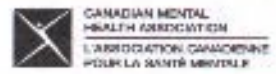


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Number 3, Winter 1998



BC's
Mental
Health
Journal

Visions



Women's Mental Health

What mental health issues
concern women?

What do women-centred mental
health services look like?

How does the context of a woman's life
have an impact on her mental health?

Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the Canadian Mental Health Association, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers and community.

In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association is grateful to the Ministry of Health, who has assisted in underwriting the production of this journal.

The Canadian Mental Health Association invites readers' comments and concerns regarding the articles and opinions in this journal. Please send your letter, including your name, address and phone number to: "Visions" Editor, Canadian Mental Health Association, BC Division, Suite 1200 - 1111 Melville Street, Vancouver, BC V6E 3V6 or e-mail to: office@cmha-bc.org

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Editorial Board Nancy Dickie, Nancy Hall PhD, Dr. Raymond Lam, Patrick Storey

Executive Director Bev Gutray

Editor Dena Ellery

Staff Writers Dena Ellery, Mark Lowes

Coordinator, Resource

Development Ina Hupponen

Design Robert MacDonald

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GUEST EDITORIAL

Context of Women's Lives Informs How We Understand and Treat Mental Health Issues

Nancy Hall

Editing this special edition on Women and Mental Health for Visions was a challenge because I look at support for women with experience with the mental health system through at least three lenses: as an advocate for women's health, as a researcher and as a family caregiver to a person living with schizophrenia. In my day to day work at BC Women's, I see how the health service system is insensitive, although not intentionally, to women's specific needs. The health care system tends to use the male experience as the norm and providers ignore the fact that relative to men, women are more likely to be living in poverty, more likely to experience violence in

relationship and more likely to have family caregiving responsibilities that create unique vulnerabilities and access problems. Unfortunately, women's mental health needs are typically seen to be relative to their biology and not due to their experience of being a woman in society.

Women want their health needs treated holistically, not according to medical specialities that are usually designated by reference to body parts. Women want the reality of their experiences and the interconnection of mental illness, violence in relationships and alcohol and drug use acknowledged. Women



Nancy Hall, Ph.D., is the director of Health Promotion at BC Women's Hospital and Health Centre in Vancouver, BC, and chair of the Minister's Advisory Council on Women's Health. Nancy is primary researcher in a number of women's health projects, including the Older Women's Health Project, profiled in this issue of Visions.

want the health care system to recognize their diverse needs and respond in a woman centred way. In this issue, Liz Choquette from the Vancouver Richmond Health Board Mental Health Team talks about women centred therapy for women who are users of the mental health system and Mahin Kodabandi from North Shore Family Services talks about providing mental health promotion strategies to immigrant elderly women whose first barrier to care is social isolation and the inability to speak English. Pat Fisher from the Trauma Services unit at Riverview reminds us that women with mental illness often suffer from sexual abuse and physical

trauma and need supportive counselling in to address trauma as well as basic medical care and safe places to live in the community.

As a researcher, I see how older women's loneliness and isolation are "medicalized" into psychiatric diagnoses that lead to tranquillizer dependency and quiet despair. While the pharmaceutical companies can be counted on to research new drugs to control the symptoms of serious mental illness, British Columbians need a renewed effort to develop mental health research that actively involves mental health consumers in identifying their issues and constructing solutions. The

Continued on opposite page

GUEST EDITORIAL

participatory action research project described in this issue is an example of a different kind of research designed to develop women centred knowledge. We are challenged to do more research with women who have experiences with the mental health system rather than research about them.

As a family member of a sibling with schizophrenia, I also experience frustration with the lack of mental health services to address the basic needs of the seriously mentally ill. I appreciate that for some family members, the concerns of "special interest" advocates tend to fall on deaf ears when these basic needs don't seem to be met. As Jill Stainsby reminds us, women aren't a special interest group; we are 52% of the population and as a group, not only are we more likely to use the mental health system but in our multiple roles as workers and family caregivers are more likely to experience unique mental health problems. Women are more likely to suffer from depression; but then as one woman working in the Downtown Eastside told me "women's lives are more likely to be depressing. Freedom from violence and pay equity would go a long way towards reducing the consumption of Aivan and Prozac!"

In this issue, we asked Maureen Fantillo to share some of her experiences living on the edge as a family caregiver of two people with rapid cycling bipolar disorder. Readers might reflect upon community strategies to support the thousands of family caregivers, the majority of whom are women, in caring for their own mental health. Supportive housing is at the core of this need but beyond that basic social contact and respite are enormously important.

Also in this issue, we wanted to portray examples of women who are working for changes in the provision of care and community supports for women who are seriously mentally ill.

The stories from Peggy's Place on the Eastside of Vancouver speak to the importance of creating a safe "woman only" space for women living with mental illness to live. In addition, the Kettle Friendship Society's drop-in gives women an opportunity to provide mutual aid and support, an important value in achieving women centred care.

Other stories in this issue portray community programs working to address eating disorders and post partum depression, mental health issues almost specific to women. The VISTA Eating Disorders Program at St Paul's is a residential treatment centre designed to address this life threatening form of mental illness. It is encouraging that Children's Hospital has been granted funds to open a similar project aimed at children. Sandy Friedman shares some of the concepts from a prevention program she developed to address some of the root causes of poor self esteem and distorted body image among young girls. Dr. Shila Misri reports on the Reproductive Psychiatry Program and the work it is doing along with the Pacific Post Partum Support Society to address the needs of women who suffer from post partum depression.

Together our contributors suggest as a province, it is time to envision communities and health service systems that will work for women and their differing mental health needs. It is truly exciting that for the first time, the new Mental Health Plan calls for gender sensitive care. Being able to realize this is the challenge before us and in publishing this issue, we hope the reader is inspired to reflect on the meaning of women centred mental health care and take action. Not only is it a request to deliver care in a different way, it is a request to consider the systemic roots of the factors that would promote women's mental health.

Editor's Message

This journal reflects current and future thinking, practice and perspectives on and within BC's mental health system. It is knowledge gathered from many sources, which reflects the CMHA Community Resource Base. Knowledge comes from an individual with a mental illness as well as from clinical perspectives, from family members and from friends and loved ones. These are the voices and visions we read in BC's mental health journal.

This journal aims to provide a place where debate and different perspectives can co-exist. Is there a difference between how mental health issues are viewed and treated between cultures? Between rural and urban BC? Between genders? Between service provider and consumers of mental health services? We need this dialogue in order to increase understanding, and to build ways to work together to make our mental health system.

Wherever and whenever possible, this journal is about putting theory into practice. We hope to always ask the question, "What does it look like in real life? How will it affect me or my family member? How can I make a difference?"

Our next two issues will focus on "What is mental health?" and "Community inclusion and integration: How welcoming is your community?" If you would like to contribute your perspective, please contact me. I look forward to hearing from you.

Dena Ellery is general editor of *Visions: BC's Mental Health Journal*.

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What are Women's Mental Health Issues?

Jill Stainsby

I find it challenging to define what is specifically a women's issue, among the many needs and realities of the experience of mental health disorder and treatment by the mental health system.

For example, women make up the larger percentage of people given treatment within general hospital psychiatric systems, compared to the high ratio of men in the tertiary care psychiatric system and the forensic system. I also know that in all sectors women stay in hospital longer once admitted. Geriatric mental health care is a growing concern, and impacts more women than men simply because women live longer. In addition, women are often poorer when elderly due to the loss of a breadwinner spouse.

In the community care sector, the clients are about 52% women, which is equal to the ratio of men and women in our society. However, statistics from the Greater Vancouver Mental Health Society show that 53% of the supported

mental health residential beds are filled by men – approximately a 5% shift from the population that needs services. Perhaps women are better at finding housing on their own? Or is it easier for a woman (traditionally less aggressive) to maintain the family and relationship links she needs to, so that she can stay in, or return to, the home in which she first got sick?

Diagnoses vary with gender as well, according to Statistics Canada:

- In the community men are 20% more likely to be diagnosed with schizophrenia than are women. Women are diagnosed with the major affective disorders twice as often as men.
- Personality disorder is diagnosed in women more than twice as often as in men.
- Post-Traumatic Stress Disorder is diagnosed nearly three times as often in women as it is in men. Men, however, have the leading edge when it comes to alcohol or substance abuse; approximately three times as many men are alcohol or drug-dependent.

Are you a professional or a manager with a psychiatric condition?

Boston University is surveying people who have middle and upper level careers or employment and who have a psychiatric condition to learn about how they get and keep these kinds of jobs. The Centre for Psychiatric Rehabilitation at Boston University would like to mail you a survey to find out how you got and keep your managerial or professional employment. The information you give will be used to describe and develop strategies so that

other people with psychiatric disabilities can get this kind of employment.

Your information will be completely confidential and anonymous. Your name will not be kept with survey documents and will not be published in any way. Everyone who fills out a survey will receive \$10 for their participation. For more information, please call collect (617) 353-3549 and ask for Dr. Marsha Ellison.

• And for all categories of alcohol and drug dependence, psychosis, and substance-induced mental disorder, the figures for men are twice as high as for women. An argument has been made in this regard that women abuse substances that are prescribed to them, although this is relatively difficult to measure.

Some issues that disproportionately affect women (aside from poverty and possibly less access to supported housing) include life experiences that quite likely lead to emotional stress, mood disorders and psychosis. These include single parenting, care-giving roles, menopause, divorce, premenstrual dysphoria, and physical and/or sexual abuse. These all typically have a greater effect on women than on men. For example, 'Single mothers are more likely to be poor, to have an affective disorder and to use mental health services than mothers in two-parent families. The risk of mental health problems is especially pronounced among poor single mothers.' (Lipman, Offord and Boyle, *CMA Journal*, 156[5], p.641). 'Women self-report poorer physical health than men... Women are much more likely than men to have depressive disorders, get prescriptions for them, and are more functionally impaired.' (Williams et al., *Am. J. Obs & Gyn.* 173(2) p.660).

And finally, "...mood, anxiety and somatoform disorders and psychiatric comorbidity were all significantly more common in women than in men... These data suggest that one of the most important aspects of a primary care physician's care of female patients is to screen for and treat common mental disorders." (Linzer,

et al., *Am. J. Med.* 101[5], p. 527).

The situation is one sometimes of quiet desperation,¹ as women are more likely to be at risk due to social deficits in their living arrangements, tend towards poorer physical and mental health as a result, and receive less intense care (though an argument could be made that, given the problems inherent in the current system, this may not be all bad). Women are also less often diagnosed accurately by their primary care physician, act out less (at least in terms of being placed in a forensic setting), and are more likely to be poor and sick when elderly. I have not even touched on the reality that a large percentage of women with mental health disorders have also experienced physical and/or sexual abuse (see P. Fisher's article, this newsletter).

I wish that what I say here was not the truth—that mental disorder was, in fact, an equal opportunity experience, but clearly this is not the case. Women's lives place them at risk for many disorders, including mental health disturbance. While it doesn't place as many women as men in tertiary care or the forensic system, it significantly lowers the quality of life for women, especially because they are more often in socially disadvantaged positions like single parenting.

Jill Stainsby is a consumer-survivor who is employed as a patient relations coordinator at Riverview Hospital. She co-produced and took part in the award-winning video "Within These Walls," on the experience of mental health hospitalization. She also works as a consultant.

Woman-Centered Therapy: Understanding the Context of Women's Lives

At the heart of a woman-centered therapy is the recognition that each and every woman has a biography, a personal history.

"We must understand that the traditional approach to therapy in our mental health system does not meet the unique needs of women," explains Liz Choquette, an abuse survivors research worker with the Greater Vancouver Mental Health Services. "Practitioners trained in the medical model are not fully prepared to focus on the individual and what it's like for them to live their life each day."

The everyday experience of being a woman in our society is complex. Women are spouses and mothers, they are also victims of poverty, of mental, physical and sexual abuse. They are caregivers and drug addicts, homemakers and homeless. And a woman-centered approach to therapy takes this reality into account.

The starting point for woman-centered therapy is with the individual. There is no rush by the therapist to label or diagnose the client, to identify something specifically 'wrong' — as is too often the case with the traditional medical model. Instead, the therapist works with the client, helping her to articulate her own needs rather than simply dictating treatment and prescribing drugs.

"When you're dealing with a woman's mental health, you can't just lump together years of mental and physical abuse, or poverty, or lack of self-esteem and 'fix' these issues with a drug."

A truly woman-centered therapy takes into account a woman's unique experiences in the world and incorporates them

into an overall treatment program.

When a woman first experiences this form of individualized therapy, Choquette says the reaction is often shock. "To be attended to as a woman, as a person sitting there with a real life, with real life experiences, many find it a little overwhelming."

Above all else, the goal of woman-centered therapy is helping women find a voice of their own. It's all about empowering women to identify their own needs; what they need in the way

of mental health services. "A woman must find her own strength before she can see herself affecting the outside world on her own terms," says Choquette.

What does truly woman-centered therapy look like?

- it must be accessible to all women, regardless their social and economic status
- it starts with the individual and an exploration of their life experiences by asking the simple questions (for example, "What is the

experience of motherhood like for you?")

- it has to be individualized to meet the unique needs of each woman: enable them to put voice to their needs
- practitioners must be responsive, responsible, and flexible to the diverse needs of women from the full spectrum of social and economic backgrounds
- it must be sensitive to issues of cross-cultural awareness, especially the experience of immigrants and refugees coming to a new culture

Woman-Centred Therapy: What Does It look Like?

Woman-centered therapy is about women defining themselves and their own experiences within an egalitarian therapy relationship. It represents a theory and practice of therapy which grows out of an expanded awareness and appreciation of women's perceptions of the world. In woman-centred therapy:

- an emphasis is placed upon celebrating a woman's unique gifts and strengths rather than identifying sources of pathology.

- a woman's capacity to relate well and intimately to others is viewed as a source of strength and competence.

- it is important to understand the ways in which a woman's gender, race, class, sexual orientation, religion, age, or disability can lead to her being oppressed or marginalized within her culture. Such an experience can serve to profoundly disempower her.

- a knowledge of the psychology of women and its relation to women's experience and development, represents a guide for helping to heal and empower women.

- a woman talks about her thoughts and feelings thereby discovering what is true for her in her life - "her truth". The process of telling the truth as she experiences it is referred to as "finding her voice".

- clients are considered the experts on the meaning of their lives and their pain, the goals of their therapy and the success of their treatment.

- the role of the therapist is to acknowledge and call forth the hidden expert powers within the client - to help her to access her inner wisdom.

- the relationship between the therapist and the client is of primary importance.

- the therapist engages the client as an equal partner in a process wherein power is shared and client and therapist each has an impact upon the other.

- a primary goal is for the client to come to value her own needs and knowledge as she seeks to become an authority upon her own life.

- the therapy functions as a guide, a witness and a trustworthy companion on a journey of healing and discovery.

- the therapist seeks to empower her client and to help her to "find her voice". She does this by serving as an attentive witness to her client's truth while validating her experience and respecting her power and choices.

Dr. Gayle Way is a Vancouver psychologist and feminist therapist who works with women in her private therapy practice and as a consultant for the Burnaby Correctional Centre for Women.

Women and Mental Health Issues: The Role of Trauma

**Patricia Fisher, Ph.D.,
R. Psych.**

Issues of gender and socialization pressures play central roles in the life experiences of us all. This is particularly true when applied to the issue of trauma. As a clinical psychologist who specializes in the field of trauma, I was asked to provide an overview of the topic as it applies to women and mental illness.

What is at issue?

Over the past decade we have witnessed explosive growth in the area of trauma studies (particularly child and adult sexual and physical abuse/assault). Thus, we can now speak with considerable confidence and authority about incidence and prevalence rates, clinical features and sequelae (consequences), assessment and treatment protocols, and comorbidity (a person diagnosed with/experiencing more than one mental illness) patterns. We also know a great deal about the systemic social and cultural factors which promote and sustain abuse, and the intergenerational family dynamics of abuse and trauma. Given that the childhood sexual abuse (CSA) of women is the most widely researched area, it is likely a useful starting point to discuss the impact of trauma on women's mental health. An extensive body of research now tells us:

■ The rates of CSA are high in the general population (25% to 38% of women), and even higher in those accessing outpatient

mental health services (36% to 76%).

■ The long term sequelae to CSA fall broadly into 5 categories:

1. emotional sequelae:

CSA survivors are more than twice as likely suffer depression and four times more likely to be hospitalized for depression. There is also an increased risk for suicide attempts and gestures. Anxiety related sequelae such as obsessive compulsive disorder, phobias, panic disorder, and sleep disturbance are also prominent.

2. behavioral sequelae:

high proportions of eating disordered patients possess a CSA history, as do women alcoholics. About one third of CSA survivors reveal alcohol and drug abuse histories, and somatization disorders are frequently noted, as are high levels of sexual dysfunction.

3. cognitive sequelae:

CSA survivors frequently assume a shame-based identity, characterized by an inability to trust and a sense of pervasive powerlessness. Victims commonly experience feelings of isolation, alienation, and stigmatization. Many experience flashbacks to the abuse and many display a range of dissociative defenses.

4. psychological sequelae:

the greatest majority of patients diagnosed with Borderline Personality Disorder have been determined to have experienced childhood sexual abuse. However, the Posttraumatic Stress Disorder (PTSD) diagnostic label, seems to best capture the symptom cluster often presented by many adult CSA survivors seeking mental health services.

5. interpersonal sequelae:

given the experiences and belief systems evolved by many CSA survivors, it is not surprising that many go on to experience seri-

ous difficulties forming safe, trusting, long-term relationships. Most importantly, they are at high risk to experience physical and sexual assault as adults.

■ the risk for serious long term clinical sequelae have been clearly associated with a range of factors. In terms of the actual abuse, increased adult symptom severity has been associated with: father offenders, multiple perpetrators, earlier age of abuse onset, greater frequency and duration of abuse, greater levels of intrusiveness and physical violence. With respect to the family context, symptom severity is also strongly correlated with: increased levels of family dysfunction, the presence of family violence and physical abuse, negative response by mother following disclosure, and the absence of a good relationship with any adult or sibling.

■ the majority of sexual abuse offenders are male (from 90% to 97%) and girls are offended at twice to three times the rate of boys. The picture becomes even more gender specific in adulthood, where women are almost exclusively assaulted by male perpetrators.

The results reviewed above are primarily based on community samples, outpatients and those without serious mental illness. However, the issue of trauma and its impact on serious mental illness has not yet received much attention. The author was recently contacted to carry out a study at Riverview Hospital

Continued opposite

Glossary for non-clinical readers

comorbidity: having two (or more) categories of mental illness at the same time. For example, depression and alcoholism, or schizophrenia, depression and alcoholism.

present: to come forward as a patient

sequela: the aftereffects of an illness or a secondary result of an illness

socialization: complex process of learning how to be³ in the world, based on the social, economic, family and many other factors which influence us as we grow up

Peggy's Place: A New Transition House in Vancouver

Kathleen Whip

Theresa came to Peggy's Place in crisis several months ago. She has had a roller-coaster life of intense pain: trying to please a man who uses and abuses her for many years, psychiatric hospital stays,

tormenting fears, and struggles with the effects of heavy medications. Last night, in our support group, she disclosed for the first time that her "happy childhood" included watching her father beat her mother. Karen, another group member, was filled with

compassion, and reached out to Theresa. They were both trying to decide whether to continue their relationships with abusive partners. Both advised each other, "You don't deserve to be treated that way." The next day they went for a walk together,

In May, 1997, after years of consumer-based planning and lobbying by the Kettle Friendship Society, the dream of many women finally opened. Those in search of safety from sexist and other forms of violence have a transition house called Peggy's Place that also addresses mental health disabilities.

which considered trauma histories and clinical sequelae. Most of the patients who participated in the study suffered from schizophrenia and the results were consistent with the research on outpatients reviewed above and with the small emerging literature on inpatients and those with serious mental illness.

Although much more extensive, the basic findings of our study were as follows:

- 58% of women and 23% of men had been sexually abused before the age of 17
- 38% of women and 36% of the men had been physically abused before the age of 17
- 46% of women and 9% of men had been sexually assaulted as adults
- 54% of women and 32% of men had been physically assaulted as adults
- the women with childhood sexual abuse histories were significantly more likely to be sexually and physically assaulted as adults (57% and 71%, respectively)
- few of the women who were physically or sexually abused as adults disclosed their abuse and even fewer received any assistance after disclosure

Those with CSA histories were significantly at greater risk for: suicidal thoughts and attempts, eating disorders, difficulties in relationships, exploitive and abusive sexual relationships, drug and alcohol abuse.

What is at stake?

The current mental health system, as it applies to women with serious mental illness, is essentially not addressing the issue of trauma. This becomes a vital system flaw if we incorporate an awareness that about 50% to 70% of the women experiencing serious mental illnesses will have a significant childhood trauma history, and, of these, about 70% go on to experience sexual and physical assault as adults. Additionally, trauma survivors often present with a wide range of comorbid conditions (previously detailed) which are significant clinical features in their own right, and act, cumulatively, to increase the risks in managing serious mental illness.

What needs to be addressed?

A mental health system which genuinely wished to usefully address the needs of women would

have to construct its delivery system based upon 5 key principles:

1. women's experience of society, their illness and the helping professions differs in fundamental ways from that of men.
2. issues of entitlement, power, differing socialization norms, experience of previous exploitation and abuse, beliefs about male privilege, etc. all serve to influence the experience and course of women's mental illness.
3. issues of historic trauma and the range of consequent clinical sequelae are essential elements in the assessment and treatment of women patients.
4. women with serious mental illness have a right to access competent, knowledgeable and respectful treatment resources which address their wider mental health needs—beyond the basic medical management of their disorder.
5. given our current knowledge about the extent of trauma and its wide-ranging sequelae, it is now demonstrably inefficient, costly and unethical for a mental health system to not address the issue.

Some women at Peggy's have long histories of abuse, and have either been turned away or don't make it in regular transition houses, which rely primarily on peer support and minimal staffing. Residents and staff at Peggy's are building a model combining the best of both worlds. As a transition house, the emphasis is on claiming power over one's life, and the validation and support of a community of women with common experiences. As a house for women struggling with mental health issues, mutual aid is coupled with a longer stay (up to 6 months) and intensive staffing.

Based on feminist principles, the weekly support group design comes out of the experiences of residents, i.e., "What do I need to feel as safe as possible to participate?" Their group guidelines include:

- one at a time, but make connections between our experiences
- women can leave to pace themselves (to prevent the flooding of painful memories, etc.)
- no put-downs
- share the time
- respect our differences
- actively unlearn prejudices such as racism, sexism, homophobia, and
- no labeling

Mental Health Worker Builds Self-help into ESL

When new immigrants come to Canada, they're confused, coping under tremendous stressors, and having difficulty making any decisions - large or small. Family relationships and individual identity suffers, and newcomers' mental health needs increase. Meanwhile, mental health centres in a more diverse community are trying to keep up with demands placed on them by the English-speaking community as well as by and cultural and language-specific groups.

Family Services of the North Shore, in North Vancouver, BC

has taken a novel approach to meeting several needs of new immigrants at once. A newly-trained and hired graduate of a cross-cultural counselling program asked if the mental health provider could set up an English-as-a Second-Language (ESL) course on the site. For the first few months, Mahin Khodebandeh worked for free, helping people to learn English and to help each other learn about a new country. That was three years ago.

Today, Mahin coordinates over 10 volunteer teachers and nearly 50 students, who gather each

week to learn English at the ESL for Adaptation for Integration program. The name is ESL but it's really a support group. The relationships between students is so close that when they leave the class, they support each other,' says Mahin.

More importantly, Mahin says this is how people can connect to all kinds of services, including health-related services. It is difficult to access health services in general, and intensely so for mental health services. In the Iranian community, families may not often feel comfortable discussing

mental health issues, especially outside the family. Added to this level of stigma is the language barrier: when someone calls to reach out for help, the voice at the other end of the phone is speaking English.

Within the context of the supportive and safe environment of the ESL classes, Mahin and her instructors can refer students to resources they wouldn't know about otherwise.

Mahin herself works closely with the Iranian community. She works for both North Shore Health as an Iranian health aide interpreter and Family Services of the North Shore as an ESL program coordinator. In these roles, she helps families to cope with changing roles and responsibilities, seniors in particular. 'They're used to a lot of respect,' says Mahin. The parents watch their adult children learning new languages and moving forward, and parents become more like children. 'They lose their status,' says Mahin, who helps them to develop a new support system and identity in their new country.

Mahin's own experience echoes transitions. As a nurse in France and England and a native of Iran, Mahin built on her nursing background with cross-cultural counselling and nurse's aide courses. (Nursing diplomas are not recognized in Canada.) Mahin has been working at Family Services of the North Shore for four years, and has become a key liaison between health service providers and the Iranian community in North Vancouver.

These groups and informal discussions throughout the day are powerful testimonies to the strength and caring possible in a world where women are routinely devalued. Within a context which emphasizes safety, women share information or learn from each other about managing feelings and pacing memories; the importance of self care and stress management; how to build community and negotiate healthy relationships (including problems of groups living); and getting back into meaningful work (be it volunteer or paid). Each resident also has a "key worker" on each day, who offers more concentrated support, including goal-setting.

Peggy's Place also works closely with the "women and violence worker" for Greater Vancouver Mental Health Services, and our community mental health team who provide consultation, training, assessment and follow-up for some residents.

Our funding comes from the BC Ministries of Health and Women's Equality.

A helpful manual used by Peggy's Place so far has been *The Elizabeth Stone House Handbook: Sheltering People in Emotional Distress*, which can be ordered by phoning (617) 522-3417.

What residents say about Peggy's Place

"The longer I stay the more I want to continue my journey of saving myself and my soul in a safe environment. Without a doubt the workers' attitudes of non-judgment, even if they never walked a mile in my shoes. Also what is astounding is their willingness to listen without being shocked, as I have been in 2 other transition houses... Last but definitely not least is the workers that have been down the road who are able to give back in some capacity."

"The support groups...helped me realize that what I was going through in my relationships was normal."

"I find it helpful that there is flexibility here in terms of comings and goings. Also I appreciate the staff challenging me to think seriously about my life and my relationships. I

*Kathleen Whipp is the advocacy worker at Peggy's Place. Her research, **Lost in the Diagnosis: Incest Survivors in Psychiatry** and extensive experience with sexual abuse survivors, have been the basis for training mental health workers in Ontario.*

have been running for a long time, so it's nice to have the addiction, abuse, mental illness etc., that are now working in some aspect of the house...I hope somewhere down the road I will opportunity to feel genuine and be myself."

Four women mentioned their appreciation of the other residents, to make new friends and "not isolate so much." At the same time two mentioned the importance of having their own rooms "relaxing, peace of mind", and "private time. Three women talked about the usefulness of staff input and encouragement to try new coping strategies, such as periodically checking in on one's feelings. The emphasis on choice was also noted as essential to two residents.

Fostering Older Women's Emotional Well-being: Reducing Benzodiazepine Use

Valerie Oglov

The Older Women's Health Project

The Older Women's Health project is developing knowledge about the experiences of older women and how they cope with the life problems that often result in depression, anxiety, grief and insomnia, and to develop knowledge about how they experience the use, reduction and withdrawal from benzodiazepines. We hope to improve health care for women as a result of our work.

There are 6-8 co-researchers, 5 resource people from the community, a coordinator and a principal investigator to carry out the work in this 2 year project. Our project has 3 phases: research, resource development, and distribution of resources in the community. It is funded by the BC Health Research Foundation and supported by BC Women's Hospital and Health Centre.

Why this project is unique

Our project is unique because of its method and because of the research assumptions we hold.

Benzodiazepines

Thirty percent of women on Vancouver's North Shore are prescribed a benzodiazepine to help them make it through the day or night. Benzodiazepines are a family of drugs called anxiolytics, which include Assign, Imovane, Serax, Rivotril and Restoril, among others.

Benzodiazepines are most commonly prescribed for acute anxiety and insomnia and are meant to be taken for a short time. However, they can also be addictive, they have many side effects and are difficult to withdraw from.

'Already, a core group of older women are working in the project. Together, we are discovering the instruments and tools through which we can describe our responses to experiences of anxiety, frustration, panic, grief, and unhappiness. Many of these are associated with psycho-socio-cultural factors such as isolation, loneliness, abandonment, low self-esteem as well as emotional and economical dependence. And those kind of experiences lead people to develop symptoms of physical illness.' – Lucila Medina, Participant/Co-researcher in the Older Women's Health Project.

Method

We are using PAR (Participant Action Research) methodology which means that the 'target population' of older women is involved in almost every aspect of research design. Many health promotion strategies fail because they are not designed by the people they are meant to benefit.

Our main 'tool' for collecting data is storytelling. Through the stories women share, we develop an understanding of the problems women face, and collectively we learn what women need to help them through their bad times. Themes that arise from the stories are then discussed with women in the larger community and the circle of knowledge is widened.

Assumptions

We assume that women, not professionals, are the experts on their own experience and that they know best what they need in order to live well.

We assume that it is empowering and validating to respect, develop and apply one's own knowledge about 'the problem' (as opposed to that of the medical establishment) to the solution of the problem.

We assume that because women are different from each other as well as similar, they will have had different experiences of life. The alternative strategies that will work best for each woman will vary according to such contextual factors as culture, language, family experience, socio-economic status, education, among others.

We assume that there is appropriate use for benzodiazepine drugs such as for short-term anxiety, grief and insomnia. But we believe that long-term use is damaging and that supports can be developed in the community that would provide women with what they need to cope and thrive in a more constructive way.

Preliminary findings

When women experience grief, what they need is grounding, balance and time for reflection. They would benefit from public rituals and collective symbols of grief which allow them to express their feelings physically, mentally, emotionally and spiritually.

As caregivers, women take full responsibility for the success of their families and they need to balance meeting their own needs with meeting the needs of others to be healthy.

Women often lose touch with their feelings. They believe they must suffer alone and they learn to 'block things out.' What they need is to become aware of their feelings, connect those feelings to what is going on in their lives, and to get recognition from others that what they are feeling is valid and 'normal.'

How can we foster older women's emotional well-being?

- We can enable women to name and describe their experiences rather than to have their experiences 'medicalized.'
- We can provide women with information on how to interact with the medical system, how to describe what they are experiencing and what questions to ask their physicians.
- We can provide women with empathy, support, validation and respect through community mutual aid groups.

Valerie Oglov is the Coordinator of the Older Women's Health Project, based in West Vancouver, BC.

VISTA Treats Whole Person in Battling Eating Disorders

Eating disorders are one of the hardest to treat mental illnesses, because at the root of eating disorders are complex relationships of power dynamics, family relationships, self esteem and work and life issues that become interconnected with the eating disorder. Having a such a strong understanding of this complexity is why VISTA, a 10-bed residential treatment centre in Vancouver, has been so successful.

For three years now VISTA has been offering a residential setting for rehabilitation from eating disorders which focuses on all aspects of a person's life. In traditional hospital settings, a 'patient' would receive psychodynamic treatment and often be in a situation where they are being tube-fed or provided with a medically prescribed diet, while their eating is closely monitored. In a residential setting, individuals attend day programs at the Eating Disorders Clinic at St. Paul's Hospital nearby, then participate in a range of activities at home which reinforce new attitude and behaviour-changes.

The emphasis at VISTA is about treating the whole person. 'It's as much about quality of life as it is about the psychodynamics of treating eating disorders,' says Tracey Dobney, Coordinator of VISTA. 'We concentrate on the day-to-day aspects of people's lives ... including practical things, like relating with friends and family ... work issues ... and what kind of leisure activities a person has.'

Each woman (there have been only 2 men in 3 years) directs her own goals within the three-



month program, working closely with staff counselors. It may include family therapy, individual and group counseling, new approaches to leisure activities, and a variety of other opportunities for personal growth and change. Building in positive experiences, goal-setting and interpersonal skills also helps to increase participants' self esteem - a building block of recovery from eating disorders.

The focus on nutrition occurs naturally. In contrast to hospital-based programs, VISTA's appears less regimented, with environments where participants must plan their response. For example, before dinner participants discuss their strategies toward the coming meal, including their response to 'trigger foods.' In a sit-down, family dinner style, dinner is served to participants and staff (up to 15 or more) around a large table. It may include foods which trigger a binge or binge/purge response in a participant. Afterwards, participants gather to check-in on their feelings

about the meal.

Participants' families, friends and even co-workers can be invited to participate in therapy, education, and/or activities. And on one day each week, every participant is asked to do something completely unrelated to anything at the rehabilitation centre. Leisure activities have included everything from volunteering at local non-profit agency, to helping out at a local pet store.

Graduates of the program are welcome to return as needed, and often come to share in the dinner meal with others. Two of VISTA's ten beds are kept open for graduates who return for shorter periods. Dobney says this supports participants to deal with setbacks which are a normal part of the recovery process.

Staff at VISTA overlap between the St. Paul Eating Disorder day programs and VISTA, and include a range of nurses and health care workers from a diverse background: social work, psychology, nursing, and art therapy. However, Dobney is quick to point out that

the differentiation between staff and participants is rarely referred to. Rather, the non-hierarchical team approach is the key to building trust and support for each other.

Dobney says that results have been very good for VISTA, with satisfaction surveys rating the program highly. The rate of recovery is hard to measure, however, since recovery is a whole-life process and not a 'quick-fix' kind of situation. Dobney says between 20 and 30 per cent of participants continue to struggle after leaving the program — which is why two beds are left open for those who need to return.

Children's Hospital has recently been granted funds to begin a similar project aimed at working with younger people experiencing eating disorders. It will be based on the VISTA model.

For more information about VISTA, contact Tracey Dobney, Coordinator, VISTA and Community Outreach Project, 604/736-9931.

Girl's Health Issues

Sandra Friedman

Adolescence can be difficult for girls. Before puberty, girls are psychologically healthier than boys and exhibit fewer behavioural problems. Until they are ten, girls flourish (if they have not been sexually or physically abused or have not witnessed violence firsthand). They mature earlier and are able to read and write sooner. They are also more adept as social skills. As girls enter adolescence, however, they begin to lose their self-esteem and sense of their abilities.

Something happens to girls as they grow into puberty. Because of the intense pressure for girls to be thin, many come to see their developing bodies as abnormal and to experience growth as being out of control. Girls stop operating from the center of their own experiences and begin to look outward for definition. They begin to disconnect from their bodies and from themselves. Girls experience restrictions in their lives and they are encouraged to accommodate themselves to the needs of others at the expense of themselves. During adolescence, girls fall victim to the tyranny of 'kind and nice' which teaches them that it is better for them to repress their feelings and ideas rather than run the risk of hurting someone else.

During high school girls deal with the distress of adolescence through physical symptoms such as stomach aches and head aches. They experience an increase in depression and in suicidal thoughts. They engage in smoking and drug and alcohol use to the same extent that boys do. Eating disorders are a particular risk for girls as they bind their self-

esteem to how they look. Without a direct means of expressing their feelings, they encode them in a 'language of fat.'

Girls in the 90's – Battling the 'grungies'

Girls in the 90's is a group program which is set in the context of girls' experiences and their lives. It looks at what 'feeling fat' means to girls and addresses this dynamic before it can become a fixed or internalized way for them to respond to situations in their lives, and before they escalate into an obsessive preoccupation with food and weight.

The program teaches girls to recognize the 'grungies'—a term coined to describe when they feel fat or ugly or stupid or anything else that makes them feel badly about themselves. Through discussion, role play and creative

expression the program encourages girls to tell the stories and/or express the feelings which lie underneath the grungies. Girls in the 90's validates the girls' feelings and lets them know why they feel the way that they do. It provides them with a context for the societal and personal pressures that they feel and teaches girls to support one another. It celebrates their interdependence and highlights the importance of the relationships girls have with the relevant people in their lives. It teaches girls skills and encourages them to practice new behaviour as they experience the physical and emotional changes in their lives.

The Girls in the 90's program can be adapted for different age groups and used to address a range of topics that are relevant to girls. Because it is set in the context of girls' lives it can be

used as an intervention program for elementary school girls as well as a support for girls as they make the transition into adolescence and into high school.

Because Girls in the 90's helps girls remain the center of their own experience, it helps them retain and rebuild their self-esteem and thus helps lower their vulnerability to eating disorders and to the other health risks that girls face.

Sandra Friedman is therapist in private practice in Vancouver and is a consultant in eating disorder prevention and girls' issues. She is the author of the Girls in the 90's Facilitator's manual (Salal Books, 1994) and of When Girls Feel Fat: Helping Girls Through Adolescence (Harper Collins, 1997). Her books can be obtained through Salal Books (604) 689-8399.

A personal reflection

As a woman with a 35-year history of a mood disorder (I have experienced lengthy episodes of depression every few years), I know my life would have been different if I hadn't had this disorder.

As it is, many people over the years have trivialized my illness with comments like:

- It's probably just PMS.
- You just haven't met the right man yet.
- Don't be a wimp. Everyone gets the blues now and then.

These sorts of sentiments have angered me, but most of the people who uttered them didn't know any better. Hopefully, with

increased awareness of mental illnesses, as promoted by organizations such as the CMHA, the true impact of mental illness on all persons will be understood better.

I'm not suggesting here that a man with a mood disorder, or any other mental illness, has an easy time with it. Being a female with a mood disorder means that I have probably been treated more sympathetically and compassionately than a man with a similar disorder would have been. Our culture has evolved in a way such that women are "allowed" to get depressed; it is not a masculine thing to do.

Women have always faced extra

challenges in many facets of life. Coping with a mood disorder, or some other mental illness, is an additional challenge. Many articles in this issue of Visions bear testament to that. Education and public awareness will move us all towards better understanding.

Woman as Caregiver: Living "on the edge of burnout"

Maureen Fantillo

When I think of what it means to be a caregiver, I do not have to think hard. You see, I am a caregiver to two mentally ill people. Both my husband and son have severe mental illness. Everyday life is like an emotional rollercoaster. As a family, we have struggled for many years with a system that refuses to recognize our illness.

For my son, who is now fifteen, it has been a difficult struggle for support and financial services. The system simply does not understand the extent to which this illness affects everyone. The emotional toll of seeing my only child fight an inner battle is heart-

breaking. Words cannot express the losses I've encountered along this lonely road. From inside I draw strength and move ahead. I must stay positive and look for the hope of new drugs and changes in the system. I allow myself to dream only so far, then wrench myself back to reality. We live for the days when my two men are at peace within themselves, and we cherish those times. I draw upon those times when the struggle becomes almost overwhelming.

At thirty-nine, I am continually grieving over lost dreams and what might have been. The man I married ... he is not the man I now live with. It is very difficult to watch pieces of the people you

love leave and never come back. I have learned that it's okay to grieve, and then let go and move on. My sense of humor has certainly helped me with the dark side of mental illness. As the magnet on our fridge reads, 'You don't have to be crazy to live here, but it helps!'

One of the many stresses is the financial end of things. For the last few years my husband has no longer been able to work. This has now added the role of main breadwinner to my duties! I also advocate for my son and husband, which is very tiring. If it is this difficult for me to advocate for help, a mentally ill person would be hopelessly lost. It is also exhausting dealing with so many

different areas to try and access any available help.

With the government not recognizing the role of caregivers, this has added to my struggle. If anything should happen to me there would be two people needing to be looked after. It costs thousands of dollars to keep people in psychiatric wards. The government needs to start addressing these issues, and recognize that it's cheaper for people to be cared for in their own homes!

In our case, we are working towards owning our home. This has given us a sense of wellness. It would be unfair to ask us to give that up because of the financial hardship this illness has inflicted on us. Losing our home would jeopardize our mental health even more!

Especially when my skills are so high, why not give us some financial help? If children end up in foster care, it is far more expensive and the staff skill level would not be like mine. I have lived with two mentally ill people for several years!

It's time we made some changes and stopped the struggle. Every day life is hard enough for the mentally ill and their families — let's not make it any harder. I will continue to advocate for the rights of the mentally ill and their families.

As for my role as a caregiver, I will continue to live on the edge of burnout. Until changes are made in our social system, life will continue to be an uphill battle. My hope is that one day soon I can write a different ending to my story.

Tickets are on sale now!

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Now in its 3rd successful year the **Greater Vancouver Open** is part of the official PGA Tour.

Enjoy a great week of golf, save money and support the Canadian Mental Health Association, B.C. Division all at the same time.

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For more information see inserts in this issue of *Visions* or call CMHA, B.C. Division at **688-3234**.

Women's Lounge Offers Privacy at Vancouver Drop-in

Erin Graham

The Kettle Friendship Society has had a woman-only space since we moved into our new building in December of 1996. Staff and members of the Kettle have long recognized that, while a large majority of psychiatric consumer/survivors are women, most of the people using the drop-in are men. The thinking behind the introduction of a woman-only space was that women would go from using just the women's lounge to eventually participating more fully in the larger drop-in.

Women who have undergone psychiatric treatment are more likely to have their children taken from their custody, be misdiagnosed for physical ailments; have greater difficulty finding adequate, safe shelter, and generally have more obstacles in their way than do men in similar circumstances, or other women without disabilities. Women with psychiatric disabilities are also more vulnerable to attacks by men (sexual harassment, sexual and physical assault) than women who are not disabled. Resources such as transition houses are often not accessible to them.

The idea of the women's lounge began in 1979 with the formation of the Women's group, which offered women a chance to gather together to talk to one another about their lives and to do things together that they may not have done in the general drop-in-setting, with men also participating.

Since that time, many women have been involved in the Kettle exclusively through the Women's

group. Most of these women now come to the drop-in to use our services and to participate in other programs as well as the women's group.

We asked women what they liked about the women's room, and what the value was to them of a woman-only space. Every woman we spoke to said that they appreciated a place they could go to get away from the men. The reasons for this were more to do with enjoying the company of women than with escaping the men, although they did say that men's behavior was sometimes disturbing or threatening. One woman said that she thought that the lounge offered protection from men, especially when a woman first arrives here. Women said to me that they enjoy the company of women and the quiet of the room itself. They felt safe.

The room was decorated by the women's committee, a group of members and staff who applied for and received a grant to furnish and decorate the lounge. The furnishings are tasteful and comfortable, and there are two lamps that provide diffuse lighting rather than the overhead that is built in. Because the room was decorated by the women that use it, they have an investment in keeping it clean, comfortable and inviting. Many women said that they enjoyed the lounge for its decor and ambiance.

The women that I spoke to said that they liked having the women's lounge because it was a place they knew they could go to for private conversations with other women. They said that it

brought women closer together, and provided them with social opportunities that they often didn't think they had in the larger drop-in. Privacy was mentioned by several women, and the increased possibility of having a quiet and uninterrupted conversation is appreciated. Because of the Women's group, the opportunity for making friends is greater than in other programs that are mixed.

'The other areas are dominated by men, ... here there are no men hollering and complaining'

'The Women's' lounge is a place to put your coat, ... women share things with each other'

'I like the decor in the Women's' Lounge, and I like interacting with the other women.'

'It's quiet, away from the men. Men don't come onto you sexually in here'

'... Fear of violence by men. In here—no fear.'

It's bright and cheery, a nice place to write or knit, and to be alone with your thoughts, or just with other women.'

'We can defend one another in here, you should hear some of the men in the smoking room, going on about themselves... it's relaxing in here.'

The majority of Kettle members (both women and men) who participated in the planning for use of the new space were supportive of women only space. Some of the men who use the drop-in were initially unsupportive of the project, and reacted to the idea of a women's lounge with defensiveness, but since have treated the space with

respect. It is explained to them that there are more women than men who undergo psychiatric treatment, and fewer women than men who use rehabilitative services such as drop-in centers. In the main, they think about this and become more accepting and sometimes even encouraging of the idea of a men only space.

The Kettle has been around since 1976. In its history, the organization has always tried to take the leadership of the folks that use the centre, and the folks that ought to use the centre. The women's lounge is one avenue we have found to increase our accessibility to women with a psychiatric disability.

Erin Graham is a mental health worker at the Kettle Friendship Society, a non-profit mental health support provider (i.e., housing, drop-in) and advocacy centre. For more information, call 604/251-2854.

Are you depressed and do you suffer from bipolar disorder?

If you are 18-65 years old, generally in good physical health, have been diagnosed with bipolar disorder, have had at least one episode of mania (persistent "highs" euphoria, irritability, decreased need for sleep, increased energy levels, activity, sociability and/or sexual drive, pressured or rapid speech, and racing or rapidly changing thoughts), and currently have any of the following symptoms:

- feeling down or sad
- Fatigued or less energy
- Loss of interest or concentration
- No appetite or weight loss
- Insomnia

You may be eligible to participate in a research study of new medication treatments. The study is being conducted by doctors at the Mood Disorders Clinic, University of BC. For more information, call 822-7294 or 822-8045.

Psychiatric Services for Women Coping with Mental Illness During Reproduction Stages

Some women who have never before had signs or symptoms of mental illness appear to develop problems during pregnancy, child birth or post-child birth. In BC, a specialized program which operates out of the BC Women's and St. Paul's hospitals helps women to deal with the effects of pregnancy and birth on their mental health.

The Reproductive Psychiatry program works with women at various stages of their reproductive cycles helping women with severe PMS, working with women who are infertile and cannot get pregnant, as well as helping women with significant mental health problems before, during and after pregnancy. The clinical services are part of ongoing research in reproductive psychiatry, and are provided by a staff of five psychiatrists who work at both sites.

Dr. Shaila Misri is a director of the Reproductive Psychiatry program, and has also published a book, *Shouldn't I be Happy?: Emotional issues of pregnant and post-partum women*. Dr. Misri says that most of the women she works with have depression, and that before they were pregnant or had their child, they had no signs or symptoms of the illness.

The good side is that many are helped. "They don't stay for a long time," says Dr. Misri, who sees patients from all over Western Canada and the northwest US states. "Because they are a highly motivated group. They want to get better — to get back to their family."

The program includes family members in the education and

therapy, and recognizes that a woman's mental health has an impact on every person in the family. In a recent interview in MacLean's magazine, Dr. Misri noted that children of mothers with mood disorders experience changes in their play, sleep and appetite.

The Reproductive Psychiatry program connects and involves women with post-partum depression support groups which also significantly supports their recovery.

The PMS Clinic at the Reproductive Psychiatry program includes counselling, dietitian serv-

ices and an educational group for spouses.

The program emphasizes involvement of and outreach to multicultural communities. Several immigrant-serving agencies have become partners in the Reproductive Psychiatry program.

1997 IAPSRS Conference identifies Women's Issues in mental health field

A group of women from around the world gathered in Vancouver at the 1997 conference of the International Association of Psychosocial Rehabilitation Services (IAPSRS) to identify issues of concern to mental health service providers, consumers, administrators, researchers and family members.

The Women's Forum was particularly concerned with ways and means to address the strengths and needs of women consumers, in order to improve their quality of life and rehabilitation more often. Psychosocial rehabilitation workers also identified workplace-based needs around balancing family responsibilities and work.

Issues the group identified, and have agreed to continue to address, were categorized as follows:

General issues regarding women and gender:

- Make women's issues a priority in programs and within IAPSRS
- Promote the voices of women: both consumers and employees
- Provide child care at conferences

- Develop family-friendly workplaces.

Specific concerns for consumers:

- Life-cycle differences among women often go unmet or are misunderstood
- Provisions for consumer women and their children
- Provide childcare so women can attend rehabilitation and mental health/social services programs
- Provide parenting groups for consumers
- Address needs of surviving childhood and adult physical/sexual abuse
- Need for more assertiveness training
- Pay attention to safety issues for women (i.e., "model Mugging")

Specific issues for Staff

- Gender-specific styles of practice and management
- Mentoring: this is a role for leaders; need mentoring across programs as well
- Caring for the caregivers: the dilemma of caregiving overload .. "how can we support ourselves?"

- Dilemmas of professional women/managers and supervisors: role strain, sexism, racism, etc.
- Gender and cultural competence for our staff; how do we do it?
- Power issues between women; dilemmas for our supervisors

Larger Political Agenda

- Needs of different women — based on age, race and ethnicity, sexual orientation, religions, class backgrounds, etc.
- Gender inequity across services
- Parallel between consumers and staff: we are all women
- Civil rights, power issues, organizational stance
- Welfare reform: this will affect women consumers negatively
- Gay and lesbian issues often go unaddressed

For more information, contact Jessica Jonikas or Sheree Neese-Todd at University of Illinois (Chicago) at 312/422-8180.

New Books Look at Psychiatry from Women's Perspectives

Reviews by Jill Stainsby

Two books written by 'crazy' Canadian women have been released this past year. They both describe journeys, and both contain interviews with people they have met who belong to the anti-psychiatry (in the case of Irit Shimrat) or poverty (in the case of Pat Capponi) communities. They remind me of what an academic might call 'participant observation,' in that they are both writing about the communities to which they belong.

Call Me Crazy

Irit Shimrat
(Vancouver: Press Gang, 1997)
I have tried to read anti-psychiatry books before. I read most of *Women and Madness*, but was unable to swallow any of Peter Breggin's rants, as I find him very repetitive. *Beyond Bedlam* had an inconsistent quality. Irit's book has the honour of being the only anti-psychiatry book I have every been able to read from start to finish. And I don't think this is because I have changed. I still believe that medication is necessary for up to two-thirds of the people labeled mentally ill, and that the term itself is a construct that refers to something which happens internally to some of us, to me for sure.

This book is easy to read because it is well written. It is not rhetorical or defensive in the way much anti-psychiatry writing is. Instead, it is a story of a woman's personal journey and the heroes she met along the way — the people in her world who are do-

ing anti-psychiatry political work. There is a chapter labeled 'Mighty Madwomen' which describes some activist women's lives.

I firmly believe that anti-psychiatry work is necessary to push the envelope, so that the services that are offered to those labeled with a mental disorder are more respectful, less invasive, and more empathetic. Irit celebrates her journey and the people she has traveled with, and the result is a very readable and enjoyable, non-dogmatic (though politically consistent) view of the 'crazy world.' I recommend Irit's book to those who have an interest in the mental health world, as a way of listening to the most disenfranchised constituency among us.

Dispatches from the Poverty Line

Pat Capponi
(Toronto: Penguin, 1997)
Pat Capponi's first book, *Upstairs in the Crazy House* (Toronto: Viking, 1992) is a classic in the world of those who have been hospitalized for psychiatric disorder, a clear-sighted view of the inhumanity of much of our residential housing. *Dispatches from the Poverty Line* expands Pat's view to include analysis of her experience of poverty (and her 'day parole' from it), the poor and crazy communities, and political analysis at the provincial level in Ontario.

The most telling moment in Pat's book is a comment from an affluent friend, who does not agree that Pat comes from a different class and life experience

than herself: 'I don't consider you a époor person.' It's just a difficult time for you right now.' I hear, intensely, her lack of understanding and recognition of what Pat is trying to do. I also feel great frustration at trying to make people understand what it means to be poor, crazy and powerless, which is the crux of Pat's writing. (I am not trying to claim membership in the poverty class, but I have spent some time crazy, hungry and frustrated by trying to get by. It's not a lifestyle of choice.)

Pat's writing is spare and clear, and the stories are told with empathy and clarity. The budgets of those who depend on assistance from the Ontario government add realism to the book. It is not depressing writing, but instead celebrates the spirit of those who are coping with poverty.

Jill Stainsby is the Co-coordinator of Patient Relations at Riverview Hospital.

Beyond Therapy, Beyond Science: a new model for healing the whole person

Anne Wilson Schaefer
Not a new book, but certainly one which speaks directly to women's experiences in seeking mental health, this is Anne Wilson Schaefer's follow-up to *Meditations for Women Who Do Too Much* and *The Addictive Organization*.

Wilson Schaefer discovered as a mental health worker in institutions and communities, that the theoretical frameworks she'd been taught didn't apply in her work help people build commu-

nities. She discovered that "objectivity was a fraud," and that women's needs were not being met when the ultimate goal was to find the right diagnosis so that the right treatment can be prescribed.

"Deep process" is Wilson Schaefer's term for the work which she has been doing with women and men for over ten years now. Deep process work answers "What do we have to learn from these [significant, often negative] experiences, and what do we have to do to work through the processes that present themselves to us, to become whole?"

Wilson Schaefer compares deep process with Freud's "boiling cauldron of the unconscious," and sees every woman's experience of deep Process as unique: from quiet, tearful memories recovered, to outpouring of rage or anger. Dreams, groupwork, one-to-one counselling and individualized work are all places for deep process work.

The model Wilson Schaefer used is organic; a growth model which sees us being constantly growing and changing, and sees psychotherapy as "partnerships in growth." And the process itself happens as individuals are ready, open and able to let it occur.

Deep process is not unfamiliar to us, it's that opportunities to enter them become more limited as we are socialized into "maturity," and that it helps us to unlearn these ways of being in the world, which can be harmful to our souls.

Resources for Women's Mental Health

Compiled by Shelly Fahey,
Patricia Wilkinson and Jill
Stainsby

Books

Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out by Jeanine Grobe
paperback Third Side Press
(1995)

Beyond Psychoppression: a feminist alternative therapy by Betty McLellan. Spinifex Press Pty (1995)

The Depression Workbook by Mary Ellen Copeland, M.S.

Feminist foremothers in woman's studies, psychology, and mental health edited by Phyllis Chester, Esther D. Rothblum, and Ellen Cole. Hawth Press (1995)

The Loonie Bin Trip by Kate Millett. Simon and Schuster (1990)

Preventing misdiagnosis of Women: A guide to physical disorders that have psychiatric symptoms Elizabeth A. Klonoff. Sage Publications (1997)

Still Sane by Persimmon Blackbridge & Sheila Gilhooly, (1985)

Trusting Ourselves: The Sourcebook on Psychology for Women by Karen Johnson, M.D., & Tom Ferguson, M.D. The Atlantic Monthly Press (1990)

Women and Madness Phyllis Chesler. Avon Books (1972)

Women creating lives: identities, resilience, and resistance, edited by Carol E. Franz, Abigail J. Stewart. Westview Press (1994)

Women of the Asylum by Jeffrey L. Geller & Maxine Harris. Anchor Books (1995)

Women's concise Guide to Emotional Well Being by

Karen J. Carlson, Stephanie A. Eisenstat, Terra Zipovyn. Harvard University Press (1997)

Journal Articles Reports and Papers

The Challenges Ahead for Women's Health: BC Women's Community Consultation Report BC Women's Hospital (1995)

Women and Mental Health Canadian Mental Health Association, National Office. One each in the Policy Statement, Focus Paper and Social Action series.

Women and Mental Health: Summary Report on Social Economic and Political Perspectives Canadian Mental Health Association, National Office (1989)

Women and Mental Health in Canada: Strategies for Change by Women and Mental

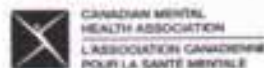
Health Committee, Canadian Mental Health Association, National Office (1987)

Women, Paid/Unpaid Work and Stress: New Directions for Research by Graham S. Lowe. Canadian Advisory Council on the Status of Women (1989)

Women: The Ignored Majority by Mowbray, Oysterman, Lutz and Purnell in *Psychological and Social Aspects of Psychiatric Disability*, edited by Spaniol, Gagne and Koehler (Boston: Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professions, Boston University (1997)

Videos

Within These Walls: a video which speaks to women's mental health issues, trauma and treatment. (1997) Available through Canadian Mental Health Association, BC Division, \$180.



BC Division,
Suite 1200 - 1111 Melville Street
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