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"Did you think I'd lay down and die? Oh no not I": From Survivors' Stories to Feminist Organizing − The Continuum of Psychiatric Resistance in the Anti-Rape Movement

Statistics reveal that two of three Canadian women have experienced sexual violence, and 54% of girls under the age of 16 have experienced some form of unwanted sexual attention[1]. Although men can be victims of sexual violence and women can perpetrate sexual violence, there is a clear gender difference when it comes to who is most likely to rape and who is most likely to be raped: 85% of victims of sexual violence are girls and women, and 98% of sexual offenders are men[2].

Sexual violence is in itself an expression of social inequality. Violence against women, particularly sexual assault, harassment and the threat of sexual assault and harassment, can be seen as part of a continuum of a social order that defines the relationship between women and men as one of subordination and domination.

For girls and women from marginalized communities, the threat of violence is, additionally, rooted in historical dynamics of unbalanced social power. Gender, race, and other social determinants influence the targets of sexual violence, as well as the frequency and severity of that violence. Risk of victimization increases if one is very young, a woman of color, non-heterosexual or poor. 50 percent of all Canadian women will survive at least one incident of sexual or physical violence, for example; but for Aboriginal women in the same country, this number climbs to an astounding eight in ten (80 percent)[3].

Social context is highly operant in sexual violence. We as a society define who may acceptably harm another, as well as to whom we tolerate harm. Nonetheless, medically labelled "psychiatric problems" − such as substance use, self-harm and anger − are regularly defined as pathological in women survivors of sexual violence[4]. Certainly, medical fields have had a long history of defining "the feminine, and consequentially women…as unstable, deceitful…irrational" and hysterical[5]. Yet while twentieth century medical practice has largely attempted to distance itself from this "patriarchal legacy"[6], contemporary psychiatry continues to unselfconsciously reproduce notions of the hysterical female when speaking of survivors of sexual violence.

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[1] METRAC Sexual Assault Fact Sheet. http://www.metrac.org/programs/info/prevent/ass_fact.htm
[2] (*Statistics Canada*, "Sex offenders," Juristat (March 1999, pg.1)

[3] METRAC Sexual Assault Fact Sheet. http://www.metrac.org/programs/info/prevent/ass_fact.htm

[4] Canadian Mental Health Association: Violence and Trauma − Impact of traumatic events upon women's mental health. http://www.ontario.cmha.ca/women
[5] Bankey, R. "La Donna é Mobile: Constructing the Irrational Woman". *Gender, Place and Culture,* Vol. 8, No. 1. 2001, 37-38
[6] Ibid, 38

Today, psychiatric understandings of women and girls whose lives have been touched by sexual violence construct and reconstruct "monolithic…representations of [female] moral goodness…sacrifice, silence, victimization and vulnerability"[7]. The sexually-assaulted female "body" is categorized as a biomedical phenomenon filled with symptoms, psychiatric affliction, abnormality, victimization − and emblematic of "the traditionally negative characteristics considered to be feminine: duplicity, theatricality, suggestibility, instability, weakness, passivity, excessive emotionality"[8].

Some examples of current, reputable, medicalized takes on the bodies and psyches of sexual assault survivors are as follows:

- "The chronically abused person's apparent helplessness and passivity, entrapment in the past, depression and somatic complaints, and smoldering anger often frustrate the people closest to them" (Judith Herman, 1992, as quoted in L. Haskell, 5)

- "We expect that adults who were victims of sexual abuse as children might experience significant difficulties in [a] caregiving role...Mothers who were sexually abused as children may have difficulties responding to their children's bids for comfort, protection, and closeness." (Koren-Karie, N., David Oppenheim and Rachel Getzler-Yosef, 2004, 305-306)

- "They have significantly more insomnia, sexual dysfunction, dissociation, anger, suicidality, self-harm, drug addiction and alcoholism than any other clients." (Briere & Jordan, 2004, as quoted in L. Haskell, 4)

The most fundamental error with psychiatric assessments of survivors of gender-based violence is that they continue to "identify individual women" as the problem and "the sites of the change that is necessary to address [this] problem of women being beaten and raped"[9]. As feminist anti-violence workers, we protest: we believe there is nothing wrong with women at all.

This work will use an anti-racist, anti-oppression framework to identify feminist conceptualizations of sexual violence as strategic resistance to psychiatry. Feminist conceptualizations of sexual violence contend that "violence against women and children cannot be cured through... treatment". Sexual violence is not treatable in specific female bodies because "the violence we are talking about here is a...*social problem*"[10].

Locating Sexual Violence

The anti-violence movement, which includes the work of sexual assault centres across Ontario, has utilized a feminist, anti-racist and anti-oppressive framework to address

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[7] Ringrose, J. (2006). "A New Universal Mean Girl: Examining the Discursive Construction and Social Regulation of a New Feminine Pathology". *Feminism and Psychology, Vol 16(4),* 412

[8] Bankey, R. "La Donna é Mobile: Constructing the Irrational Woman". *Gender, Place and Culture,* Vol. 8, No. 1. 2001, 40.

[9] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 25

[10] DeKeseredy, Dr. W. S. "Understanding Violence Against Women and Children: The Need for a Gendered Analysis", *Presented at the 2010 OACAS Conference, Critical Connections: Where Woman abuse and Child Safety Intersect, Toronto, Ontario,* 14

sexual violence in Canada for over thirty years[11]. This framework maintains that "sexual violence against women and children is power-based, gender-based, [and] structurally supported". The feminist framework asserts that psychiatry is a part of this structural support: "traditional psychiatry and its institutions are sexist and are used as a means of social control to coerce women to adjust to and accept oppressive roles, and...punish[es] them if they don't"[12].

Feminist support – whether through a crisis line, counselling, lobbying, or advocacy – "holds perpetrators accountable for [their acts of] violence", instead of critiquing women, or psychiatrically labelling them, for their reactions to violence[13].

The feminist approach "does not predetermine desired outcomes for women or put women on schedules for change" or recovery; nor does it identify pathology in the ways women live their lives "or in the ways they cope with trauma"[14]. Instead of asking about problematic symptoms and then setting about to dispel them, a feminist approach asks how it is that each woman has survived. "There's an old expression," writes Laura Davis in her workbook for survivors of childhood sexual abuse: "'Whatever gets you through the night'...We all have strategies for getting by, [for] compensating for the hurts we've suffered...Everyone uses coping mechanisms. They're helpful, necessary survival tools"[15].

Historically, "the standard[s] for psychological strength [have] been influenced by Western [white] male values such as autonomy, stoicism, self-determination, individualism, and rationalism"[16]. There is "no evidence that those traits are inherently better for living effective lives"[17]; yet these attributes and values are nonetheless used to evaluate women, girls, and other marginalized populations – no less, they are used to evaluate us when we are in crisis! Psychiatric assessments of mental health do not recognize that "women and minorities experience different crime patterns, prejudice and bigotry, hiring and salary inequities", and that these "lead to different life stresses and ways of coping"[18].

A feminist framework for counselling contests this privileging of "health" traits and values: instead, it offers "meaningful challenges to the ways in which we conceptualize both client "pathology" and strength[s]"[19]. A feminist framework identifies every coping behaviour, be they popular, healthy, 'less-healthy', or entail other incidental consequences, as a "strength that allows people to deal with oppressive environments in realistic fashion"[20]. This reframing is particularly significant to survivors of sexual violence, who are, overall, statistically most likely to be female, more likely to represent marginalized populations of women and girls, and most likely to be shamed,

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[11] Riggs, Joan. 2009. "Ontario Coalition of Rape Crisis Centres (OCRCC) Strategic Plan". Ottawa, 2
[12] Ibid, 3
[13] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 25
[14] Ibid
[15] Davis, L. 1990. *The Courage To Heal Workbook*. Harper & Row Publishers, Inc.: New York, NY, 144
[16] Whalen, M. and Karen P. Fowler-Lese, Jill S. Barber, Elizabeth Nutt Williams, Ann B. Judge, Johanna E. Nilsson, and Kozue Shibcizaki. "Counseling Practice With Feminist-Multicultural Perspectives". *Journal of multicultural Counseling and Development.* 2004, Vol. 32, 380
[17] Ibid
[18] Whalen, M. and Karen P. Fowler-Lese, Jill S. Barber, Elizabeth Nutt Williams, Ann B. Judge, Johanna E. Nilsson, and Kozue Shibcizaki. "Counseling Practice With Feminist-Multicultural Perspectives". *Journal of multicultural Counseling and Development.* 2004, Vol. 32, 379
[19] Ibid, 380
[20] Ibid, 381

psychiatrized, or criminalized for their means of coping. A recent Canadian survey, for example, identified that young women from marginalized racial, sexual and socioeconomic groups are most vulnerable to being targeted for sexual harassment and sexual assault than other girls[21]; further, we know that "psychiatry and medical institutions have a long history of discriminatory treatment of women, First Nations people and other racialized groups, disabled people, and lesbians and gay men"[22]. In this case, "counselling [models] which maintain the status quo"[23], privilege hegemonic definitions of wellness, and "label the severe distress of women who have experienced violence and oppression in the language of 'mental health'[24]" symptomology are in fact "more harmful than helpful"[25]. Feminist perspectives reframe ostensibly problematic psychiatric "symptoms" as useful, innovative strategy, employed by women to survive every day. Further, it understands women as active agents in their stories: women's reactions to and coping strategies in the face of violation are strategic resistance to violence, pain and fear.

Indeed, "whenever individuals are treated badly, they resist"[26]. Feminist understandings of sexual violence asserts women's "resistance as ubiquitous"[27] and resilient, as opposed to a psychiatric pathology to be contained. In this, feminist anti-rape work understands survivors' bodies, emotions, and coping behaviours as constructive "site[s] of resistance and oppression"[28].

Speaking of Sexual Violence

When psychiatry speaks of sexual violence, it does so with a voice of decisive authority. Psychiatry posits that only the "so-called 'expert professional'"[29] owns knowledge about sexual violence, its impacts, and its "cures". This privileging of knowledge, assessment and professional treatment echoes the authoritarian doctor-patient relationship of the past: "women bec[oming] transformed under the influence of male, scientific, medical profession"; women "in need of the moral guardianship of a 'rational' medical or scientific system for care"[30].

Feminist perspectives on sexual violence resists psychiatry's paternalism. An equal, teamwork relationship exists between the counsellor and the survivor. The survivor

[21] Wolfe and Chiodo, CAMH, 2008, p. 3.

[22] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 26

[23] Whalen, M. and Karen P. Fowler-Lese, Jill S. Barber, Elizabeth Nutt Williams, Ann B. Judge, Johanna E. Nilsson, and Kozue Shibcizaki. "Counseling Practice With Feminist-Multicultural Perspectives". *Journal of multicultural Counseling and Development.* 2004, Vol. 32, 382

[24] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 28

[25] Whalen, M. and Karen P. Fowler-Lese, Jill S. Barber, Elizabeth Nutt Williams, Ann B. Judge, Johanna E. Nilsson, and Kozue Shibcizaki. "Counseling Practice With Feminist-Multicultural Perspectives". *Journal of multicultural Counseling and Development.* 2004, Vol. 32, 382

[26] Coates, L. and Allan Wade. "Telling it Like it Isn't: Obscuring Perpetartor Responsibility for Violent Crime". *Discourse & Society* 2004: 15, 502.

[27] Ibid

[28] Bankey, R. "La Donna é Mobile: Constructing the Irrational Woman". *Gender, Place and Culture,* Vol. 8, No. 1. 2001, 39.

[29] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 36

[30] Bankey, R. "La Donna é Mobile: Constructing the Irrational Woman". *Gender, Place and Culture,* Vol. 8, No. 1. 2001, 40

brings expertise about herself and her own experiences, for example; the counsellor brings expertise on coping skills, and helping resources in the community. Feminist counselling "'competencies' include: the ability of workers to assert and reinforce boundaries in ways that do not exploit power differences between clients and staff, the ability of workers to talk comfortably, and in boundaried ways, about their own experiences of marginalization"[31], and an ongoing recognition of the skills and knowledge survivors bring to healing work.

Within the feminist anti-rape movement, "survivors are at the centre of the work"[32]. This work includes activities and services facilitated by sexual assault centres, as well as larger lobbying action for legal and systemic changes that support survivors. Survivors "know from experience...where the gaps and traps are in systems and policies"; they are important stakeholders and experts in anti-violence work[33]. Indeed, feminist anti-violence activities, "knowledge, standards and ethics...are all built on the experiences of women," and on "listening to women's experiences, not as patients...but as members of a social change movement"[34].

"In the late 1960s and early 1970s," writes Eileen Morrow from the Ontario Association of Interval and Transition Houses, "energized by the civil rights and women's liberation movements, Ontario women who experienced intimate violence began to talk…But women didn't just talk, they acted to help create their own services: Women's shelters, rape crisis centres, [and] women's centres"[35]. This discussion and action was highly effective. Women survivors and women's rights activists together effected a "displacement of conventional medical [including psychiatric] wisdom and authority [with] the authority of women's own…experiences"[36]. This woman-centred authority perseveres in feminist anti-violence organizations today.

Naming Sexual Violence

Today we face a new challenge as feminist understandings of sexual assault are suppressed under "the growing tendency to label the…distress of women who have experienced violence…in the language of 'mental health'[37].

While "mental health" language and framework is certainly less pathologizing than that of "mental illness", like medicalization, it removes women's experiences from the realm of systemic struggle[38]. The focus on individual women and their mental health "obscures

[31] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 40
[32] Riggs, Joan. 2009. "Ontario Coalition of Rape Crisis Centres (OCRCC) Strategic Plan". Ottawa, 5

[33] Ontario Association of Interval and Transiion Houses. 2008. "Survivor Voices: Welcoming Women to Make Change. Calling on Services and policymakers to Include Survivors in Their Work", vii.
[34] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 31
[35] Ontario Association of Interval and Transition Houses. 2008. "Survivor Voices: Welcoming Women to Make Change. Calling on Services and policymakers to Include Survivors in Their Work", 1
[36] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 27
[37] Ibid, 28
[38] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 27

the collective nature of traumatic experience"[39], and disguises a significant social problem as a problem that women own individually, and must be cured of.

Two of three Canadian women have experienced sexual violence. A "social determinant of health approach" *is often not critical enough* to address the problem of sexual violence. A social determinants of health approach promotes a mental health framework, which encourages "changes at the individual level in lifestyle, behaviour, and individual coping"[40]. And we as anti-violence activists will agree, no amount of yoga, self-defense classes, or breathing exercise by any one woman will necessarily reduce her chances of being sexually-violated if our laws, medical fields continue to tolerate it. Additionally, while a mental health approach supports women in identifying healthy ways to cope emotionally after sexual violation touch their lives, these tools alone simply represent "means by which individuals deal with a society that forces them to survive in an unhealthy environment"[41]. It does not name that environment for what it is, or encourage us to acknowledge or change it.

Feminist anti-violence work urges us to name violence as violence. Psychiatry presents an ongoing threat to survivors of sexual violence. Its medicalization and credentialism "'consolidate'[s] victim-pathologization and class privilege into the specialist 'business' of aiding and individualizing the unfortunate"[42]. Additionally, psychiatric explanations are increasingly used to rationalize the behaviours of sexual offenders: for example, "'he became obsessed', exhibited 'sexual deviancy', or 'there is no cure for paedophilia'"[43]. These are just a few psychopathology attributions that have been used in legal arguments to construct perpetrator responsibility as ambiguous or accidental.

In short, psychiatric constructs of sexual offenders and sexual assault survivors too often let society off the hook.

We encourage survivors and those that support survivors to resist psychiatrization by using a feminist lens:

- Frame women's and girls' actions and reactions as normal, human reactions to abuse and violence, as opposed to defects to be treated
- Understand that women and girls of differing social locations have different reactions to and ways of coping with sexual violence
- Identify that mental health problems (i.e. anxiety, panic attacks, depression, and behaviors associated with mental health diagnoses such as Borderline Personality) are normal, human reactions to abuse and violence

The feminist anti-violence movement resists psychiatry by insisting that sexual violence against women is one of the strongest indicators of prevailing societal attitudes towards women and children. We believe that social and political change – not changing individual women − will better the lives of all women, men and children.

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[39] Ibid, 29
[40] Ibid
[41] Whalen, M. and Karen P. Fowler-Lese, Jill S. Barber, Elizabeth Nutt Williams, Ann B. Judge, Johanna E. Nilsson, and Kozue Shibcizaki. "Counseling Practice With Feminist-Multicultural Perspectives". *Journal of multicultural Counseling and Development.* 2004, Vol. 32, 381
[42] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,*Fredericton, New Brunswick, Canada, 37
[43] Coates, L. and Allan Wade. "Telling it Like it Isn't: Obscuring Perpetrator Responsibility for Violent Crime". *Discourse & Society* 2004: 15, 505