THE SOCIAL RECONSTRUCTION OF SEXUAL ASSAULT BY WOMEN VICTIMS: A COMPARISON OF THERAPEUTIC EXPERIENCES

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ABSTRACT

In this study, the conventionally accepted view of sexual violence against women as manifested by traditional therapy is contrasted with the feminist perspective represented by feminist therapy and feminist self-help groups for victims of sexual assault. The focus of the research is on the ways in which consumers of different therapies are taught socially to reconstruct their sexual assault experiences. On the basis of intensive interviews with victims of sexual assault or incest who have subsequently experienced therapy, the reconstructions of the assault encouraged by conventional therapeutic approaches are found to differ sharply from those developed in feminist modalities. The conclusion is that conventional therapies for victims of sexual assault tend to perpetuate the existing belief structure about rape and incest by isolating and blaming the victim. In contrast, feminist counselling and feminist self-help groups remove the woman's false sense of guilt, validate the woman's experience with sexual violence, and enable the victim to develop an understanding of the social structural context in which sexual assault occurs.

INTRODUCTION

This is a study of the power of perspective to affect reality. We compare and contrast the conventional interpretation of sexual violence against women, as manifested by traditional therapeutic approaches, with the emergent feminist perspective represented by feminist therapy and feminist self-help groups for rape and incest survivors. The means by which victims of sexual assault reconstruct their experiences as a result of therapy permits examination of the power of labelling, the prerogative of those with power to define what is real and the means by which it should be seen, the legitimation of knowledge, and the relative efficacy of women's realities as allowed or disallowed by therapeutic interventions. This research permits the voice of the sexual assault victim who is a consumer of mental health services to be heard.

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The prevalence and power of the victim-blaming ideology identified by various researchers (Ballou & Garbalac, 1985; Burt, 1980; Field, 1978; Mazelon, 1980), in which the victim is deprecated and the offender excused, an ideology the victim herself internalizes (Janoff-Bulman, 1979), acts as an explanation and justification for sexual violence in our society. Myths surrounding sexual assault overlook women's powerlessness and subordination to male authority. Women's experiences tend to be denied in order to fit into male-produced modes of knowledge about what "really" occurs in incidents of sexual assault. Therapists, as well as others such as police, courts, hospital workers, doctors, and family members tend to serve as gatekeepers for testing the reality of women's experiences with sexual assault. Therapists in particular exercise considerable power to redefine the experience for the victim in terms consistent with generally accepted societal explanations. That the gatekeeper's interpretation often does not match that of the victim is manifested in women's reluctance to report incidents of sexual assault to authorities. Note, for example, a recent victimization study conducted by the Federal Ministry of the Solicitor General (1981) which found a non-reporting rate for sexual assaults of 50%, 60%, and 85% for the cities of Montreal, Toronto, and Edmonton, respectively.

Women's own reports of their experiences with sexual assault and the subsequent therapeutic interventions aimed at helping them cope with their rape/incest experiences provide the basis of this research. We ask how different therapeutic perspectives enable the woman to reconstruct her rape/incest experience. Our enquiry is conducted within a framework which allows women's experiences, perceptions, and interpretations a viability and credibility not permitted by more structured traditional methodologies such as those which compare the philosophical underpinnings of different therapeutic approaches from the therapist's perspective. Specifically, women's experiences with traditional and feminist treatments are compared to assess whether, and to what degree, the ideological underpinnings and conceptual bases of therapies, as experienced by the victim herself, may tend to invalidate the experiences of women as victims of sexual assault. We observe, record, analyze, and compare the experiences of sexual assault victims with different types of therapy as seen through the eyes of the consumers themselves. Our central variables, then, are therapeutic modality (traditional versus feminist) and the women's accounts of their own therapeutic experiences.

THEORETICAL CONTEXT

Feminist scholars have clearly articulated the disjuncture between women's experiences and the male-dominated theoretical schemes, images, and vocabularies with which women's experiences in the world are examined and explained (Rowbotham, 1973; Smith, 1975a, 1978; Spender, 1980). Variance between male-produced explanations and women's realities is particularly salient in the attempt to understand the systematic societal denial and invalidation of women's experiences as victims of sexual assault. The universality of victim-blaming demonstrates the political nature of knowledge, sexuality, victimization, and therapy (Ballou & Garbalac, 1985).

Male-ascribed terminologies simultaneously reflect the definitional privilege of the dominant group and the omission of the powerless in the construction of social reality. With sexual assault, submission becomes "consent"; mere presence of the woman becomes "victim-participation"; and travelling alone, pleasantness to men, acts of assertiveness, or rejection of the double standard of sexuality become "provocations to rape" (Reynolds, 1974, p. 65). In the case of sexual abuse of female children and adolescents, sexual intercourse and fondling become "love," "sex education," or the "fantasies" of precocious children (Ward, 1984).

That men have named the world from their point of view becomes problematic when we consider the deleterious effects for women of this monopoly on naming (Spender, 1980). The relevancies and realities of the victim disappear and are subsumed by "the persistence of the privileged version" (Smith, 1974, p. 12). One can imagine the emergence of new paradigms to explain sexual violence against women if the silencing of victims were not so complete.

In an attempt to move theory closer to women's reality, feminists call for the construction of autonomous knowledge bases grounded in women's "direct experience of the everyday world" (Smith, 1974, p. 12). Feminist analysis affords a credibility to women's experiences as victims of sexual violence—a legitimacy not previously allowed by conventional male-dominated explanations of sexual assault. Thus, feminism challenges the sexual assault myths, recognizes personal victimization as political, and negates the assumption of female culpability.

TRADITIONAL AND FEMINIST APPROACHES TO TREATMENT

The sharp differences between the conventional and feminist therapeutic modalities in terms of the locus of pathology, the role of the therapist, the interpretation of symptoms, the focus of intervention and therapeutic goals have been clearly articulated in the literature (Brickman, 1984; Rawlings & Carter, 1977; Sturdivant, 1980; Tennov, 1975). Traditional therapies based on an illness-remediation model (Sturdivant, 1980) and an objective, authoritative therapeutic stance which identify distress as emanating from psychopathological and largely unconscious forces within the individual, have failed to address the gender politics central to the sexual victimization of women. The attribution of pejorative psychiatric labels to women who do not conform or overconform to the female sex-role (i.e., the "angry woman" syndrome and the "dependency" syndrome respectively) reflect the political nature of therapy. The focus on the individual's childhood trauma, fantasies, dreams and associations (Tennov, 1975), as well as the emphasis on adjustment to the status quo in which women are subordinate to men, further removes women from any comprehensive, critical understanding of the economic and political conditions which impinge on their well-being.

Feminist counsellors, therapists, or group leaders, by contrast, reject the individual-based medical disease model, posit a gender-role analysis, and prefer a self-help modality (Rawlings & Carter, 1977). Particular emphasis is placed on women's powerlessness and subordination to men, the damaging effects of women's imposed minority-group status, and the function of sex-role expecta-

tions in the etiology of women's mental illness (Sturdivant, 1980). Women participants in feminist counselling or feminist self-help groups assume the power to define and interpret their own situations, rather than this being assumed by the therapist or group leader. Women are seen as possessing the knowledge which best reflects their own experiences. Women's subjective experiences are allowed a credibility. Anger and depression are not viewed as individual pathologies but are recognized as a collective problem which women share as a consequence of the oppressive and often contradictory demands and expectations of male-dominated society. Beginning with the experiences of women, rather than male-produced translations of those experiences, and with the premise that the personal is ultimately political, feminist therapy is able to examine sexual violence as part of women's sexual oppression.

LITERATURE REVIEW

Institutional reactions to sexual assault include the traditional reluctance of police to believe the victim (Hickl-Szabo, 1982), reluctance of physicians to examine rape victims (Burgess & Holmstrom, 1973; Hickl-Szabo & Stead, 1982; Holmstrom & Burgess, 1978; Le Bourdais, 1976), as well as the anti-victim bias of the legal system (Brooks, 1975; Canada, Department of Public Affairs, 1983; Goar, 1983). Similarly, childhood and adolescent victims of sexual abuse may not be "heard" when they reach out for help, and are often held responsible for the abuse (Ward, 1984).

Members of the helping professions are not excluded from this cultural and professional lore. Smith (1975b) eloquently writes of the role of psychiatry in sanctioning the disjuncture between women's realities and the concepts psychiatry uses to understand their circumstances. Because men hold the prerogative of authoritative speech, women's experiences are "made over into a resource for the interpretative work of the psychotherapist" (Smith, 1975b, p. 9). Stark, Flitcraft, and Frazier (1979) document the presence of patriarchal domination in therapeutic models in their examination of physicians' formulations of the construct "battered wife." Abused women are "cooled out," labelled as psychiatric cases, and the battering interpreted as a consequence of the woman's more basic problems. In essence, women become the problem and no longer the victims. Maynard (1983) documents the insensitivity of social workers who recognize that although one-third of their clients are abused women, the abuse is seldom defined as the central problem. Dietz and Craft (1980) report that social workers tend to hold the mothers of incest victims responsible by virtue of unconscious consent, while acknowledging the husband's use of physical intimidation. American courts even award fathers committing incest custody of their children rather than the mothers who are seen to be "interfering" with the incest (Chesler, 1986). The helping professions look quite different when we consider them from the woman's perspective as consumer (Penfold & Walker, 1983; Smith, 1975b). Although systematic studies have yet to be done on therapists' and counsellors' treatment of victims of sexual assault, we would not expect them to be immune to the widely accepted victim-blaming stance. In fact, cultural biases reflected in clinical theories (Marolla & Scully, 1979; Richardson, 1977), sex biases in therapy (Sherman, 1980), and the lack of services for women who are

victims of male aggression (Carmen, Russo, & Miller, 1981) attest to a strongly held victim-blaming ideology.

Empirical studies examining sex-role stereotyping of clients by therapists (Aslin, 1977; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Fabrikant, 1974), therapists' attitudes toward women (Brown & Hellinger, 1975; Stark-Adamec & Graham, 1983), counselling "analogue" studies (Abramowitz, Jackson, & Gomes, 1975; Miller, 1974), as well as the few studies of actual therapists and clients (Fabrikant, 1974; Pietrofesa & Schlossberg, 1970), consistently document the predominance of sex-role stereotyping and sex-bias on the past of mental health professionals. While these studies with their varied methodological approaches find evidence of a double standard of mental health and are suggestive of the potential problems faced by assault victims seeking help, we have no direct evidence of ways in which sexist values and male dominant ideology in actual therapy sessions are seen by the woman consumer of mental health services.

Orlinsky and Howard (cited in Gilbert, 1980) cite the need for research on therapy as an experience, that is, "the occurring involvement in the therapeutic experience as it is viewed internally from the perspective of the participant-observer" (p. 260). This recommendation merits serious consideration given our knowledge of victim-blaming and sex-bias in therapy and the commonplace occurrence of sexual violence against women. In 1979, the Canadian Advisory Council on the Status of Women reported that six percent of Canadian women are raped and 20% sexually assaulted, at some point in their lives (Kinnon, 1981). Three random surveys cited by Finkelhor (1984) report that from 12% to 38% of women questioned had experienced some form of sexual abuse. Respondents queried in a recent nationwide random telephone survey conducted by the *Los Angeles Times* Poll (1985) reported that 27% of women said they had been sexually abused. Given the prevalence of sexual violence against women in Canadian society and the well-documented problems women face in therapy, our study is important in examining whether or not women's explanations of their sexual assault is dependent on the form of therapy they receive.

METHOD

Twenty-one women who had been sexually assaulted and subsequently experienced some kind of therapy were interviewed. Each woman was asked, under informed consent and strict confidentiality, to provide us with a reconstruction of her assault experience and her perceptions of how therapy contributed to this reconstruction. The interview is a social history, in that women's past experiences and perceptions are data. The research is causal-interpretative in that characteristics, assumptions, methods and practices of the two therapeutic perspectives (traditional and feminist) are compared. The sample was obtained from personal contacts with counsellors/therapists who were informed about the study and were asked to have clients who might wish to participate contact us, contacts with women's self-help groups, professional agencies, and responses to advertisements placed in local newspapers and cable T.V. stations.

Twelve women who had been raped and nine women who were sexually abused as children or adolescents contacted us. Over three-quarters of the women

interviewed learned of the study through a "gatekeeper" (i.e., therapist or group leader); the remainder by word of mouth or advertisements. Using an interview schedule comprised predominantly of open-ended questions, the following themes were examined: the manner in which different types of therapy present or describe the victim and offender; accounts of motivation and attributions of responsibility; social control themes; explanations for the sexual assault; and the women's assessment of the therapy. Interviews were tape-recorded after the respondent was asked if this was acceptable to her. Each interview lasted three hours on average, and took place in the woman's home. We have chosen to illustrate what we believe to be a meaningful distinction between traditional and feminist therapies. We acknowledge that these two treatment types are not "pure" or "polar," but we see the difference between them as large enough that we can compare and contrast them. To clarify, we are not comparing the various approaches "within" a perspective. Differences within perspectives are minimal compared to differences between perspectives.[1] We liken the distinction between the traditional and feminist perspective to that between traditional and radical therapy.[2]

We defined a "traditional" therapist as any therapist "who may reinforce some of the societal attitudes and stereotypes which prevent women from gaining greater self-awareness, self-confidence and control over their lives" (Women's Counselling Referral and Education Centre (WCREC), 1982, p. 5). Conversely, we defined a "feminist" therapist as any therapist "who applies an awareness of the social, political, and economic constraints on women in her or his practice" (WCREC, 1982, p. 5). At the time of data gathering, efforts were made to classify therapists and group leaders according to their therapeutic perspectives. Counsellors, therapists, social workers, community mental health workers, or lay persons who were employed in counselling on a one-to-one basis or coordinating a self-help group and using a "self-identified" or "client-identified"[3] feminist perspective comprise the "feminist" category. Women who have participated in feminist one-to-one counselling and/or in feminist self-help both fall under the feminist category. Although we do not assert that counselling is the same as self-help, our primary concern is with the implications of the feminist and traditional perspective (rather than individual versus group therapy), for the reconstruction of the sexual assault experience. Out of the total sample of respondents, there were no reports available documenting women's experiences with feminist psychotherapy. Although we acknowledge that all psychiatrists or psychologists may not adhere to a traditional clinical ideology, in the absence of "self" or "client" identification (just over a quarter of the sample), therapists were classified according to profession (i.e., psychiatrist, psychologist was equated with a traditional perspective).

Of the 21 respondents' experiences with therapy, four were interviewed regarding feminist one-to-one counselling, 10 regarding feminist self-help, one concerning self-help with no identifiable perspective, and six concerning traditional therapy. Seven of the 21 women, because of their experiences with multiple therapeutic modalities, were able to provide extra reports regarding traditional therapies. Hence, we can compare and contrast 13 traditional reports (six primary and seven secondary) and 15 feminist accounts.

Our research is distinctive in that it investigates the sexual assault victim as a consumer of mental health services. Until recently, this has not been defined as an important area of research. Additionally, ours is a "process" study, rather than an attitudinal or analogue study, illuminating the actual treatment of women in therapy as consumers. The study focuses on a traditionally silenced group for whom a comparison of various therapeutic perspectives is of critical importance. We do not claim to be objectively assessing the various therapeutic modalities here. Rather, we are allowing the sexual assault victim a voice as a consumer and an authority (rather than those of therapists and counsellors), and thus grant her experiences validity.

We have no way of measuring the representativeness of the therapeutic experiences reported, the frequency with which sexual assault victims seek help, or the degree to which they seek a feminist versus a more traditional modality. We believe in the strength of the Verstehen approach, a means of obtaining social truths from intensive understanding of the experiences of a few people.[4] A large representative sample, due to its more structured methodology, may not capture the nuances, subtleties, and intimacies of the informal, private spheres of the everyday lives of women. Our objective is not to make generalizations to all women based on an analysis of a representative sample, but rather to gather comparative impressions of women's experiences as consumers in different therapeutic situations.

SAMPLE DESCRIPTION

At the time of the interview, participants ranged from 16 to 65 years of age. The average age for all participants at the time of the interview was 30 years. Rape victims averaged 28 years of age and incest victims 34 years. Over 80% had completed high school and 62% had completed post-secondary education. Forty-three percent of women in the sample were currently married, nine percent cohabiting, 38% single, and 10% divorced. In other words, just under half of the sample lived without a male partner. Also just under half of the sample were parents. Included in the sample were homemakers, students, skilled workers (i.e., bartender, waitress, factory worker, health care aide), clerical workers, professionals (i.e., administrator, teacher), and research assistants. Forty-eight percent of the women earned their own income outside the home, and the remaining 52% were dependents (i.e., 24% were housewives; and 14%, 9% and 5% relied on unemployment insurance, welfare, and mother's allowance, respectively). Over a quarter of the sample depended upon government assistance of some sort, and over half had no independent source of income.

DESCRIPTION OF THERAPEUTIC EXPERIENCES

Ninety percent of the sample had seen a counsellor or therapist in an attempt to remedy the ill effects of the sexual assault/abuse. Eighty-one percent had participated in a self-help group. At the time of the interview just over 75% of the sample was engaged in counselling, therapy, or self-help. Rape victims reported seeing an average of two mental health professionals each, while incest survivors reported seeing an average of three each. Half of the incest survivors had seen

four or more "professionals"[5] each. There were no differences in the frequency of visits to a counsellor/therapist versus a self-help group. Women attended both approximately once a week. The majority of women attended counselling/therapy and self-help (73% and 65% respectively) for less than a year. Of those women attending for two to three years, approximately 10% stayed with the therapy/counselling versus 30% who stayed with the self-help.

The data suggest sequential help-seeking behaviour, where the women move from one-to-one counselling/therapy to self-help, and from traditional to feminist/self-help alternatives. Comparable numbers of women reported that this transition was a consequence of personal preference or referrals. Within six months of the assault, 83% of the rape victims had sought counselling and therapy; in less than five years, all had. Of the incest victims, almost 90% did not seek counselling/therapy until at least five years after the termination of the abuse (33% within 10 years; 55% within 15 years; and 88% within 25 years).

Of the women who saw psychiatrists, 57% found them "not at all helpful"; 14% "just a little helpful," and 29% "quite helpful." None of the women found self-help groups "not at all helpful"; 29% and 65% found them "quite" and "very helpful."

Of the therapists, counsellors, or group leaders seen by the women 27% were men, 54% were women, and 19% were a male/female team (i.e., self-help group co-leaders). Sixty-seven percent of the women reported a preference for a woman therapist/counsellor, none of the women preferred a male counsellor, nine percent preferred a male/female team, and 24% stated no preference. Women reporting a preference for women counsellors mentioned the following reasons: women are more understanding, men have an inability to comprehend the meaning of sexual assault for women, difficulty discussing the sexual aspects of assault with a man, and difficulty trusting and opening up to a man.

COMPARISON OF THERAPEUTIC PERSPECTIVES

Women interviewed for this study who had participated in feminist treatment, consistently reported that issues important to them predominated their feminist counselling or group sessions. These are issues intimately tied to the sexual violence; women's feelings and responses are not divorced from their past victimization. Issues such as guilt, blame, vulnerability, self-esteem, anger, shame, depression, and how to cope with everyday life, are weekly concerns. Interpersonal relations, the way in which the sexual assault has affected their lives, their relations with family, spouse, or lover, perceptions of men, reactions to men, women's sexuality, and sexual assault as violence, are recurrent themes for discussion. The following quotes illustrate issues personally important to the women, which subsequently become their therapeutic issues:

> We talked about parts of the sexual abuse, and "fuck-ups" now related to the abuse.
>
> We spend a lot of time speaking about present relationships and how to keep them going well, while still acknowledging that the past (the sexual abuse) had an influence. A lot of emphasis is upon interpersonal relationships.
>
> We talked a lot about how the rape impacted on us, the fear we felt, what we thought. We talked a lot about sex. Whether it was a violent act to begin

with. I remember those two clearly. We talked a lot about how a sexual assault is not your fault, and the feelings you have surrounding your self-esteem, and how it gets twisted.

These reports and the nature of the issues raised contrast vividly with the following reports by women participating in therapy based on traditional psychiatric and psychological models:

> The one thing that he was always insisting on was how angry I was. And the more he pressed me, the more I wasn't angry. He would choose the session topic. And he would sit on his side of the room and I would sit on my side of the room. And I wouldn't say much, because I didn't feel that I was accomplishing very much. And I felt like telling him, "What the hell do you know?" You know there are different stages, and I feel that he was trying to push me too quickly into something that I wasn't really feeling at that time. I think that that is the worst thing that you can tell somebody: "This is how you are feeling, and if you will only tell me that back, we can start on something here."

Anger seems to be the primary focus of intervention even though the woman herself does not voice it as a primary concern. This respondent's silent rebellion at definitional tyranny and her recognition that therapy could work if only she cooperates with the therapist's definition of the situation is apparent. Another respondent, a spousal rape victim, states:

> Any time I would attempt to describe details of the assault, what it felt like to be tied to a bed or whatever, he would get right back into the sexual . . . "Well, did that incur sexual feelings in you? Did you like it when you were tied to the bed?" Extremely removed from my reality. And I would just kind of look at it—"Well, did I?" And then I would wonder . . . . And then you would start to wonder, "Well, am I supposed to like it?" Exactly. And then I would think, I am really weird—now I am totally gone. I thought I was nuts before but now I am having it verified.
>
> He would talk a lot about how my supposed anger toward my father related to the abuse. He really had a need to put some transference to the issues. He really talked a lot about his own sexual needs which I really found disturbing. We spent a lot of time talking about what *I* was doing, isolating what I did that caused whatever incidents which occurred . . . what did I say? what was I wearing? . . .

Denied is the woman's real pain and humiliation, as are her issues, and her actual experiences of physical and sexual exploitation as the therapist's definition of the situation prevails. Invocations of provocativeness, masochism, and victim-blaming arise, leading her to question her own perceptions and sanity. Further, unresolved anger toward her father is identified as the issue creating her desire for violence, an interpretational tactic which tends to confuse the woman, and redirects her anger away from its actual source. Any reference to the structural exigencies enforcing her situation are rendered invisible or inappropriate to the therapy.

This glaring disjuncture between the therapist's analysis of the situations faced by these women and their own experiences fails to provide the women with the tools to comprehend their conditions. Here there is no discussion of issues of importance to her such as the need to understand her anger, shame, sense of vulnerability, and sexual violation.

Concerning the primacy of the sexual assault in the women's lives, one would expect its discussion during the therapy or counselling sessions. Women report the inadequacy of traditional clinical therapies to meet their needs; as the "abuse is hidden or defined as something else—its presence virtually disappears as a real and determining factor in the woman's life" (Bograd, 1982, p. 70).

> No, we didn't talk about the rape. He would try and talk about feelings and always get back to anger. I was getting frustrated with everything . . . we talked about vacations one time. A whole session on vacations. I remember that one well. Not too far removed from what I was going through!
>
> I would say discussion of the sexual abuse was neglected. I related several incidents that happened. He (the psychiatrist) never offerred any information or feed-back on the effects it had on me. I felt frustrated because I thought that was why I was in therapy. I came to the conclusion that trying to talk about it was a waste of time.
>
> He (the psychiatrist) definitely didn't come back to the sexual abuse. I really didn't come back to it at all to talk about it. He didn't ask anything further. It just wasn't seen as important.

In traditional therapies, the woman's reality may be redefined as well:

> He did a lot of transsexual things, too, to find out if I was perhaps homosexual, and if that's where all my anger towards men came from. It was a big thing. That's why I was angry with me, with my dad . . . .
>
> He spent a lot of time talking about sexual feelings . . . maybe he had a thing about who he was . . . . Any summations he gave me about who I was, or what I was doing, I couldn't accept. I couldn't believe I was doing that. He would say things like, "Oh, you are just a sexually frustrated lady, *you* have a lot of sexual power and you are not directing it and this is what you have to do." And I had no sexual power—*I had experienced that.*
>
> I was so confused. I came away thinking maybe it just wasn't rape, but maybe *my* sickness which had caused this. My perception, my confusion, that I had interpreted it incorrectly, that it probably wasn't always rape. That I had sort of inculcated some of that violence, it was my request for it that created its existence. Rape became inseparable from everything else, it wasn't something distinct. The only thing that was distinct is that I did not have a clear understanding of my subconscious development.

If the sexual assault is acknowledged in conventional therapy, discussion revolves around the role of the woman in causing it. The cultural denigration of women comes through in these comments. Any summations of her are sexual, in congruence with sex-role stereotypes. She is sexually frustrated, she projects sexual power. For exhibiting anger *and* being a woman she receives cultural reprimands in the form of negative injurious labels, such as transsexual and homosexual. In essence, the victim rather than the offender, becomes the source of pathology.

Conversely, given the impact of the sexual assault on the woman's life, its eventual discussion in feminist counselling or feminist self-help is welcomed:

> Oh, it is a relief to discuss the assault! This is the word that the other women say, that it is a relief. Especially women that come and say that I have been raped eight years ago, and I hate men, and I still fear, and I still have nightmares, and I was told about the group. She wouldn't talk, no way. And then she sits there for a couple of sessions, and then she talks for two hours.

> And then next week she comes and she says that she never felt so good . . . she feels on top of the world. Because she talked it out, and after that she talks a few more times. And those are cases from the group that I am thinking of. This is a place where it happened to other people—she is not a unique case to have to hide grief.

> Discussion of the rape made me feel clean. The rape was a very filthy experience for me emotionally and I really felt unclean by it.

The importance of the mental health professional's level of comfort when discussing sexual aspects of the assault cannot be overstated. An adult incest survivor participating in traditional therapy reports:

> She (the counsellor) is uncomfortable when discussing sex—she talks faster, or tells me to read, cuts me off verbally, or ends a session. This makes me feel like I should put it aside. It leaves me feeling more rejected and lonely—like I did something wrong and it is not supposed to be talked about.

Similarly, in feminist counselling and feminist self-help, the offender is discussed openly. According to women's reports from their experience with traditional therapies, the offender remains largely invisible, or discussion of him revolves around apologia for his actions.

> We talked about the sexual assault but I came away feeling that I certainly had an awful lot to do with it and why it happened and therefore a lot of my anger became self-directed. It was just that whole powerful male image thing and that probably still makes me angry now—I am still angry about that therapeutic situation, because I allowed it to happen because of all the conditioning which I received in the past. The therapist didn't deal with my husband (the offender) at all.

> To a small degree I would describe my husband. But he (the psychiatrist) never discussed him. I can't say that he made direct excuses for my husband's behaviour, but there was a lot of indirect innuendo there. There were some comments like, "Well, you know a man is conditioned to expect certain things in a marriage . . . ." When he didn't qualify these kinds of statements, it created more problems for me.

> Except for the few incidents that I related about my father, he (the psychiatrist) did not attempt to discuss him in any way that I can recall.

Also, group discussion of the rapist in feminist self-help situations shatters the myths, based on the disease-oriented model, which views offenders as psychopathological individuals. Consequently an avenue is provided for understanding a culture in which women are defined as legitimate objects of male sexual aggression.

> We watched a film once on offenders. We talked about the offenders who came to our group, and we talked about what we thought they said. I guess we have the idea that the rapist is a biker, or that he might be a kind of weird person who is very sick. Actually he can be the man next door who wears a three-piece suit and drives a Mercedes. The offender is anybody; which is kind of frightening too, because you can't spot him, same as you can't spot a victim. Things like that. And it is not your fault that you can't spot him.

> We usually think of the offender as a three-eyed monster, but when you meet some of them they are nice-looking young men who you would never dream of being an offender. You stereotype an offender as a grubby, obnoxious man. You have your own thoughts when you think of a rapist, and as what

> one would look like and it is really shocking that a lot of the rapists don't fall into that category. So we talked about that in the group on occasion. But you stereotype them yourself, like you never think about getting raped. Probably a warning bell would have gone off in my mind if he had have been really big and obnoxious and ugly looking. Because that would have fit the stereotype.

Excusing or ignoring the actions of the offender was not an aspect of feminist modalities. Full responsibility was attributed to him.

> I disbelieved that the offender was responsible when I first heard it. I was still feeling guilty. I still felt it was all my fault.
>
> The strongest statements that the group leader is coming out with is that whatever you did you didn't ask for it. You had a right to be where you were. And in whatever attire you chose to wear. If you decide to jog in a bikini, does that give permission to all the men to come after you and rape you? She is very emphatic about it and I think that is what women need to hear. Whatever you did, whatever happened, rape was not on the agenda.
>
> The offender was seen as responsible. That made me feel much better. It was like, whoosh!! I could stop this infernal searching for clues.
>
> The group leaders used to challenge people, but it wasn't confrontation like: "That's really stupid, you shouldn't be feeling that way or thinking that." It was, "Why do you think you feel that way?" "Where do you think that guilt is really coming from?" "Do you honestly believe that you are responsible or are you just buying into what somebody else is saying to you?"

Removal of the false sense of guilt and self-blame which women experience as a consequence of sexual violence becomes one of the primary foci of intervention in feminist models. Women are allowed to "hear" that they are not guilty, and that they need not accept the culturally sanctioned definition of woman as a legitimate object of male sexual aggression. Women are perceived as persons with rights to sexual self-determination. The power of the dominant victim-blaming ideology is reflected in the women's statements: "I thought for sure the counsellor would see blame"; "After a while women in the group start believing they are not guilty." Feminist forums counter the "mind-binding" (Ward, 1984) that makes women believe they play a causative role in the acts of sexual violence against them: "Once in the group I see I am not to blame"; "Every week we hear, 'you're not bad, you're not dirty' "; "I find out I'm not the rotten person I was brainwashed into believing I was." In contrast, traditional therapies may perpetuate the cycle of self-blame as they preserve the woman's sense of alienation from her self and her situation: "He made me feel absolutely guilty . . . as if I had a role in the assault"; "He didn't try to change the way I felt about it." Feelings of guilt, if not aggravated, are at least maintained, as their validity is not actually challenged.

As an exception to the above reported sexist bias in traditional therapy, an incest survivor speaks of the way the responsibility issue was addressed in her therapy:

> She usually starts by explaining that I was young, and that my father was in a position of trust. It was part of my conditioning and I didn't know any better. She tells me that I tried to reach out before, but nobody listened and I did everything I could. She keeps encouraging me to talk about it (the lack of choice the woman, as a child, had in the incest).

Also, feelings of anger and despair are validated in feminist one-to-one and feminist self-help therapy.

> We would talk about feeling very angry about the person who raped us. All the women would get their two cents' worth in and it depended on how we felt. Like string them up, castrate them, all those kinds of feelings. You know we just wish we could get back at them. All of that was discussed. And then another feeling that came out . . . . You would just really like to meet your rapist to find out why . . . you know the anger disappeared.

> I felt like my feelings were legitimized. I didn't feel like I was the only one who was angry . . . there were some women there who were more angry than me. And some people are less angry. Anger was a normal thing to feel.

> She wanted me to express more strongly by screaming, crying, or whatever, in her presence if I wanted to. She explained that these feelings needed a release.

> I'm finding out that other people have the same feelings. I'm made to feel normal.

Witness the different interpretation of anger from a traditional psychiatric perspective:

> He said I was angry at my father. My anger was a result of something that my father did to me in our relationship as I was developing. And that I carried this tremendous anger through to all men, especially my spouse and therefore I had huge responsibility in perpetuating the violence and the sexual assault, and most importantly that I chose this type of man. It wasn't a conscious decision but my subconscience did it. And you walk away thinking, "Hey, I'm supposed to be controlling my subconscience."

When the women were questioned whether they discussed why women are predominantly victims of sexual assault, or why men commit sexual assault, participants in feminist modalities revealed an understanding of gender-role analysis of sexual victimization.

> Society has always taught, conditioned men to be self-reliant, confident, assertive, strong; and I suppose that women are raised to be compliant, less assertive, more nurturing, giving, that sort of thing. Stereotyping, I guess. Women as the natural victim. And they are physically much easier to handle. You can't take on a two-hundred-pound man, but you can take on a one-hundred-pound woman and it's not even that. You could have a dwarf attack you, but it's up here—in your head—psychologically that this guy has the advantage.

> Some men want to be overpowering . . . they want to be the boss. They want to be in control. They are not in control of themselves so they want to control someone else.

> The therapist said that sexual assault was an act of aggression and power against women not necessarily a sexual desire. Some women are victims only due to circumstances.

Contrast the above to the following comment from a spousal rape survivor who had experienced traditional psychiatric therapy:

> No. He didn't deal with the issue at all. He didn't even consider why men hit, let alone rape.

Feminists have criticized the "helping" professions, specifically in relation

to the perpetration of victim-blaming ideologies and the perpetuation of the existing sex structure. The hierarchically structured therapies seem to reflect the power relations of the patriarchal society of which they are a part, and therefore serve to keep women in a subservient, powerless position. One woman describes the control the therapist had over her, at a time of great vulnerability:

> A couple of times I would say, "I don't need to talk about my dad," which then he interpreted to mean that I was denying the fact that I really need to deal with my dad. He just saw that as further evidence of my denial. And I would think: "He must be right, he is a doctor." I am sure he didn't say "I am going to make her crazier than what she already is," but it sure worked.
>
> With his type of therapy if he didn't respond to my concerns, I didn't have a clue what he was thinking. I was extremely subservient to him at that time and I would fill in to him what he wanted to hear. And then those things he would respond to. I didn't realize it at the time but that was pretty perverse manipulation.
>
> I felt that I was becoming more passive and dependent, more hysterical, more frightened, more confused. The fragmentation of interpretations was confusing. He treated dreams, not a person; he treated sexuality, not a person . . . he treated symptoms and expectations, but not a person. There were no connections.

Another woman, a childhood victim of incest, conveys how her real needs for love, affection, security, and understanding, were distorted and labelled as a "dependency" syndrome:

> She said that my need for affection is normal, but that I'm an adult now and I can't expect someone to be a "parent" to me. I feel like I just want someone to care about me, to show affection instead of sex, and to be there if I need a hug.

Even though the following respondent had never heard of Phyllis Chesler's 1972 book *Women and Madness*, she made the following comments:

> My husband and the therapist weren't too different . . . but I didn't recognize it then. This man's style was identical to everything that I associated with male power, it was just what men do, so I accepted it at that. I bared myself to this man, in an attempt to reconcile some of the things which were happening in my own life . . . and all it did was increase my fear of that type of male power.
>
> He was in total control. He was the individual who directed the conversation, he directed what we talked about, suggested what I should think. It is a feeling that would be very similar to being on a merry-go-round. It is difficult to make sense out of that dizzying type of questioning. Totally and completely strange. Confused and angry. And I knew that I was angry. And the more angry I got, the sicker I got.

The feminist rejection of hierarchically structured therapies and emphasis on the importance of the group approach is verified by the following statements:

> We were always made to feel it was "our" group. Right from the beginning we were told that it was our group. "You are free to go whichever way you need to here." The group leader does not see herself in the role of a counsellor in the group. She lets the group take its own course and she keeps it going. We all ask each other questions according to what we see the situation requires or what we want to know from the person who is talking. And

very often when we don't have any questions, we'll look to her and she then takes over, and moves the group. I don't think that she advises people to do anything. In the group, no, she does not give advice. Besides we are encouraged to talk to each other, exchange telephone numbers, etc. It is a place where the woman can come and be honest about her experience. Whatever comes to her mind she can say—it is not a judgemental group in any way. There is a feeling that all of the women have been through this thing or worse. If she needs advice of some kind, or comparison of experience, that is what she gets . . . a feeling of understanding and belonging, which does not happen in other social groups.

I would just like to say that the self-help group has done wonders for me. It has opened up so many doors and has brought things out from inside of me that I didn't even know were there. And it was simply being with people that understood, people who gave me back my self-confidence, that gave me back my ability to feel good about myself. And to be really honest, about it all. It was certainly one of the best things that I could have done for myself. No matter how hard you try to bring up an issue with someone who has never been through it, it is like the blind leading the blind. You need someone that has been there themselves, someone who understands.

The group was a good experience. The biggest thing is that you are in a group with women who have been through a similar experience. The give and take, back and forth, gives you that extra little push, "I made it, you can do it." "I know how you feel, you'll live through it."

I think that the self-help group is one hundred times better than a one-on-one. I really do. Because it is like I said, no matter what you are feeling, and sometimes you are feeling really secluded with your feelings, when you bring them out there is at least one other member of the group that can relate to you. I have seen it so many times where you think that nobody else could practically feel that way, but there is always somebody else who is able to relate to it, and who can say, "Hey, I know how you feel." That is really important because you don't feel alone.

Participants in feminist one-to-one therapy report a satisfaction with counselling as well:

From the counselling I get peace of mind by finding out I'm not the rotten person I was brainwashed into believing I was.

It was support, it was validation of my experience. Because then I had no support network. I'm not sure that friends could be a substitute for counselling. But counselling made me go out and establish support. For awhile I was so depressed and I felt like such a burden to my friends.

The counselling made me think. It was supportive and a chance to work things through. It was a real open, encouraging atmosphere where you could say what you want. Basically no judgement.

Finally we asked the women who had participated in traditional modalities what counselling or therapy had to offer victims of sexual assault. Commenting on their experiences with psychiatrists, two respondents said:

I think just in summary that the most important thing for me at that time was to find my personhood relative to all the things that were happening in my life. What I did not need to delve into was some psychiatric gobbledy-gook, that only separated further any ties to reality and personhood. I had that

whole power thing, that Freudian type of philosophy that perpetuates assault by making it the woman's fault. And it is totally, totally destructive.

The therapy was just really negative, a very bad experience. It increased my anger towards men, it made me increase some of my pace and fury in terms of trying to find out who I was. I had no identity of being an individual, but more important of being an individual *and* a woman. I couldn't be a woman because as soon as you wanted to be a woman you are no longer an individual, you are a piece of property, a sexual thing. And that made no sense to me—it just made no sense . . . . That was probably, most interestingly enough, one of the most angriest times . . . during the assault there was something tangible, something you could put your finger on . . . this often was mind games and very insidious.

It didn't change the way I felt . . . except that I usually ended up feeling worse, which is one of the reasons why I stopped going. I was usually upset when I left there. I always hoped it would help, but it didn't. I think time helped me more than anything. I don't think he did anything to make me feel better.

CONCLUSION

The conventional view of the helping professions and particularly of mental health practitioners, holds that these people are committed to assisting clients/patients in adjusting, in becoming persons who are in command of their day-to-day lives and capable of planning a future for themselves. Much has been said recently in the social science literature about the way in which these widely held beliefs about mental health practice are invalid and premised on myth. It has been well documented that conventional mental health services pose particular problems for women. Yet remarkably little has been done to include the consumer's voice when talking about mental health services. To the extent that this component has been considered, it commonly involves journalistic testimonies about individual experiences with unjust treatment. There are few examples where an attempt has been made to systematically analyze groups of women's experiences and to compare the structure of experiences across types of therapy.

The present study attempts to redress this gap in the literature. Women who have been victims of sexual assault or incest and who have experienced therapy as a result, were asked to share their insights with the researchers on how the therapies enabled them to reconstruct and explain their sexual assault experiences. Sharp contrasts are found between conventional and feminist therapeutic approaches from the point of view of the consumer. In conventional therapy, sexist attitudes, individualization of the problem, victim-blaming, control over the woman by the therapist, defining rape as a sexual act, and relabelling her reality are common themes. In contrast, sexual assault victims who have experienced feminist therapies seem confident they have found a framework with which to explain their victimization, feel relieved of guilt surrounding the incident, and report the emotional support and understanding which the group approach especially provides.

Women as participants in feminist self-help groups refer to the nonjudgemental atmosphere, the unconditional acceptance, the validation of experience, and the feeling of belonging, understanding, encouragement, and

security which the group provides. Interestingly, women as victims report a sense of belonging and acceptance from the group not provided by other social groups; they feel support, where they do not perceive it anywhere else. Group members in particular, report the development of friendships, networking among group members, the removal of alienation, the invaluable comparison and evaluation of experiences, as well as feeling useful and needed by contributing something out of their experience(s) with sexual violence.

This study reveals the degree to which conventional mental health practitioners have been cast as legitimators of the existing belief system. Sexual assault victims report that they feel three times victimized—by the assault, by the legal system which frequently distrusts their reports of their own experiences, and by mental health practice which makes them further question their reality. It may be that as a culture we have not been able to face the reality of sexual assault, rape, and incest. Even when presented face-to-face with victims, the societal apparatus of social control, operated in this instance by conventional mental health practitioners, gears up to reconstruct the woman's perception, rather than facing the possibility that sexual assault is rampant and real. As Ehrenreich and English (1981) suggest in a different context, this is "crazy-making" of the first order. The need seems apparent for changing our view of mental health to encompass the social conditions that make women "crazy." Our hope is for a transformation of mental health services, for sexual assault victims and for all women, from being an instrument of oppression to becoming a means of discovery and enhancement of human efficacy.

RÉSUMÉ

Dans la présente étude, on souligne le contraste entre, d'une part, la perspective habituellement acceptée par la thérapie traditionnelle à propos de la violence sexuelle exercée contre les femmes, et, d'autre part, l'approche féministe représentée par la thérapie féministe et les groupes de support pour les victimes d'abus sexuels. La recherche porte sur la façon d'enseigner socialement aux consommatrices des différentes approches thérapeutiques à reconstruire l'expérience de violence sexuelle. Des entrevues en profondeur avec des victimes d'abus sexuels ou d'inceste qui ont par la suite eu recours à la thérapie, indiquent des différences très claires entre les reconstructions encouragées par les approches conventionnelles et celles proposées par les modalités féministes. On conclut que les thérapies conventionnelles tendent à perpétuer les croyances qui isolent et blâment les victimes tandis que l'approche féministe écarte les faux sentiments de culpabilité, valide l'expérience vécue par la femme et l'aide à comprendre le contexte structurel social dans lequel émerge cette violence.

NOTES

1. For example, within psychotherapy there is a vagueness of theoretical approach, methods, and objectives. Compare Roger's "client-centered" therapy which focuses on immediate feelings, and the phenomenological approaches of the humanists, Maslow, and Fromm. All are basically insight theories, as is psychoanalysis. Theoretical differences are asserted, but little real differences in treatment are found (Tennov, 1975, p. 156).

2. Radical Therapy: The school of thought represented by Szasz (1978) and Halleck (1971) critiquing psychiatry as an institution of social control and espousing client awareness of environmental impact upon behaviour, as well as the recognition of therapists' political biases.
3. For purposes of categorization, counsellors and group leaders were asked their perspectives, as were the clients regarding their counsellors'/group leaders' perspectives. One referral from a self-help group leader professing no identifiable perspective has unsatisfactorily, but conveniently been placed under the "feminist" category as we assume commonalities between feminist and self-help modalities as alternatives to traditional therapy. We in no way suggest that all self-help employs a feminist perspective.
4. This approach is adhered to by feminist researchers such as Roberts (1981).
5. The word "professional" refers here to counsellors and therapists as well as lay persons leading self-help groups, who do not necessarily define themselves as professionals.

REFERENCES

Abramowitz, S.C., Jackson, C., & Gomes, B. (1973). The politics of clinical judgement: What non-liberal examiners infer about women who do not stifle themselves. *Journal of Consulting and Clinical Psychology, 41*, 385-391.

Aslin, A. (1977). Feminist and community mental health centre psychotherapists' expectations of mental health for women. *Sex Roles, 3*, 357-364.

Ballou, M., & Garbalac, N.W. (with Kelly, D.). (1985). *A feminist position on mental health*. Springfield, Illinois: Charles C. Thomas.

Bograd, M. (1982). Battered women, cultural myths and clinical intervention: A feminist analysis. *Women and Therapy, 1*(3), 69-78.

Brickman, J. (1984). Feminist, non-sexist, and traditional models of treatment: Implications of working with incest victims. *Women and Therapy, 3*(1), 49-67.

Brooks, N. (1975). Rape and the laws of evidence. *Chitty's Law Journal, 23*(1), 1-11.

Broverman, I., Broverman, D., Clarkson, S., Rosenkrantz, T., & Vogel, S. (1970). Sex-role stereotypes and clinical judgements of mental health. *Journal of Consulting and Clinical Psychology, 3*, 1-17.

Brown, C., & Hellinger, L. (1975). Therapists' attitudes towards women. *Social Work, 20*, 266-270.

Burgess, A., & Holmstrom, L. (1973). Rape victim in the emergency ward. *American Journal of Nursing, 73*, 1740-1745.

Burt, M. (1980). Cultural myths and support for rape. *Journal of Personality and Social Psychology, 38*(2), 217-230.

Canada, Department of Public Affairs. (1983). *Sexual assault: The new law*. Ottawa: Justice Canada.

Carmen, E., Russo, N., & Miller, J. (1981). Inequality and women's mental health. *American Journal of Psychiatry, 138*(10), 1319-1330.

Chesler, P. (1972). *Women and madness*. New York: Avon Books.

Chesler, P. (1986). *Mothers on trial: The battle for children and custody*. New York: McGraw-Hill.

Dietz, C., & Craft, J. (1980). Family dynamics of incest: A new perspective. *Social Casework*, 602-609.

Ehrenreich, B., & English, D. (1981). The sexual politics of sickness. In P. Conrad & R. Kern (Eds.), *The sociology of health care and illness: Critical perspectives* (pp. 327-349). New York: St. Martin's Press.

Fabrikant, B. (1974). The psychotherapist and the female patient: Perceptions and change. In V. Franks & V. Burtle (Eds.), *Women in therapy* (pp. 83-109). New York: Brunner-Mazel.

Federal Ministry of the Solicitor General. (1981, 14 February).

Field, H. (1978). Attitudes toward rape: A comparative analysis of police, rapists, crisis counsellors and citizens. *Journal of Personality and Social Psychology, 36*, 156-179.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. London: The Free Press.

Gilbert, L. (1980). Feminist therapy. In A. Brodsky & R. Hare-Mustin (Eds.), *Women in psychotherapy: An assessment of research and practice* (pp. 245-266). New York: Guilford Press.

Goar, C. (1983, January 17). New terms under the code. *Macleans*, p. 96.

Halleck, S. (1971). *The politics of therapy*. New York: Science House.

Hickl-Szabo, R. (1982, October 4). Doubt that crime happened found highest in rape claims. *The Globe and Mail*, p. 1.

Hickl-Szabo, R., & Stead, S. (1982, October 1). Bid made to ensure treatment in rapes. *The Globe and Mail*, p. 1.

Holmstrom, L., & Burgess, A. (1978). *The victim of rape: Institutional reactions*. New York: John Wiley and Sons.

Janoff-Bulman, R. (1979). Characterological versus behavioural self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 27*(10), 1978-1809.

Kinnon, D. (1981). *Report on sexual assault in Canada*. Ottawa: Canadian Advisory Council on the Status of Women.

Le Bourdais, E. (1976). Rape victims: The unpopular patients. *Dimensions in Health Service, 53*, 12-14.

Los Angeles Times Poll. (1985, September 20). Child sexual abuse. *The Kitchener-Waterloo Record*, p. 4.

Marolla, J., & Scully, D. (1979). Rape and psychiatric vocabularies of motive. In E. Gomberg and V. Franks (Eds.), *Gender and disordered behavior: Sex differences in psychopathology* (pp. 301-318). New York: Brunner/Mazel.

Maynard, M. (1983). The response of social workers to domestic violence, Part II. In J. Pahl (Ed.), *Private violence and public policy* (pp. 125-141). London: Routledge and Kegan Paul.

Mazelon, P. (1980). Stereotypes and perceptions of the victims of rape. *Victimology: An International Journal, 5*, 121-132.

Miller, D. (1974). The influence of the patient's sex on clinical judgement. *Smith College Studies in Social Work, 44*, 89-100.

Penfold, P., & Walker, G. (1983). *Women and the psychiatric paradox*. Montreal: Eden Press.

Pietrofesa, J., & Schlossberg, N. (1970). *Counsellor bias and the female occupational role*. Detroit: College of Education, Wayne State University.

Rawlings, E., & Carter, D. (1977). *Psychotherapy for women: Treatment toward equality*. Springfield, Illinois: Charles C. Thomas.

Reynolds, J. (1974). Rape as social control. *Catalyst, 8*(Winter), 61-67.

Richardson, L. (1981). *The dynamics of sex and gender* (2nd ed.). Boston: Houghton Mifflin.

Roberts, H. (Ed.). (1981). *Doing feminist research*. London: Routledge and Kegan Paul.

Rowbotham, S. (1973). *Woman's consciousness, man's world*. New York: Penguin Books.

Sherman, J. (1980). Therapists' attitudes and sex-role stereotyping. In A. Brodsky and R. Hare-Mustin (Eds.), *Women and psychotherapy* (pp. 35-66). New York: Guilford Press.

Smith, D. (1974). Women's perspective as a radical critique of sociology. *Sociological Inquiry, 44*(1), 7-13.

Smith, D. (1975a). An analysis of ideological structures and how women are excluded: Considerations for academic women. *Canadian Review of Sociology and Anthropology, 12*(4), Part 1, 353-369.

Smith, D. (1975b). *Women look at psychiatry*. Vancouver: Press Gang Publishers.

Smith, D. (1978). A peculiar eclipsing: Women's exclusion from man's culture. *Women's Studies International Quarterly, 1*, 281-295.

Spender, D. (1980). *Man-made language*. London: Routledge and Kegan Paul.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a 'private event.' *International Journal of Health Services, 9*(3), 461-493.

Stark-Adamec, C., & Graham, M. (1983). Untitled paper presented at the University of Toronto's Department of Psychiatry Research Day, September.

Sturdivant, S. (1980). *Therapy and women: A feminist philosophy of treatment*. New York: Springer Publishing Company.

Szasz, T. (1978). *The myth of psychotherapy: Mental healing as religion, rhetoric, and repression*. New York: Doubleday.

Tennov, D. (1975). *Psychotherapy: The hazardous cure*. New York: Abelhard-Schuman.

Ward, E. (1984). *Father-daughter rape*. London: Women's Press.

Women's Counselling Referral and Education Centre. (1982). *Choosing a therapist*. Toronto: WCREC.