Violence In the Lives of Women On Psych Wards

BY TEMI FIRSTEN

The Provincial Lunatic Asylum in Toronto opened its doors to those deemed mentally ill on January 26, 1850. Better known locally as "999" (its Queen Street number), it retained this nickname many years after the address changed and it adopted the less stigmatizing name of Queen Street Mental Health Centre. Growing up in Toronto, I always wondered what mysteries lay behind those century-old walls. This curiosity played a role in my choosing to work there in 1983.

It took a few years of employment in a psychiatric institution to come to appreciate the extent to which the patients are treated as genderless. The most prominent problem within the general theme of gender insensitivity is violence in the lives of female patients — whether in their families of origin, in intimate relationships, on the streets, in boarding homes or on the psychiatric wards themselves. Given this violence, which appears to be more pervasive than patients hearing voices or hallucinating, it is most peculiar that clinicians systematically ask patients about hallucinations in taking routine psychiatric histories, while disregarding the importance of histories of physical and sexual assault.

There is resistance to asking about physical and sexual abuse in psychiatric settings, and even when it is questioned it can be denied, minimized or interpreted as delusional without sufficient exploration. When it is recognized, it often isn't examined as a causal factor or considered seriously in relation to women's clinical presentations. When it is recognized, there is often victim-blaming. I've heard the terms "masochistic" and "self-defeating" readily applied to women who are in relationships with violent men without appreciation of the context in which the abuse is taking place. I've seen women who are fearful and suspicious of their husbands labeled paranoid, and the "paranoia" enhanced when husbands are taken aside by hospital staff to talk about their wives. I recall one woman who said her injuries were self-inflicted to protect her abusive partner. She was then labeled

Wooden sculptures outside Queen Street Mental Health Centre, Toronto *Photo by Dana Marks*

for self-injurious behaviour. In spite of allegations of incest or wife assault, I've seen alleged perpetrators treated as reliable informants with the best interests of their hospitalized family members at heart. Marital and family interventions at times take place without attention to the risk factors when active abuse is present.

Interviews with Hospitalized Women

A large number of clinical experiences such as these spurred me to design a study about physical and sexual abuse in the lives of female psychiatric inpatients. Implemented between 1988 and 1989, the study intended to explore three areas: prevalence rates for physical and sexual abuse in both childhood and adulthood; the relationship between the experience of abuse and particular diagnostic features and symptomatology in adulthood; and the response on the part of staff to the problem of abuse during a hospitalization.

A random sampling of eighty-five women in five Toronto hospitals were interviewed for this study over a period of one year: 50 women on provincial psychiatric wards and 35 on general hospital wards. While limited resources precluded the opportunity to interview deaf women and women who were not fluent in English, all women who were deemed capable of giving informed consent, not too disorganized to give a reliable history and not too agitated to handle the interview, were approached. Twenty-seven per cent of the women approached refused to be interviewed. Many of the women who refused stated that their experiences were too painful to talk about. This, and additional factors, point to the likelihood of underdisclosure for prevalence rates.

We made sure that women had access to therapeutic support following the interviews. Where appropriate, we provided information on community resources for assaulted women. If women chose not to share their stories with hospital staff, confidentiality was assured.

Staff at the hospitals were concerned about the impact of the interview on the patients' well-being. The process proved such concerns to be unwarranted. Women often noted they were telling their stories for the first time and found the experience helpful. There were several instances where documentation was in the chart only after the interview because women were going to treatment team members and talking to them about these experiences for the first time. There were even cases where women developed insight during the interview, drawing some connection between their current distress and earlier experiences.

Prevalence of Physical and Sexual Abuse

The findings regarding prevalence rates indicate hospitalized women are more vulnerable to violence than the general population. Even with the use of very conservative criteria as to what constitutes severe abuse, 83 per cent of the sample reported severe physical or sexual abuse in childhood and/or adulthood. Over three-fifths of the women reported on more than one category of abuse. Sixty-nine women talked about 255 assailants.

Fifty-seven per cent of the women reported physical abuse as a child. Thirty-seven per cent reported child sexual abuse. While as late as 1975, a prominent psychiatric textbook (Freedman, Kaplan & Sadock, 1975) estimated that the incidence of all forms of incest was only one in one million, the finding for this study closely approximates one out of three. Thirty-one per cent of the women reported incest. Comparing this to the finding of 16 per cent in a random survey of 930 women among the general population (Russell, 1986), this suggests that the likelihood for incest doubles for women found on psychiatric wards. Only two of the 26 incest victims experienced abuse that did not escalate to oral or vaginal rape. Twenty-five per cent of those reporting incest talked about more than one family member as an assailant.

Sixty per cent of the women reported physical assault in adulthood. For those ever married or living as married, 50 per cent reported wife assault. That contrasts with the finding of 24 per cent for Russell's general population study (1986). Thirty-eight per cent of the women reported rape or attempted rape. The rates of 26 per cent for completed rape and 12 per cent for marital rape closely resemble Russell's findings of 24 per cent and 14 per cent respectively.

Almost one-third of the women interviewed reported either minor or severe physical or sexual assault incidents during their hospital stay. All severe incidents took place in the provincial hospital setting, suggesting that one in every four female provincial patients may be at risk. Thirteen severe physical abuse incidents were reported and 10 incidents of sexual abuse of a minor or severe nature. The severity could not be ascertained for the majority of sexual assault incidents since they involved male co-patients making sexual contact when the women were either asleep or in some way not fully conscious. Even on the wards, therefore, women were found to be at risk.

The Mental Health Consequences of Abuse

While the relationship between trauma from abuse and emotional damage in adulthood is a complex one, the findings on mental health consequences lend support to the notion that physical and sexual abuse should be recognized as potential contributing factors to many psychiatric diagnostic features and stigmatizing labels. Voices of women whose histories of violence were largely ignored during their hospitalizations exemplify the aftermath of their trauma. When asked how the violence affected them, statements such as these were made:

I can't have a normal relationship with men or trust men. I'm always afraid it will happen again. It's hard... Maybe it has to do with my problem with drug abuse and alcohol now. I don't know... because it was after that that I started with drinking and drugs. (A victim of violent rape at the age of 15 who was hospitalized for cocaine addiction and alcohol abuse.)

It has affected my life in every conceivable way. (A woman who was raped orally and anally by both her brother and father from the age of five.)

It's what put me in here. I worry about brain damage... because he always hits my head. (A victim of life-threatening wife assault over several years.)

All of these assaults are the reason that we are multiple. It stopped us from being able to function normally in the world and hold a job. (A woman with multiple personality who was a victim of incest by multiple perpetrators.)

It made relationships with people impossible. It's the reason I'm in institutions all the time. (Victims of chronic abuse in childhood and adulthood.)

The Brief Symptom Inventory (Der-

ogatis, 1975), a 53-item self-report inventory, was used to quantitatively analyze the relationship between histories of abuse and psychological distress in adulthood.[1]

For child sexual abuse, statistically significant correlations were drawn between the existence of a history of abuse and every symptom dimension that was measured: interpersonal sensitivity, depression, anxiety, hostility and even psychosis. Relationships were more positively correlated for child sexual abuse than any other form of abuse — regardless of whether the abuse was incestuous or not. We also found statistically significant relationships between suicidality, self-destructive behavior and histories of child sexual abuse.

For adult physical abuse, there were only statistically significant relations found when the abuse was committed by a spouse. Wife assault was correlated with anxiety, depression and general psychopathology at levels that were statistically significant.

Adult sexual abuse was found to correlate with interpersonal sensitivity, hostility and anxiety at levels that were statistically significant.

While post-traumatic stress features were found to be vividly present among women with abuse trauma in their backgrounds, the diagnosis of post -traumatic stress disorder came up only once among the entire abused sample. It suggests that this diagnostic category, less stigmatizing than many, may be overlooked in hospital psychiatry.

Of the 83 women interviewed, only 7 had either a primary or secondary diagnosis of borderline personality. It is noteworthy that 6 out of 7 with this diagnosis were victims of physical abuse by parents, and 4 out of 7 were victims of incest.

Staff Response to Abuse during a Hospitalization

Of the 69 women who reported abuse, almost half (48 per cent) had no documentation in their charts. For the 36 cases for which there was documentation, in only six instances was there an explicit connection between the abuse and the diagnosis; four instances in which treatment plans acknowledge the problem; three for whom discharge plans addressed the problem and only two cases in which family or marital interventions addressed the problem.

In addition to reviewing charts, women were asked whether they had ever been asked about their abuse during their hospital stay or even volunteered the information. Only 35 per cent of the 69 women reported ever being asked about it. Only four out of 26 incest victims reported being asked about it. Five of the remaining 22 incest victims noted that they volunteered the information without being asked. So the unlikelihood that the information will be attained unless asked about directly and openly is supported.

We are left to consider the treatment limitations when abuse is not identified. Women are at risk of misdiagnosis, therapeutic alliances may be obstructed, transference issues may be misconstrued, treatment interventions at any level may be ineffectual or even harmful. The findings of this study point to the susceptibility of this target group to such risks.

The Role of Feminists in Institutions

Hospital statistics for 1985-86 reveal that mental disorder is the leading cause of hospitalization for women. In that year, 98,850 women spent 1,374,832 days on psychiatric wards in Canada (Statistics Canada, 1990). Concomitant with the large number of women on hospital wards is a growing trend toward the privatization of feminist mental health services. The Women's Counselling Referral and Education Centre, a community-based mental health service in Toronto, whose function includes linking women to feminist and non-sexist counselors and therapists, notes a growing problem with accessing services that are publicly funded. While 90 per cent of the 3,000 women who contacted the agency for assessment and referral in 1989-1990 could not afford a fee for service, 75 per cent of the listed feminist therapists were private practitioners (Lepischak, 1990). Being a feminist therapist has almost become synonymous with being a private practitioner.

Coinciding with the influx of feminist practitioners into private services is a growing sense of isolation on the part of feminists working in the public sector. Those of us who work in traditional mental health settings and/or are medically-trained psychotherapists experience a sense of marginality in that our training and/or our workplace both serve to alienate us from the feminist therapist movement. That our feminism might be compromised by such endeavours is put into question. Many of us burn out in organizations and then pursue private practise, where we reconcile our free enterprise pursuit with our feminism by resorting to sliding fee schedules. But the majority of the women to be found on psychiatric wards are not touched by this solution. Not one woman interviewed for our study reported family earnings in excess of $30,000. Most never have and never will visit a private practitioner.

I think that feminists have an important role to play within hospital psychiatric services — as clinicians, as consultants, as researchers, as educators and especially as advocates. Hospitals eat up an enormous percentage of health-care dollars — both for services and for research. What goes on in institutions plays a major role in defining problems and delineating solutions. Women who can't afford a fee for service, and those who genuinely need hospital confinement, will continue to flow to hospitals as their primary source of mental health care; to facilities where there are not many visible feminists. And, in the absence of a feminist voice in such settings, female patients will continue to be recipients of mental health services and subject to mental health research that are largely male and medically defined.

A strong feminist voice is needed to challenge the interpretation of women's problems and wade beyond the stigmatizing diagnostic labels that render our common social experiences invisible. We need to learn to do research and compete for research dollars to acquire knowledge that really matters to the lives of women. The etiology (causation) of women's problems must be redefined through research. Funds that are awarded solely to physicians and only for biological research need to be redirected to non-medical researchers for research that is psycho-social in nature. We must challenge the practise of major drug companies funding research that asks questions that make their profit a part of the solution. We need to ally with members of the numerous traditionally female-dominated health disciplines to ensure that "women's work" ceases to be undervalued and that non-medical staff are rewarded both monetarily and in their status as advisors, consultants and decision-makers. We need to mutually support and validate other feminists to bolster our inner strength to survive in the system. Finally, it is imperative that we build strong alliances between feminist colleagues in the private and public sectors and develop a common

language that ensures that neither women confined to psych wards nor the health care providers who work with them remain marginal to the feminist movement.

[1] To assess comparisons in findings, a two-tailed t-test was used. A value of .05 level of significance was required for the acceptance of any hypothesis.

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Visit to the Psych Hospital

broken daughters of the fathers
i watch you shuffle aimlessly
through the endless halls
of psychiatric wards
mumbling occasionally
but much more often silent
Yes, silence rules!
you learned that long ago
when you first tried to speak
your Truths
truths that have been silenced
with threats and bribes
with unbelief
and if you yet persisted
the fathers brought you here
to strait jackets, ECT
watchful eyes, lobotomies
and now the ultimate in civilized
little magic pills
that numb the brain
calm the affect (read rage)
and dull the shards of memory
to rob you of your voices
your will, your intellect, your choices
O my sisters! lost souls, crushed spirits
your stories have been lost to us
as you wander through the endless
halls
mumbling occasionally
but much more often
silent

Marcia Lane

Advice

Attention
all men:

when walking down
the boulevard,
do so
only in
broad daylight.

If perchance
you're foolish enough
to risk
the evening,
keep yourselves
well-lit
under the lampposts
and for
god's sake
walk in numbers
and take your dogs
as an
extra
precautionary measure.

If you happen
to be raped anyway,
scream "FIRE!" —

more people listen
that way.

Tanya Adele Koehnke

Ziplock

Just come out of the wrapper
air tight
soul
puckered up
like vegetables in a ziplock
bag
air sucked out
life sucked out
been squashed in there
so my insides
turn to jelly
that molds into anything

hands all around me
their hands
his hands
while my hands
work on the inside of the bag
till I unzip me
come oozing out
I breathe
pull it all back together

I stand up
going to live
finally.

Margot Henning