make sense given their lived experiences. Categorizing the behaviours as symptoms of illness undermines women’s agency and sense of self. The world isn’t a safe place for some people and violence and oppression occur on a daily basis. This is reality. The idea that the world is a safe place for everyone is a myth that causes people for whom the world is unsafe to believe that there is something wrong with them.

The medical approach to the issue of violence frames women’s behaviours as the problem and the interventions, usually medicinal, are designed to stop or reduce the behaviours. Any violence and oppression that the woman may have experienced are identified as “causal factors” that may have led to the problem, but are not viewed as the problem itself. This is the deficiency framework: “There is something wrong with the way you deal with your problems; therefore, there is something wrong with you”.

Framing a woman's reality as distorted based on a normalcy/deficit framework can be dangerous for women whose behaviours are helping them to live through their experiences of violence and oppression. Women seek to control both the level of violence they experience and the impact of the violence on themselves and the people they care about. These are acts of resistance — not victimology.

Scientific knowledge does not represent objective universal truths. What we “know” is a result of social construction and is influenced by who, where and when (in time) we find ourselves. Distinctions of normal/healthy or deviant/unhealthy are determined by political and social forces. Science, specifically psychiatry and psychology, has been used as a form of social control and still continues to be used as such to this day. This perspective does not identify scientific research as useless, but suggests it is not at all objective. For example, psychiatry has been used historically and is used currently to control sexuality and identity: hysteria, which used to be identified as a disease of women caused by their reproductive organs (Maines, 1999); homosexuality which was only de-listed from the Diagnostic and Statistical Manual (DSM) III in 1973³ (Horrocks, 1998); and the current listing of “gender disorder identity”⁴ (Harry Benjamin International Gender Dysphoria Association, 2001), are examples of institutional control of identity and social constructions of “normal”.

Medicalizing women's experiences of violence has political and social implications. Women who use feminist anti-violence services have not intrinsically changed since the inception of women's services, but, how their experiences are framed and labelled by dominant mainstream culture has. Feminist anti-violence workers must deconstruct mainstream constructs of mental health, illness and violence, both in theory and in practice, and be thoughtful about how we engage in this discussion with women who access our services.

³ In 1973, the DSM III changed the listing from homosexuality as a psychiatric disturbance to “sexual orientation disturbance” then in 1978 it was changed to “ego-dystonic homosexuality” and then in 1987 version of the DSM III the category changed to “sexual disorder not otherwise specified” to encompass any emotional disturbance about sexuality (Healthier You, 2001). Retrieved from <http://www.healthier-you.com/mhexpert/exp1052101c.html>

⁴ DSM-IV-TR, ICD-10

FOR HER OWN GOOD: EMOTIONAL RESILIENCY AFTER ABUSE

Part 1: Distress and Coping with Violence

The women in the film identify the various ways that they have coped with their experiences of oppression, (interpersonal, institutional, and systemic violence) and how their coping strategies were pathologized⁵ by those around them. In the film, Cheryl notes that it was her mom who first labelled her behaviours as “manic depressive”. Using a feminist anti-oppression lens, we can deconstruct the process by which women are being judged and pathologized.

The medical system including psychiatry is an institution that was established within the larger society. As such, the system reflects patriarchal and colonialist social structures. Social institutions such as the medical/psychiatric system as part of dominant culture, sets behavioural parameters or standards of acceptability for various group identities and then conditions (or teaches) us accordingly. For example, on a website focused on child development an article by a professional therapist suggests that boys require more physical activity than girls and that requiring him to “play quietly in the house and pay attention to his homework... pushing him toward girl behaviour” is damaging to him (Parrish, 2010).

We also see how some ways of coping, or merely living our lives are more socially acceptable than others and what is more acceptable depends on who you are. For example, women’s ability to make sexual choices is already laden with complicated layers of judgment based on gender. Within women as group there are further expectations for different women. For example, stereotypes in society may lead people to believe that racialized women and poor women would have multiple sexual partners so this behaviour may not be seen as pathology for these women as much as it would be for a white middle class woman. Women who act outside of socially constructed “gender/race” behaviours are often additionally targeted as deviants, troublemakers and crazies.

Psychiatry has also been a weapon of control used by abusive partners and family members to silence and discredit women who have experienced violence and oppression. A feminist anti-oppression framework reframes coping strategies as “active resistance to experiences of oppression” (Brown & Bryan, 2007, p. 1123), rather than pathology or indicators of deficiency. Women use these strategies to gain control over their situations, to solve problems, and to control the impact of the oppression. They are acting out of instinct and self-preservation and generally use whatever methods they have access to, with mixed results, of course (Brown & Bryan, 2007).

⁵ Categorizing behaviours as symptoms of illness, or diagnosing

Working with women should be an integrative process where feminist anti-violence workers and women accessing services work collaboratively to assess coping strategies; where coping strategies are placed on a moving scale of most effective and least effective given the context of the woman's life (Brown & Bryan, 2007). Women must be acknowledged and empowered as the experts of their lives and of the choices they make; what will and will not work for them. The goal of feminist anti-violence workers should not be to eradicate behaviours that we judge unsuitable or inappropriate, but to use our expertise to create an environment where change is possible (Brown & Bryan, 2007).

Activity: See Appendix 1 for Self-Reflection Exercise 1

Part 2: Labels

In *For Her Own Good*, the women talk about their experiences of violence when they were children and adults, and how that violence led to emotional struggles within themselves that left them vulnerable to systemic abuse.

The women talked about how their experiences of being labelled as ill, was both helpful and problematic. Some women felt a sense of relief when their struggles were named through a diagnosis. The diagnosis of illness and the accompanying treatment gave them a way of understanding what they were experiencing. Women identified that the treatment — pharmaceutical and others — was helpful sometimes and in some contexts.

Other women identified some significant problems with being labelled with a mental illness. They found that once they were labelled people perceived them as the illness and not a whole person with thoughts, feelings, and knowledge outside of the stereotype associated with their label.

The stories in this film also highlight the hierarchy that exists between the types of diagnosis. There is a tangible relationship between the type of diagnosis and the way an individual is perceived as deserving compassion. In Leona's case, she was affected by violence in an interpersonal relationship, but her primary source of distress was the rape and murder of her 19 year-old daughter. Leona was labelled with "nervous shock" also known as post-traumatic stress disorder. Her illness and situation was one that engendered compassion and understanding. On the other end of the spectrum, both Cheryl and Robin experienced people's dislike and mistrust as a result of diagnoses of borderline personality disorder and Munchausen syndrome. Cheryl described how she internalized the characteristics associated with her diagnosis as well as the feelings of dislike that others showed toward her.

Several women in the film described their process of being diagnosed; some several times by different people, who came up with different diagnoses. These examples serve to highlight the subjectivity of the diagnostic process. It also shows how the application of a psychiatric assessment to a woman's behaviour can become truth. This situation is unfortunately too common. Not only is this incredibly damaging and disempowering to women, it increases their vulnerability to further violence.

In the film both Nancy and Robin talked about how they were denied medical care when the health care professionals discovered they had a psychiatric label. Knowing that psychiatric survivors have an increased vulnerability of experiencing interpersonal and systemic violence, feminist organizations have an important advocacy role to play both in making sure women know they are welcome to access services, but also to work with women in the community to create consumer/survivor advocacy groups.

The role of feminist anti-violence workers is to work collaboratively with women and use our systemic and formal access to power to ensure that women are seen and heard. We need to make sure that our services are not complicit in making women invisible. It is important that we do not "see" women through a psychiatric lens. We need to treat every woman who comes to us as special and individual; having a right to tell her own story in her own words and in her own time.

Activity: See Appendix 1 for Self-Reflection Exercise 2

Part 3: Prescription Meds

People experiencing emotional distress will often seek out a doctor for help. In North America, that is what we have been socially conditioned to do. And often upon leaving the doctor's office we have a prescription in our hand. In the film, Nancy says, "Why wouldn't she take the medication when it made her feel good for the first time in a long time?" Prescription drugs can provide some relief in some situations; however, there are some significant problems for women that need to be addressed.

The process of getting a drug to market is quite problematic as there are all kinds of ways that pharmaceutical companies can side step any safety mechanisms put in place by Health Canada. In addition, there are not enough safeguards, nor are they adequately enforced. For example, it is pharmaceutical companies that fund a huge portion of new research on treatments for illness and clinical trials of newly developed drugs (Olivieri, 2010). The findings of these studies are often incomplete and compromised by serious conflicts of interest, such as "gifts" to the research department or researchers themselves (Olivieri, 2010).

Canadian pharmaceutical companies see women as their largest target market and aggressively campaign in direct advertising to women by co-opting women's language around choice and empowerment (Olivieri, 2010). This type of advertising creates a culture where people view their life experiences as illness and sickness and look for pills to "cure" themselves. According to Dr. Janet Stoppard (2004), "women make up an estimated 70 percent of people who are prescribed anti-depressants" (p. 29).

In Canada, we experienced an incredible 353% increase in the number of anti-depressant prescriptions in a 20 year period; from 3.2 million in 1981 to 14.5 million in 2000 (Stoppard, 2004). There is probably a variety of factors that are relevant in examining this increase, and certainly one of them is the marketing plans of pharmaceutical companies and the way drugs come to be sold in Canada. Another is the introduction of SSRIs.

Anti-depressant drugs these days are largely classified as SSRIs or selective serotonin reuptake inhibitors (Stoppard, 2004). Generally SSRIs have less serious side effects compared with earlier drugs for depression and so tend to be prescribed quite often and patients often report the medication as assistive (Stoppard, 2004). However, the clinical studies that support SSRIs as a viable treatment for this thing called depression have been flawed from the start. Many doctors and laypeople in other "helping" professions have been telling women that depression is caused by a biochemical imbalance, a reduction of serotonin; however, this is an oversimplification of a complex multi-layered issue (Stoppard, 2004). And as Dr. Stoppard (2004) points out, this fundamental assumption has never been established. Because the side effects are deemed less serious and some women say the drugs help in some ways, the benefits may seem to outweigh the harm, but a closer examination of this notion is required.

A review of clinical trials for the six most prescribed drugs revealed that none of the drugs was any more effective than a placebo in treating depressed people (Stoppard, 2004). In fact, there were other elements that factored into why people felt good, including the ability to regularly talk about their feelings with a person — the researcher or doctor in this case (Stoppard, 2004). The pharmaceutical companies that originally funded the trials are a lot more interested in findings that support the purchase of drugs over findings that suggest a non-prescription alternative such as finding someone to listen and care.

What had not been fully examined are the long-term effects of SSRIs and other prescribed medications on women's bodies. What portion of the chemical stays in women's bodies and where? What does that do over time? And what are the effects of depending on a synthetic chemical to take the place of something the body does naturally; like balance serotonin? People need to be given accurate data in order to make informed choices.

Some of the women in the film talked about their experiences with prescription medication. Opal talks about feeling altered and not herself on some drugs, from feeling suicidal, to feeling nothing at all. These women's stories of being wrongly medicated, overly medicated, and coercively and forcibly medicated are unfortunately not uncommon.

Women in the psychiatric system for the most part are not given much choice about their treatment. Or they lack accurate information that would enable them to make an informed choice. Part of this has to do with doctors themselves having inaccurate information (they read the same flawed trials that the general public do and receive little or no training on violence against women), psychiatric system workers lack time to spend with people to discuss information fully, but by far the reason is that people with a psychiatric diagnosis are disempowered and discriminated against within the whole of the institution and society. Women especially are labelled as non-compliant and manipulative if they resist, or they are deemed too ill to realize that what is being done to them is "for their own good".

Feminist anti-violence workers have witnessed how listening, caring, and validating women can affect a woman's well-being. We have felt the effects of these ourselves and as a result incorporate talking and listening strategies into our staff supports. We do not underestimate this way of working; in fact, it is our primary strength. The primary reason that women come to feminist shelters, and feminist rape crisis centres and other feminist community services and stay connected for years is that they feel heard. The push to credentialize our workplaces works as a backlash strategy, undermining feminist anti-oppression practice (Bonisteel & Green, 2005) and has left many feminist anti-violence workers doubting their work, believing that they lack some formal institutional education or training necessary to do their job.

The founder of Mad Lib and a psychiatric survivor, Katherine Hodges (2003) says: We need consciousness-raising and support groups and self-help centres, that take a non-judgemental approach to psychiatric drugs, but inform people of their limitations and help them withdraw if desired. We need to promote many options – artistic, nutritional, spiritual – for emotional healing (p. 15).

Part 4: Falling Through the Cracks

A common element in all the women's stories is how an apparently caring system of support failed them. In every instance these failures of the system increased women's pain — for some both emotionally and physically. Their stories portray continual judgements, assumptions, and times in their lives where they were ignored, discredited and silenced by service providers of all kinds. The women were rendered invisible, untouchable, unserviceable and abuse-able.

Our helping systems have become largely hierarchical institutions where the person who is accessing the service becomes the least important element in the equation instead of the most important. Budgets, egos, agendas, expert opinion, schedules, and other factors take precedence over the needs of the person using the service as the priority.

Women seeking support from traditional mainstream systems have experienced that in order to get “help” they must give up control and autonomy. Not in a position to decide what that help would be; they must comply completely or risk losing any support at all. Women who don’t follow the rules risk punishment; they may lose their children, their community, their freedom, and some have ultimately lost their lives.

Feminist anti-violence organizations have been sliding down this slippery slope as we attempt to deal with pressures to conform to what mainstream institutions think our work should be, to conform to budget and government expectations and to deal with the impacts of continued cuts to the social safety net that has left more and more women disenfranchised and desperately seeking assistance. In response to the pressures, we have become in some ways more authoritarian and hierarchal in working with women. When we listen to women’s stories, it appears that coercive and controlling practices have begun to seep into our services (Bouchard et al, 2006, Hagedorn, 2005). In some ways, we have become complicit by urging women to comply with systems, instead of on behalf of women by making systems work better for people.

We know that coercion, force, and manipulation are not better ways to work with communities; that these ways of working do not lead to a better quality of life for marginalized people. Women accessing our services represent women in the frontline of the struggle for social justice and reform. The stories from marginalized and vulnerable women — women with the least amount of power and influence — act as a barometer for the condition of our communities and how people are treated. Their stories hold very important lessons for all of us as they represent the real world, as opposed to the dominant culture distortion of reality.

Feminist anti-violence workers need to revitalize our networks so we can support each other to resist and withstand these pressures to conform to these ways of working. We need to keep talking to each other, building our analysis, and strategizing our broad-based advocacy.

Discussion

What is the agency broad based advocacy plan in regards to systems and institutions in my region?

How does (or does not) your organization collect information from women about their experiences with social systems – If so what is done with that information?

This is an area where women who access services can be invited to participate with the organization in social change action. Think of ways women can participate in this work. For example: court watch programs or handing out flyers to women that contain accurate Ontario Works information. Would your organization consider these type of outreach activities?

Part 5: Finding Hope

The gift given to feminist anti-violence workers by the six women in this film is immeasurable. Each of them: Leona, Cheryl, Opal, Robin, Nancy and Rhonda have given of their trust, their knowledge, their time and their hope, in order to support us to do good work. They have also reaffirmed our work. They have confirmed our beliefs in what women want in terms of support. Our responsibility in receiving this gift is to use it wisely, to be thoughtful and reflective in our practice.

Their message is clear. “See and hear me, treat me as a human being — as you yourself would like to be treated in the same circumstance. I am an adult, a person who is experiencing distress and I need some help. I haven’t given up my right to humanity, to citizenship, to choice and autonomy.”

INTEGRATING THEORY WITH PRACTICE: FEMINIST ANTI-OPPRESSIVE SUPPORT

Women who access feminist anti-violence organizations do so because they have had experiences of violence. Some of these women also identify as having a psychiatric diagnosis. We need to challenge ourselves not to jump to conclusions or make assumptions about women based on how they have been labeled by others.

As advocates we must not only be thoughtful about how to work on an individual level with women who access the services, but also about how each woman's story works into the broad-based advocacy that we must do if we are to meet our mandate to end violence against women.

Feminist advocacy includes:

- listening to women talk about their lives — being compassionate and caring, believing and validating her experiences and celebrating her survival
- working with women to identify and understand their goals: they may be simple and/or complex
- uncovering all the work she has done already, including the information she has gained, the connections she has made, the coping mechanisms she is using and how it has worked for her
- filling in the information she may not have, including some deconstruction of any internalized assumptions, for example: she is not a bad person, does not deserve to experience violence, she is not deficient in anyway
- assisting her to discover where she is stuck, where the barriers are, and when the coping mechanisms she uses are not working for her
- discussing options and the impacts of the various options
- developing a plan of action together and include next steps
- encouraging her to keep trying and be understanding about how difficult it is to keep trying in the face of adversity
- deciding together if action(s) should be taken at this point

Feminist advocacy also includes not recreating, systemically or individually, the oppressive and abusive nature of past abusive relationships that she may be seeking support to escape from. This is highly problematic for mainstream and institutionally-based supports and it is now what feminist anti-violence workers struggle to resist doing in our own organizations. Examples of this slippery slope include:

- “Case management” approaches to working with women that exclude the women from being the “experts”
- Dictating appropriate behaviour, thoughts and feelings
- Rules and guidelines that infantilize women — such as bedtimes, mealtimes, curfews, etc.
- Disrespecting privacy and confidentiality or obtaining consent which is not fully informed.
- Controlling women’s choices
- Paternalism – such as believing “she doesn’t know better” and making decisions with other service providers “in women’s best interest” without women involved, present and leading decision-making processes

Feminist praxis involves being reflective in our work. This includes actively thinking about oppression and how we can work collectively with women accessing our services.



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APPENDIX 1: SELF-REFLECTIVE EXERCISES

Critical self-analysis of the ways we think about things is a foundational aspect of feminist anti-oppressive work. Understanding dominant culture constructs (ideas of normal, valuing and devaluing groups of people, etc), and how these constructs become internalized within ourselves and frame our thoughts and actions, is the beginning of transformational work.

Self-reflective practice offers us the opportunity to become aware of the ways we think and the way we act and make conscious choices about our practice. It is a concrete way to align our beliefs with our actions.

Reflective practice involves engaging in consistent structured reflection of your work and the thoughts and beliefs that guide your work. It involves recognizing both what you do well and the areas in which you require improvement. Reflective practice can easily be formalized as part of supervision and/or training strategies for staff and volunteers in our organizations. Reflective practice can enhance feminist anti-violence workers by creating concrete and tangible resources for learning and models for the decisions we make in our day to day practice.

These tools can be adapted for use in a variety of different ways. For example they can be used as a supervision checklist or part of a performance evaluation. They can be used by individual workers as part of their accountability process and personal growth initiatives. They can also be used as a staff training tool at a staff meeting or for new workers during their orientation process.

Part 1: Distress and Coping with Violence - Exercise 1

Ways of Knowing	Questions
Influencing factors: Self	<ul style="list-style-type: none"> • What are my beliefs about women’s coping behaviours? • What behaviours am I most comfortable with? • What behaviours make me feel uncomfortable? • Why do I think I get uncomfortable when women behave in these ways? • In what ways do I act out my discomfort?
Influencing factors: Workplace	<ul style="list-style-type: none"> • What are the organization’s statements (principles, policies, procedures, practices) about women’s behaviours? • What coping strategies are validated and which coping strategies are disapproved of? • Who determines which strategies are okay and which are not? How is this communicated to women? • What practices support and validate women’s coping strategies as strength and power? • What practices indicate disapproval of certain behaviours? • How do the organizational practices influence my own thinking?
Process	<ul style="list-style-type: none"> • How do I talk to women about coping? • What am I trying to achieve when I am talking about coping with women? • Which women do I talk with about coping and when? • How do women receive this information? How do I know this? • How do I feel when I am talking to women about coping?
Feminist anti-oppression beliefs	<ul style="list-style-type: none"> • How do my actions match my beliefs? • What actions do not match my beliefs?
Evaluation	<ul style="list-style-type: none"> • How could I improve my practice in this regard? • What other choices do I have? • What would be the consequences of these choices?
Action	<ul style="list-style-type: none"> • What concrete steps can I practice in my next interaction? • What further learning can I do for myself?

Part 2: Labels - Exercise 2

Focus	Areas to examine
Description of the experience⁶	<ul style="list-style-type: none"> • Phenomenon – describe the here and now experience. • Casual – what essential factors contributed to this experience? • Context - what are the significant background factors to this experience? • Clarifying – what are the key processes for reflection in this experience?
Personal: Self awareness⁷	<ul style="list-style-type: none"> • How did I feel in this situation? • What are my beliefs, values and feelings about this issue relevant to this situation? • What internal factors were influencing me? • What would I like to be doing?
External influences	<ul style="list-style-type: none"> • Workplace • Environment
Practice	<ul style="list-style-type: none"> • What am I trying to achieve? • What are possible consequences of that for the woman? Others? Myself? • How are my beliefs actualized in my practice? • How was this person (people) feeling? How did I know this? • How am I feeling about this practice as it unfolds?
Feminist, anti-oppression beliefs	<ul style="list-style-type: none"> • What knowledge did or should have informed me? • How did my actions match my beliefs?
Evaluation	<ul style="list-style-type: none"> • How do I collect information to determine how my work is perceived? • What change is possible? • What are potential consequences of change? • What factors made me act in an incongruent way? How do I now feel about this experience? • How have I made sense of this experience in light of past experiences and future practice? • How has this experience changed my ways of knowing?
Action	<ul style="list-style-type: none"> • Next steps? • Changes in practice? • Determining new areas for learning

Part 3: Grounding in Feminist Anti-Oppression - Exercise 3

Ways of Knowing	Questions
Influencing factors: Self	<ul style="list-style-type: none"> • What are my beliefs about my role as a feminist anti-violence worker? • What is important to me about my job? • Why do I identify my work as feminist? Anti-oppressive? Transformational? • Why is my work different from mainstream work? Why do I believe this is a better way to support and ally with other women? • What does hearing women's stories do for me personally? • What does hearing women's stories do for my practice? • How does my work reflect how I live my life? • Do I believe that violence against women is a social justice issue? • Do I consider myself part of a social movement to end violence?
Influencing factors: Workplace	<ul style="list-style-type: none"> • What are the organization's statements (principles, policies) about feminist anti-oppressive practice? • What procedures and practices accurately reflect this way of working with women? • What procedures and practices contradict this way of working? • How do the organizational practices influence my own thinking?
Process	<ul style="list-style-type: none"> • How do I demonstrate to women I am working with that I am not judging them? • How do I demonstrate that I want to hear their story – that it is important to me? • How do I demonstrate compassion – that I care about her? • How do I discuss the power dynamic in our working relationship with each woman? • How do I discuss violence and oppression with women? • How do I demonstrate my thoughts about women's social justice and the efforts to end women's oppression? <p>(continued on next page..)</p>

⁶ This section is adapted from Chris John's Structured Reflection Model (1994).

⁷ Ibid.

Part 3: Grounding in Feminist Anti-Oppression - Exercise 3 (Continued)

Feminist anti-oppression beliefs	<ul style="list-style-type: none"> • How do my actions match my beliefs? • What actions do not match my beliefs?
Evaluation	<ul style="list-style-type: none"> • How could I improve my practice in this regard? • What other choices do I have? • What would be the consequences of these choices?
Action	<ul style="list-style-type: none"> • What concrete steps can I practice in my next interaction? • What further learning can I do for myself?



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