Dilemmas as Solutions : The Development of Feminist Mental Health Care.[1]

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INTRODUCTION

Feminist Mental Health Care (FMHC) is grounded on the feminism inspired critique that traditional mainstream mental health care misrepresents, unequally treats and unjustifiably pathologizes women. FMHC combined the movements for democratisation and deprofessionalisation in health care along with a shift from a predominantly illness-oriented form of health care to one emphasising clients' well being. Alternative (mental) health practices were developed by both professional and lay volunteers. Initially these were self-help groups. Gradually, FMHC also emerged within mainstream mental health services.

FMHC is characterised by its sex-specific, politicising and client-centred approach (Brown, 1994; van Mens-Verhulst, 1991, 1998; Watson & Williams, 1992). The sex-specific approach opposes the sex neutrality of most traditional mental health care practices. It asks for attention for the different health problems men and women have and for acknowledgement that problems may look alike but that the reality of experience may differ between women and men. As a consequence, different treatments may be required. FMHC does not predominantly localise the sex differences in biology but in society. It emphasises that the socialisation of women is a very important factor in the genesis of mental health problems. For the most part, women have to deal with values, norms, roles and opportunities that are very different from those of men when they are growing up, but their mental state is judged by male standards (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970). Moreover, during their lifetimes, many more women than men are confronted with physical and sexual violence - some of the acknowledged risk factors for mental illness.

The politicising approach of FMHC counters the individualistic assumptions that are so common in traditional practices. It focuses on the influence of societal and cultural contexts on the problems of women and their therapeutic relationships. Inequality of power is the central theme, empowerment the essential process. A politicised approach implies an attitude of anti-domination combined with a selection of emancipatory goals, methods and settings for treatment. The client-centred approach tackles the inclination of traditional therapists and institutions to let their professional prescriptions, methods, language, procedures and schedules prevail over clients' needs. In contrast, it considers clients as active and competent participants - just as much when

1 From: A. Kolk, M. Beker, K. van Vliet (1999) (eds). **Advances in Women and Health Research. Toward gender-sensitive strategies**. Tilburg: Tilburg University Press. p. 139-163

they are female as when they are male. Thus, the `patriarchal' vision of women is undermined.

However, the FMHC's characteristics do not remain untouched by it's growth and integration into regular health care. On the one hand, its success easily leads to a kind of self-confirmation and self-closure that impedes openness to the needs of new clients, or the new needs of old clients (van Mens-Verhulst, 1998). On the other, integration furthers depoliticisation because it is often limited to those aspects of FMHC that fit into the existing structure and culture of the institution (ten Dam, Rijkschroeff & Steketee, 1994). This tendency may be reinforced by FMHC providers' wish for professionalisation, which unavoidably coincides with some adaptation to the traditional language, methods and standards. Such adaptation unevitably leads to increasing medicalisation, e.g. by a request for diagnoses, protocol treatments and a tendency to prescribe medicines. All in all, this situation furnishes many ingredients for dilemmas.

In search for FMHC dilemmas

Obviously, FMHC is a practice in which women - psychologists, psychotherapists, psychiatrists, psychiatric nurses as well as social workers - have tried to `live' feminism. In doing so, they go through a process of professionalisation that inevitably gives rise to dilemmas in "lived" as well as intellectual ideology. Such dilemmas may result in personal and professional confusion, sometimes cynicism, and eventually lead to paralysis and stagnation of the total movement.

In general, exploring dilemmas is not a very popular activity, neither in daily life nor in the world of professional work. Actually, dilemmas have a bad smell. In the New Shorter Oxford English Dictionary (1993), for example, dilemma is defined as: `A choice between two (or several) alternatives which are equally unfavourable; a position of doubt or perplexity; a difficult situation' (Bond, 1997, p.181). So, dilemmas predominantly seem to reveal the vulnerable aspects of a person or situation.

However, dilemmas can also be seen as an opportunity for creating a realm where a profession is able to prove its strength by exploring why the alternatives are unfavourable and by reflecting on the limitations of available knowledge, organisational systems and personal beliefs. As such, they constitute the gateway to a hidden treasury of insights and facilitate the surpassing of collective and personal limitations (Bond, 1997).

Intrigued by this potential of dilemmas, the first author invited prominent publicists on feminist mental health care in UK, USA and the Netherlands involved in (a combination of) therapy, teaching and research to reflect on dilemmas in Feminist Mental Health Care. In response, six of them identified and analysed some relevant dilemmas from their current work and described their strategies in dealing with them. Subsequently, the initiator reflected on the similarities and dissimilarities between the dilemmas and looked for their potential contribution to an ongoing development of gender-sensitive mental health services.

Facing FMHC Dilemmas

Teresa Bernardez describes the choice between non-drug treatment and the general pressure to prescribe anti-depressant drugs. Helmi Goudswaard reveals the tension between the transparency principle and the therapist's need to show abstinence. Majone Steketee points out how FMHC-ideals cannot simply be transferred from an

ambulant into a clinical setting. Jennie Williams and Gilli Watson focus on the difficulties and possibilities of working with a perspective of social inequalities , both 'inside' and 'outside' mainstream mental health services. Gaby Jacobs explores the paradoxical sides of the empowerment concept. The dilemmas will be discussed in turn from the perspective of the author who raised the specific dillema.

ANTI-DEPRESSANTS OR TALKING CURE: WHOSE CHOICE?

Women have at least double the rate of depression than men; and despite considerable commotion about the progress that women have made in society in the last two decades, this rate continues. (NIMH D/ART Program, 1987; Klerman & Weissman, 1989; Nolen Hoeksema, 1990; Weissman, 1987). Social factors that contribute to the vulnerability for depression, the predisposition to depression and their greater frequency in depressed women are: lack or loss of social status, low income, social isolation, all types of violence (sexual abuse in childhood, wife battering, marital/ acquaintance rape, sexual harassment, stalking and sexual assault), unemployment, discrimination in employment and education, double burdens in social conditions (more responsibilities for care of others, and less help), disadvantages due to sexism and ageism combined, and objectification leading to dependence on attractiveness and youthfulness. Several of these factors are evidence of the devaluation of women in a patriarchal society, of the domination of men in spheres of power, knowledge and economics and of a conscious and unconscious hatred for the female, and of women's bodies. For women reared in this culture, the internalisation of the devaluative, hateful and envious notions of femininity preponderant in a society where social conditions are so disadvantageous would obviously increase the incidence of depression, particularly when there is no interference with the acquisition of these notions and when recurring experience of discrimination/devaluation in everyday life, leads to an unnoticeable introjection of such distortions and judgements.

General practitioners are used to treating a large percentage of patients with anti-depressants (Mc Grath, Keita, Strickland & Russo, 1990). As neither physicians nor biological psychiatrists are trained in psychotherapy, there is a very unlikely possibility that they could offer skilled help aside from the drugs. As a feminist psychiatrist and psychotherapist, however, I (TB) consider psychotherapy the most effective treatment for depressed women. This implies several choices: not only weighing the administering of drugs versus psychotherapy, but also managing the balance between my preference and those of my clients.

Drugs versus psychotherapy

Positive aspects of medication are the relief of symptoms (when antidepressants are effective) and return to functioning. In addition, the disclosure or exploration of painful or embarrassing feeling or experiences can be avoided and the patient is exempted from guilt or a sense of inadequacy since she is labelled as suffering from a medical illness. The possible need to change life circumstances or life style can be disregarded.

However, the guidelines of the Agency for Health Care Policy and Research encouraging pharmacotherapy as the first line of treatment as well as the studies upon which they are based are subject to very serious critique (Antonuccio, 1995; Fisher &

Greenberg, 1993; Karon & Teixeira, 1995, Munoz, Hollon, McGrath & Rehm, 1994). Moreover, it turned out that a combination of psychotherapy and pharmacotherapy offers no advantage over treatment by psychotherapy alone (Wexler & Cicchetti, 1992).

Positive aspects of psychotherapy are its interpersonal and personal validation, assertiveness retraining, increase of locus of control and decrease of ruminative episodes. It encourages the ability to mourn losses, fosters competence in decision-making (but with allowance for regression, support and care from others), decreases the harshness of superego demands, stimulates reworking dreams and ambitions, helps to find supportive resources and space of one's own. It offers the re-working of marital relations, freeing women in sexual pleasure so as to increase marital enjoyment, increasing freedom of action and stopping violent or abusive relationships.

By and large, four arguments favour psychotherapy over drugs. First, while medication neither alters nor corrects the unhealthy social conditions nor their introjection, psychotherapy does. If properly conducted, it ameliorates, eliminates and corrects the effects of these conditions. It can lead to exploration and examination of socio-cultural factors in the actual life of the patient with specific discovery of the precise way in which these factors are silently integrated in the personality so that the connection between their capacity to produce injury and depression in women and the way in which they are present in their lives is lost.

Second, medication by its very silence and presence disconfirms the social nature of the ailment in women and locates it in the biological sphere. It automatically states that something is wrong in her body, something that requires correction that can not be helped by her. Psychotherapy, on the other hand, can help the patient explore the absence of anger in depression, subsequently support its integration and consequently stimulate self-esteem, achievement of mastery, creative action, thus protecting against depression. By re-training in the expression of normal anger, the woman can find her own expressive style and can make the necessary alterations in her relationships to her family, her work and her social world.

Third, medication cannot protect against relapse, because the various factors involved in the occurrence of depression are not altered. For that reason, physicians may maintain patients on medication for long periods of time, even if the long-term effectiveness of some of these drugs has not been established. Patients are induced to feel reluctant to discontinue medication because of fear of relapse and may become overly dependent on their use. On the opposite side of the spectrum, many women discontinue treatment with medication because of side effects or poor outcomes and go untreated, their depression worsening without due attention. In contrast, psychotherapy addresses the socio-cultural and psychological factors. Psychotherapy utilises women’s psychological strengths, helping them to eliminate their vulnerabilities and social disadvantages, and to resolve their conflicts.

Fourth, medication accentuates the woman’s subordinate position vis-à-vis the physician who gives the treatment: s/he decides the dose, the type of drug, the duration and if other treatments are necessary. So, the locus of control resides outside the woman's sphere of power. As she cannot change this position herself, this is even conducive to the development of depression. In psychotherapy, the woman can be actively involved in the choice of treatment and even be strengthened in her agency.

Whose choice?

Patients may come to you and tell you they want the magic drug or they may

confess that they do not want to look at their life in any detail, but want a `quick fix'. How does a feminist therapist offer her patients informed choice over these matters? How does she avoid "didactic" instruction in favour of an alive experience? How can she instruct without dictating? Here is how I (TB) have come to deal with it.

> "I discuss my understanding of the situation after a first consultation. I explain that I would like a period of exploration and initial treatment of 5 to 6 sessions without medication, over which time they would have an opportunity to: 1. experience relief of feelings of depression 2. understand their situation in a different way and 3. have a chance to see me at work with them. At the end of this period of evaluation, she and I gather our findings and recommendations share observations and answer remaining questions. Among them. Is a discussion of recommended treatment, how long and why. Medication or psychotherapy (and what kind) is discussed at this time.
> Patients accept this format of short evaluation with little hesitation. If they are interested in medication after the first session, I refer them to appropriate colleagues, but do not feel obligated to give medication if I do not think it is indicated. In all my years of practice, treating women with depression with all degrees of severity, I have only used medication with two patients and only once referred one to a colleague for medication after just the initial session."

In short, most women choose psychotherapy when they have an opportunity to learn what is involved in depression and when they can test its efficacy.

After the initial period of evaluation, the specific psychotherapy indicated may be individual, marital or a women's group, or any of those combined. The average duration of my individual sessions for the remission of the depression is a period of 3 to 4 months.

TRANSPARENCY VERSUS ABSTINENCE: THE MANAGEMENT OF THE THERAPEUTIC RELATIONSHIP

The early FMHC had developed a new paradigm for the relationship between the therapist as provider of psychosocial and psychiatric help and the (female) client. On the basis of egalitarian ethics, a more reciprocal, more involved and more transparent attitude for the therapist was recommended instead of the abstinence prescribed by Freud and his followers. The aim was to reduce asymmetries in the power balance between the `white middle-class male' omniscient therapist and the female client that was dependent upon him. Emphasis was put upon `recognition' as a powerful tool, and the roles of therapist and client seemed interchangeable. The relationship between therapist and client was considered to be a direct, spontaneous encounter between two women (or more, in a group) who had experienced the same kind of repression in patriarchal society. As Mander put it:

> "Therapy in feminist terms, then, means healing, not helping [..] there are no experts, no authorities. There are no patients, there are no doctors. There are no labels [..] Feminism does not exclude individual therapy, but it does say no to the traditional therapist-patient model. We, as women, work against hierarchical systems: the therapist is not the objective observer of our soul; she is another

> woman with intuitive and intellectual reactions to us, which stem from her own personal sources .." (Mander, 1977, p. 287).

Clearly, this was not a purposeful management of a therapeutic relationship. Subsequently, no attention was paid to the possible counter-transference phenomena, e.g. the uncontrolled, unconscious feelings aroused in the therapist when working with a particular patient. According to the object-relations theory, counter-transference has a rational and heuristic value because it gives a clue to the role relationship that the patient wants to impose on the therapist and thus gives meaning to the reaction of the therapist (Sandler, 1977).

Limitations of transparency

In the process of professionalisation, feminist therapists increasingly became confronted with women who suffered from severe disturbances due to emotional neglect as well as physical and sexual abuse early in their lives. It became clear that the possibility for a negative outcome of (feminist) therapy is high when the therapist becomes emotionally involved in her clients' attachment patterns.

Those severely traumatised women are characterised by impulsive behaviour combined with a pattern of instability in affects, self-image and relationships. Their attachment anxiety alternates and conflicts with their separation anxiety. Attachment figures are idealised, but when they get too near they are at the same time devalued by them. In the language of DSM IV this reaction pattern has become known as the Borderline Personality-Disorder. Obviously, these women also bring their complicated attachment patterns into the therapeutic relationship. Dawson and McMillan (1993, pp 47-48) describe the pattern as follows:

> "In contacts with health care professionals the borderline patient is seeking resolution of self-system and ambiguity, or, put simply, is seeking self-definition [..] Borderline patients seek self-definition [..] and engage others in the externalised dialogue of their central conflicts [..]. The patient's conflict is then well externalised into a dialogue or negotiation, with the patient assuming the `bad' role and the therapist the `healthy, responsible, good role [..] Besides, there is a special kind of control over others that comes from not being in control of oneself.'"

Their advice is that the therapist should respond neutrally to both crises and positive changes in the relationship. In other words, the therapist has to manage the relationship by showing abstinence. In addition, she may use counter-transference as an instrument of research into the patient's unconscious (Heiman, cited in Orbach & Eichenbaum, 1993).

Management of the transparency-abstinence dilemma

The question is: in what way can the feminist therapist hold on to her ethics and at the same time keep a professional distance in managing her counter-transference so as not to become entangled in a relationship with these traumatised clients.

> "In my practice (HG), I try to solve this dilemma by functioning on two levels at

the same time. On one level, I try to sympathise and show solidarity with my client. On the other level, I keep a strict professional distance and censor every intervention. It means, for example, that my attitude in the case of a dramatically presented psychological crisis can look very distant instead of empathic."

A similar 'solution' is advocated by Goldner, known for her system therapeutic approach in the treatment of heterosexual couples where male violence is an issue. She states:

> "It is important to get clear the tension in the various attitudes in our work. […] we [the feminist system therapists of the Ackerman Institute, *H.G.*] work within an `as well as'-framework [..] in order to describe as fully as possible the existential and therapeutical dilemmas that these couples pass on us." (Goldner, 1997, p. 131)

All in all, the case of the `borderline patient' illustrates the limitations of FMHC's transparency principle and brings back the therapist as an objective observer. When the therapist sticks to empathy and transparency it is highly probable that , for example, severely traumatised patients will end up with a negative therapy outcome. It seems that a `post-modernist stance' is required to meet the instability and ambiguity with which therapists are confronted by their clients, especially by the ones with a tormented personality.

THE LIMITATIONS OF THE EMANCIPATORY APPROACH: FMHC IN A PSYCHIATRIC HOSPITAL

Clients in clinical settings are not only confronted with a larger number of health-care providers, but the dependency relationship is extended to their private lives. They have a strong feeling of dependence with respect to health-care providers because they live in a psychiatric setting 24 hours a day. So, they feel dependent not only with regard to their treatment, but also with regard to their accommodation, food, and so on. (It happens that when female clients harm or mutilate themselves, they are discharged from the hospital as reprisal). Knowing this, introduction of FMHC principles seems all the more important in their cases, especially to raise their inferior position in terms of power and rights.

But how does a commitment to FMHC affect the work of psychiatric staff? My research (Steketee, 1995) compared two departments, one where FMHC is part of the treatment and another (`traditional') where it is not. Two dilemmas emerged from the findings: firstly, disruption or reinforcement of differences; and secondly, the limitations of the emancipatory approach.

Disruption or reinforcement of differences

FMHC was apparent in the way in which the staff defined female and male clients' problems. The psychiatric staff from the 'feminist oriented' department appeared to pay more attention to their clients' social network, relationships, gender-related experiences in their lives (sexual abuse, for example) compared to the staff from the 'traditionally oriented' department.

However, these differences in problem definition did not lead to differences in

treatment. In both departments, clients apparently received the same treatment with the same goals and clear differences could be identified in the staffs' interpretation and working methods in relation to clients' gender. The problems of female clients were mainly placed in relational contexts, whereas external circumstances were named far more often in relation to male clients' problems. Furthermore, a masculine norm was evident in the solutions or treatment goals suggested for female clients, such as `furthering psychosocial skills so that women would learn how to stand up for themselves'. Women were to learn how to set limits and say, `No', whereas men were to learn practical skills so that they could better take care of themselves. The treatment goals for male clients concentrated far more on practical skills, such as being able to run a home independently, regardless of the type of housing. However, in the division of labour, traditional gender roles were evident. Work and schooling were suggested as treatment goals far more often for male clients, whereas voluntary work was more often suggested in treating female clients. After all, both the staff from the 'feminist oriented' department and the health care providers from the 'traditionally oriented' department used the same gender dichotomy with respect to labour, treatment goals and the treatment itself.

Clearly, the FMHC principle of thinking in terms of differences between women and men implies a pitfall in that it might endorse the current views on 'femininity' and 'masculinity'. Obviously, a shift in traditional role patterns has taken place: in the seventies women were always sent to cookery classes. And now, men were expected to learn how to look after themselves and run their own homes, whereas women should concentrate on self-realisation and assertiveness. However, new generalisations of women have emerged. For example, in improving women's autonomy, the underlying assumption is that they are too dependent, do not have enough grip on their lives, or are too vulnerable.

Gradually, (feminist) health care providers have become aware of the meaning of gender in the statements they make about women and realise how concepts such as `autonomy' and `independence' are inevitably tied to a particular time and culture. They have started to ask themselves if they are not producing new stereotypes on women as well as new obligations by not allowing dependency and celebrating assertiveness and autonomy.

As a consequence, the consciousness has grown that FMHC needs an approach that must be able to demolish fixed images, and in addition will upgrade the concept of 'femininity'. The final goal cannot be that femininity is used as a criterion. The aim should be that differences between and within genders are recognised without relating these to a hierarchical opposition of these differences.

Limitations of the emancipatory approach

FMHC advocates an emancipatory approach allowing clients to play an active role in the decision-making process regarding their treatment. It infers that a client's possibility to make her own choices in the treatment process increases her ability of self-determination both on a personal and social level. The above mentioned study (Steketee, 1995) revealed some limitations of this principle, on both levels.

Firstly, most clients and particularly female ones did not bring up their personal needs and wishes with regard to their treatment, although these were different from what was offered. Presumably, the strong power relationship between health care provider and clients make the latter tend to conform to the health care provider's

wishes. Moreover, it appeared that female clients were much more inclined to comply with taking the prescribed medication than men.

Secondly, increasing the autonomy or self-steering abilities of female psychiatric clients did not necessarily lead to improvement in their social status. After treatment in the psychiatric hospital, only a few women from the 'feminist oriented' department had a job or followed further education, whereas more women of the 'traditionally oriented' group appeared to have had a paid job, becoming active participants in society. The explanation might be found in the different rules in both departments. At the 'traditionally oriented' department, clients' participation in all therapy programs was mandatory, unless they had other activities outside the ward. The consequence was that these clients (who often had a long psychiatric history) actively looked for employment, although their motivation to look for a job stemmed from a refusal to participate in the therapy program. In contrast, at the `feminist oriented' department, clients were neither obliged to participate in the therapy programs nor to look outside for activities because such `directives' did not fit into the emancipatory approach.

It must be concluded that feminist goals and methods do not work out in the same way in non-residential and residential settings. Allowing self-determination does not suffice to break the hierarchy between therapist and client, and self-determination on an individual level is no guarantee of social change. For that reason, health care providers have to be constantly aware of the undesired side effects of their interventions and principles and of the consequences of the various rules for their clients' position. In addition, the relationship between changes on the individual and on the social level need additional exploration and investigation.

WORKING WITH A SOCIAL INEQUALITIES PERSPECTIVE: WHERE AND HOW EXPLICIT?

A central dilemma is located in the fundamental clash of purpose between FMHC and mainstream mental health services. FMHC identifies social inequalities as major determinants of the despair, distress, and confusion that is named `mental illness'. Social inequalities are linked to the mental health of women in ways that help to make psychological distress understandable, and which can be used to define individual and collective approaches to empowerment. Mainstream mental health services do not share this commitment to clarifying the relationship between social inequalities and mental health. As social institutions they, like other institutions, protect the interests of those who are already powerful and privileged in our society. Denying and obscuring the role of social inequalities in the aetiology and maintenance of mental health difficulties is, arguably, the most important way in which they fulfil this function and help preserve the social status quo. The central dilemma, therefore, is that FMHC workers are trying to make explicit those things which mainstream mental health services are trying to conceal. Consequently FMHC workers have to continually make choices about how to be effective, and to survive in this context.

Inside/Outside

Mainstream mental-health services are shaped by ideologies that deny and minimise the effects of social inequalities on women's lives and mental health. As such, they are a hostile environment for women clients and indeed for FMHC workers.

One response to this has been to develop women-centred mental health services in the margins of statutory services. In the UK, there are many fine examples of alternative mental health service provision for women, e.g. Women and Mental Health Forum[2], Threshold [3] and LYSIS [4]. These services are less constrained by psychiatric ideologies and dogma, and provide an important context within which women-centred ways of understanding and responding to mental health distress can develop. Although these services are usually strongly endorsed by women service users, they are only a partial solution to the problem. As yet, women-centred mental-health services are neither securely funded nor widely available. Non-statutory services for women in the UK, like comparable services for people from Black and minority ethnic groups (Watters, 1996), rarely have a stable source of funding, and many developments are not sustainable in the long-run (Williams, 1996; Perring, 1996). However, working outside mainstream mental health services has not been the only way that women have tried to solve the essential ideological clash between FMHC and psychiatry.

Another response has been to stay inside mainstream mental-health services. In the UK a group of FMHC workers in Exeter, which includes one of the authors (GW), has over ten years experience of working within mainstream mental-health services. This group has been especially concerned in developing effective mental-health services to women survivors of childhood sexual abuse (CSA). Here some reflections are offered on their struggle to solve the dilemma by staying `inside' psychiatry. The FMHC workers who have been involved in the development and provision of this service (Watson, Scott & Ragalsky, 1996) are strongly committed to the view that working with the mental health consequences of CSA should be at the core of mental health service provision for women. They are well aware of the high rates of CSA among women using mental-health services, and of the central significance of CSA for subsequent adult mental-health difficulties. They have not sought specific funding for the service, partly because of the vulnerability associated with being an `outside' service, but mainly because this would place the task of responding to the consequences of CSA outside of, and seemingly irrelevant to, mainstream mental-health services. Instead, these FMHC workers continue to find creative ways of allocating time to this service as part of core mental health work, and of securing small amounts of funds from within existing budgets to pay for contributions from colleagues outside of mainstream mental-health services. They are involved in an ongoing task of persuading the managers and the purchasers of mental-health services to acknowledge the serious impact of CSA on the mental-health difficulties women experience. This includes making them aware of the significant costs, both in economic and mental health terms, of failing to provide specialist therapy within adult mental-health services for the trauma of CSA.

The women involved with this service - mental health workers, community psychiatric nurses, and psychologists - are aware of continually trying to find a language that bridges the gulf between FMHC and mainstream psychiatry. Moreover, they are searching for ways of speaking about the connections between CSA and women's mental health that helps to build an alternative account of women's mental health difficulties, while minimising the risks of isolation and marginalisation within mainstream mental-health services. As `insiders' who do not occupy a strong position, FMHC achievements

2 Women and Mental Health Forum: Newsletter of the Women and Mental Health Network UK. Information available from *15 Woodbury Street, Tooting, London SW17 9RP*.

3 Threshold: Women's Mental Health Initiative. Information available from *14 St. George's Place, Brighton, East Sussex, BN1 4GB*

4 Lesbian Youth Support Information Services. See Bridget, J., & Lucille, S. in *Journal of Community and Applied Social Psychology, 6*(5), 355-364.

are limited, and this can be hard to endure. It is also difficult to witness the continued misunderstanding and mistreatment of women service-users within mainstream mental-health services, especially in-patient facilities.

Broadening the struggle

The dilemma identified here (the clash of purposes between FMHC and mainstream psychiatry) can only be satisfactorily resolved by the transformation of the knowledge base and the practice of mainstream mental-health services. Although there continues to be huge resistance to these changes, it is important to recognise that the FMHC movement is in a considerably more powerful position than twenty or thirty years ago. There is now a vast literature that reconstructs the aetiology of women's mental-health difficulties from a social inequalities perspective, and documents the ways in which this knowledge can be translated and elaborated within FMHC. Although mainstream mental-health services and professions continue to be very resistant to this knowledge (e.g. Williams, Liebling, Lovelock, Chipchase & Herbert, 1998), it is nonetheless a powerful resource for achieving change, and one which could help secure public acceptance of social inequalities as a central mental-health issue. This goal may be achievable given that there is increasing acceptance that social inequalities are significant for physical health and general health care (e.g.Wilkinson, 1996). Moreover, FMHC workers do not have to struggle with this task alone. Women are not the only people who will benefit when social inequalities as a major etiological factor in mental health difficulties is accepted. FMHC workers can strengthen the profile of inequality and mental health by forming alliances with kindred campaign and advocacy groups including those concerned with mental health service provision to Black and minority ethnic groups (see Fernando, 1995,; people with disabilities (see Campbell & Oliver, 1996), and the broader based Mental- Health Service User Movement (see Campbell, 1996). Social inequalities also impact upon the mental health of men (e.g. Miller & Bell, 1996), and it is important that this also be cited and acknowledged.

It is crucial that the struggles with this dilemma on articulating or concealing the social inequalities perspective take place within the public domain, as well as within mental health services. There are indications that many FMHC workers prefer to locate their struggle with social inequalities in therapy and service provision to women. This is important, but it should not be the only response to the psychological damage and distress created by social inequalities. It is vitally important that FMHC workers are not silenced and that action is taken to ensure that connections between inequality and mental health become widely accepted. FMHC workers need to continue to exert pressure on policy makers, the media, and the professional bodies that shape the provision of mental health services. The power of collectivity cannot be over-estimated and, therefore, alliances with other interest groups must be the most effective way of resolving the dilemma and establishing social inequalities as the central issue in the understanding and treatment of mental health difficulties.

THE PARADOXES AND TENSIONS IN EMPOWERMENT

All practices of FMHC can be said to share an ideology of empowerment for women. Empowerment is

> "… a process by which oppressed persons gain some control over their lives by taking part with others in the development of activities and structures that allow people increased involvement in matters which affect them directly. In its course people become enabled to govern themselves effectively. The process involves the use of power, but not `power over' others or power as dominance as is traditionally the case; rather, power is seen as `power to' or power as competence which is generated and shared by the disenfranchised as they begin to shape the content and structure of their daily existence and so participate in a movement for social change.' (Bystydzienski, 1992, p.3)

In the last decades, this ideology has shown its merits for women struggling against the adverse effects of power imbalances in society. However, several tensions and paradoxes are present in the assumptions of this concept. Firstly, its notion of subjectivity is problematic. Secondly, the idea of a direct link between self, other and society rests on an unjustified simplification.

The denial of multiplicity, fragility and connection.

Empowerment is based on the assumption that women can be the agents of their own lives, capable of growth towards self-knowledge and self-determination (McWhirter, 1994; Steinem, 1992). This assumption is rooted in the Enlightenment view of an autonomous, rational and unitary self, developing into maturity by separation from others; getting emotions under control; and behaving consistently. This image of self was essentially male, as was the standard of mental health. In contrast, women were viewed as dependent, emotional, irrational and physically and mentally weak.

In claiming subjectivity and agency several aspects of human existence are ignored. Firstly, the French philosopher, Michel Foucault has shown that power consists of complex, both discursive as well as pre-discursive (embodied) processes, expressing itself in practices which are at the same time disciplinary and subjectification practices. Power also very effectively flows directly through the body, giving shape to and thereby oppressing (sexual) desires and needs. Following his post-modern view of power, it cannot be sufficient to define empowerment in terms of a linear rational - cognitive and behavioural - transformation. As Waterhouse (1993) argues, the movement from ‘angel child’ to ‘wild woman’ cannot be achieved by a mere act of will. The multiplicity of empowerment - and of human beings in general - can better be captured by ‘desire’, which never fully disappears and can be felt bodily and sensually. It stands for the preconscious and prediscursive which evades us in the very act of propelling us forth. Therefore, it is a life-force capable of freeing us from hegemonic habits of thinking and being (Braidotti, 1994).

Secondly, the Foucauldian insight that human existence is an embodied existence brings forth another exclusion. Human beings are vital, passionate and full of power on the one hand, and a source of vulnerability and dependency on the other. Vulnerability and dependency not only refer to oppression or determination by inescapable cultural forces. They also refer to a perspective on life and death, an inevitable human fragility and mortality. Thus, the concept of empowerment fails to notice the possibility that the process of empowerment may consist of the acknowledgement of fragility and the expression of confusions and doubts; in a ‘letting go of the self’ or ‘surrender’, instead of mastery and control

Thirdly, the predilection for traditionally ‘masculine’ concepts such as power,

mastery and control has ignored connectedness and community (Riger, 1993). The Stone Center theoreticians have grasped this problem by redefining women's growth as a growth in connection, instead of separation (Jordan, Kaplan, Baker Miller, Stiver & Surrey, 1991). As a consequence, they plead for 'autonomy-in-connection'. Thus, a theory of empowerment should be based on the tension between autonomy and connection, and empowerment should assume complex and dynamic connections between self, other and society.

The dualism between individual and society

The process of empowerment assumes a link between individual empowerment and social action. However, there is a lot of controversy on which 'level' one has to intervene to facilitate this process and about the way these 'layers' of empowerment are linked.

Cultural, spiritual and liberal feminists argue that individual empowerment is necessary to struggle against gender-stratification, because self-empowerment frees the energy and `gives one the strength to continue working for social change' (Luff, 1990). Worell and Robinson (1993, p. 94) defend the current focus on feminist individual counselling and therapy by saying that this `may be a response to the call to heal ourselves before we can return in full force to a collective approach' . In these approaches, individual empowerment is seen as a prerequisite for social change. Steinem (1992) goes even further by saying that individual empowerment itself is a revolutionary act in a heteropatriarchal world - 'the revolution from within'**.**

This way of thinking is criticised by Kitzinger (1993) who does not think 'that social change happens from the inside out. On the contrary, our inner selves are constructed by the social and political contexts in which we live, and if we want to alter people's behaviour it is far more effective to change the environment than to psychologise individuals' (Kitzinger, 1993). So, from a radical or socialist feminist viewpoint, a focus on self-authority and the inner life of clients, can even be profoundly `disempowering'. Feminist therapists and counsellors lay the onus on the individual woman of transforming her subjective relationships to others and to an external reality that basically remains the same, although they recognise the politics at work in client's personal problems. Waterhouse (1993) , for example, warns that burdening the client with such responsibility can exacerbate feelings of helplessness, powerlessness and low self-esteem. And Caplan (1992) wonders if addressing the structural and interpersonal constraints on women's lives by only helping women to deal with them at times might collude with a very subtle form of `victim-blaming'. A similar concern has been articulated by Riger (1993) who warns us against reducing the political to the personal and thereby overlooking 'real' power inequalities in society. All these feminists remind us of what Lerman noted more than a decade ago: " When we help people ease their pain in living, we help them live in a world which they are less motivated to change" (Lerman, 1985, p. 5).

The problem with assuming a link between individual and social empowerment is that the notion of 'link' assumes two different entities, the individual versus the social. The debate between individually oriented feminists on the one hand, and politically oriented feminists on the other, is based on a dualist thinking about agency versus structure/culture. Here, empowerment appears as a progression from a state of relative powerlessness to a state of having 'power to', which can be reached by *either* intrapersonal *or* social transformation. However, empowerment is a much more

complex process *in between* person and society. To stay with Foucault's theory of power, it turns out to be impossible to distinguish between powerless people and oppressing structures or discourses. Disciplinary practices limit the range of the kind of subjects people can become, whereas, at the same time, they enable people to become subjects of speech and action. Simply put: in their production of human subjectivity, disciplinary practices are both oppressive and empowering. An ecological theory of empowerment is needed in which people as living systems are part of culture as a higher-order eco-system, without assuming linear and predictable relationships between individual and social developments.

The link between individual and collective empowerment

In the early years of feminist mental health care, women met each other in groups to share their problems and help each other. They were assumed to be bound by their common identity as women. Therefore, their individual empowerment was seen as unproblematically linked to their collective empowerment as women. Unfortunately, this assumption has overlooked the probability that identities, individual as well as collective ones, are multiple, conflicting and `nomadic' instead of stable and coherent. After all, individual women make multiple and often contradictory identifications with several social groups, whereas `women' as a social category do not have a close and unambiguous identity with a pre-given, non-problematic definition of the boundaries of their group. Accordingly, neither a close and unambiguous link can exist between individual and group identity nor the assumed unproblematic transition from individual empowerment to collective empowerment (Yuval-Davis, 1994). So, it is impossible to `voice' `women' because there are the voices of the non-white, the poor, the homeless, and others in the margin. Moreover, several conflicting voices may be present in one individual, and the question is how these will relate to which collective.

To avoid exclusion and disempowerment of women in therapy, FMHC needs a notion of empowerment which is based on differences alongside commonalities. This means that a form of coalition politics is needed in which the differences among women are recognised and voiced next to `the unfinished knowledge' that each situated positioning can offer (Hill Collins, 1990), without fixing the boundaries of this coalition in terms of `who' we are, but in terms of what we want to achieve.

In conclusion, the concept of empowerment in FMHC is based on several paradoxes and tensions. These are not to be dissolved, however, because they reflect the tensions of living in a post-modern world. We would rather reconceptualise empowerment as complex, multiple, seemingly contradictory and ever-changing processes in between self, other and society. What is needed then in FMHC, is an open attitude in dealing with ambivalence, flexibility and contradictions.

REFLECTION ON THE FMHC 'S DILEMMA'S

The range of FMHC's dilemmas appears to cover the first five types identified by Dryden (1997) in his exploration of therapists' dilemmas. He discerned six themes: 1. Compromise dilemmas which centred on the tension between the `ideal' and `the pragmatic' ; 2. Boundary dilemmas which involve the choice of whether or not to cross a variety of boundaries which frame therapeutic work; 3. Dilemmas of allegiance in which the therapist struggles with conflicts between clients' interests and his or her own

professional community; 4. Role dilemmas when therapists negotiate roles such as practitioner, educator, healer, scientist and so on with themselves; 5. Dilemmas of responsibility in weighing to what degree one should take responsibility for the clients' welfare and to what extent one should respect clients' autonomy; 6. Impasse dilemmas which relate to how a therapist should behave in case of therapeutic impasses.

Neither in Dryden's study nor in ours were dilemmas mentioned which undermine the therapists' motivation - either through personal vulnerability or through disillusion, or because of having grown out of the original motives. Here, self-selection of the participants in the study may be the explanation.

However, the selection clearly demonstrates that dilemmas are not confined to therapists' actual choice-making behaviour. Apparently, dilemmatic aspects of_thought also exist. According to Billig, Condor, Edwards, Gane, Middleton and Radley (1988, p. 24) these `are preconditions for any dilemmatic choice and continue to exist in common sense, even in the absence of actual situations which necessitate the taking of difficult choices'. Billig and his co-authors distinguish between dilemmas in lived and intellectual ideology and dilemmas in the passage from intellectual to lived ideology and vice versa. With 'lived ideology' they mean ideology as a - non-formalised - community's way of life, whereas intellectual ideology refers to the - formalised - system of political, religious or philosophical thinking.

Actually, the dilemmas here selected can be categorised in three groups: those arising from the application of the original FMHC-principles with `new' groups of clients, those arising from the institutionalisation of FMHC which requires application in new conditions, and those connected with the guiding concepts. In the first category, the choice between a non-drug treatment and the general pressure to prescribe anti-depressant drugs has been described. While the therapist sticks to her original preference (no drugs), she shares the responsibility of resolving the dilemma with her client and offers the client the conditions (five sessions) to enable her to make a well-informed choice. In addition, the tension has been revealed between the transparency principle and the therapist's need for abstinence when working with `borderline patients'. This dilemma, and the therapeutic relationship, was managed by applying both attitudes (solidarity and distance) simultaneously while thinking of them as distinct levels. In this manner, a middle course which avoids the undesirable aspects of the options that constitute the dilemma is defined.

The second category contains the dilemmas that arise from FMHC's integration into a psychiatric hospital. The intended disruption of sex differences may result in reinforcement of them, just as the methods to enhance autonomy and to break hierarchical sex differences may have reverse results. Therefore, demolition of fixed sex images is recommended alongside sensitivity to differences between and within genders without pinning them down to hierarchical oppositions. In fact, a better intellectual equipment of the intellectual ideology was called for. Moreover, alertness to the undesired side-effects of FMHC-principles and interventions when applied in residential and non-residential settings was advocated. So, the solution of this dilemma is sought in less rigid reflexive categories and more detailed observations and analyses. Another type of dilemma appeared to emerge from a refusal to adopt the social inequalities perspective by the regular mental health services. The conclusion was that to win the professional and scientific struggle, the FMHC will need networks and alliances, not only within but also beyond mental health services. In other words, the solution cannot be expected from compliance with the professional and scientific rules or from allegiance with the FMHC community alone, but must come from developing power by connecting with kindred

spirits.

In the last category, the paradoxical sides of empowerment (as a concept and as a process) have been exposed. By the denial of fragility, by the empowerment ideal and by unravelling the assumed linearity of the process between individual and collective empowerment insight is offered into the excluding effects. A continued conceptualisation is suggested with an eye to the importance of desire and the diversity of women.

The strategies proposed in this chapter parallel the responses to the dilemmas as distinguished by Bond (1997) based on the therapists' interviews held by Dryden. With regard to the dilemmas in current therapeutic relationships three of the six strategies Bond has extrapolated have been confirmed. *Choosing one of the available options* was reported, but the therapist combines her preference for a talking cure with the strategy of *sharing her responsibility with the clients* for resolving the dilemma. *Taking a middle route* between the horns of the dilemma is found in the way the relationship with a borderline patient was managed. Additionally, *avoidance of dilemmas* by referring clients to another source of help or by avoiding taking on any client likely to raise the dilemma is not explicitly reported, but can be read into the difficulties FMHC has with awarding the social inequalities perspective. *The progressive refinement of responses* has not been found in the sense Bond explains it: progressively trying a number of strategies and reflecting on the experience. W*atchful watching* is also missing from our material, but this is not explicitly referred to either in the interviews Bond analysed.

Two additional types of strategy can be observed in response to the dilemmas concerning the strategic and ideological shortcomings of the FMHC-profession. On the one hand, power acquisition is pleaded in order to persevere in the preferred option. On the other, deconstruction of dilemmas and progressive refinement in the intellectual ideology is advocated. Both responses can be understood against the background of the authors. Involved in women's studies, both are very conscious of the empowering and disempowering effects of professions, science and theories. Their responses perfectly share the original, politicising, character of the FMHC-movement.

DILEMMAS AS SOLUTIONS

The FMHC dilemmas and strategies presented here confirm that dilemmas do not only bring negative experiences, characterised mainly by emotional pain and cognitive uncertainty. They also offer starting-points for discussions that challenge (feminist) practices and ideologies in mental health care, and may further them. As Bond has stated

> "Dilemmas may well combine some dysfunctional with some functional capabilities. When they arise, dilemmas pose immediate challenges regarding work with a current client, which frequently tests therapist, client, and the therapists' supervisor. Outside the immediate therapeutic relationship, dilemmas can be seen to act as boundary markers of the competence of the individual therapist and the profession as a whole. Dilemmas chase us away from a tendency to see ourselves as omnipotent and omniscient. They do not necessarily undermine the value and purpose of therapy." (1997, p. 190).

It has become clear that FMHC as an ideologically-driven practice gives rise to more and different dilemmas and strategies than mainstream mental health care does. In

particular, it gives rise to dilemmas of ideology and of reconciling ideology and lived reality alongside strategies of power acquisition and of unravelling concepts and theories.

Spotting and exploring dilemmas as is done here opens to first, as well as second, order learning. The question is not only `do we things rightly?' and `do we think rightly?', but also `are we doing the right things?' and `are we doing the right thinking?' As such, it is a form of distance supervision that touches the methods as well as the ethics of FMHC and in this way may contribute to a responsible development of mental health care for women.

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