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**BULLSHIT
PSYCHIATRIC
DIAGNOSIS
WOMEN AT THE MARGINS
WOMEN AND BORDERLINE
PERSONALITY DISORDER**

**SPECIAL
EDITION**
BY
*Women at the
Margins*

Founding Editor: Alec Jenner
 Manor Farm, Brightholme Lane
 Wharmcliffe Side, Sheffield S35 0DB
 Tel: 0114 286 2546 Fax: 0114 286 4591
 F.Jenner@btinternet.com

Executive Editor: Terence McLaughlin
 29 Heathbank Road, Cheadle Heath,
 Stockport SK3 0UP
 tmcLaughlin@asylumonline.net

Deputy Editor: Helen Spandler
 h.spandler@asylumonline.net

Editorial Consultant: Diane Burns
 d.burns@asylumonline.net

Associate News Editor: Adam James
 www.psychminded.co.uk

Business Manager: Peter Bullimore
and correspondence for Asylum Associates
 Limbrick Day Service, Limbrick Rd,
 Sheffield, S6 2PE.
 Tel: 0114 2718210 Fax: 0114 2716039
 pete.bullimore@asylumonline.net

Poetry and Creative Writing Editors:
Paula Quick and Mark Hinchliffe
 63 Cowlersley Lane, Cowlersley,
 Huddersfield HD4 5UB

Ian Parker
 The Discourse Unit, Department of Psychology and
 Speech Pathology, the Manchester Metropolitan
 University, Hathersage Road,
 M13 0JA I.A.Parker@mmu.ac.uk

Jim Campbell jim.campbell@tees.ac.uk

Clare Coutts clarecoutts@aol.com

Communications Promoting Recovery (CPR)
Benson, Marie and Quest: cpr@asylumonline.net

Jaqui Dillon jaquidillon333@aol.com

Peter Good peter-good@lineone.net

David Harper d.harper@uel.ac.uk

Janice Hartley janice.hartley@asylumonline.net

Caroline Hellewell
 Flat 14, Townfield Gardens, Townfield Rd,
 Altrincham, Gtr Manchester WA14 4DT

Nisar Khan awaaznisar@yahoo.co.uk

Tamasin Knight T.M.Knight@student.liverpool.ac.uk

Angela Linton-Abulu bwmhp@yahoo.com

Rufus May rufus.may@asylumonline.net

Polly Mortimer pollym@hornsey.haringey.sch.uk

Ian Murray IanNWales@aol.com

Gillian Proctor gillian.m.proctor@btinternet.com

Clare Shaw shaw_clare@hotmail.com

Chris Stirk c.stirk@tiscali.co.uk

Sam Warner sjwarner@aol.com

Stephen Ticktin
 29 Church Garth, Pemberton Gardens, London
 N19 5RN stephen.ticktin@asylumonline.net

Philip Thomas P.Thomas@bradford.ac.uk

Shoestring Theatre Company 07899 772903
 shoestringtheatre@hotmail.com

Administration & Subscriptions: Stella Thomas
 Lane Head Farm Cottage, Heptonstall
 Hebden Bridge, West Yorkshire HX7 7PB
 subs@asylumonline.net

Design: elmano
 mano@elmano.co.uk

Printed by: RAP Ltd
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THE MAGAZINE FOR DEMOCRATIC PSYCHIATRY

INCORPORATING

THE NEWSLETTER OF PSYCHOLOGY POLITICS RESISTANCE



THIS EDITION WAS PUT TOGETHER BY WOMEN AT THE MARGINS:

Bernie Tuohy, Christine Spice, Gillian Proctor, Fiona Venner,
 Clare Shaw, Pip Goff, Maddy Smith, Tamsin Walker & Monica Hill

Edited by Clare Shaw and Gillian Proctor

Graphics co-ordinated by Bernie Tuohy

womenatthemargins@hotmail.com

Front and back cover illustrations by Maddy Smith

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WOMEN AT THE MARGINS:

This is our chosen title as a campaigning group of women survivors and mental health workers. We started to meet over four years ago because of our concerns about women and the diagnosis of Borderline Personality Disorder (BPD). We meet monthly in Leeds for discussion and debate; we've also been involved as a group in collating information about the impact of this diagnosis on women, organising an open day for women given the diagnosis, and presenting women's experiences to interested workers. Our latest big achievement was the Women at the Margins conference held on International Women's Day, 2004. Our current plans are to set up a support group for women with this diagnosis, to create a web site and to plan a direct campaign.

Why Women at the Margins? Because women given this diagnosis become marginalized as a direct result of it. BPD has always been a diagnosis of exclusion from mainstream mental health services, women are marginalised and stigmatised within services by descriptions such as manipulative, attention-seeking nuisances. Women are punished - sutured without anaesthetic in A&E; marginalized in society - women have their children removed, and fall between benefits - often unable to claim disability benefits but too distressed and stigmatised to work.

Women already marginalised by society are further stigmatised by BPD. Some are already institutionalised and abused by mental health and criminal 'justice' systems, have experienced unemployment, poverty and homelessness. Women are often lesbians, lone mothers, and other women who, in different ways, have 'failed', or maybe succeeded in refusing to live up to cultural, moral and normative expectations of what it is to be a woman in this society. Kalikhat suggests in this issue that it is difficult to find a home where we are not marginalized. As Sam Warner further argues in this issue, there is little if any cross fertilisation between feminist and radical mental health groups. As a matter of urgency we should examine and consider the appalling situation of these women, particularly in the current political climate.

Until recently, most people would never have heard of Personality Disorder or BPD specifically. However, these days it is likely to ring a few more bells in the general population as a result of media coverage of:

- 1 Government proposed legislation on 'Dangerous and Severe PD', which proposes to detain people deemed suitable for this diagnosis before any crime has been committed, and without the need for the current criteria for detention under the Mental Health Act.
- 2 The recent focus on 'mad, bad' women and their association with this diagnosis.
- 3 The media fascination with self injury.
- 4 A growing focus on PD diagnosis, as a growing market in medication and therapy cashes in on treating human expressions of emotion.

As a result, BPD comes weighted with negative associations - manipulative, dangerous, extreme, confusing - are they or aren't they disordered?

So why is BPD a women's issue? Throughout history, society has created multiple categories for women who do not fit into society's norms and expectations. Just on the basis of diagnostic prevalence alone - 75% of those diagnosed with BPD are women (DSM IV 1997: 652) - BPD is a gendered diagnosis. We argue in 'Women at the Margins' that the diagnosis of BPD is the latest manifestation of society's attempt to explain away the strategies which some women use to survive and resist the oppression and abuse they experience, by describing these strategies as symptomatic of a disturbed individual. BPD is a feminist issue.

It is a feminist issue when women who overcome their fear to disclose their experiences of childhood sexual abuse are called "attention-seeking" and "manipulative" (see 'Why cut up?'). It is a feminist issue when women are visited in hospital, and people who care for women are shocked and appalled at the conditions (see 'Two flew over the cuckoo's nest'). It is a feminist issue when as a result of being given this diagnosis, women are told they are "virtually unemployable" and a "risk to other people" (see 'Jo's story'). It is a feminist issue when women who have survived abuse at the hands of men are given the same diagnosis as serial rapists and murderers (see 'Suzi's story'). It is a feminist issue when women are incarcerated and have their children removed as a result of this diagnosis (see 'Sylvia Hurts'). It is a feminist issue when Black women are labeled for having emotional responses to the experience of racism (see 'Paying the price for not fitting in'). It is a feminist issue when "victims of criminal savagery beyond understanding which will reverberate through their lives awake and asleep, as long as they live" are locked up "until you grow out of it" (see 'Truly Photographic Memories').

We will not rest until the answer is not to prescribe DBT, the therapy currently most publicized and seemingly popular with workers, misguidedly being presented as the 'benign' response to BPD. Instead, it plays right into the agenda of the label, accepting it wholeheartedly along with the implication that women with BPD are damaged creatures who need to be saved by the professional and taught how to be more 'appropriate'. Again, DBT depoliticises and personalises the real issue. The real issue is the pervasive abuse of women and girls in this society, coupled with the continued silencing and invalidation of women's experience.

However, there are hopeful responses. Rape Crisis (see 'Breaking the silence around sexual violence') honour and support the ways women have survived sexual violence. Some workers do work to support women in respectful ways, without judgment or blame, within real, honest and self-aware relationships (see 'Disordered Boundaries'). Women with this diagnosis are getting together, challenging their stigma and supporting each other. We hope that this issue and our continuing work with Women at the Margins will encourage women (and men) to get together to act out of anger and hope.

Clare Shaw (survivor activist and poet)

Gillian Proctor (activist, Clinical Psychologist at North Bradford PCT and honorary lecturer at Bradford University's Centre for Citizenship and Community Mental Health)

N.B. thanks a lot to Carole A. Bressington for her helpful suggestions for this editorial.



Jo's story

My name is Jo and I was given the diagnosis of BPD in 1992. I was initially admitted to a psychiatric hospital due to self-harming and recurring thoughts and feelings surrounding early childhood abuse.

I wasn't initially told anything about what the professionals thought was wrong with me, even though I knew it was due to my past. Looking back, I don't believe I should ever have been hospitalized. I wasn't told directly by a professional that I had been diagnosed with BPD, I actually read it after a meeting whilst in hospital on my first admission. At the time I didn't really know what it meant and indeed the implications it would have for me; I was aware of other patients having this diagnosis but they themselves didn't really know much about it. When I did read the 'symptoms' of the BPD diagnosis, I was taken aback by what I read. I remember feeling upset and a little confused at first but as time went on I became increasingly annoyed and frustrated.

I have been told I am an 'attention seeker' mainly because I am a self-harmer, yet I was self-harming for 15 years before I sought any professional help. It has always been a very private and personal experience, yet ironically I asked for help and virtually straight away was seen as an 'attention seeker'. I have been accused of and told that I'm 'manipulative' and that I have lied about situations... just for gaining attention and wanting my own way and I've even been said to be a devious person.

I, like many others who have the BPD diagnosis, have gone through traumatic experiences in our lives; a vast majority have suffered some form of abuse at some point in our lives. I have had problems with a variety of life events due to my past, which have resulted in me, in 'theory', meeting the criteria for BPD. I suggest that most people in society have done or may do something reckless and destructive in their life, due to a personal situation occurring, so in 'theory', far more people in normal everyday society could fit in the BPD diagnosis. But unfortunately, it's mostly people who have been sexually, physically and/or emotionally abused who are put in the BPD category. People who have suffered any form of abuse could

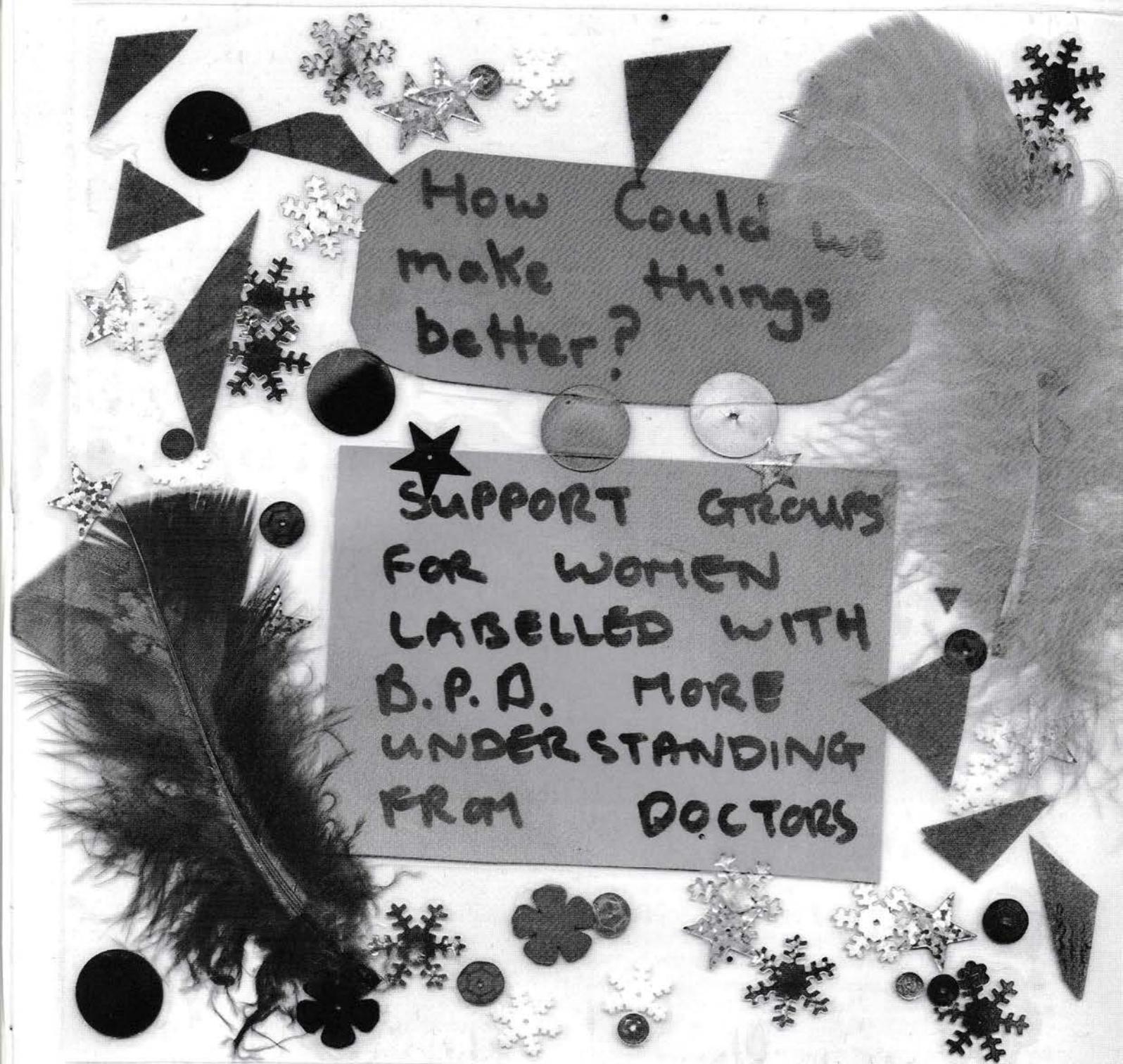
suffer from bouts of low mood/depression, they may contemplate suicide and/or start self-harming. Yet this is not deemed a 'normal' response to abuse by many professionals. But I think that these responses are 'normal' for people who have been abused, and are so distressed and traumatized by their experience that at times there is no alternative.

My own experience was that I sought help and came up against a system that doubted whether I was telling the truth about my past and I felt I had to prove I wasn't lying. No-one can begin to imagine how hard it was to disclose that I'd been abused as a child; the reason I didn't tell someone until I was an adult was because I was scared I would not be believed as a child. As an adult I expected to be believed, and to be virtually accused of lying - the consequences could be quite devastating and cause more damage.

I feel I have every right to feel angry about my childhood experiences and I have always tried to deal with my feelings appropriately. Although I now know I could have prevented certain situations from happening, then I could say I wasn't given a fair opportunity by my initial contact with psychiatric services. I feel I was tarnished with a label, which has a huge stigma attached to it, which affected my life in many ways.

I have missed out on things as a result and it has been largely due to my experiences of psychiatric services. I have had to prove so many things to other people because I was seen as an 'attention seeker' who was capable of manipulating a situation for my own purpose or gain. I lost out on completing my degree at university due to being in psychiatric hospital. I wasn't treated equally to other people; there were always lots of doubts about my capabilities and whether I could handle stress and so on.

Due to my diagnosis of BPD I have been turned down for jobs. Because my chosen profession was social work, I had to have a medical; I was told I was virtually unemployable and that I was a risk to other people. Members of my own family, when they initially found out about my diagnosis and what it meant, no longer trusted



GRAPHIC - SKIPKO ART WORKSHOP, WAM CONFERENCE

me to look after their children and were very wary of me. I lost friends because I was seen as unpredictable and not to be trusted. They were frightened of me yet I'd never harmed one of them.

For a long time I had an overwhelming fear and distrust of professionals who wanted to help me and I felt that I would always have to prove myself. I never thought people would accept me for who I was and not this person with a label. I am very fortunate that I met one professional who helped me turn my life around, who in turn, took me for who I was, did not prejudge me and had 100% faith in me as a person unique in my own right and a person with lots of capabilities. Through this person I met other people who had mental health issues and I have been able to share my experiences with them.

I have had a support worker for the past two years who didn't know much about me initially because I could do my own referral. This was the first opportunity I'd had in a long time to let me be me, without being prejudged with the BPD label. I have an excellent relationship with her because she has always taken me for who I am and not what other 'professionals' have written about me.

Having the diagnosis of BPD has never been a positive experience, it's always hung over my head like a dark cloud. I've always felt that since being given this diagnosis; people have already made their minds up about me without actually knowing me. My kind of story is not unique; plenty of people have had similar experiences. I just look to the future now and hopefully people accept me for who I am, not this person with a BPD label.

BORDERLINE PERSONALITY DISORDER

UNDER THE MICROSCOPE

GILLIAN PROCTOR AND CLARE SHAW

Throughout its short history, BPD has been a particularly controversial diagnosis (Roth and Fonagy, 1996), critiqued for its weighted construction; its inconsistent and unclear meaning; and its uneven, stigmatising and punitive application. This article aims to provide a basic overview of the diagnosis of Borderline Personality Disorder - its historical background; diagnostic criteria; treatment responses; and some of the common debates around the diagnosis.

The term 'borderline' was first used by analyst Adolf Stern in 1938 to describe patients who he believed were more disturbed than 'neurotic' patients but who, he believed, were not 'psychotic'. However, it was not until 1980 that BPD was first introduced as a diagnosable personality disorder in America. Now BPD is by far the most common PD diagnosis, one of ten personalities disorders currently classified by the psychiatric classification system (DSM IV).

These are:

Paranoid PD

Interpreting actions of others as threatening

Schizoid PD

Indifference to social relationships. Cold and aloof

Schizotypal PD

Disturbed thought but not enough to diagnose schizophrenia. Odd, eccentric.

Antisocial PD

Irritable or aggressive; breaks law. No remorse for effect of behaviour on others.

Borderline PD

Instability of self-image, relationships and mood

Histrionic PD

Excessive emotionality and reassurance-seeking

Narcissistic PD

Exaggerated sense of self-importance alternating with unworthiness

Avoidant PD

Social discomfort and fear of negative evaluation

Dependent PD

Dependent and submissive, helpless when alone

Obsessive-compulsive PD

Perfectionism and inflexibility, preoccupation with rules.

Like all psychiatric labels, Borderline Personality Disorder depends upon the practice of diagnosis. This practice is fundamental to psychiatry and other mental health systems, and is based on the assumption that mental illnesses are diseases like physical illnesses - that their causes are biological. Diagnosing is also based on the idea that these 'diseases' can be identified and categorized as such by the mental health professional. There is a particular lack of clarity in psychiatry about the 'causes' of personality disorders. Yet the emphasis is - as usual - on discovering physical causes and then finding 'appropriate' medication. As for all other psychiatric diagnoses, there is absolutely no evidence for any biological basis or disease structure for this diagnosis.

DIAGNOSTIC CRITERIA OF BPD:

Roth and Fonagy (1996) offer this definition of BPD:

'The essential feature of this disorder is a pervasive pattern of instability of self-image, interpersonal relationships and mood. The person's sense of identity is profoundly uncertain. Interpersonal relationships are unstable and intense, fluctuating between the extremes of idealisation and devaluation. There is often a terror of being alone, with great efforts made to avoid real or imagined abandonment. Affect is extremely unstable, with marked shifts from baseline mood to depression and anxiety usually lasting a few hours. Inappropriate anger and impulsive behaviour are common, and often this behaviour is self-harming. Suicidal threats and self-mutilation are common in more severe forms of this disorder.'

For a diagnosis of Borderline Personality Disorder, 5 of the following 'symptoms' must be present (DSM IV 1997):

- Unstable and impulsive
- Intense interpersonal relationships verging between idealisation and devaluation
- Affective instability and reactivity of mood
- Inappropriate intense anger
- Frantic efforts to avoid abandonment
- Identity disturbance; unstable self-image
- Suicidal and self-mutilating behaviours
- Chronic feelings of emptiness
- Transient stress-related paranoid ideas

As can be seen from the above 'symptoms', most of them embody moral or cultural judgments - for example, 'inappropriate anger' involves a professional making a judgement about what degree of anger is appropriate from which person in what circumstances. This has led many people to point out that diagnosis is an inherently subjective process which has distinct political consequences, and that - as Szasz (1961) argues - "We now deny moral, personal, political and social controversies by pretending they are psychiatric problems" (in Wilton, 1995: 28).

So what useful medical treatments does this diagnosis lead to? Very few. In fact, it has generally given to people who are seen as 'untreatable'; and who are often told that services can do little to help them.

TREATMENTS OFFERED INCLUDE:

1 medication, which is sometimes prescribed to help with sleep, anxiety or depression.

2 Some people are given dialectical behavioural therapy (DBT) - a development of cognitive behavioural therapy (CBT) specially designed to treat BPD. CBT is based on the assumption that people have faulty cognitions - that they don't see the world as it is - unlike therapists, who are assumed to have value-free cognitions. The theory behind DBT suggests that women with BPD are unable to tolerate and 'regulate' their 'extreme' emotions. DBT focuses on teaching people diagnosed with BPD 'coping skills' to 'regulate their emotions'. The focus is on the present, as opposed to past experiences of trauma and on teaching people to think and behave in the 'right' ways, in particular to stop self-injury.

More recently, there have been calls for services to include people with this diagnosis and for workers to be trained to deal with people with the diagnosis. At the same time, pharmaceutical companies are jumping on the bandwagon and trying to sell medication suitable to help people with this diagnosis - rebranded versions of the same drugs already marketed for depression, anxiety and other conditions.

In short, what treatment has been available to people with a BPD diagnosis is very limited and has often been unhelpful or even destructive. In addition, a BPD diagnosis has often been seen as sufficient grounds to exclude people from other mental health services such as day centres or therapies. People with the diagnosis have acquired a worse and worse reputation, being known as "difficult" or "challenging" patients, especially where people have expressed dissatisfaction with their diagnosis and with their consequent treatment. The general consensus is that people with BPD are 'untreatable', the only hope being that you may 'grow out of it' by middle age; or that you may develop a 'more stable' personality disorder.

In summary, Borderline Personality Disorder has - no established causes; few associated treatments; a wide ranging set of diagnostic criteria which are based upon personal, moral and cultural judgments; assumptions of untreatability; and lifelong stigma. A 'controversial diagnosis' indeed.

REFERENCES

DSM-IV (1997) Diagnostic and Statistical Manual of Mental Disorders: fourth edition. Washington DC: American Psychiatric Association.
 Roth, A and Fonagy, P (1996) What works for Whom?: A Critical Review of Psychotherapy Research London and New York: Guilford.
 Wilton, T (1995) "Madness and feminism - the Bristol Crisis Service for Women" in Griffin, G (ed) Feminist Activism in the 1990s, London: Taylor and Francis Ltd



GRAPHIC BY BERNIE TUOHY



women at the margins:

A FEMINIST CRITIQUE OF BORDERLINE PERSONALITY DISORDER

CLARE SHAW AND GILLIAN PROCTOR

Shazia has just taken an overdose. She is 19 years old and has just been dumped by her girlfriend who she has known for 6 months and lived with for the past 4 months. Shazia was sexually abused by her father when she was younger and was placed into care by her mother when she couldn't cope with Shazia's behaviour. Last night she felt so lonely and desperate she overdosed. Her friend found her and brought her to A&E.

DIAGNOSIS

When Shazia was interviewed by the psychiatrist in A&E, he noted the overdose attempt, which led him to question Shazia about her relationships. On hearing about her history of relationships with women lasting a few months at a time, and that she feels angry with her mother for having put her into care when she was younger, he ticked some boxes on his list of BPD symptoms. He assumed that she had relationships with women as a result of the sexual abuse she had experienced. The fact that Shazia also sometimes burnt herself with cigarettes confirmed his suspicions and BPD was on her record.

Having received this diagnosis, Shazia was sent home with her friend, the psychiatrist asking her friend to watch that she doesn't do "anything stupid" again. The nurses told Shazia that she should be ashamed of herself taking their time from people who really needed them. The psychiatrist told her not to worry about her relationship ending, that there was time yet for her to find a nice man. Shazia went back home vowing never to go back to A&E and feeling really upset at how little she had been understood.



GRAPHIC BY BERNIE TUOHY

GENDER AND BPD

Feminists have shown how gender and madness have been related for a long time. There are basically two ways of looking at this relationship between gender inequalities in society and the diagnosing of madness:

1 The social construction of madness: women are labelled 'mad' when they don't conform to society's norms. This approach argues that the concept of 'madness' - rather than describing disease entities - is an idea which has been created by society to exclude and stigmatise people who don't behave as society expects people should behave.

2 The social causation of madness: women are driven mad by their lot in this society. This approach looks at how women cope with life in a society in which they are less likely than men to have access to money, power and other resources; and are more likely to experience sexual abuse and violence.

The social construction of Borderline Personality Disorder

BPD is only one of the most recent diagnoses which applies particularly to women - Ssasz (1972), for example, traces the history of the concept of madness all the way back to 'witchcraft'. Women who threatened social norms in the middle ages weren't called mad; instead they were called 'witches,' who could then be isolated and punished. Later, as science, medicine and psychiatry took over the social control function of religion and The Church, the concept of 'hysteria' arrived in the nineteenth century.

Hysteria occupies a central position in the history of women's madness. It was used to indicate behaviours which are disapproved of, and specifically employed as a male term of abuse for 'difficult' female behaviour. Feminists suggest that behaviours that were diagnosed as 'hysteria' were a response to powerlessness; a reaction to expectations of passivity and an attempt to establish self-identity (Showalter, 1985). We argue that the diagnosis of BPD is the latest manifestation of this historical attempt to explain away the strategies which some women use to survive and resist the oppression and abuse they experience, by describing these strategies as symptomatic of a disturbed pathology (that something is wrong with the mind, brain or personality of an individual).

BPD as a diagnosis is used to label and exclude women whose feelings and behaviours do not meet the standards of 'normality' and 'acceptability'. Chesler (1972) talks about how women are in a 'double bind' - that we can be pathologised both for conforming to, and for failing to conform to, mainstream expectations of feminine passivity. In the case of BPD, the diagnosis can be applied to women who fail to live up to their gender role because they express anger and aggression, which is unacceptable for women in this society. Conversely, the diagnosis is also given to women who conform 'too strongly', by internalising anger, and expressing this through highly stigmatised, self-focussed behaviour such as self-injury.

In addition, the diagnosis of BPD is focused on the idea of irrationality which has long been associated with the stereotype of the feminine. Women are 'typically situated on the side of irrationality, silence, nature and the body, while men are situated on the side of reason, discourse, culture and mind.' (Showalter, 1985; p.3-4). Emotions - already defined as pathological - are located within the individual woman, rather than understood as a reaction to the social context of women in distress. The act of diagnosing BPD depends upon a psychiatrist judging whether emotions are appropriate and healthy, with reference to the norm of 'rationality'. This means that both anger, and fear of abandonment, can be - and frequently are - judged to be inappropriate, as opposed to being understandable in the context of a person's history of being violated or abandoned.

So Shazia's fear of being abandoned and alone and anger at her mother for abandoning her, were judged by the male psychiatrist to be "inappropriate" as opposed to being totally understandable in terms of her history. When he asked her about what her family thought of her sexuality given her religion, and Shazia angrily questioned the homophobia and racism implicit in his questions, she was further diagnosed by him as 'inappropriately angry'. When she explained that she had taken an overdose to punish herself because she felt stupid for feeling so upset about her girlfriend leaving, the psychiatrist suggested she may benefit from an assertiveness course. She was pathologised for both internalizing and externalising her anger, and was given the message that she was wrong to feel angry at all.

Shazia was also put on a waiting list for DBT (Dialectical Behavioural Therapy - or, according to Louise Pembroke, Doing Bollocks Therapy). Based upon the premise that women with a BPD diagnosis are unable to control their emotions properly, DBT exists to teach women how to respond more 'appropriately' and contain their emotions. The result of this is that other people don't have to see and experience even second hand the distress that women are going through.

SOCIAL CAUSATION

We're going to take a look now at how the contexts of women's lives - the pressures and oppressions that women have to cope with - can actually cause the feelings and behaviours which can lead to a diagnosis of BPD.

To say that we live in a male dominated society usually provokes a lot of reactions. People like to point out how much things have changed in the past few decades for women. Yet many things remain the same. Women still earn much less than men; are overwhelmingly found in low paid, low status work, are massively under-represented in structures of power; are still largely responsible for childcare and housework; are sexually objectified by the media, we are told how our lifestyles, bodies and appearances should meet up to a feminine norm, and stigmatized and excluded if we 'fail'. Without a doubt, this has a huge impact on women's mental health.

One important feature of women's experience of society is the sexual abuse of women and girls. Research has shown that between one in ten and one in three women will have experienced sexual violence or abuse at some point in their lives. The figure for women with a diagnosis of BPD is even higher: Castillo found that 88% of the people she talked to who had a diagnosis of BPD had experienced abuse. For 70% of women diagnosed with BPD this was early sexual abuse - the highest prevalence across gender/diagnostic categories (Castillo, 2000). This is reflected in other research as well as in our own personal experience.

The 'symptoms' defining BPD can often be better understood as memories, thoughts and feelings associated with sexual abuse and trauma. Instead, what happens when people are given a diagnosis of BPD is that this context of abuse and trauma is obscured as an important factor in a women's distress. The focus is placed on her as an individual: defining her as defective and disordered, and failing to recognize her 'symptoms' as appropriate expressions of feeling; and as ways of coping and surviving. In this way, "Health professionals have transformed the feminist practice of working with women and children survivors of sexual violence into a medical practice of treating patients. What feminists viewed as realistic responses to an unacceptable reality are now conceptualised as pathological effects" (Kelly 1988/89:14-15)

FEMINIST PRACTICE

As is implied in the quotation above, feminists have developed a very different model of working with women in distress. Feminists begin from the basic starting point of recognizing the links between a women's distress and her experiences of sexual abuse. This leads to a very different model of response to the psychiatric model.

Within the psychiatric system, a survivor of sexual abuse is subject to a profound loss of control over her own life, as power is assumed by the psychiatric professional (Johnstone 1995, Proctor, 2002). This loss of control can be heavily critiqued on the basis of theories and accounts of how important it is for survivors to feel a sense of regaining power and control following the experience of sexual abuse, theories which are at the centre of the feminist response to sexual abuse (Kelly 1988). It can sometimes mean the psychiatric interventions are experienced as abusive in and of themselves (Breggin, 1993), especially practices such as control and restraint, forced medication, ECT and hospitalisation. In short, psychiatric responses and even psychological therapies (see Proctor, 2002) can actually worsen the impact of abuse by "denying to victims the healing experience of informed consent. They reinforce her status as victim, ignore her capacity for survival, and undermine her recovery" (Koss and Harvey 1991: 133).

The development of the Rape Crisis network grew out of a feminist critique of mainstream responses to sexual abuse. "Feminists articulated the emotional and physical trauma of rape and the extent to which this was ignored and exacerbated by medical, mental health and criminal justice institutions" (Koss and Harvey 1991: 123); developing instead a model of response which is based upon principles of empowerment, mutual support and politicisation.

Qualitative research has illustrated how such models meet with what women say that they want - to be listened to, accepted and supported, and to have practical issues dealt with appropriately. In the Bristol Crisis Service Survey (Arnold, 1995) women identified those services which criticized, dismissed and controlled as being amongst the most unhelpful service responses. On the contrary, the main point of a helpful intervention was being heard and supported. Service could make a huge difference "simply by being accepting and supportive, listening and taking seriously the person's experience and needs" (Arnold 1995:21).

SHAZIA:

When Shazia ended up in A&E one day, she noticed an ad for a self-help group for survivors. She decided she certainly wasn't getting anywhere with her visits to A&E so she might as well give the group a try. She was really nervous at first but found the other women friendly and when they talked she realized she had a lot in common with them. She actually made a few friends in the group and got a lot of support from talking to other women. One woman suggested she could access counselling at a local voluntary feminist counselling service. Here, above all, she felt listened to and believed, after years of swinging between feeling that her abuse was her fault, or that she was making it all up anyway. Although it was hard for her to accept, she came to realize that she was not to blame for the abuse. Her ways of surviving the abuse and coping with her distress were understood and validated; so that instead of seeing herself as a mad person with a disordered personality, Shazia began to appreciate herself as a strong determined woman who had survived deeply painful experiences and feelings in the best ways she could. Although she still has bad days, she now feels much better about herself and finds it easier to ask for support when she needs it. It helps to know there are other people out there who respond to her in a supporting way which respects the strong, capable, complex woman she is. And hopefully we'll be seeing her at a Women at the Margins meeting soon where she'll get involved in challenging this diagnosis and the damaging impact that it has on individual women and on our society as a whole.

References

- Arnold, L. (1995) Women and Self-Injury - a survey of 76 women Bristol: Bristol Crisis Service for Women
- Breggin, P. (1993) Toxic Psychiatry: Drugs and Electroconvulsive Therapy - the Truth and the Better Alternatives G.B: HarperCollins.
- Castillo, H (2000) User Views on Personality Disorder: An account of an emancipatory research study about Personality Disorder, carried out by service users who have attracted the diagnosis. Mental Health Care, October.
- Chesler, P (1972) Women and Madness Jovanich: Harcourt Brace
- Johnstone, L (1995) 'Self-Injury and the psychiatric response' in 'Cutting Out the Pain' National Conference on Self Injury 26th September 1995, Bristol Crisis Service for Women
- Kelly, L (1988) Surviving Sexual Violence Cambridge: Polity
- Kelly, L (1988/9) "From politics to pathology: the medicalisation of the impact of rape and childhood sexual abuse", Radical Community Medicine 1988/9:14-18
- Koss and Harvey (1991) The Rape Victim - Clinical and Community Intervention London: Sage Publications
- Proctor, G. (2002) The Dynamics of Power in Counselling and Psychotherapy: Ethics, Politics and Practice. Ross-on-Wye: PCCS Books.
- Showalter, E (1985) The Female Malady: Women, Madness and English Culture, 1830-1890 London: Virago
- Szasz, T (1972) The Myth of Mental Illness London: Paladin



Suzi's story

During the past year I have been trying to have a diagnosis of BPD removed from my medical records. This experience has highlighted for me many injustices within psychiatric services, and some of the very negative consequences, both personal and professional, of having been given a diagnosis of BPD.

As the diagnosis of BPD is frequently given to women who have experienced abuse I wish to begin by talking about my background. My mother, sister and myself were all subjected to domestic violence; I was also sexually abused by an uncle and a friend's older brother and sexually assaulted by several strangers. As a child I displayed many behaviours that are indicators that a child is being sexually abused; I had problems at school, self harmed, and had disturbed and sexualised behaviour. This was never picked up on at school or anywhere else. I believe that this was due to the ignorance and denial about sexual abuse that was even stronger in the 1970s and 80s than it is now.

I first sought help in my early twenties after I had become involved in prostitution, and had problems with alcohol and drugs to the point that my life had become unmanageable. For some years I experienced a level of distress which seriously got in the way of my ability to function. I had flashbacks, terrifying anxiety symptoms and felt so dirty that I could barely walk down the street. At that time I attended survivors' groups and had counselling and over a number of years worked hard to come to terms with my childhood experiences and their impact on every aspect of my adult life and ability to function. I eventually stopped having formal support and although I still had some difficulties related to my childhood experiences I felt ready to move on in my life.

However in January 1996 my sister committed suicide and I was supported for a short time by the same professionals through the immediate aftermath of what was a totally devastating experience. I had believed that I had already lost everything I had to lose from my childhood experience, loss of innocence, loss of trust and loss of good feelings about myself. To then lose my sister in such a horrifying way was probably the worst thing that could have been added to that. Quite soon after this, I went and lived abroad for several years, but came home as I was aware that I had not really dealt with the issues surrounding my sister's death. This was a very difficult time for me

as trying to come to terms with my sister's suicide inevitably brought back all of the bad memories and feelings about our shared history of abuse. I became very unwell and was eventually admitted to a psychiatric ward, after a violent incident with an ex-partner. I really did not believe that I would ever be okay, and did not feel that I could fight back anymore. I spent 3 weeks in hospital followed by several months as a patient at day treatment services. When I got better I resumed voluntary work I had been doing on a project for homeless young people and completed a number of courses including a foundation in art therapy. Eventually I began to work in direct access hostels for homeless adults. Since I had worked so hard to recover, and felt so much better about everything, I felt that I was well positioned to work in that setting as I had personal experience of many of the issues that clients were presenting with.

I discovered that I had been given a diagnosis of BPD almost 2 years after my admission to the psychiatric ward when I was on a routine visit to my GP and happened to see on the computer screen that I had been given this diagnosis. I was shocked, upset and angry to find this out by accident, as I had never been informed by psychiatric services that this was on my records. When I asked for an explanation I came into contact with a different psychiatrist who gave me an alternative diagnosis of depression which I felt more accurately described my experience.

Last year I began to work with children with emotional and behavioural problems related to experiences of violence and sexual abuse. I have had good feedback from colleagues and have built positive relationships with the children who I have worked with. It was only at this point that I became worried that having this diagnosis on my records might affect my work. Although my current psychiatrist did not agree with the BPD diagnosis I was afraid that I would not be able to apply for any job that required me to have occupational health checks. I believe that having a BPD diagnosis on my records would put a question mark over my suitability to work with vulnerable client groups. I returned to psychiatric services to request that what I believed to be a misdiagnosis be removed from my notes. I explained to the consultant psychiatrist that I was concerned that having this diagnosis could prevent me from continuing to work in the caring professions or from ever fostering or adopting children. My notes were sent with a letter from my former

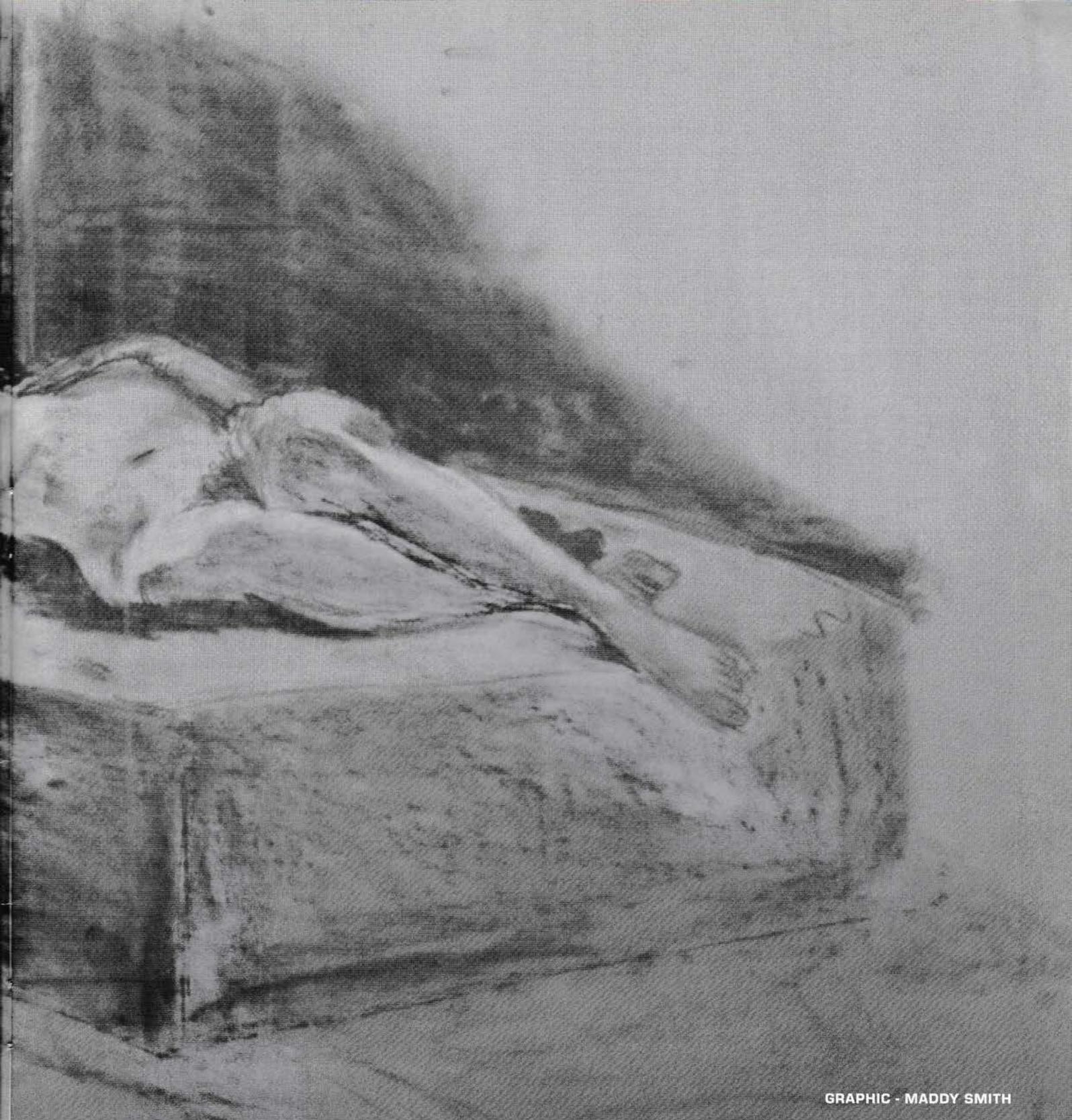
counsellor, and a letter from myself to the health Trust. In my letter I commented that I thought it unacceptable that anyone could be left to find out that they had a diagnosis on their records by accident, and on other aspects of my care at that time.

I also requested access to my GP notes amongst which was the discharge summary from my admission in 2000, where the diagnosis appeared. I was shocked to find that there were a number of inaccuracies on the summary. The diagnosis was put on my notes by a psychiatrist who stated that I had alleged that I had been sexually abused by my father, that I had smashed windows at school and that I had been self harming since I was a teenager. I have never said any of these things to that psychiatrist, or to anyone else. At that time I couldn't believe that a professional could ask on first meeting me many intrusive questions about my childhood, family and experience of abuse and then not have been respectful enough to have listened to the answers. I also felt that the incident with my ex-partner had been misrepresented as the discharge summary mentioned that I had punched him but didn't mention that this was in response to being attacked. One of the suggested 'symptoms' of BPD is inappropriate anger. I believe that fighting back is an appropriate response to being physically attacked, and I don't think that had I been a man, having punched someone in the mouth would have contributed to me being given a diagnosis of BPD. The discharge summary made no reference whatsoever to any of the steps I have taken towards my own survival and recovery, maybe this would have been too much of a challenge to the view that personality disorders are untreatable, and that survivors of abuse are damaged goods beyond hope of leading happy healthy lives. It is outrageous that one three week admission to an acute ward could lead to a person being given any diagnosis. I saw doctors on the acute ward perhaps four times, so do not believe that there is any way that they had enough experience of me to draw any conclusions about the state of my personality. The potential power that doctors have over patients under their care is frightening. The first time I met a consultant psychiatrist on the ward she suggested that I should have ECT, never having spoken to me before in her life and knowing nothing more about me than what was written by the person who admitted me to the ward. The criteria for giving a person a Personality Disorder diagnosis are so subjective that they are wide open to being interpreted through the prejudices of individual psychiatrists. From what I have learned of the experience of people bereaved by suicide, clinical depression is a very common grief reaction. I believe that my distress was an understandable and appropriate reaction to my sister's death and to the violence and abuse I have experienced, not evidence of having an untreatable Personality Disorder.

When I received a reply from the Trust, they said that they could not remove this diagnosis from my notes, but that my current psychiatrist's opinion that this was a misdiagnosis could be formally added in. The reply made no reference at all to the aspects of my contact with psychiatric services which had been upsetting and damaging to me. On this basis I made a formal complaint with the help of an advocate, and eventually received an apology from the trust. Trying to sort this out has taken up a lot of my time; I have felt very insecure and anxious about my work and generally upset by what I have learned about the negative aspects of the system. Recovery is difficult enough without having to deal with this kind of stuff. Having heard what other women have been through in terms of bad treatment by psychiatry I feel very lucky that my contact with it up until this point has been minimal, and lucky that I have been supported by alternative organisations throughout my attempts to get well.



I cannot understand how the vast majority of perpetrators of sexual violence walk free in this society, whilst the people who struggle to survive its after-effects are told that they have disordered personalities. During the time that I was challenging the diagnosis of BPD I watched a documentary about the Camden ripper who murdered and dismembered a number of women in his flat. I noticed that he had been given diagnosed with an untreatable Personality Disorder. When there is so much stigma in this society about mental illness and distress, to be given the same type of diagnosis as a serial rapist and murderer is unthinkable. The stigmatising effects of being given a label of BPD are very damaging. To have trusted psychiatric services at a time when I was in a



GRAPHIC - MADDY SMITH

vulnerable state and to then feel that this trust has been betrayed has been upsetting for me. From what I have come to understand it is not that survivors of violence and sexual abuse are untreatable - it is that psychiatric services are not able to respond appropriately to our needs to be heard, respected and supported in our struggles to recover. My contact with psychiatric services has done more to stand in the way of my recovery than it has done to support it. I spent much of my childhood being told directly and indirectly that I was mad, bad and that being treated badly was in some way my fault. In a society where women continue to be sexually objectified I believe that I have been oppressed. Our society continues to openly hold oppressive attitudes towards women and sexuality which

allow sexual abuse and violence to thrive. From my own experience and the experiences of other women I have met or read about I believe that these same oppressive attitudes remain unchecked within psychiatric services where the abuse of power continues to damage peoples' lives.

Having said this, I am very grateful to some of the nursing staff on the ward whose care and compassion helped to keep me in one piece. Without those people, my friends and other professionals who have helped me so much I don't believe I would be here today. Lastly I am very grateful to other service users I have met for their honesty, humour and courage.

TRULY PHOTOGRAPHIC MEMORIES

BY CAROLE A. BRESSINGTON



GRAPHIC BY SYLVIA HURT

I was fitted snugly into the most elastic of 'diagnoses', Borderline Personality Disorder, when in reality I was burdened by fifteen years of ritual cruelty and neglect at the hands of a paedophile father and his deeply sadistic wife. Being caught and thereby attracting public attention doesn't mean that couples like the Wests of Gloucester are by any means unique. I don't know how rare they are, but my two beauties certainly didn't operate alone.

I was brought up to believe volumes of very strange ideas, one being that nobody was interested in anything I had to say, ever. That was a daily reminder which later became the more serious 'One word out of you and you're dead my girl', accompanied by painful finger stabbing at whichever bit of me was handy. We lived in a regime based on silence where children had no voice or rights and where fear was a constant.

Although I hadn't words for the unspeakable acts and paedophile camps I regularly attended, I had as a thread throughout my childhood the stink of bloodied bedsheets, the heart-stopping (almost) savage agony of penetration while bound and gagged with my own socks and the constant fear and dread of what was around the next corner. Every day was a minefield planted with the terrifying planned precision you only encounter when a torturer is enjoying their craft. They are stimulated by new ideas.

My pair were the founder, and organisers of a series of cultural events enjoyed over the years by thousands. They had the male voice choir, some barbershop quartets and the children's choral society. Everyone sang in perfect harmony, and the male voice choir and quartets was a travelling monstrosity which pre-dated the internet. They entertained in churches and concert halls, holiday camps and religious campaigns, even singing for the American evangelist Billy Graham. They shared everything including their own and others' children who were merely handed around, so as the only daughter of the founder and director, I had lots more than a fair share. Occasionally I still meet men and women who tell me of the damage done to them, and still struggle not to feel responsible for the sins of the father.

Following his recent and long awaited death the trustee of my father's estate apologetically handed me an ancient cardboard suitcase containing many photographs of children, nameless for the most part and to start with all I recognised was their air of fear. They were in daft 'sexy' poses with foolish looking pale men of all ages trying to appear 'manly'. I knew some of the kiddies wailed and some wet themselves, were slapped and roughly cuddled and were forced to endure horrendously painful criminal acts of savage ferocity. I remembered the dusty shed, the darkened greenhouse, the cold vestry and smoky parlours. And the smells and the silent cold weeping.

Many years into maturity I once attempted to articulate some of this. I nibbled around the outside edge only partly aware of the enormity and severity of what was waiting in my mind for its first airing. An ambitious young psychiatrist played straight into my father's hands with "She's a compulsive pathological LIAR" and then laughed, and I was just at the start of the first telling of the easy bits. He laughed, and everyone in the room joined in, as they do. Nobody has seriously asked since which is just as well.

However, I entirely failed to live quietly and at peace with the oddity I had grown into so as a BPD (Breakable Pouting Defiant) I was sent to Broadmoor for which I was of course jolly well trained. (Brutally Plucked Daffodil) Keep a low profile and your mouth shut. Don't talk or cry or complain and don't look for help or assistance and before you know it (Broadly Pink Dreaming) you are back in the wide world which still however had one nasty trick up its sleeve. (Bilious Panting Dragons) Two weeks before my Section expired, with freedom in my sights I was beaten up and raped while 'in the care of services.' Many other women have very similar experiences. Anyway free at last (Beaten Punched Dripping) I walked, and kept walking for years, right to where I am now.

Post Broadmoor I was doubly stigmatised by BPD and Broadmoor, and how does that make any sense to anyone. Naturally my BPD was treated with sophistication. "We lock you up and you grow out of it". "Oh righto, how long does that take?" "Dunno really. OK?" "Well - alright then". Like I had a choice. Those stigmatised with the BPD nonsense are not helped by being told to adjust their behaviour but comply with "Let's treat this Gurtensplitter with ten hours of Milperstanz-wrangling" If this is what it takes to win freedom from incarceration, wouldn't anyone?

Obviously there has been progress since then. Oddly unhappy young women who are compulsive liars are still being rubber stamped BPD but now they receive DBT ECT TTA BMT CBS Anger Management, Social Skills, and Marxist Dialectic - just kidding.

'Personality Disorder: No longer a diagnosis of exclusion' (1) page 9 lets us into how difficult mental health professionals find it to get the diagnosis just right. "...nine categories of ICD-10 personality disorder and ten categories of DSM-IV personality disorder..." That's nineteen variations so far but wait, it gets sillier by dividing and subdividing subcategories of DSM into three clusters. The battered wounded women who have survived some of the worst treatment that mankind could hand them, on their knees and in despair, or still standing and fighting a rearguard are consigned to the disordered mayhem of sub-categories clustering and anger management. Monkeys, typewriters and politicians spring to mind.

How difficult is this? These are women who have endured generations of injustice and oppression. They have been victims of criminal savagery beyond understanding which will reverberate through their lives awake and asleep, as long as they live. They will re-experience the psychological equivalent of a motorway pile up eight or nine times a day and be called nasty names like LIAR on a regular basis. They are already described as malingering, manipulative, demanding, hormonal, bed blockers, attention seekers, the patients all psychiatrists love to hate, difficult to manage, promiscuous, addictive personalities, how long have you got. At this point somebody will sagely "Tut" and remark of me "She's quite angry still..." and you bet your life I am, wouldn't you be?

Give some serious thought to this. I am an Accredited Trainer with Inequality Agenda and we deliver intelligent staff training in secure units accommodating women. I had to train myself and then be trained to carry out the work. We studied and debated the historical, sociological political and economic implications relevant to the lives of today's women. Talked through the nature of abuse and its outcome, with colleagues who became trusted friends (it's mutual) and we explored with painful honesty our feelings about this amazing collection of women who have become lumped into the BPD population. And they are amazing or they wouldn't have survived thus far. Brilliant Proud Dancers

I witnessed something of a miracle when I went on the road with my co-trainer and our magic. Some people started to think in different ways. Some found it terribly hard because for many years they just believed all the old rubbish about these (Bloody Pathetic Doormats) women. Some were having their eyes opened to the fact they had been getting it dreadfully wrong for years, while some are so young they haven't learned yet how to challenge the old masters, and some still refuse to believe the truth when it is staring them right in the face. A few were moved to tears because they heard the truth for the first time and they are going back to the wards inspired, and the enlightened few who have always known, had their beliefs vindicated. The truth is a very potent magic isn't it.

I had been waiting for half a century to hear it and it brought me some unexpected extras. It calms my rumbling self-destruct mechanism when it kicks in and I don't have to live out the prophecy of my abuser. It enables me to identify the why and wherefore of some ugly feelings and has helped me find my own way of dealing with them. I have uncovered the creative woman in me, utterly denied before, who paints and writes a bit and is creating a nice safe home for herself and her cat. I discovered I could forgive my fellow victims for wrongly blaming me and I understand now why they need to hurt me just for being his daughter. Life is getting sweeter for me and it is about time.

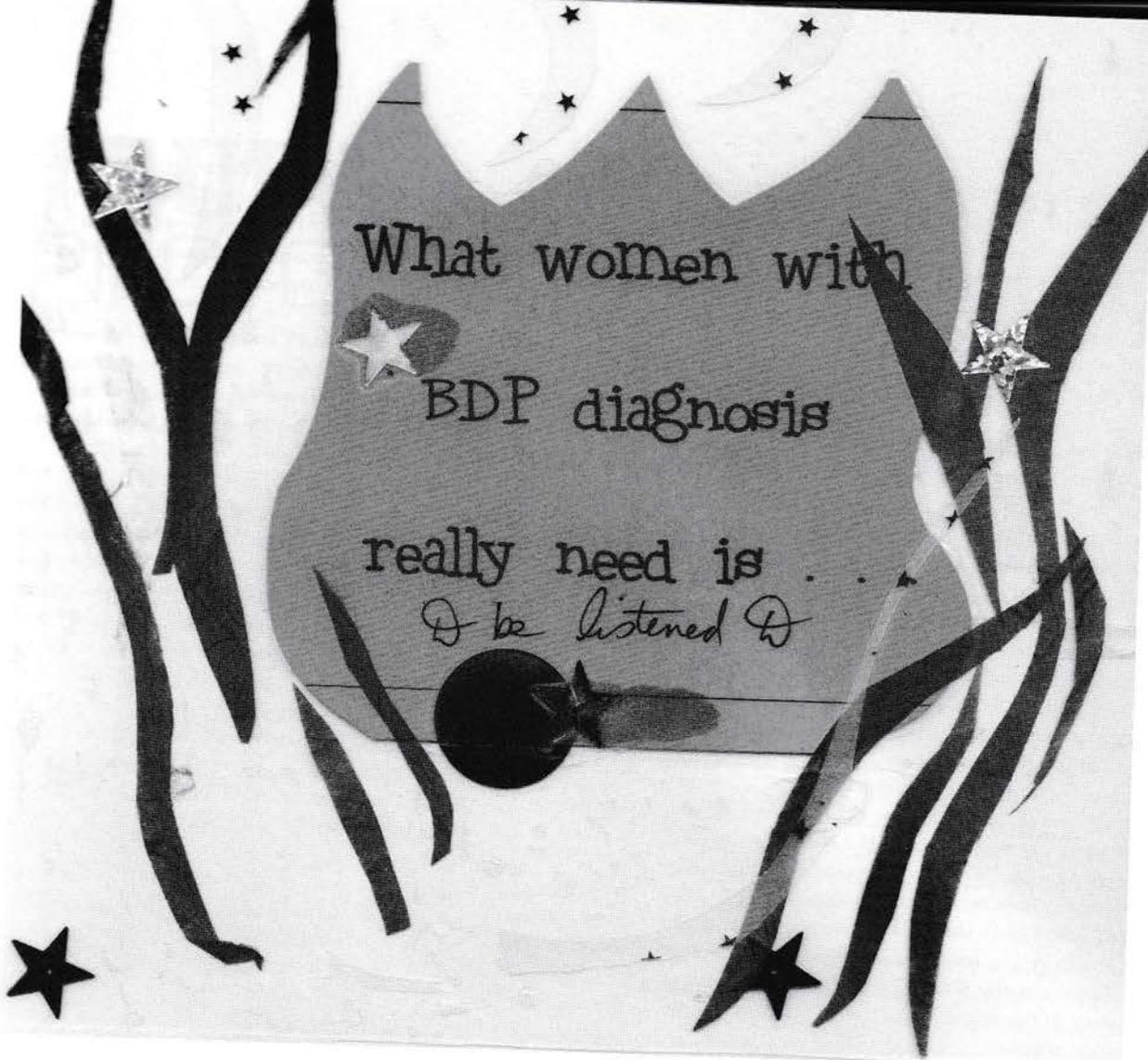
Now for the penny dropping moment - it occurs to me we should be giving this same training to incarcerated women, who could then train their workers. That is a definition of empowerment if ever I heard it. And by workers I mean the entire team, especially young psychiatrists some of whom still have a tendency to dismiss the truth.

This is not one of those opiates for the masses 'user involvement' scams where people are encouraged to believe that they have some power in their lives. I once worked in a voluntary organisation where my life experience was perceived as a weakness by people who couldn't recognise the strength it brought to my position. Being a token survivor is about as insulting as it comes when actually what you are, is an expert. We deserve to be given the learning, the language, and an understanding of our true selves, not the rubbish still being peddled by the arrogant ignorant. (Badly Damaged Professionals)

I should like to think that we might offer true hope and inspiration to women who like me, have no good reason to trust anyone. I can tell you that the truth is the power I live on and it rocks. I am a Bodacious Party Diva.

(1)Personality Disorder: No longer a diagnosis of exclusion

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BREAKING THE SILENCE AROUND SEXUAL VIOLENCE

MONICA HILL

I joined Bradford Rape Crisis Group (now known as Bradford Rape Crisis & Sexual Abuse Survivors Service) over 20 years ago because of my own fear and anger about male violence. I wanted to talk to other women who felt the same as me and I wanted to do something about it rather than feeling powerless.

When we began, rape was the subject of jokes and myths. There was a widespread belief that women lie about rape in order to get themselves out of trouble. Rape was seen as a crime committed by a sex-starved maniac, on an attractive, young woman, who was foolishly walking down an alley, late at night. The police were instructed to "let the woman make her statement and then drive a horse and cart through it". Juries were warned that "it is dangerous to convict on the uncorroborated evidence of a woman". Judges frequently implied that false allegations of rape are common when in fact there is no evidence of this. Despite years of campaigning and more realistic stories of rape appearing in our soap operas, these myths persist and prevent women gaining justice. Police attitudes have changed and the number of women reporting rape has doubled

since 1985. However conviction rates are the lowest they have been for 30 years and the justice system is still clearly failing women. Most women who come to us have not reported to the police and there will be many more who have never told anyone. The pain and the shame of rape are still being carried by women, not by the rapists.

We initially set up as a telephone helpline. We recognised how difficult it was for women to speak about rape and we wanted to provide something that was easily accessible and anonymous. From the beginning we received threatening and abusive calls from men and we had to protect our own identity as well as that of our callers. But over the twenty years since we began, women have been breaking the silence surrounding sexual violence and letting go of the shame. More and more survivors requested face to face counselling and led by them we have focused increasingly on providing individual and group therapy services. We now provide many kinds of support including the helpline, information and practical help with the justice system, health and housing issues, counselling and psychotherapy.

When Rape Crisis began, we already knew from other centres that we would not be dealing only with rape committed by strangers. We knew that women were most likely to be raped by a man they knew. However I don't think we were prepared for the fact that by the mid-eighties at least two thirds of our calls would be coming from women and girls who had been raped by a man in their own family. This kind of abuse usually began in early childhood, committed by a man who was loved and trusted by the child and continued for months or years. Again responding to the users of our service, we began facilitating Incest Survivors Groups and the demand was such that at one time we were running two weekly groups. At the same time child sexual abuse was discovered by the media and that prompted more women to want to share their secret and heal.

Our experience has been that with every positive change in the arena of sexual violence there is a backlash and this was no exception. No sooner had women begun speaking about their experiences of sexual abuse than so-called False Memory Syndrome appeared in the media. Whilst there is ample evidence of the recovered memories in people who have experienced all kinds of trauma, the evidence for FMS is flimsy to say the least. There is a mantra we have come to recognise used not only by rapists but also by a society that does not want to recognise the extent of sexual violence: Deny, Justify, Minimise. For women we are working with, the publicity surrounding so-called FMS only added to their feeling that they would not be believed and there must be something wrong with them. Most of our clients remembered all too clearly what had happened to them, though they may have been trying to live as though they didn't for a long time.

With the diagnosis of Borderline Personality Disorder, yet again, women are being pathologised and re-victimised. Instead of recognising the devastation caused by rape and child sexual abuse, honouring and supporting a woman's survival, she is described as in need of treatment or perhaps "untreatable". Living with sexual violence or the memories of abuse can lead to a woman developing complex and difficult ways of coping. We try and offer appropriate support to any woman who asks for it. We do not make diagnoses or offer treatment but we do try and respond to the whole person and their different needs.

Since we began we have seen ourselves as having more than one role to fulfil. First and foremost we have always been and continue to be a support service for women who have been raped or sexually abused but we are also here to campaign for justice and raise awareness about the reality of rape. We seek to dispel the myths surrounding rape, about where it happens, when it happens and who are the rapists.

Some people claim that the battles for women's liberation have largely been won. Some may question the need for a women-only, feminist service. They may claim that so much has changed, there is more awareness, we have services for men and women who have been raped. Some say we now live in a post-feminist society. Post-feminist society? Not for women who are struggling to deal with the aftermath of sexual violence - labelled, stigmatised, pathologised.

It's not enough to blame the victims again and say: why don't children tell or why don't women report rape? We have to look at what happens when they do tell. And we have to be prepared to listen to the different ways in which children and women tell. We have to understand the nature of violence which reduces a person's self-worth so much that they feel they are not worthy or deserving of help. We have to acknowledge that yes, men can sometimes experience sexual violence, and yes, women can sometimes be abusers, without ignoring the real issues of gender and power that underlie rape and mean that perpetrators are so much more likely to be men. If we ignore this, we are bound to fail in understanding and putting an end to sexual violence.

Rape is a political crime. We need a service by and for women and we need a political perspective. Rape is a war crime - for most women it is one of the most powerful and devastating weapons in an undeclared war. Misogyny - the war that goes on every day, in every society, where the enemy is your friend, your neighbour, your father, your uncle, your ex-partner. The war against women, simply because we are women - "bitches", "whores", "lolitas", "fantasists", "disordered", "disturbed".

Let us have fewer labels, more respect and greater understanding.

Review of

'MOTH DIARIES'

BY RACHEL KLEIN

TAMSIN WALKER

This novel is written as if it is the teenage diary of a girl later given a diagnosis of BPD, depression and psychosis. Although the diarist writes well, for an annoying brat, this is not enough to make the story interesting.

The story is set in an exclusive girls' boarding school in the 1960s, which I'm sure we'll all find easy to identify with, and is extremely clichéd. The narrator's boarding school chums are divided into clever, sporty, ever-dieting, and rebellious, which is probably less original than Enid

Blyton. The book contains danger, which seems tame and emotions that seem dull. The girl whines continuously and dislikes the new popular girl Ernessa. This hatred is manifested in her deciding that this girl is a vampire. From what I can gather this hatred is based on the fact that the girl is a European Jew who is having a relationship with the narrator's 'best friend' (racism, anti-Semitism and homophobia anyone?).

I was really disappointed by this book and am amazed it has had so many good reviews. Although it reads like a well written cross between 'Girl Interrupted' and 'Harry Potter' it is both offensive and boring. I had much more empathy for the vampire than the writer and I definitely won't go and see the film when it comes out.



2 FLEW OVER THE CUCKOO'S NEST

TERRI SHAW

My name is Terri and I'm Clare's older sister. We come from quite a large family but even though there is quite a few years between us, Clare and I have always been particularly close.

My background is in nursing, I am R.G.N. qualified although I haven't practised for a few years since my little boy was born with Down's Syndrome. I have spent the last few years at university where I completed my degree in nursing and I have just finished an MA in Bioethics and Medical Law.

It was my total confusion about Clare's experiences in hospital that actually formed the focus of my dissertation for my MA. I had, until the time of Clare's admissions to hospital, always been under the impression that the aim of the health care system was primarily to assist its users by providing services designed to meet their needs. Yet Clare's admissions contradicted this belief - they certainly never seemed to help Clare and in fact seemed to be very negative experiences. I therefore chose to explore the possible practice of safer self-injury within an in-patient hospital setting. In this article though, I will be talking about what it is like when someone that you care for is in distress, in hospital, and has been given a Borderline Personality Disorder (BPD) diagnosis.

MY EXPERIENCE

It was quite difficult to actually try and formulate my experiences into any sort of sequence, mainly because it was such a distressing time, and because the emotions evoked were all so intense it was hard to separate them into any logical order.

I remember the first time I went to visit Clare - she was in an acute psychiatric ward in an inner city area. I was with my two young children and obviously in a real state of anxiety having just found out that my sister had been admitted for having taken an overdose and for self-harming.

My initial reaction when I walked into that ward was one of pure horror - it was like all my nightmares come true. I can only describe it as a noisy, chaotic, dirty, frightening, horrible environment. I've seen films where they've shown psychiatric wards, and you hope to God that things have changed and moved on - but all I remember thinking was that it was just like 'One Flew Over the Cuckoo's Nest'. I recently asked my daughter if she remembered anything about the first ward Auntie Clare had been admitted to. Carla - who would have been about six years old at the time - turned to me and said, 'Oh mum, it was like a prison, it was like the worst place ever'.

There was absolutely no privacy. Clare was there in an extremely distressed state and there was nowhere to go for some peace and quiet to talk to her - no side rooms. The only place was her bed with a curtain around surrounded by other patients who were also in extreme distress.

I couldn't believe that there were all these men there - it was mainly male patients and a lot of them were shouting and being quite aggressive. Even to this day I can't get my head around the fact that psychiatric units are mixed sex. A lot of people who are given a BPD diagnosis have a history of sexual abuse so to admit them to a place where they are forced to mix with men just beggars belief.

I went home that day so upset, not only trying to deal with the fact that Clare was so distressed but knowing that I'd left her there in that place. If someone you know and love is ill, that's hard enough to deal with, but at least if you've got the knowledge that they are being cared for in a safe environment you can get some comfort.

There were times when I visited Clare when she was under a section and under one-to-one surveillance. Imagine what that was like, not even being able to talk to Clare on her own and not being allowed out for a walk or anything. Clare is such a sporty, active person and to see her in there with no access to anything that might provide some distraction or relief was just so upsetting. I remember that one of the hospitals actually allowed Clare to have her violin and a room to play it in and I was so grateful and relieved and I'm sure that provided more therapy than any of the drugs she had to take.

I can't remember just at what stage the term BPD was used, but I do remember that when I heard the phrase I just thought 'What an absolutely stupid name'. I thought it was just some vague description referring to just being on the borderline of having a personality disorder but not really being sure of whether she'd got one or not - a bit like a medical doctor saying that someone has got a 'virus' when they are not too sure what is wrong with them. It was only years later that I read a list of criteria that are apparently used for diagnosing someone with BPD and I couldn't believe them - without a doubt, there have been times in my life that I could easily have fulfilled many of the criteria and I think that is true for a lot of people.

No-one took the time to explain exactly what the diagnosis meant or what the implications were, I spoke to our mum about it yesterday and she said that that one of the worst things was the absolute unknown of it all - she said 'It was the not knowing what was happening, not knowing what was going to happen, all I knew was that Clare was suffering and I didn't know how to help her'

One of the strongest memories I have was the hostility of the staff. It would have meant so much for someone to have shown some sympathy or concern towards the distress we were experiencing. It was difficult because, without going into detail, there was a lot of family stuff coming out. But this was all new stuff to us as well and it was really hard trying to come to terms with that ourselves knowing

the distress it had caused Clare without having staff placing judgments on us for not knowing or stopping it. We blamed ourselves enough without it being reinforced.

I also blamed myself for not having realised that Clare had actually been self-harming for quite a long time before her first admission. This is a sister, that I had always been so close to and yet I had absolutely no idea that things were so bad

We lived with the absolute fear that Clare was going to kill herself. Knowing what I do now, I understand that self-injury is used as a coping mechanism and it is used to help avert suicidal feelings, but I didn't know that then - we thought that Clare was trying to kill herself and for all those years just lived waiting for that knock on the door telling us that she was dead. Mum remembers begging the consultant to section Clare out of sheer desperation because she didn't know what else to do and she just wanted to try and keep Clare safe. However safety didn't even come into it - some of the worst injuries Clare inflicted upon herself were done in the psychiatric hospitals.

I think that if someone - any member of staff - had taken one us to one side and just shown some acknowledgement of the pain and suffering we were feeling, it would have helped. Even just provided us with a booklet, web-site address or phone number, so that we could access support and information. At the end of the day, the stronger the carers are and the more support they are offered then the stronger and more supportive they can be towards the person in distress.

I look back now and feel ashamed that I allowed myself to be so ignorant as to what was going on and wish that I had had the wits about me to actually ask more questions or research things myself. However, it's all well and good saying what I would do if I had the time again. Hindsight is a wonderful thing, but at the time there was just too much going on to even think straight. Psychiatric illness is such a frightening term - I didn't even know where to begin to try coming to terms with it. Obviously I understand a lot more now, though more about self-injury than BPD. However they're really intertwined as it's the old circular argument - Why does someone self-injure? - because they have BPD. How do you know someone has BPD? - because they self-injure. It explains nothing and means nothing.

I'm aware how incredibly negative I've sounded but I don't think I can think of a single positive thing to say about Clare's diagnosis and treatment. I haven't intended to launch a personal attack on the quality of nursing care. At the end of the day, I know all too well how emotive self-injury can be, and I know from my research with nursing staff, just how difficult it is to care for someone who self-injures. My negativity is directed at the psychiatric system itself rather than at individual nursing staff.

(teresa.shaw@bopenworld.com)



GRAPHIC BY TAMSIN WALKER

Studies have shown that around 80% of people with a BPD diagnosis have histories of self-injury (Dubo 1997). So it is unsurprising that there is a strong correlation between BPD and self-harm in peoples' minds. I have found that whenever I talk publicly about the subject of self-harm someone is guaranteed to bring up the idea that self-harm is solely a symptom of BPD. Self-harm seems to be the key diagnostic criteria for many women who receive a BPD diagnosis and I would argue that BPD is purely a label created to enable women who self-harm to be medicalised and diagnosed. I was given the BPD label by a psychiatrist the first time I saw her. She started by asking me all the standard questions from her sheet until she had established that there were times when I had harmed myself, at this point she only asked me questions which related to the diagnosis of BPD. I don't believe that I would have been given this label if it wasn't for my self-injury.

Self-harm is often very stigmatised, receiving fearful or angry responses from people. People seem to find it difficult to face the fact that people are so distressed that they hurt themselves. They don't want to face the reality of women's distress. It also seems that concentrating on self-harming behaviours is an easy way to avoid thinking about the cause of distress. Underlying issues and trauma can be ignored when people choose to focus on the mechanical issue of self-harm instead. This is like trying to stop the holes in a rusty pipe instead of finding the source of the water supply.

Self-harm breaks gendered social norms, which may be another reason that it is so stigmatised. Women are stereotypically caring, passive and image conscious. If you injure yourself you are not being caring towards yourself, self-harm can be seen as an aggressive act (although one directed at yourself) and self-harm also seems to be in conflict with the stereotype of women being really image conscious (spending ages choosing what to wear and putting on make-up etc.)

Why cut up?

TAMSIN WALKER

For many women hurting themselves is a useful way of coping with experiences of abuse (BCSW 1995). Self-harm can serve many functions and be a very effective way of coping. If you have been hurt and abused by other people then self-harm can be a way of regaining 'control' of your body, it can also be about 'communication', 'punishment and cleansing' and getting 'a break', amongst other things (42nd Street). Pain is always difficult to talk about and whilst abuse can still feel like a taboo it can be easier to communicate feelings through self harm instead of words. Punishment and cleansing are also important functions of self-harm for many women who have experienced abuse; punishing yourself for 'allowing' abuse to happen and getting rid of the 'badness' inside (42nd Street). It can be very symbolic, when you see blood coming out of a cut it can be easy to imagine that it might contain some of the evil you feel inside -don't forget that people once believed that using leeches was a cure to purge any illness! Self-harm providing a break is about escaping from your feelings or situation for a while - for me concentrating on the physical pain and the action of self-harm helped give me a break by immediately providing a different focus. If you are dealing with strong emotions and the trauma of abuse then it is understandable that you might resort to a multi-functional coping mechanism like self-harm.

Self-harm has been negatively correlated with suicide (Kroll 1993); self-harm helps people survive. Self-harm is not about trying to die, it is about trying to cope. Self-harm can relieve enough pressure to prevent you from being actively suicidal. I also found that it helped me to keep myself safe in other ways -if I was in a dangerous situation I would be paralysed by fear but if I cut myself the fear disappeared and I was able to take the actions I needed to get myself safe. We all survive in different ways and if self-harm didn't serve a function then women wouldn't do it.

I understand that self-injury can be distressing; I don't like seeing people I care about hurting themselves, but I also understand that it is a way of coping and that self-injury is just one behaviour on a spectrum of self-harming behaviour. Self-harming behaviours can include using cigarettes, alcohol, medication, food, drugs etc. to cope. Even wearing high heeled shoes is something that people do in order to feel a certain way or to conform to expectations, but which can be painful and cause permanent damage. Women are not stigmatised for hurting themselves in ways which conform to 'feminine' social norms. It is not seen as shocking and deviant when women do not eat well because they are permanently dieting, it is not seen as shocking when women smoke, yet these are harmful and damaging behaviours.

The diagnosis of BPD is at least as stigmatised as self-injury. NIMHE found that service-users considered personality disorder to have the most stigma of all mental health diagnosis and found that many people with this diagnosis felt blamed for their condition (NIMHE 2003). Our personalities are what we think of as our 'self' - to say that someone's personality is disordered or faulty is to place a judgement on someone's whole sense of 'being'.

The diagnosis of BPD rests on the assumption that others must be mad or irresponsible to act in a way that you wouldn't, however self-injury and many of the other coping mechanisms which are classed as symptoms of BPD are no more mad or irresponsible than many which are widely accepted in society. Smoking tobacco is not included as a symptom in the guidelines for the diagnosis of any type of mental illness, yet self harm is. This is an example of definitions of mental illness being based on social norms. Smoking is an addictive coping behaviour used by large numbers of people. It is seriously damaging to the physical health of the smoker and those

around them and can lead to premature death. Self-harm in the form of cutting or burning, tends to only be superficially damaging to the individual, causes no harm to those around them, and need never result in death. As already mentioned self-harm serves functions for people and helps them survive yet it is assumed, by many mental health professionals, to be a problematic behaviour which must be prevented. Being confronted by behaviours that they do not understand seems to make people distressed and angry, which in turn leads to the self-harmer being held responsible for the distress and anger other people feel in response.

Common methods of dealing with painful emotions caused by abuse can include self-injury, suicide attempts, addiction, eating difficulties and gambling (Bass & Davis 1988). All these are classed by DSM-IV as symptoms of BPD. If someone has developed these behaviours then they have done so because these were important ways of dealing with the circumstances they were faced with, at the time and in adulthood. The manifestations of this pain in later life can often be made worse by the negative effects of being labelled with BPD. Children are often made to feel responsible for the abuse that happens to them and made to feel that their emotions and responses to this abuse are inappropriate. Many survivors already have strong feelings of self-blame and guilt for things they were not responsible for and had no control over; to label them as having BPD only reinforces these negative feelings causing even more distress.

The huge stigma attached to the BPD diagnosis is due to professionals not seeing the whole picture. If someone had their ear pierced and you just looked at the symptoms you would think they had a disorder of the ear, if you took a partial account of their environment you would know it had been pierced but confused and worried about them inflicting damage on themselves, however if you took a full account of their environment you would know this was the norm in their immediate environment and would have a much clearer understanding of their condition. You would know that although the person might not want their ear to go septic and painful

they also don't want the hole to heal over. This applies to the BPD diagnosis; whilst women might not want to be in emotional distress they don't need their whole personality to be recreated and realigned to fit in with psychiatrists' idea of what's acceptable.

Women with histories of self-injury are at risk of being given a BPD diagnosis. Self-injury is a multi-functional coping mechanism, which many women use to cope with the trauma of abuse. It should be recognised that self-injury helps many women survive. Self-injury is stigmatised. Women are often blamed for their distress with people concentrating on the action of self-injury and not acknowledging the causes of women's distress. Self-harm is a coping mechanism which can only be understood in context. Women shouldn't be held responsible for other people's action or reactions. Self injury exists on a spectrum of self-harming behaviours, some of which are more socially accepted than others. Definitions of mental illness are based on social norms, not on how effective or damaging different behaviours are. BPD is a label constructed by psychiatry to medicalise and individualise women's experiences and has the effect of drawing into question the validity of their responses to their experiences. The blame that is associated with self-injury and a BPD diagnosis is inappropriate and unhelpful; it stems from lack of understanding of individuals and the effects of trauma and is used as a way of avoiding recognising or tackling rape and abuse in our society. 'Blaming the victim' is an easy option for people with power who refuse to recognise and take responsibility for the impact of their actions.

References

- Arnold, Lois (1995) Women and self-injury: a survey of 76 women (BCSW)
- Bass, E and Davis, L (1988) *Courage to heal* (Vermilion)
- Dubo, E.D. et al. (Feb 1997) Childhood Antecedents of self-destructiveness in Borderline Personality Disorder (Canadian Journal of Psychiatry, vol 4, No.1)
- Kroll, Jerome (1993) *PTSD/Borderlines in therapy: finding the balance* (W.W. Norton & company)
- NIMHE (January 2003) *Personality Disorder: No longer a diagnosis of exclusion* (DoH)
- Spandler, Helen (1996) *Who's Hurting Who? 42nd Street* (Manchester)

GRAPHIC BY SYLVIA HURT





Sylvia Hurts

I am a survivor of the mental health system. I feel it failed me miserably. I am now in my 50's and at the age of 16 I was taken before the courts as a juvenile runaway - I was being abused. I was raped three times by the age of 16 only to be taken back to the abuse every time I ran away. It was decided I should be taken to court as I was 'beyond parental control'. As my abuser stood up against me I was frozen with fear, without a voice. It was decided I would be sent to a 'low grade' mental institute. As I left court I was sandwiched between two police officers; there was not a thing said. I looked out of the window to see what looked like a military establishment. They escorted me to what was to be the ward I was on. A nurse came with a huge key around her neck to unlock the door. I was taken to the clinic room where I was checked for head lice; my nails were checked and my private parts examined. I was so, so scared. Then, I was taken to the store room where I was given harsh regulation clothing and given the regulation haircut, cut around a basin. As I was taken to the dining area it was as if we were all clones. What had we done to be in this place?

I was constantly put on scrubbing the stairs for showing emotion. There was a heavily pregnant girl being force fed. I started to cry and that was my punishment. I remember having to line up naked for a communal bath. We were all escorted to school and on our way we passed the 'low grade' wards where people were sat in wheel chairs with rubber bibs on; their chins red raw, no stimulation - just left. Surely these people had a right to have dignity and the best quality of life? How could the human race be so cruel?

On one of the occasions we were being escorted I heard a voice in the distance shout my name. I turned to see my cousin; she hadn't forgotten me. She asked how I was - she had been incarcerated in Aston for having two children out of wedlock, where she was for well over 22 years. I was very lucky to get out of Aston. The sad thing is I have seen my notes - I was labelled not much above subnormal. The notes also detailed I had a Personality Disorder. That label followed me. People should not be given labels - they affect our lives.

Even after being released from Aston, the label of Personality Disorder affected my life. As a result of this label, my children were nearly taken away from me. I am going to write about my battle with the authorities for my children. I remember so vividly sitting doing a crossword and listening to my favourite country and western

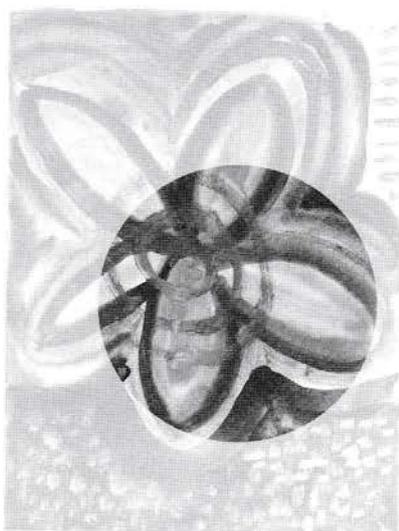
music. Sometimes I had problems sleeping and it was my way of winding down. But my ex husband had his instructions that if I was ever down, he had to phone the authorities, which he did on this particular night. I felt I was a normal human being relaxing doing my crossword when I was startled with a knock at the back and front doors - police officers and social workers at both. "What are you doing here?" I raged. "Sit down Sylvia", the social worker said in a patronising voice. "How do you feel?" she enquired. "How do I feel?" I raged; "like killing you and everyone around me." That fickle threat sealed the fate of my children.

My eight-year-old daughter was woken in the dead of night to sort her two younger brothers' clothes out. I could hear her childlike sobs, crying "I can't see", but nobody took any notice and gave her the glasses she needed to see. As they were dragged out, my eldest son was screaming for his comfort cushion. But I was already handcuffed and couldn't do a thing about these people taking my lovely children. I was sectioned and once again silent without a voice - the label had followed me in every walk of my life.

On my return home from hospital I knew I had a battle to fight for my babes - they had become pawns in the system and the system was intent on getting a care order on them. I fought a hard battle and thankfully after an awful experience with a bad practice social worker, I was assigned the head of social work. She saw I was a loving doting mum to my children and my children were returned to me. Luckily, there was no court. Now, my eldest son is a plasterer, my youngest son is an electrician and my daughter is a housing manager with the council - all very successful. I have all the social work reports written about me - they make horrific reading.

I have been sectioned 27 times under the mental health act. I was given every highly hypnotic drug on the list, I hasten to add, forceably. This practice is still going on (even more so in ethnic minority communities) and has to stop. We should be able to talk out our feelings in a safe place and not be sectioned or given drugs and ECT as I was. We must not forget people still being incarcerated. Visit my website at www.sylviahurst.org.uk to see more details about the book about my life and please sign the guest book. Please keep the campaign going. My next direct action campaign is in London.

Thanks for listening.



DISORDERED BOUNDARIES?

GILLIAN PROCTOR

I am a Clinical Psychologist currently working in primary care. Having always been uncomfortable with my power as a therapist over clients, I explored this further in 'The dynamics of power in psychotherapy and counseling: Ethics, Politics and Practice' (PCCS Books 2002). I work in a person-centred way as this model best suits my ethics and politics and the explicit aim is for the therapist to not take power over the client, but instead to work towards a real, mutual relationship between two people. I challenge all therapists and mental health workers to consider the ethics of power in their practice and how their work could do more harm than good.

'Boundaries' are usually explained as the importance for clients of the therapist or worker setting limits which are predictable and consistent. The idea originates in psychodynamic therapy, based on Freud and other psychoanalytic theorists. This model is of an expert therapist, who can interpret and predict a client's needs. Boundaries usually refer to the timing of sessions and to rules limiting contact between therapist and client outside the session time. Often a picture is painted of a client 'pushing' the boundaries of a therapist or 'resisting' the therapist's boundaries and the usual advice given to therapists is of the danger of 'giving in' to the client. Already we can see the links between this approach and the common stereotype of women diagnosed with BPD as 'manipulative'. Indeed, the 'symptoms' of BPD include reference to no boundaries in relationships. It seems that women with this diagnosis are seen as deficient in their ability to have 'boundaries' in relationships and so it is the workers job to help them by setting boundaries for them.

'Boundaries' are very culturally-rooted. In the UK and especially in England, there is a pervasive culture of us boxing ourselves in and away from others in fear with ever increasing security around individual properties. As one of the most densely populated countries in the world, the way huge amounts of people live in smaller and smaller spaces has encouraged a more and more

protectionist culture. Yet, as trying to help women in distress is fundamentally a relational enterprise; we need to take care not to apply an individualist protectionist model to determine how we are, in relationships that are designed to heal.

A major difficulty for me in discussions of 'boundaries' is the danger of constraining ourselves to avoid potential abuse, but totally missing the danger of neglect. This is a particular concern with the increasing professionalisation of caring. Taylor (1990) emphasises the consequences particularly for women patients of this power dynamic and criticises the remoteness of the worker who emphasizes 'boundaries'. She suggests that most women have already experienced too much emotional remoteness and that relating to a real person in helping relationships is an essential part of empowering women. My personal experience with a psychodynamic therapist who was emotionally distant and remote resulted unhelpfully in me feeling stupid and needy (see Proctor, 2002b). A refusal to be authentic and present in relationships can be experienced as abusive, and can result in harm. Heyward (1994: 137) comments "I knew there was something wrong with a system of treatment that notices greater potential for harm than healing in authentic relationship between healers and those who seek their help and that fails to notice as harmful those rules and boundaries that block authenticity." (p.113)

As mental health services are currently struggling with how to respond to recent government legislation suggesting that BPD should not be a diagnosis of exclusion from services, surely the bottom line of any service aims should be to avoid making womens' distress worse? Service providers should not constrain ourselves by arbitrary or theoretical boundaries that restrict our human capacity to respond to people and care. Why should our boundaries be constrained by anything more than our own limitations of comfort within which we can look after ourselves and be able to honestly and openly respond to the needs of women in distress?

MUTUALITY

Instead of the focus on boundaries in 'helping' relationships, perhaps we would all benefit from a focus on mutuality. Mutual relationships are real relationships between people, where each has needs and each has limitations and these are discussed openly and honestly. There may also be roles but these do not prevent each person fulfilling a role from primarily being a person. Relationships based on mutuality emphasise equality of all and respect for all, rather than dominance and submission, the more usual model for relationships in our society (Benjamin, 1988).

From a feminist model of mutuality, the therapist or mental health worker is not an expert on knowing the needs of the client, and is also a person in the relationship with their own needs. In the standard 'professional' model of care which ignores the subjectivity or personhood of the therapist or worker, the danger is that the ignored needs of the therapist/worker are projected onto the client and then used to justify the therapist's limitations as being 'boundaries for the good of the client'. For example, a worker with many responsibilities becomes increasingly frustrated with a client who regularly turns up in distress wanting to speak to only this worker. The worker decides the client is 'overstepping boundaries' and introduces a rule that the client can only turn up once a week, explaining to the client that these boundaries are for her benefit. The worker does not explain that she is unable to keep up with all her responsibilities and has reached a limitation.

For women with a diagnosis of BPD, this then justifies women with the diagnosis being blamed when the boundaries set by the services mean that services are not offering enough to help when a woman is distressed. Consequently, the woman herself is pathologised for being 'too needy'. This message can reinforce how women may see themselves, as being unworthy of care, and can increase distress at times when women are in most crisis. Often these service responses end up inadvertently retraumatising women, whilst workers involved maintain that their responses are for the benefit of the client.

A far more honest way to deal with the inevitable limits to what services can offer would be for mental health workers to be honest about their own limits and express them as such without trying to pretend that these limits are good for the client. In the above example, if the worker could have been more honest that she has limitations on her availability, then the client's need for crisis services could be identified and filled elsewhere. With this honest exchange, there could then be real attempts to fill the gaps in services and try to provide what women say they need.

PRIORITISING MY NEEDS WHILST UNDERSTANDING THE IMPACT ON ANOTHER

Within my own work, my aim is to respond honestly and with care to the needs of my clients whilst being aware of and prioritising my own needs. This also involves trying to acknowledge and understand the impact of my needs on my clients. When I am able to express my needs to a client at the same time as trying to understand and respect their needs; and express my regret when my limitations or needs leave me unable to respond to my client's needs, I find that usually it's possible for us to work out together what service gaps there are and how they can be filled.

AUTHENTICITY

I take my role as a therapist very seriously as it has great power attached to the role. However, I also aim to be myself as a real and authentic person in that role and to have a real relationship with my clients which goes beyond our roles. I believe strongly in the power of this authentic person-to-person connection and the abuse of power in with-holding our personhood from therapy. Too often, workers display a coldness justified by professionalism, that could lead them to be pathologised for their lack of ability to be in relationships! Of course, this distance also protects workers from the emotional impact of really being with their clients in distress, but it is often dishonestly claimed again to be for the benefit of clients.

MUTUAL NEGOTIATION

In my work, I do have restrictions on how much I can offer my clients, some due to the service I work within and some due to my own personal limitations. When I first meet clients, I ask them if they want to ask me any questions about me as a person in addition to how I work. Sometimes I am asked questions and my sole basis for deciding whether to answer these personal questions is whether or not I feel comfortable to answer. If I do not, I explain my discomfort as my reason for not answering. I do not believe that I can know whether a client may find it helpful or not for me to answer and so trying to judge this is not part of my decision.

Rather than stick to fixed 'boundaries', I try to be flexible and dynamic in my arrangements with clients and I am always open to reconsidering any decision we have made concerning a therapy contract, in terms of timing of sessions or any other factors. This seems to be a realistic expectation that individual needs may change and relationships may change - an openness to reconsider the limitations of any relationship seems to be an openness to their dynamic nature.

DEFENSIVE OR HEALING PRACTICE?

I believe that to take the ethics of mutuality seriously is a big commitment, emotionally and politically. It requires clear commitment to our own self-awareness and to discussing our ethical decisions and ways of being with clients in open and mutual ways in supervision and with clients. If we want to take seriously the healing potential in mutuality, this will not be an easy or safe process. It has the potential to transform mental health services and indeed all our relationships. However, we cannot work this way without strong relational networks of support and solidarity. So we need to make a decision: do we work to create the networks that will support us to do transformative healing and mutual work or do we work to continue the status quo of our cosy constrained and emotionally and politically boxed-in lives?

References

- Benjamin, J. (1988). *The Bonds of Love: Psychoanalysis, feminism, and the problem of domination*. New York: Virago.
- Heyward, C. (1993) *When Boundaries Betray Us: Beyond Illusions of what is ethical in therapy and life* New York: HarperCollins
- Proctor, G. (2002a) *The Dynamics of power in counselling and psychotherapy: Ethics, Politics and Practice*. Rosee-on-Wye: PCCS Books.
- Proctor, G. (2002b) *My experience, as a Client, of Power in the Therapy Relationship*, *The Journal of Critical Psychology, Counselling and Psychotherapy*, 2(3), 137-148.
- Taylor, M. (1990). *Fantasy or reality? The problem with psychoanalytic interpretation in psychotherapy with women*. In E. Burman (ed.), *Feminists in Psychological Practice* (pp. 104-118). London: Sage.

PAYING THE PRICE FOR NOT FITTING IN

KALIKHAT



GRAPHIC - SYLVIA HURT

"Personality - personal existence or identity; the condition of being a person; the distinctive character or qualities of a person" (OED definition).

So if my personality is disordered, does that mean I'm :

- a less of a person, with no identity and a disordered character and personal qualities
- or
- b too much of a person with too strong an identity and a character and personal qualities that are too distinctive to fit into society's norms?

I'm not sure which is worse. Either way I end up feeling like someone who clearly does not belong, whose personality is not what society finds acceptable and so bars me from fitting into the jigsaw of the world around me.

As a Black woman growing up through the frankly racist fifties, swinging sixties, liberal seventies, Thatcher's eighties and the nineties, I know about not fitting in. Always too quiet or too loud, too stupid or too clever, too different, too assimilated, too Black, not Black enough. Mad contrasting messages, each one as familiar as the other as I learnt to turn myself inside out and back to front in any audience in order to fulfil their specific requirements of me. I adapted with terrifying ease to be what others wanted for the meagre prize of not being rejected and, even on occasion, seemingly accepted. But in the end the more I squeezed myself into the gaps of other people's worlds the more distanced I felt, knowing that there was a deeply undesirable me inside which had to be kept firmly hidden. How do you ever explain to anyone that dreadful feeling of dislocation, the terrible fear of being oneself and the guilt of knowing that self is wrong?

Perhaps in some ways psychiatry helped me for a while. By naming my distress as "personality disorder", psychiatry made it clearer for me, an illness and (to my shame) I have to admit that at first it was almost a relief. Documented proof that I was all wrong, my feelings of anomie immediately justified as something inevitable that would

forever keep me distant from the world.

And so they labelled me with that particular diagnosis

And with that act, sealed my fate.

Making me less of a person

Differentiating me from family, community and the rest of the world.

But now, many years on, I realise that in many ways that act of labelling echoed an earlier experience from my childhood :

And so he called me by that special name

And with that act sealed my fate

Making me his special child

Distancing me from my mum, my siblings and the rest of the world,

In retrospect the parallels are startling : being drawn in because of a personal need for help/support or closeness/affection; being explicitly taught how to be a good and compliant patient or daughter, separating me out from the world around me lest I blow it apart by revealing some unspeakable truths.

And now I realize that psychiatry, instead of addressing some of the serious life events that resulted in me being repeatedly brought (unconscious and overdosed) to their door, reinforced for me the same unbearable pressures of an abusive childhood - comply or else. Bad enough to be a woman in our society; bad enough to be Black, bad enough to have a psychiatric diagnosis but being labelled "personality disorder" is like the ultimate - categorizing me in isolation as a disordered soul who must be separated from the rest of society until I could conform. Maybe I once felt that about being Black - wanting so much not to be me, internalizing all the overt racism around me, feeling it grow inside me into vicious and violent self-hatred and guilt. But when I think more about being Black, or being a woman, or being someone with a psychiatric diagnosis or someone with a specific personality disorder, I feel that the degree of stigma, discrimination and oppression in different situations may not be the same.

A personal view of the degree of discrimination and oppression in various situations as a result of being Black, a woman, someone with a psychiatric diagnosis and someone with a specific diagnosis of personality disorder:

	society	My community	mh user movement	mh services
being black	++	-	++	++
being female	+	+	-	+
having a psychiatric diagnosis	+++	+++	-	+
having a specific diagnosis of personality disorder	+	+	+++	+++

+ = degree of oppression

This considering of degrees of discrimination and oppressions fascinates me. From the chart above it seems that society discriminates against me for having a psychiatric diagnosis and for being Black. Similarly, my own community discriminates against me for having a psychiatric diagnosis but obviously not for being Black. Both discriminate against me (but to a much lesser extent) for being a woman and for having a specific diagnosis of personality disorder. In comparison, the MH service user movement (that very right-on body that campaigns for users' rights) obviously does not discriminate against those with a psychiatric diagnosis but can be very discriminatory against those known to have a specific diagnosis of personality disorder, and those who are Black. Statutory MH services (who are meant to have an understanding of MH issues and work in anti-discriminatory ways) similarly discriminate against those with a diagnosis of personality disorder (typically referring to us as "heartsink" patients), and those who are Black, and also against women and those with a psychiatric diagnosis (these last being the very people they are meant to be helping).

So where does that leave me as a Black woman with a diagnosis of personality disorder? In these very PC days there is endless talk of the benefits of living in a diverse society, of valuing difference and of sharing and learning from one another. Our society prides itself on being inclusive, yet sensitive to difference, open to a range of values and beliefs that may modify those at the mainstream. But my life experience tells me how conditional this is, so that difference is only ever accepted on other people's terms, and must never be TOO different or challenging. Thus, a known world is preserved and the status quo maintained. And in psychiatry the situation seems even worse. The very discipline which prides itself on understanding the human psyche seems to be remarkably intolerant of difference, be it gender, 'race', ethnicity, sexuality, class or diagnosis, particularly personality disorder. And by decreeing there are norms of character and personal qualities, they ensure they can categorize people according to these norms as normal or abnormal, regardless of life experience or history/herstory.

At this stage in my life I am not denying that certain aspects of my personality cause me (and maybe other people) problems, but that is not the whole of me. The majority of me is fine and functions well. And in the context of my childhood family experiences and the often devastating and overt racism I have endured, it's maybe not surprising that I've developed some ways of being that are maybe not seen to be normal. But rather than help me to look at this and work with it, psychiatry blanks if ever I dare to mention abuse, or racism or confusion over my identity. Rather it prefers to up my dose of anti-psychotics - never questioning why I'm being given anti-psychotic if I'm not psychotic and it's simply my personality that's at fault. Trying to negotiate this mad system can, I believe, truly turn you psychotic in the end. Maybe at least then I'll have a valid diagnosis and be more acceptable to the statutory MH services and other MH system users. The Department of Health may be crying out for personality disorder to not be a reason for exclusion but I wonder if anyone's told the rest of the MH world yet????

The price of paranoia

(AN ODE TO THE DLA FORM)

BY JACKIE HAGAN

We know you're not too well,
 but could you please pull up your socks
 to answer some very important questions?
 Nothing serious - just tell us your life story (but leave
 out the good bits)
 Any abuse you've suffered: Nothing personal, no
 need to give names, (just national insurance
 numbers)
 If you're illiterate...write to tell us
 If you have problems communicating with
 others...give us a call
 and please list in alphabetical and chronological
 order any implements you've used to harm yourself.
 Don't worry if you misspell anything or write outside
 the boxes;
 tell us the wrong things or slip up and tell us that
 (god forbid)
 you do charity work,
 or study,
 or perform poetry,
 or feed yourself!
 We'll just shoot you, no pressure.

Visit my website! Poetry, Poundland, Children in hats and much more...www.geocities.com/elin_loves_agnes

FEEL THE FEAR BUT DO IT ANYWAY! -

HOW WE CAN USE THE
MEDIA INSTEAD OF THE
MEDIA USING US

PAULINE BISPHAM

'Why me? - because things won't change if we aren't prepared to speak out.' The words of Liz Main, survivor and media consultant, echoed in my mind as I confronted the full page photograph of myself in the Yorkshire Evening Post with details of my life laid bare on the opposite side of the double page spread.

Just over a year ago I had started work as a media officer for positive mental health in Leeds. The idea was to promote more varied coverage in the media and to challenge the negative and stigmatising coverage that mental health usually receives in the newspapers and on the telly. The media still too often link mental health problems to violence and criminality and use inappropriate, inaccurate or insulting terms. 'Nutter', 'loony' and 'psychotic' are just some of the words that spring to mind. Not forgetting the journalistic convention that comes into play when someone discharges or otherwise 'absents' themselves from a mental health facility - they are 'on the loose', then they are 'trapped' or 'snared' like an animal.

Of even greater concern is the lack of voices of service users and carers speaking directly about our personal experiences of mental distress and the mental health system. Research was conducted by Mental Health Media of mental health coverage in national and regional papers in the three-month period to February 2001 - just 6.5% of the clippings analysed included the voice of a mental health service user. This reinforces the stereotype of mental health service users as either helpless, pathetic, always in need of someone to speak up for us. Or we are volatile and unpredictable - an image which ramps up public fear and could be used to justify a more punitive mental health bill.

Service users' voices being directly represented in the media mean more opportunities to challenge the dominant medical model of mental health. They bring alive important issues and debates and uncover fresh, challenging and highly knowledgeable perspectives. If the experiences and opinions of service users are not reflected in the media, we risk allowing the same, damaging politically motivated theories and stereotypes to continue to dominate the public mind - as well as the psychiatric system.

Of course, some believe that by blaming the media, we are avoiding confronting the wider issue of labelling people and the conventions of mental health services. Sarah Nelson is a journalist with a particular interest in survivors of childhood sexual abuse and other severe childhood traumas. She has reacted with a degree of cynicism



to the Royal College of Psychiatrists Changing Minds campaign, which also focused on media representation of mental health. 'Stigma and discrimination aren't just the result of ignorant Joe Soap confusing schizophrenia with split personality nor of the tabloid press branding every sufferer a mad axeman. I believe the most important task for psychiatrists is not to educate an uninformed public but to put their own house in order, to examine their own attitudes to patients and to mental health issues. How courageous, valuable and destigmatising that would be.'

I was recruited into the job partly because of my public relations skills and partly because of my experience of emotional distress. Yet, I had lived in denial, rather like a person of mixed race in apartheid-era South Africa, passing as white. My status was a person with one foot in the mad camp and one foot in the sane. Denial was about 'getting on with my life', reinserting myself into society and distancing myself. I had 'airbrushed' my experience of severe depression out of my C.V.....until now.

The media like a personal angle. I wanted to highlight the taboo of mental health and the scandal of 85% of those with mental health problems being unemployed. I wanted to target employers to appeal for more openness in the workplace and more mentally healthy workplaces. The dry article became my story. If I couldn't write this piece, then I couldn't do the job. I couldn't expect others to feel they could use the media rather than the media use them.

I thought hard about what I wanted to say, what I didn't want to include and my limits. In the interview with the journalist, I felt in control. The article was read back to me before publication and came out fine (apart from the unexpectedly huge photo!).

Things can spiral out of control, though. A woman using mental health services wanted to raise concerns about a new state of the art facility where the temperature in summer was like a sauna and a much-vaunted gym remained closed. She wanted to write a letter to the editor of a local paper to challenge articles/corporate publicity about the brave new age of mental health. This was followed by a telephone call from a journalist offering to run a full feature piece rather than print the letter. Problems mounted as she appeared then to retract some of what was in the original letter. The group she claimed to speak for said she hadn't consulted them about contacting the press and distanced themselves. Ultimately, her confidence was dented.

For those of you campaigning on Borderline Personality Disorder, the media will play a key part, because it is where most people get information on mental health. There are many opportunities - but media training is essential, preferably using trainers who themselves have used services. This helps people to focus on whether they want to engage with the media, and their personal boundaries. They will also gain confidence in interviews and getting key messages across. Once a media interview has been secured, support needs to be built in before, during and afterwards.

TOP TIPS FOR PREPARING FOR MEDIA INTERVIEWS

- Have you seen, heard or read the publication/programme?
- What do you want to say. Find three key points
- What are your limits? You can control what you want to say about yourself.
- Where will the interview be? Are you happy to let the media into your home or do you want to go somewhere else?
- How will your family and friends feel if they see the programme or article?
- Think about how you might feel after seeing/hearing the article/programme
- Think about how you might feel if they don't run the programme or article

My article and outsized photograph spun off into unexpected conversations with the person who came to fix my central heating and had experienced depression and at my local hairdresser where 'schizophrenia' became a topic of debate. A wave of emails reflected unfair dismissal from work, struggling with benefit tribunals but also a sense of connection. The 'Why me?' question has a swift answer - because it's the only way to change perceptions; and changing perceptions is a first step in our journey towards changing the world.

FOR FURTHER HELP CONTACT:

Mental Health Media

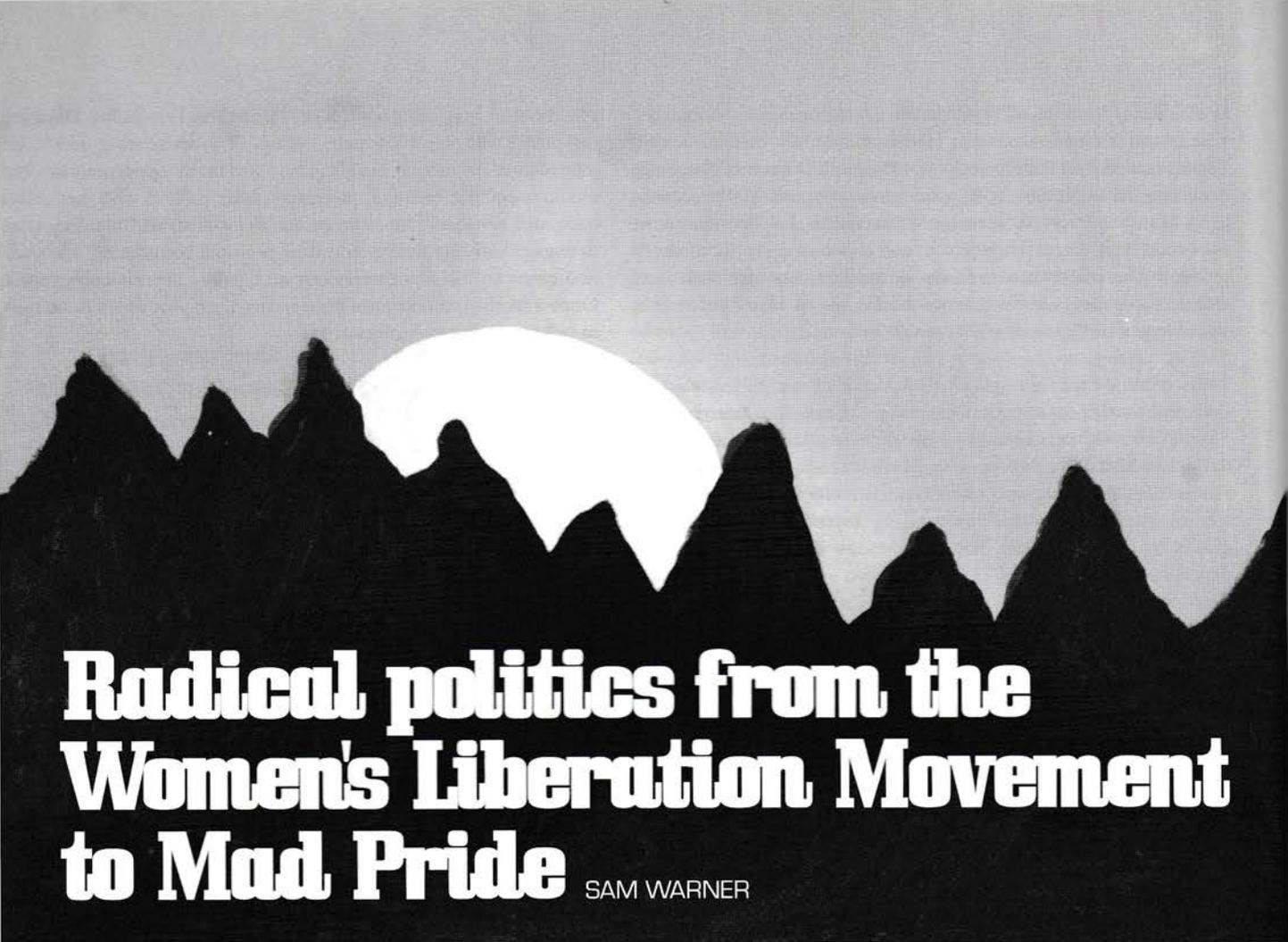
Uses the media to promote people's voices in order to reduce the discrimination surrounding mental health. Offers tailor-made courses-responding to the media, building an organisation's media presence, introduction to local press work (all costed). Contact Katie Brudenell Tel 020 770 8171 email katie.brudenell@mhmedia.com web www.mhmedia.com

worth it she began to plan her escape . . .

movie, what's the dream?"

n as
del

GRAPHIC - MADDY SMITH



Radical politics from the Women's Liberation Movement to Mad Pride

SAM WARNER

INTRODUCTION:**TRACING THE TACTICS OF USING 'EXPERIENCE'**

Liberation movements have traditionally taken identity as a starting point for political action. We have used our experiences as, women and service users for example, to challenge traditional understandings about us that discredit our knowledge and restrict our lives. We have used our experience to dispute the idea that women are essentially flawed. Rather, we have drawn attention to the social context and the abusive relationships that give rise to women's distress and our attempts to cope. Yet our 'experiences' sometimes are contradictory and whether women, service users and/or providers we do not always agree. My aim here is to consider the tactics of using 'experience' for radical political ends. I do this by tracing some of the ways feminists and mad activists have addressed the issues of women, child sexual abuse and mental health.

I first worked around the issue of child sexual abuse in women-only community groups in the 1980's. I then trained as a clinical psychologist as an explicit means of gaining power, status and some money (voluntary sector was never well paid). My account of the ebbs and flows of contemporary radical politics in Britain in respect of child sexual abuse is based on my multiple experiences outside and inside statutory services. It provides an historical overview that begins in the 1960's and ends in the present day. Different concerns have predominated at different times and these have translated into competing approaches to addressing the issue of women and child sexual abuse by feminists and, more latterly by mad activists.

THE 1960'S TO THE 1970'S:**POLITICS OF EQUALITY**

The 1960's were marked, in the West, by the growth of New Left politics and the introduction of the contraceptive pill, which heralded the so-called sexual revolution. This context set the stage for women to challenge inequalities in gender and sexual relations, and to examine their roles and positions in society (see Friedan, 1963). The aim was to locate women's personal difficulties within the context of wider patriarchal oppression. Oppression, through patriarchy, was not believed to be a-historical nor simply personal. Rather, women's subordination under patriarchy was understood to be modified by class, race, and geography; and to be embedded in legal, economic and cultural constraints (Enns, 1997). The predominant concern, therefore, within the first phase of second wave feminism, was to address gender inequality through emphasising women's commonalities with men as equal subjects before the law.

Small discussion groups were formed, these developed into consciousness-raising groups, and the slogan 'the personal is political' was born. Links were made between women's personal feelings and experiences and the wider social triggers to which they related (Enns, 1997). The explicit aim of such groups was to use women's personal insight as the dynamic foundation for political action. Women began to articulate their adult experiences of domestic abuse and sexual oppression, although it would be some time before the sexual abuse of children would be identified as a concomitant key issue. Issues of

mental health, psychiatric abuse and detention were at this stage also a limited concern within the Women's Liberation Movement (WLM) - with some exceptions (e.g. Chesler, 1989/1972). Indeed, whilst some women's lives changed, they had limited impact in wider political contexts. The failure of women's needs to be adequately addressed both in the 'male-stream' and through related liberation struggles, including those around mental health, set the stage for the autonomous politics that characterised the 1970's and early 1980's.

1970'S TO 1980'S:

POLITICS OF AUTONOMY

In the 1970's a politics of autonomy developed in response to the failure of the New Left to adequately address the 'woman question'. In contrast with the first phase, this phase rejected the assumption that liberation can ever be achieved through emphasising similarity with men, as to do so is to be judged by their standards. The social world was believed to be 'man-made', controlled by men in order to maintain male privilege. Because all men were deemed to benefit from the patriarchal order all men were deemed to be guilty. The second phase of second wave feminism, therefore, emphasised women's difference from men.

Women's unique experience under patriarchy was understood to mean that women were able to provide not simply a different, but better, perspective on the world. Psychology and psychiatry were condemned as being anti-woman and reflecting male bias. They were viewed as regulatory social mechanisms that reinforced women's subjugated status. As such, most activists agreed that statutory services and 'state-sponsored oppression' should be avoided, in favour of grass-roots activism located within the community. Services were often autonomous and issue-based: 'run by women for women'. Their aim was to address the direct effects of patriarchy, for example sexual and domestic oppression, first identified through consciousness-raising groups. Women's Aid refuges and Rape Crisis centres were set up, and women began to extend their concerns about male violence to consider the domestic abuse and rape of children.

The existence of these grass-roots organisations demonstrated that women could control their destinies, that their bodies were their own, and that self-help was a legitimate approach to mental and social distress. The reality of women's lives was acknowledged and validated. Support was given to individual abused women, but these same women were encouraged to join in the WLM and share in the wider political agenda. Women's experiences became the new expertise, and service users often did become volunteer workers. This is still the case in relation to 'Hearing Voices' groups, for example. This valorisation of experience over expertise further acted to challenge the hegemony of the medical model (Showalter, 1985).

The recognition that women's mental health was disrupted not by their inherent biological inferiority, but rather by actual abuse signalled the ways in which dominant theories of insanity would be challenged by radical mental health activists in the years to come.

Yet women with long-term mental health problems, often confined in mental institutions, remained a marginal issue for many feminists and other progressive activists. Not all women were equally welcomed into the WLM. Women were increasingly finding that similarities between women had been over-stated and that there was considerable need to address oppression within relationships between women.

1980'S - EARLY 1990'S:

POLITICS OF DIFFERENCE AND DIVERSITY

In the 1980's the assumed unity of the WLM was questioned as zones of exclusion became increasingly apparent. The WLM was felt to exclude many of the women it strove to represent. Racism, ethnocentrism, classism, heterosexism, and ableism seemed endemic to the WLM. The general assumption of common experiences between women and shared goals within feminism was being increasingly scrutinised and challenged. And, as Davies (1981) argued, viewing men as the enemy undermined and denied alliances with men. It also served to camouflage differences between women.

Self help approaches and collective work-practices were still viewed as preferential because they encouraged power-sharing rather than hierarchical leadership. Separatist strategies, based on models developed through the 1970's, were utilised to develop more specialist services organised around ever more specific issues or groups. Gradually the strategy of autonomy from men was extended to include autonomy between groups of women. Yet, increasing separatist strategies failed to eradicate inequalities between women who could claim shared identities. No group of women, whether Black, gay, disabled and/ or mad is homogenous, and women continued to disagree. It was in these unsettled times that child sexual abuse became a significant issue for Western feminists.

Women increasingly drew on their multiple experiences of subjugation to make the complex interactions between different aspects of identity explicit. Women, marginalised through race, class, and sexuality wrote stories and autobiographies that elaborated the multiple forms and effects of child sexual abuse (e.g. Angelou, 1984; Danica, 1989; and Lewis, 1994). Women struggled to make the devastating impact of child sexual abuse clear. At the same time women worked hard to challenge the assumption of inevitable damage made within traditional accounts of the 'effects' of abuse (see Warner, 1996). Hence, feminist strategy of the time emphasised women's strength, agency and capacity to overcome abuse through naming the abused as survivors, and not victims (a tactic also adopted by psychiatric survivors).

During this period feminism insinuated itself into the mainstream. Feminists directly and indirectly forced changes in institutional and legal practice regarding sexual and domestic violence, and the treatment of child abuse. Nevertheless, the fragmentation of women's collective identity and the 1980's general slide towards individualism signalled a loss of common will and a decrease in political activism. With this came a shifting focus from radical

politics to more personal solutions (e.g. Norwood, 1986). Personal growth was emphasised over social transformation, and many women left grassroots organisations for statutory services. Yet feminism was still not reaching socially disabled women with long term mental health problems (Kitzinger and Perkins, 1993).

Mental health activism had not yet forced its concerns onto the progressive agenda, although it was in the process of becoming organised. Alliances were formed between service users and providers, for example, regarding 'Women in Special Hospitals', established in 1991. Psychiatric survivors started to write about those issues feminism had, to some degree, overlooked such as self-harm (Pembroke, 1994). In some ways, radical mental health activists were just beginning to find their voice, whilst radical activists in the WLM were seemingly in the process of losing theirs. Women could no longer assume a common identity was the starting point for political organisation and action.

1990'S TO EARLY 2000'S:

POLITICS OF DECONSTRUCTION

The 1990's heralded a sustained attempt to question and critique identity politics. We knew that our identities, as women, were multiple and often in conflict. The experiences we had, as women, did not always lead to the same conclusions. Moreover, when we spoke 'from experience' it was difficult for others to disagree with us. As such, identity, as shorthand for experience, actually impeded opportunities to talk about our differences. Increasingly feminists began to question whose experience was heard, and whose experience was deemed to be more valid. A more complex concern with the strategic deployment of experience was beginning to be thought through. We began to consider how our identities and our understandings of experience were constructed through language (Butler, 1990).

As such, women's experiences and women's values were no longer understood to be beyond examination. Child sexual abuse was no longer a straightforward issue, but rather a complex and disputed concern. Political activism was being rethought in terms of what women want to achieve rather than defined by who women are. Unfortunately, women's increasingly fragmented 'post-modern' voice, and related decrease in collective action paved the way for the growth of a liberal humanist feminism, whereby the personal remained personal and the aim of therapy was no longer inextricably linked with wider social concerns. On the positive side, a valorisation of difference and a disavowal of absolute truth reinforced the need for plurality in feminist theory and women's activism.

As such, there was a gradual recognition that one 'treatment' model could not suit all women. Rather, women needed both integrated and separate services, within both voluntary and (some) statutory contexts. This translated into mixed services and mixed strategies and tactics. Yet, much of the therapy developed by feminists still seemed to favour privileged groups of women. Whilst this was not

always the case (e.g. Warner and Wilkins, in press), as argued, women with long term mental health problems were still largely ignored. Instead it was the nascent service user movement that would increasingly challenge dominant mental health practices and the hegemony of psychiatry and psychology. Services-user movements addressed cross-gender issues (for example, The Hearing Voices Network), and gender-specific concerns (for example, Women at the Margins).

Child sexual abuse was becoming, for the first time, a clear issue for mental health activists, as it had been previously for feminists. Radical mental health activists (both service users and workers) came together to promulgate these ideas through staging events (e.g. Women at the Margins conference, Leeds 2004), and writing about key concerns (e.g. this special issue of *Asylum*). Statutory bodies were finally being forced to take account of service users' experiences and to recognise the social foundations of mental distress (see the Department of Health, 1999; 2002). Ultimately, however, whilst service users are increasingly expected to share their knowledge and experiences with statutory services, they continue to have very little control over their own treatment. Indeed, the new British Mental Health Act may restrict their choices even more.

In response to this, some radical mental health activists have returned to a politics of autonomy, although with a distinctively deconstructive feel. As with 'queer' activists, 'mad pride' activists aim to use language to subvert social stereotypes, and advocate for their own self-determination. 'Mad Women', established in Liverpool, in 1998, is an example of this (madwomen@btinternet.com). Whilst identity is still central to this radical political agenda, there is increasing recognition that who we are should not close down what we can speak about. This is evident in collaborative relationships between service users and providers. This understanding is crucial because when identities become frozen, 'speaking from experience' ends debate and restricts opportunities for change. A deconstructive identity politics that seems to have influenced current radical mad activists offers the hope that this social movement may avoid some of the difficulties feminists have faced.

STAYING CRITICAL:

SOME STRATEGIES FOR PROMOTING RECOVERY

Feminists and mental health activists have many overlapping concerns, as well as sometimes common identities, and we can learn much from our diverse histories. We know that our differences can enrich debate and extend our strategies for change, but only if we give up believing that we are always right. We can never speak for everyone. Nevertheless, making links between personal experience and political enterprise opens up the landscape of recovery because it makes individual misery a fully social issue. It is no longer about individually disordered personalities, for example, but about the social relationships, both past and present that shape who we are and what we do. We can use our experiences to challenge dominant models of mental health (see example one). Yet we should not hide behind our experiences to avoid challenging each other. Disagreement is risky, but if we do not argue and engage in

conflicting ideas we can never change and this limits the possibilities for recovery. We need to remain open to challenging ourselves (see example two).

Feminism, in its many forms, remains a source of inspiration to me. It does not provide all the answers. There cannot be one right way of working with women, but I think we should still try to detail, situate and theorise progressive forms of action.

The recent history of feminism has taught me that experience is a problem, but is a problem that is still worth engaging with. As Ramazanoglu and Holland (1999: 391) argue:

Experience, and reflections on experiences of living in unequal societies, provide feminism with its foundations of rage, pain, endurance and hope for something better, without which it will wither.

It is this passion that sustains political activism, as well as sometimes impedes our ability to work together for the 'common good'/make common cause. I was, and still am, committed to challenging sexually abusive behaviour and to developing more egalitarian and emancipatory therapy practices and mental health services. I make no apology for still hoping for social transformation. Without hope and passion, the will to change cannot be sustained. And without hope there can be no recovery. This does not mean that we always have the energy to campaign and organise. We all need a break, sometimes. But social issues have to be part of any radical agenda around mental health. Child sexual abuse still happens, and structured inequality underlies contemporary British and world politics. If we are concerned about individual change then we have to be interested in the transformation of society. That is something still worth fighting for.

EXAMPLE ONE:

DISPUTING THE CATEGORY AND TREATMENT OF 'BORDERLINE PERSONALITY DISORDER'

When children are subject to repetitive abuse they must find ways of withstanding the negative effects on their sense of self. Children may cope by distancing themselves during the abuse through denial, distraction, and dissociation (Warner, 2000; 2003). They may cope with their subsequent feelings of powerlessness by self-harming (using self-injury, drugs and alcohol, and over or under eating). These strategies of self-harm may further help women to distract and dissociate from the feelings associated with abuse. When self-harm is viewed as being a symptom of borderline personality disorder, for example, women's creativity, in adversity, and their will to live is not recognised. The need to explore how women have been tricked and constrained through experiences of abuse can then be ignored.

This is evident in the pharmaceutical management of women, which is an institutional form of distraction and dissociation. Women may feel less, but have no opportunity to explore and address why they feel the way they do. This is also evident in some forms of psychological therapy. For example, dialectical behaviour

therapy has been developed to address the 'deficient' emotional modulation skills and 'suicidal' behaviour that is commonly associated with BPD (see Reynolds, and Linehan, 2002). According to this model women misunderstand their emotions (e.g. everyone is untrustworthy) and their self-harming behaviour is reinforced by the environments in which they live and receive care (e.g. they gain attention). Treatment aims to increase their emotional knowledge and to change the environment so that it is no longer reinforcing of self-harm.

However, why women cope in the way they do is not simply because they are 'reinforced' in the present. Women need opportunities to reflect on how they were set up during past abuse, in order to recognise why their emotional responses to current events is not indicative of their 'stupidity', but is related to real life events. Women do not self-harm because they lack information or imagination. They self-harm for multiple reasons: because they have few choices, are trying to keep themselves safe, are trying to take some control, and are trying to stay alive. Only sometimes is self-harm about the will to die. This is evident when we listen to women and validate their experiences.

EXAMPLE TWO:

SOME PROBLEMS WITH ADDICTION MODELS

One way women cope with past experiences of child sexual abuse, and the negative feelings these engender, is by using drugs and alcohol. Drugs and alcohol can provide distraction and dissociation from difficult emotions, such as shame, guilt, fear, anxiety, and anger. Drugs and alcohol act as a cocoon that protects women from their negative feelings about the past, and numbs them to abuses in the present. Sometimes, however, women's use of drugs and alcohol may spiral out of control. They may then need help to cope with the coping strategies they use to survive. It is in this context that some women turn to 12-step addiction models, such as Alcoholics or Narcotics Anonymous (see for example, Narcotics Anonymous, 1988).

According to this approach women must admit that they have a disease, for example alcoholism, over which they have no control,

and that it is only when they put their faith in a higher authority their lives will improve. Any emotion they felt or any action they did when drunk is not real and nor valid and, therefore, should not be trusted. They must remain vigilant around alcohol for the rest of their lives. They may be permanently 'in recovery', but they can never recover: once an alcoholic always an alcoholic. The medical model, from which this understanding derives, 'works' for many service users. Psychiatric drugs, like illegal drugs and alcohol, can provide release from negative emotions. But this just maintains people in their misery. People can never get better because they are understood to be fundamentally diseased, and the issues that bring them to drugs or alcohol can be ignored. There is a price to pay in joining AA. Women must accept their disorder and embrace their powerlessness. They must dismiss their emotions and actions associated with alcohol (or drugs) as being unreal and invalid.



Yet, whilst drugs and alcohol can dull emotions, sometimes they do the opposite and enhance our capacities to feel. Experience suggests that drug and alcohol use is not always pathological. Additionally, some of the skills, creativity and commitment needed to secure alcohol and drugs are not invalid, these are skills that are useful in everyday life. The AA model cannot recognise this because everything women do is dismissed as a symptom of the disease that is alcoholism or drug addiction. Their behaviour is their identity. One drinks therefore one is an alcoholic. Yet women drink and use drugs for many different reasons: for pleasure, for distraction, in celebration, as well as in despair. Our desire to respect other's experience should never be used to foreclose healthy debate. I do not doubt that AA works for many women. I do think there are problems with disease models. I think women are best served when they can make informed choices about the services they use. They may still choose AA, but they do not have to accept that being diseased is the only way their problems can be understood.

SAM WARNER

**Consultant Clinical Psychologist
and half-time Research Fellow,
Manchester Metropolitan University**

REFERENCES

- Angelou, M. (1984) *I know why the caged bird sings*, London: Virago.
- Butler, J. (1990) *Gender trouble: Feminism and the subversion of identity*, London: Routledge.
- Chesler, P. (1989/1972) *Women and madness*, London: Harvest/ HJB Books.
- Danica, E. (1989) *Don't: A woman's word*, London: the Women's Press.
- Davies, A. Y. (1981) *Women, race, and class*, New York: Vintage Books.
- Department of Health (1999) *The National Service Framework for Mental Health*, London: The Stationery Office.
- Department of Health (2002) *Women's mental health: Into the mainstream - Strategic development of mental health care for women*, London: Department of Health Publications.
- Enns, C. Z. (1997) *Feminist theories and feminist psychotherapies: origins, themes, and variations*, New York: The Haworth Press, Inc.
- Friedan, B. (1963) *The feminine mystique*, New York: Norton.
- Kitzinger, C. and Perkins, R. (1993) *Changing our minds: Lesbian feminism and psychology*, London: Onlywomen Press Limited.
- Lewis, H. (1997) *House Rules*, London: Secker and Warburg Limited.
- Narcotics Anonymous (1988) *Narcotics anonymous*, 5th Edition, Chatsworth, California: Narcotics Anonymous World Services, Inc.
- Norwood, R. (1986) *Women who love too much: When you keep wishing and hoping he'll change*, London: Arrow Books Limited.
- Pembroke, L. (1994) *Self-harm: Perspectives from personal experience*, London: National Self-Harm Network.
- Ramazanoglu, C. and Holland, J. (1999) 'Tripping over experience: Some problems in feminist epistemology', *Discourse: studies in the cultural politics of education*, 20, 3: 381-392.
- Reynolds, S. K. and Linehan, M. M. (2002) 'Dialectical behavior therapy', *Encyclopedia of Psychotherapy*, volume 1: 621-628.
- Showalter, E. (1985) *The female malady: Women, madness and English culture, 1830-1980*, London: Virago Press.
- Warner, S. (2003) 'Disrupting identity through Visible Therapy', in P. Reavey and S. Warner (Eds.) *New Feminist stories of child sexual abuse: Sexual scripts and dangerous dialogues*, London: Routledge, pp. 167-186.
- Warner, S. (2000) *Understanding child sexual abuse: Making the tactics visible*, Gloucester: Handsell Publishing.
- Warner, S. (1996) 'Constructing femininity: Models of child sexual abuse and the production of "woman"', in E. Burman et al, *Challenging women: Psychology's exclusions, feminist possibilities*, Buckingham: Open University Press.
- Warner, S. and Wilkins, T. (in press) 'Between subjugation and survival: Women, borderline personality disorder and high security mental hospitals', *American Journal of Contemporary Psychotherapy*.

Unwanted Gift? No Wear

(this poem is part of a longer sequence)
Maggie Baker (maggie.baker2@virgin.net)

Jacket I
It's there on the chair
The red fleece jacket
With hood and drawstring waist
That I don't want to wear
Don't want to keep.

It's warm and soft when I put it on
But far too big for me
Drowned in a red sea
Shapeless, I feel
A baggy, saggy, faceless entity.

I look at the jacket
On the chair
In limp, loose folds of red, and seams
This isn't the jacket of my dreams.

It's theirs to wear
Not mine to keep
Their tears to cry
Not mine to weep.

It's there on the chair
The red fleece jacket
With hood and drawstring waist
That I don't want to wear
Don't want to keep
So I've put a price on its head
To let it go free
To someone who wants it
But that's not me.



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What I meant

BY JACKIE HAGAN

He has a face like a raised eyebrow,
takes charge like a short man with a big dog.
Wants you to fling your insides out,
wants you to take the bait and open the box
and talk, talk, talk.

You try to make your words
sound like something you know
but the gap between your brain and your tongue is growing
and he won't let you take a breath.

The depth he'll sink his hands into,
pinches your words between finger and thumb,
crumbles what you meant to say,
tweezers some sort of gist.

Grips the skin of sounds and makes a sense
of your pilfered fears
sponges up your tears into academic notebooks
into spider diagrams,

flow charts of everything you value and keep secret
and you kneel at his feet as he whitewashes
as he scrapes the inside out with a biro

the pulp of your problems is spread
and picked at, picked at, picked at
until it all adds up in a perfect sum

and the equation of why you're so fucked up is complete
makes you neater, sleeker and discrete
and he's happy.

You close the door and leave and think
that you forgot to say
"That wasn't what I meant."

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