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Blaming the Victims: Silencing Women Sexually Exploited by Psychotherapists

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This paper articulates a radical feminist analysis of psychotherapist–patient sexual exploitation, a problem that has affected an estimated one million North American women. I argue that such exploitation is rooted in misogynous attitudes that pervade the major institutions in contemporary culture, including the mental health professions. I examine ways that mental health professionals use sexist constructs and language to blame victims for their abuse. Through textual analysis of a series of letters and articles by prominent psychiatrists, I show that the male writers attempted to silence victims and their female advocates by subjugating the women's voices to their rhetorical control and by indirectly drawing on the power of deeply-held cultural stereotypes of women. This analysis of therapist–patient sexual exploitation and the blaming of its victims points to the broader problem of oppressive androcentric bias in psychiatry's ideology, epistemology, and discourse. The article closes with a suggestion for correcting psychiatry's harmful biases and with recommended strategies for preventing psychotherapist–patient sexual exploitation.

Lying is done with words and
also with silence.
Adrienne Rich

A word after a word
after a word is power.
Margaret Atwood

Adrienne Rich and Margaret Atwood express profound truths about women's victimization. Women are oppressed by what is said of them as well as by what is unspoken or unspeakable. When a woman is not allowed to define reality for herself, when she is silenced or her voice subjugated to another's, her personhood is diminished. Robbed of the power to create

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meaning in her own image, she is rendered less than fully human. Unfortunately, the poets' insights elude many in the mental health professions.

In recent years, national surveys (Gartrell, Herman, Olarte, Feldstein, and Localio, 1986; Gechtman, 1989; Pope, 1990; Pope and Vetter, 1991), survivor accounts (Noel, 1992; Plasil, 1985; Walker and Young, 1986) legislative initiatives (Jorgensen, Randles, and Strassburger, 1991; Schoener, 1990a; Strassburger, Jorgenson, Randles, 1991), and media coverage (Beck, Springen, and Foote, 1992; Goode, 1990; Sherman, 1993; *My Doctor, My Lover, a Frontline Report*, 1991) have focused increasing attention on the problem of psychotherapist–patient sexual exploitation. Approximately seven to 12% of therapists admit to sexual contact with their patients (see Schoener, 1990b, p. 40). Studies show that the most common pattern involves a male therapist exploiting a female patient (Committee on Physician Sexual Misconduct, 1992; Gartrell, 1992, p. 42; Gartrell, Herman, Olarte, Feldstein, and Localio, 1986; Pope, 1990); that many of these therapists are involved with more than one client (Holroyd and Brodsky, 1977; Gartrell et al., 1986; Schoener, 1990b); and that clients usually suffer negative consequences (Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg, 1983; Feldman–Summers and Jones, 1984; Pope, 1988; Pope and Bouhoutsos, 1986).

Prevalence rates, such as the seven to 12% previously cited, probably underestimate the scope of this problem because some offenders are reluctant to reveal misconduct, even on confidential surveys (Pope, 1990). Perhaps a closer approximation of the problem's actual extent is conveyed in the findings that 65% of psychiatrists (Gartrell et al., 1986) and 50% of psychologists surveyed (Pope and Vetter, 1991) reported having consulted with a patient who had been involved with a sexually exploitative therapist. Publicity materials for a *Frontline* documentary (*My Doctor, My Lover*, 1991) reported that over one million North American women have been victimized by sexually exploitative psychotherapists. Although the media sometimes presents exaggerated figures, the prevalence rate reported by *Frontline* seems consistent with extrapolations based on data from the studies cited above and from other credible sources (Schoener, personal communication, July 1993).

Commentators from diverse backgrounds voice nearly universal consensus in decrying psychotherapist–patient sexual contact as a misuse of professional power (for example, Council on Psychiatry and Law, 1993; Fortune, 1990; Jorgenson and Appelbaum, 1991; Nugent, 1992; Roberts–Henry, 1992; Rutter, 1989; Siegel, 1991). Every major mental health profession has a prohibition against sexual contact with patients in its Code of Ethics, and, as of this writing, 12 U.S. states have enacted legislation criminalizing psychotherapist–patient sex .[1]

[1]To date, U.S. states that have criminalized therapist–patient sex are: Minnesota, Wisconsin, North Dakota, Colorado, California, Maine, Florida, Iowa, Georgia, Texas, South Dakota, New Mexico.

Through their disclosures, survivors of sexual exploitation by therapists have contributed substantially to the growing understanding of this problem and its negative consequences (Schoener, 1990c). Additionally, victim–survivors play a crucial role in protecting the public from offenders. Without survivors' testimony, the professions would be impeded in their efforts to identify, rehabilitate, sanction, or expel offenders.

Complaints through licensing boards are the prime vehicle for restricting or removing offenders from practice; however, one source (Beck, Springen, and Foote, 1992) has reported that patients file complaints in only 4% of cases. Moreover, two recent reports (Committee on Physician Sexual Misconduct, 1992; Independent Task Force, 1991), note that victim–survivors are often reluctant to report because they fear their allegations will be dismissed or that they will be blamed for the abuse. Thus, victim-blaming not only inflicts distress on already traumatized individuals, but also engenders harmful consequences that are significant from a broader public policy perspective. In view of the low reporting rate, it seems reasonable to expect that interest in the public welfare — along with compassion for individual survivors and concerns about the ethical integrity of the professions — should result in a large-scale effort that encourages survivors to speak out.

Unfortunately, the climate for victim–survivors is often more hostile than compassionate. Since 1988, I have been involved in education and advocacy on the issue of therapist–patient sexual exploitation. In 1992, I helped organize a self-help recovery group, Treatment Exploitation Recovery Network (TERN). Anecdotal accounts from over 100 survivors point to a disturbing fact: the patient who has been sexually exploited by her therapist frequently meets with disbelief, blame, and contempt. Because they anticipate these responses, some women delay reporting or decide not to report at all.

In subtle yet powerful ways, sexist language that blames the victim conveys the negative reactions that victims so often dread. My focus in this article is on oppressive language that silences women who have been victimized by their male therapists. (Since 80% of cases involve a male therapist and a female client [Gartrell, 1992], this strategy applies to the majority of survivors.) Even though my focus here is male/female sexual exploitation, it is important to qualify that a psychotherapist's exploitation of his or her patient always represents a breach of trust and an abuse of power regardless of the gender pairing .[2]

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[2]Very specific strategies for denying or blaming the victim suggest themselves in cases of female/male or same-sex exploitation. Because men hold the balance of power in our culture and because it is widely recognized that most sex crimes are perpetrated by men against women, many in our culture refuse to acknowledge that a man can ever be victimized sexually. This is especially so when the victimizer is a woman (for example, in cases of maternal incest or of abuse by a female therapist). In cases of same-sex exploitation (whether two men or two women), the victim is subjected to the stigma that a heterosexist culture attaches to all sexual

Arguing that therapist–patient sex is intrinsically exploitative, this article challenges the mischaracterization of such exploitation as an "affair." I will argue that women in psychotherapy are subject to a variety of forces that undermine their capacity for consent and that render sex within the context of the power-based therapy relationship inherently coercive. I also challenge the corollary frequently associated with the "affair" model — the view of the woman as "seductive" or "manipulative," a provocateur. I focus on the "woman as provocateur" conception because, in my experience, that is the depiction most frequently invoked against the victim's credibility and blamelessness. I challenge this image also because it draws on the power of a deeply-held cultural myth, one that has informed and enforced a long tradition of silencing women victims.

Survivors experience distress when family or friends do not believe that they have been abused or imply that the survivor is at fault. Anticipating such responses has kept some TERN members from risking any disclosure of their exploitation outside of the group. Some others who do disclose their abuse to family or friends experience such stifling failures of empathy that they are reluctant to speak again of it. These accounts underscore the need for public education — to replace damaging myths with accurate information.

But professionals' statements often convey the same stereotypes as those of the general public. Survivors frequently attribute particular significance to professionals' perceptions. They are also more likely to consult psychotherapists over other types of providers for counseling or advocacy. Therefore, blame-the-victim statements such as this one, by a Toronto physician, are especially dangerous:

> The idea that the woman complainers . . . never did anything to tempt male physicians is a bit far-fetched. Women normally coming in to see a male doctor put on their best clothes, their best shoes, decorate themselves up to make them look as attractive as possible (Independent Task Force, 1991, p. 120).

idea that a woman's clothes and shoes could "tempt" a physician into a boundary violation might seem laughable if it did not tap into the associative power of the common notion that women are responsible for men's sexual behavior.

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acts between persons of the same sex, including abusive acts. By focusing on female victimization as the most prevalent pattern and as carrying a particular meaning in our culture, the feminist critique in no way denies or minimizes men's victimization or women's abuse by other women. To repeat: therapist–patient sex is always exploitative and, hence, abhorrent. Moreover, the feminist critique of this problem provides a useful perspective on the stigma associated with both male victims and with victims of same-sex perpetrators. Feminist analysis of sex role socialization, of the social construction of masculinity and femininity, and of the role of homophobia in maintaining patriarchal hegemony (see, for example, Pharr, 1988) uncovers the roots of these stigma.

Seymour Zelen (1985) perceives such statements as reiterations of "the old rape–seduction theory" dragged out of mothballs and "dressed up in new clothes" to make the "poor, male therapist" appear the "victim of the manipulative female patient" (p. 181). Gary Schoener (1990b) provides another example. He quotes a prominent psychologist, Rogers Wright, denouncing those "unscrupulous consumers" who prey on the "vulnerability of the provider." Wright questions whether the "consumers" are "so weak . . . and so poorly integrated that they are unable to set limits for themselves or the provider" (p. 50). In a recent American psychiatric journal, psychologist Ralph Slovenko (1991) commented that "especially with patients who are young, attractive, and malicious," the therapist "is the innocent and vulnerable one" (p. 604).

Psychiatrists and psychologists help shape societal perceptions of mental health issues. Their statements mediate how other professionals and the public will think about the problem of therapist–patient sexual exploitation. Their words cultivate a psychological environment that will enable survivors to speak or will silence them. For these reasons, I focus my analysis on professionals' statements.

I want to qualify my speaking on this topic. I do not claim to speak for all survivors, for all women, or for all women–survivors. I feel confident, however, that I do represent the views of many of the women who have contacted me through TERN. I speak for those women, for those who have been silenced or have not yet found their voices, and for myself.

Through my discussion, I hope to increase empathy for the experiences that survivors, most of them women, have discussed with me. I would be pleased if this article helped to cultivate an environment that supports survivors who want to tell their stories, report their insights, and voice their concerns about therapist abuse. But this analysis of the mental health professions' misconceptions of therapist–patient sex directs attention to a problem larger than the silencing of abuse survivors. My critique points to the androcentric bias that is embedded within the professions' constructs and discourse. Therefore, I hope that this paper may serve as a call for thoughtful dialogue concerning the mental health establishment's role in maintaining a power structure that subordinates — and so necessarily harms — women and other oppressed groups.

Not Exactly a "Love Affair"

Members of the public and the professions frequently misconstrue psychotherapist–patient sexual exploitation, particularly between a male therapist and female patient, as a love or sexual "affair" (Schoener, personal communication, June 1993). The term "affair" connotes a liaison that is illic-

it or forbidden, as in an extramarital relationship, that occurs outside of a socially sanctioned boundary. Because sex between psychotherapist and patient clearly transgresses a professional boundary, it shares with extramarital affairs their occurrence within the context of a boundary violation. Beyond this obvious similarity, the relationship between therapist and patient is imbued with psychological and social meanings that set it apart from relationships we usually reference with the term, "affair."

One major difference is that spouses and lovers generally relate as *equals*, while therapists and their patients cannot. By definition, a patient is vulnerable and dependent; she places herself in the care of the professional whose knowledge and expertise she seeks for help with her problems.

Each client brings a particular constellation of problems and a unique history to therapy. The very fact that she consults the therapist for psychological problems testifies to the client's vulnerability. However, patients exploited by therapists often have a history that makes them especially susceptible to boundary violations (Rutter, 1989). Frequently, they are survivors of sexual child abuse (DeYoung, 1981; Herman, 1991; Pope and Vetter, 1991; Russell, 1986; Rutter, 1989). Because they are so rarely equipped with the skills necessary to protect themselves, sexual child abuse survivors have been described as "sitting ducks" for exploitative therapists (Kluft, 1990). Clinicians have identified specific vulnerabilities that place incest survivors at risk, including: defense mechanisms, such as dissociation, automatic obedience, and inappropriately assuming the blame (Herman, 1991); cognitive distortions, inability to interpret others' threatening acts, and "perceived involuntary helplessness" (Kluft, 1989, 1990); and impaired ability to assess others' trustworthiness (Finkelhor and Browne, 1985). Richard Kluft (1989) also has suggested that a client's tendency to repeat "eroticized behaviors that are sequelae of childhood sexual abuse" places her at increased risk (p. 485). And Thomas Gutheil (1989a), whose views I discuss more fully later, has said that "borderline" patients who behave "seductively" or "manipulatively" increase their risk of exploitation.

In addition, interpersonal arrangements unique to the practitioner–patient relationship augment the client's vulnerability. A psychotherapy patient *willingly* lowers her normal social defenses as part of the treatment; she opens herself because the therapist gains her trust and offers assurances that her openness is a necessary condition of psychotherapy. But such unilateral vulnerability represents a departure from the accepted pattern of most social relationships. Outside of a professional relationship, it is unusual for one individual to reveal deeply intimate information while the other shares little or nothing of a personal nature. Therapists' special knowledge of their clients' deepest secrets can lead to a feeling of heightened intimacy as it simultaneously gives them a psychological advantage over the patient.

Therapists also derive power and privilege through their social role as "professionals." As Glen Gabbard and Kenneth Pope (1989) indicate, society confers status through formal systems of recognition. Academic institutions confer a degree and title, and the State issues a license to practice. The therapist has authority to diagnose the client's condition and to prescribe a course of treatment. In doing so, the therapist uses a specialized vocabulary and techniques that may acquire a certain mystique in the eyes of the patient. By charging a fee for services, the therapist further establishes his or her role as a socially-sanctioned source of expertise. Moreover, the social elevation of the therapist becomes possible or meaningful only within a social hierarchy that simultaneously lowers the client's status. Seen this way, the patient's relatively lesser status becomes an indication and a source of diminished power and control.

In relation to their clients, all therapists, male and female, hold not only personal, but also institutional and social power. But male professionals are differently empowered than their female counterparts. Men, more often than women, occupy the positions of power in society. Moreover, even in equivalent roles, men frequently command more attention and hence exert greater influence than their female co-workers. Of course, these are not random patterns; they reflect that women are socialized into nurturing and submissive roles and men into more authoritative ones. Consequently, the relationship between a male therapist and female client is imbued with social meanings that distinguish it from therapeutic relationships involving other gender combinations. A woman perceives her male therapist's power over her not only in relation to her role as *patient*, but also superordinated to her role as *woman*. Furthermore, all power relations between men and women are influenced by socio-cultural ideas concerning acceptable ways for men and women to experience and express power. Cultural notions of appropriate "masculine" and "feminine" behavior mediate male therapists' and female patients' perceptions and conceptions of power, as well as the ways they enact power "plays" or "struggles." Feminist theorists, such as Catherine MacKinnon (1984), have pointed out that our culture constructs the "masculine" as dominant, the "feminine" as subordinate.

In sum, asymmetry of power pervades the meaning and structure of the male therapist–female patient relationship at every level. The "politics of therapy" exert intense influence over all clients but particularly over women clients. The patient's already compromised ability to control the therapeutic situation is further undermined by the interpersonal, institutional, and social forces to which she is subjected. That clients acquiesce to their therapists' demands, requests, or even subtle suggestions for sex is not surprising.

Linda Jorgenson and Paul Appelbaum (1991) have observed that sex between therapist and patient is intrinsically coercive because the patient

always perceives an implicit threat that failure to comply may result in the therapist's refusal to continue treatment. In my experience, clients usually invest themselves to such a degree that they would consider the loss of therapy or therapist as a great detriment or harm. They look to the therapist for help with life problems that they are intensely committed to resolving. (Patients sometimes perceive the loss of the therapist as so intolerable that even after sexual exploitation has occurred, they may still turn to the idealized "good" therapist for comfort from the distress they experience as a result of the abuse.) The implied threat that therapy will end if sex does not begin or continue places therapist–patient sex in the category described in sexual harassment literature as "sexual activity coerced by threat of punishment or harm" (Tuana, 1985, p. 50).

Sexual Exploitation As Social Control of Women

Feminist analysis offers a perspective on another implied harm that is particular to the male/female pairing and crucial to understanding the coercion that is intrinsic in sex between male therapist and female patient. Feminist theorists such as Susan Brownmiller (1976), Rus Ervin Funk (1992, 1993), Andrea Dworkin (1983), Carol Sheffield (1984), and Lenore Walker (1989) have explained that men's sexual abuse of women carries a meaning and purpose that transcend the individual act of one man against one woman. In this view, men use all forms of sexual violence — rape, battery, incest, sexual abuse of children, sexual harassment, prostitution, sexual exploitation in trust-based relationships — to control women and to maintain their own dominant position in society.

Rus Ervin Funk (1993) observes that "sexist behaviors" may be seen as existing on a continuum, ranging from gender-based slurs to pornography, sexual harassment, various forms of rape (stranger, acquaintance, marital, gang), woman battering, and, finally, to femicide (p. 12). Funk explains that each of the behaviors on this continuum supports the others, and that in one sense there are none "better or worse," since the occurrence of even the "less intense" acts reminds women of the "more intense" ones. Here "less" accomplishes the same political and symbolic function as "more."

But this "sexual terrorism" (Sheffield, 1984) operates even more complexly. Brownmiller (1975) has explained: "That some men rape provides a sufficient threat to keep all women in a constant state of intimidation" (p. 209). No woman is exempt from potential sexual assault. Moreover, men who commit acts of sexual violation represent all ages, races, and religions; come from all income, educational, and social class levels; are married, single, separated, divorced (Sheffield, 1984). This fact makes women apprehend their potential vulnerability to any man. From a woman's perspective, any man could be a potential rapist. Consequently, every woman must live with the knowledge that she could be the next victim of any man.

The generalized fear that "sexual terrorism" engenders is the cornerstone of the complex constellation of forces converging in the situation of male/female therapist–patient sex. The therapist brings to the situation power at every level: personal, interpersonal, institutional, cultural, and socio-political. Of particular importance is the fact that, whether deliberately or unwittingly, the male therapist appropriates to his act the power of pre-existing symbolisms and social meanings when he engages in sexual behavior with his woman client. The male therapist brings to any demands, requests, suggestions, or even agreements a sociopolitical power to which the woman has little access. It is a power that, by virtue of its ubiquity, is rendered nearly invisible and, hence, even more potent. The male therapist brings the power that all men derive from women's fear of men's sexual violence.

On the other hand, the female client brings to the situation vulnerability and powerlessness — personal, social, political. As Marie Fortune (1990) has observed: "To be vulnerable is to lack . . . (the) power . . . to choose for one's self; consequently, one may be *overpowered* . . ." [emphasis added] (p. 83). Once we place therapist–patient sex in this socio-political context, the woman client's acquiescence looks more like surrender than consent, and what has been misconstrued as an "affair" becomes, more accurately, sex coerced by implied threats of harm.

The feminist critique examines the relationship between male therapist and female patient in the context of a social reality which it mirrors and simultaneously reinforces. Traditionally, women have been excluded from the religious, educational, and political institutions that establish meaning and define social order. Moreover, men have pronounced the linguistic rules, have defined the language that cultivates and conveys social reality. Feminist analysis reveals that men create social reality in their image, to their benefit, and at the expense of women and other oppressed groups (Chesler, 1972; Daly, 1990; MacKinnon, 1984; Penfold and Walker, 1983). Feminist analysis unmasks social institutions, including the mental health establishment; it reveals that they are not neutral, unbiased, or apolitical structures. It uncovers that the mental health establishment protects the cultural hegemony, a distinctly *political* function. The feminist critique points out that the mental health institution represents, as scientific truths, theories that embody and enforce white, heterosexual, class-bound, male social norms. It suggests, by extension, that clinical practice based on androcentric theories is necessarily problematic. And, as I will discuss shortly, feminist deconstruction of dominant texts on therapy abuse exposes the role of psychiatry's discourse in women's oppression.

Backlash: Silencing "Strident" Feminist Voices

Given the threat that feminist analysis poses to the mental health establishment, it is not surprising that the perspective has gained little accep-

tance. But the feminist critique is not new. Twenty years ago, Phyllis Chesler (1972) indicted the mental health system for its role in controlling and oppressing women. In *Women and Madness*, Chesler explains that patriarchal psychotherapy mirrors the institution of marriage. Both operate to restrict women's options and to keep women in their "proper place," that is, subordinated to men. Chesler devotes a full chapter to therapist–patient sexual exploitation, which she sees as paradigmatic of the mental health system's treatment of women. Chesler perceives that this extreme form of control and exploitation serves the same purposes as psychotherapy in its "everyday" forms: to isolate women from each other; extinguish their initiative, assertiveness, independence and any other "unfeminine" traits; blind them to their social oppression by conceptualizing their unhappiness and resultant anger as personal pathology; and, by ensuring the "continued 'preference' for Daddy, followed by the approved falling in love with and/or marrying of powerful father figures," to enforce their dependence on and subordination to male authority (pp. 138–158).

Since Chesler's pioneering study, a steadily increasing literature on therapist–patient sexual exploitation has developed. I think it significant, however, that few of the current writers acknowledge Chesler's contribution or pursue her feminist, social, or political analysis. In fact, much of the literature on therapist–patient sexual exploitation reads as a record of the cultural backlash against feminist thought in general (Faludi, 1992). Those feminist voices who challenge the status quo are dismissed as "strident" (Gabbard and Gutheil, 1992, p. 517), or their message is diminished, distorted, or silenced.

Psychiatry, the most powerful and conservative of the mental health professions, has been the discipline least receptive to the feminist analysis. Two prominent psychiatrists, Thomas Gutheil of Harvard's Program on Psychiatry and the Law, and Glen Gabbard of the Menninger Clinic, have been vocal representatives of their profession.[3] Gabbard and Gutheil (1992) oppose the feminist critique, asserting the superiority of the psychodynamic view over it. As I discuss shortly, their discourse is complicated and indirect; therefore, it is neither easy to follow nor to explain.

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[3]In fairness, I should note that Gabbard and Gutheil (1992) do not explicitly claim to speak for the psychiatric community. However, they do not qualify their opinions as uniquely their own. Moreover, by describing their position as "scientific," they assume the "voice of authority." Additionally, their presentation of their impeccable credentials ("extensive experience" in "sexual-misconduct litigation," "clinical work" with sexually exploited patients and with exploitative therapists, "numerous consultations, extensive discussion and study") [p. 517] suggests that they are respected experts in the field whose views are representative. Additionally, the publication of these men's writings in prestigious journals such as the *American Journal of Psychiatry* and *American Journal of Psychotherapy* further substantiates the conclusion that Gabbard and Gutheil's views are mainstream. I should also note that not all psychiatrists, nor all male psychiatrists, share Gabbard and Gutheil's perspectives. For example, Peter Rutter (1989) articulates a position that is closely aligned with the feminist than the psychiatric analysis.

To my knowledge, the closest approximation of a debate between feminists and male psychiatrists is a series of articles and letters which appeared in professional journals over a three- year period. These include Gutheil's (1989a) article on therapist–patient sex and women diagnosed with borderline personality disorder; two responses penned by women therapists who advocate for victim–survivors (Beal, 1989; Jordan, Kaplan, Miller, Stiver, and Surrey, 1990); Gutheil's replies (1989b, 1990); and, finally, a co-authored article by Gabbard and Gutheil (1992). This latest piece interprets the controversy over Gutheil's earlier article. Taken together, these documents constitute a dialogue between what, for simplicity's sake, I would like to refer to as the psychiatric and the feminist voices.[4]

Analysis of this dialogue is revealing and disturbing: it uncovers how psychiatry's discourse, through both its constructs and its rhetoric, operates to oppress and silence feminist victim–advocates in the same way it attempts to silence victims.

Gutheil's article (1989a), "Borderline Personality Disorder, Boundary Violations, and Patient–Therapist Sex: Medico-legal Pitfalls," discusses the author's observation that patients diagnosed with borderline personality disorder "are particularly likely to evoke boundary violations, including sexual acting out" (p. 597). Gutheil explicates "borderline psychodynamics" (p. 598), discussing characteristics such as the borderline's "narcissistic entitlement" (p. 599), and "volcanic rage" (p. 598). He states that borderline patients "possess the ability . . . to seduce, provoke, or invite therapists into boundary violations. . ." (p. 600). To illustrate, he presents ten vignettes from his clinical, consultative, and supervisory experience. Early on, Gutheil states that he is not "indicting the patient . . . (nor) . . . excusing the therapist's behavior" (p. 597); and later, he reminds readers that his "empirical observations neither blame the victim nor exonerate the therapist" (p. 600). He hopes that his analysis of the patient's "relevant borderline psychodynamics" (p. 598) will help therapists avoid the "pitfalls" (p. 597) he describes and will, thereby, "serve the clinician and the patient well" (p. 602).

In separate letters, Stephanie Beal (1989) and Judith Jordan, Alexandra Kaplan, Jean Baker Miller, Irene Stiver, and Janet Surrey (1990) respond. These women perceive Gutheil's analysis as "bias(ed)" [Jordan et al., 1990,

[4]Neither Beal (1989) nor Jordan et al. (1990) explicitly name their position "feminist." However, I think that their texts are responsive to my reading of them as expressing at least a liberal (if not a more radical) feminist position. Also, I am using the term "the feminist voice" as a rhetorical device for simplicity's sake. I am aware that the term "feminism" does not define a monolithic ideology. I am using it in a highly inclusive way. I do not mean to restrict "the feminist voice" to only Beal's and Jordan's perspectives, or to the radical feminist critique I explicated earlier in this paper. By the term, I mean to include the range of feminist perspectives (liberal, Marxist, relational, radical, postmodern, lesbian separatist, and so on). (Readers seeking a brief description of the major schools of feminist thinking may wish to consult Iannello, 1992.)

p. 130]. In support, they cite the language he uses to describe patients (or their psychodynamics). For example, they cite his references to the woman's "powerful manipulative skills" and "waif-like demeanor"; and his characterization of the patient as "trapping," "seducing," and "provoking" the therapist into boundary violations (p. 129). The victim–advocates criticize Gutheil for not providing information that could constitute a plausible alternative to his explanation (i.e., that the patient's "borderline psychodynamics" are "powerfully operative"). Among other omissions, the feminists note that Gutheil does not discuss the power dynamics in the practitioner–patient relationship, or acknowledge the high co-occurrence of borderline personality disorder with a history of sexual child abuse, or mention that incest survivors may be vulnerable because of perceptual, cognitive, and other deficits that limit their abilities to protect themselves from exploitation. Both letters criticize his failure to discuss research or clinical material offering a feminist conception of women's sexual victimization. Both letters allude to psychiatry's past role in implicating women and children in their own victimization and suggest that Gutheil's article follows in that tradition.

In reply, Gutheil (1989b, 1990) expresses "disheartenment" that his detractors have "miss(ed) [his] point" (1990, p. 130), which he reasserts is to offer "instruction on abuse prevention." He emphasizes that he condemns the therapists' behavior (" . . . the clinicians I described committed ethical and legal violations, malpractice . . . and abuses . . ." (1990, p. 130, and he maintains that "the patients played a role" (1989b, p. 1519; 1990, p. 130). He says that only from a "very limited perspective" could one conclude that studying the "patient's role and responsibility" diminishes the "doctor's unequivocal culpability" (1989b, p. 1519). He maintains that understanding the patient's role is critical in preventing the problem.

Psychiatry's Refusal: The Personal Is Not Political

With this background in mind, I turn now to the Gabbard and Gutheil article (1992), "Obstacles to the Dynamic Understanding of Therapist–Patient Sexual Relations." The authors' thesis is that sexual misconduct, "a topic of great affective intensity," stimulates "conflict" that evokes resistances to "dynamic understanding" of it. Such "resistance," the authors assert, leads to the problem's "undiscussability" (sic) or otherwise "interferes with" "discourse" on the subject. Moreover, in the authors' view, "resistance" to the psychodynamic perspective prevents "thinking realistically about the issues"; results in rigid adherence to an "oversimplified," "politically correct" explanation; hinders the problem's "scientific" study; and creates "a blind spot" (p. 516) that, ultimately, impedes its prevention (p. 524).

Gabbard and Gutheil's (1992) discourse is complicated and troubling. In even the most generous reading, it is difficult to perceive much about their

article that is not self-serving. The authors establish an internal system of logic that makes their arguments appear unassailable. Their constructs and rhetoric create a linguistic house of mirrors, a psychodynamic world that admits no diversity.

For example, the way that the authors have framed their thesis compels agreement. The authors' point seems to be that the primary "obstacle" to understanding therapist–patient sex from the perspective they favor is one's unwillingness to face the "(un)pleasant" or "(un)comfortable" (p. 518) "truths" (p. 524) that such analysis produces. Thus, the authors create a logic that excludes the possibility for one to reject their formulation of therapist–patient sex for reasons other than unconscious resistance. Gabbard and Gutheil interpolate Jordan's and Beale's letters into their article by specific reference and by implication (see p. 517). They reframe these women's objections to serve their own argument rather than answer those objections in terms of their actual content. Thus, in one masterful stroke, the psychiatrists have neatly dismissed the feminists' arguments as "resistance."

But the double-bind through which Gabbard and Gutheil (1992) coerce one to accept their thesis points to a deeper, even more disturbing problem in the text. The authors state that the purpose of examining the part that the patient plays in eliciting the therapist's sexual response is to help clinicians avoid exploiting patients. They insist that such examination will educate mental health professionals, benefit patients, and be "valuable to society at large" (p. 518). But the article fails to accomplish its stated purpose at the same time that it advances an unspoken political agenda. All of the authors' arguments attempt to keep women — women colleagues and women patients — in their place. Gabbard and Gutheil reduce the sincere and appropriately offered objections of the feminist–advocates to the uncritical following of a trendy, fashionable "politically correct" position. Simultaneously, they reduce the constellation of social, political, interpersonal, and intrapsychic forces influencing the woman patient to a narrow, rigid, recursive formula.

Once they begin their argument, Gabbard and Gutheil (1992) never give their audience a fair reading of the position they purport to critique. They interpolate the feminist voice into their article by quoting from the Jordan and associates (1990) letter. But their (mis)quotation of it diminishes and distorts Jordan's point. They state that the letter "accused the author of 'blaming the victim' *even by examining (borderline) dynamics*" (emphasis added) [p. 517]. But this is not accurate. Jordan's point, among others, was that Gutheil *over-examined* the patient's dynamics and, more importantly, that he examined them with obvious and excessive *bias*. Because Gabbard and Gutheil have so diminished, they distort — and, hence, misrepresent — Jordan's critique. By subjugating her voice to their rhetorical control, they make it sound trivial, ridiculous.

On the other hand, Gabbard and Gutheil (1992) establish their voice as "objective" and "scientific" (p. 524) and, most importantly, as politically disinterested. The psychiatric voice is "realistic" (p. 516), "careful," and "candid" (p. 518). Using the phrase "all political considerations aside" (p. 518), Gabbard and Gutheil represent their model as politically pristine, while, at the same time, implicating the feminists as politically motivated in the worst sense of the phrase. But their language accomplishes even more. Recall that the "political considerations" at issue here include men's domination and subordination of women through sexual abuse. The authors' offhand treatment belittles and dismisses such painful and highly significant (to women) realities of living. Their language suggests that perhaps the psychiatrists view these oppressive conditions as merely a collection of pesky details or a series of distracting annoyances to be brushed aside so that one can move on to more important "considerations" — i.e., those that concern the authors.

But Gabbard and Gutheil go further. By implication, they reduce the feminist position to the level of a trendy fad with the catch-phrase, the "politically correct" model. The authors create a fictive "politically correct" version of therapist–patient sex, which they use as a trope or rhetorical device throughout their article. The trope serves multiple purposes. If examined singly, no one instance seems particularly damning. However, when one looks at the authors' use of the device as a whole — and looks within the context of the culture of psychiatry and of society — one sees its ultimate effect: to refuse to acknowledge that Jordan, Beal, and others who object to Gabbard and Gutheil's framing of the content might have a profoundly true point of view, not merely a fashionable one. Deconstruction of this rhetorical device is illuminating; it provides one example of how the dominant discourse teaches audiences to perceive therapist–patient sexual exploitation and of how it operates to silence voices opposing the dominant view.

Gabbard and Gutheil (1992) define what they call the "politically correct" model in this way: "a psychopathic male therapist preys on a victimized female patient, who herself plays no role in eliciting such behavior, and who is always severely traumatized by the experience" (p. 516). At a recent national conference, Gabbard (1992) used more dramatic language, referring to those "evil, corrupt male therapists" and "passive, helpless female patients."

Gabbard and Gutheil (1992) define their "politically correct" model in "coded" language, that is, using terms that communicate through indirection. Coded language culls in the reader associations with what is unstated but implied. In this instance, the terms carry references to deeply-held attitudes in the culture — and particularly in the culture of psychiatry — about women. The coded message is that women, whom the psychiatrists have scripted here as espousing the "politically correct" model, are hysterical; women exaggerate, distort and misrepresent the facts, particularly when it comes to allegations

of sexual abuse. By defining their fictive category using such coded language, the psychiatrists practically ensure its categorical rejection.

But even those readers who do not break the code will be likely to reject the "politically correct" model. First of all, Gabbard and Gutheil's version presents a scenario populated with cartoon figures. Most people would be loath to accept the descriptions on either side of the equation. The psychotherapists become "psychopathic," "evil," and "corrupt." The women become "passive," "helpless," and "victimized." The terms the psychiatrists use to define the category make the victimization it describes sound too extreme, too histrionic to be believable. Yet as even Gabbard and Gutheil admit on the final page of their document, the "politically correct" model is "accurate in many cases" (p. 524).

The psychiatrists state that their "politically correct" model is "stereotypic" (Gabbard, 1992; Gabbard and Gutheil, 1992; Gutheil, cited in Sherman, 1993). By calling it a "stereotype," Gabbard and Gutheil imply that the model is cliched and exaggerated. Recall, however, that they chose the formulaic language to define the category in the first place. This creates a classic example of what George Orwell called "double-think." Gabbard and Gutheil seem to imply that they have successfully used the rhetorical device of exaggeration solely to make a point. That they identify the hyperbole themselves makes them seem totally above-board with no hidden agenda to conceal.

The logic that supports the authors' concealed message is complicated, but highly effective: if the "politically correct" model is a stereotype, then it must truly be a "politically *incorrect*" model, because it is "politically incorrect" to stereotype others. Here, through indirection, Gabbard and Gutheil implicate the feminists as hypocritical or unthinkingly insensitive (or just stupid), because the "politically correct" model that the psychiatrists have falsely ascribed to the women has now, through this complex double-think, been identified as "politically incorrect." Moreover, the authors imply that they themselves are truly "politically correct" because they have been so careful about stereotyping. When they wish to demean, they reject the concept of "political correctness." When they want to appear sensitive and competent, they indirectly ascribe it to themselves.

But the notion that we should dismiss the "politically correct" model because it is stereotypic requires more careful thought. We reject stereotypes not because they are *never* true, but because they are not *always* true, and, more importantly, because they oppress individuals and groups. Yet even Gabbard and Gutheil (1992) admit that in "many cases" women clients are "passive and helpless."

Frances Olsen (1984) explains that stereotypes, such as the "woman-as-helpless-victim" one, are not necessarily harmful. Whether or not a stereo-

type stigmatizes depends on "the concrete context in which the label is attached and the practical effect of the labeling" (p. 309). Olsen observes that "women rightly object" when their helplessness is used against them "as an excuse to deny them certain opportunities or to foreclose choices" (p. 309). However, open acknowledgement of women's vulnerability in certain situations can become not a way to oppress, but, rather, "a reason to empower (them) against coercion" (p. 309). Naming a woman's vulnerability does not necessarily harm that woman or women as a group. However, refusing to admit that women sometimes are helpless against predatory psychotherapists does obscure conditions of social existence that are harmful to women.

Gabbard and Gutheil's (1992) "politically correct" model harms women in at least one other significant way. By applying such a catchy, pop-psychology label to actual situations that do occur — by their own admission "in many cases" — the authors trivialize the suffering of women victimized under the "politically correct" conditions. Their language actually supports the victimization because it so demeans the very real pain of very real women. Though perhaps harsh, that last observation is neither hypothetical nor gratuitous: discourse riddled with double-speak has happened to most of the women in the TERN group.

Psychiatry's "Dangerous 'Truths'"

By reducing the feminists' socio-cultural and political analysis to such a simplistic and rigid formula, Gabbard and Gutheil play a linguistic game that produces, in their own words, "dangerous truths" (p. 524). The psychiatrists' "truths" are dangerous because they are deceptively simple — that is, deceptive because they oversimplify.

The psychiatrists' word game exemplifies what Mary Daly (1990) calls a "reversal," an inversion of the truth. Notice how smoothly it operates: a recent *Psychology Today* article (Sherman, 1993) quoted Gutheil extensively in a section titled "A Male Practice?" The writer concluded that the "complex issue" of "therapy abuse has been reduced to a burning symbol of male oppression" [emphasis added] (p. 67). [The section's title, posed as a question, perhaps conveys the level of confusion or denial about basic facts that reversals engender and require.] The notion that elucidating the sexist social context within which therapy abuse occurs somehow "reduces" or "oversimplifies" its complexity represents a stunning reversal, for it is the psychiatric model that actually operates this way.

The psychiatric model seeks to understand problems within the narrow context of the individual, or, sometimes, the dyad or family. What is missing from the model, and from Gabbard and Gutheil's presentation of it, is the

model's relation to the institutional structure, to the larger context, which would "allow us to see the model as a particular way of understanding human behavior in psychiatric terms, as opposed to any other terms in which we might understand it" (Penfold and Walker, 1983, p. 49). The psychiatric model is derived from and defines a world seen only from the limited perspective of its own terms, terms that reduce social problems to the level of individual pathology.

The feminist analysis rests upon the presumption articulated by Catherine MacKinnon (1992) that "a woman's problems are not hers individually, but those of women as a whole" (p. 95). This analysis requires one to differentiate between what P. Susan Penfold and Gillian Walker (1983) have called "individually experienced problems" and those problems that truly are "individual." The feminist critique so differentiates by locating "the damage and dysfunction of . . . subordinate status" within the system that produces it, *not within the individual woman* who experiences it" (emphasis added) (Penfold and Walker, 1983, p. 31). Such a perspective broadens our understanding so that we perceive a woman's powerlessness and submission "not as a matter of personal fault, misfortune, or choice, but as the outcome of living out the structuring of social relations in a . . . society where power and resources are not equitably distributed" (Penfold and Walker, 1983, p. 39).

Moreover, feminist analysis points out that psychiatry as an institution does not stand outside of the social system. Psychiatry's theories, methods, and discourse all reflect androcentric bias since men, not women, have constructed them. Psychiatry is an institution created in men's image; it serves men's, not women's, best interests. As an institution in a society that oppresses women, psychiatry participates in women's oppression.

I think that Beal (1989) and Jordan and her associates (1990) perceive rightly that Gutheil's (1989a) article does blame "borderline" women for their sexual exploitation. I think also that the Gabbard and Gutheil (1992) article offers nothing more than an elaborate justification using more of the same problematic reasoning and discourse. However, I do not think that Beale or Jordan necessarily suggest, nor do I believe, that Gutheil or Gabbard intentionally blame women victims. I do not perceive Gabbard and Gutheil as the ring-leaders of a psychiatric conspiracy to blame women who are sexually exploited by their therapists. I do not believe that most psychiatrists, individually or as a group, set out deliberately to do this. I know many psychiatrists who unequivocally contend that women so victimized are not to blame for their abuse.

What I do believe, however, is that the *ideology behind analyses* such as Gabbard and Gutheil's blames the victim (Penfold and Walker, 1983). I am saying that even though they contend that theirs is "neutral," all writing and all speaking, at least in English, is gendered. What I have been calling the

"psychiatric voice" is so embedded with androcentric bias and constructs, so fundamentally informed by a patriarchal way of understanding reality, that it inevitably speaks in the idiom of victim-blaming. This is the regrettable but unescapable result of the context in which it resides.

Psychiatry's ideology fails to recognize that "the everyday world is not fully understandable within its own scope. It is organized by social relations not fully apparent [or even apparent at all] in it or contained in it" (Smith, 1964, cited in Penfold and Walker, 1983, p. 50). Psychiatry's epistemology, like all patriarchal knowledge, is "based on the premise that the experience of only half the human population needs to be taken into account and the resulting version can be imposed on the other" (Spender, 1985, cited in Reinharz, 1992, p. 7). Such a one-sided way of knowing, of defining, is intrinsically oppressive to the other side. Whether the speaker blames unwittingly or intentionally is beside the point in the final analysis, because, finally, his speaking does blame the victim.

Gabbard and Gutheil's (1992) "dangerous truths" are dangerous — but not, as the authors suggest, because they force us to confront unpleasant "truths" about women that we prefer to deny or resist. They are dangerous because they are distortions and half-truths. They are dangerous because they draw on the power of deeply-held myths and stereotypes that have hurt and continue to hurt women: that women's psychology is organized around the male penis — that we want one, feel less than and hate men because we don't have one, and are men's physical and moral inferiors in the absence of one. They draw on the myth that because rape, battery, and abuse fulfill our inherent "masochism," we unconsciously enjoy and provoke them; that only "nice girls" can be abused or exploited; "bad" girls, for example "rageful," "narcissistically entitled" "borderlines" cannot. In short, the psychiatrists draw on the myth that we "ask for it" and then "cry rape."

Called To Account

In view of the foregoing, how are we to understand Gabbard and Gutheil's (1992) claims that they do not blame the victim? Are they duplicitously misrepresenting their true motives? I, for one, believe them when they say that they abhor victim-blaming. I think that they honestly do not see that they are doing it.

But they *are* doing it. My reading of their text suggests that their ideology and discourse sabotage their better intentions at every turn. In fact, the very language they choose to assert their claim to the contrary ascribes blame to the victim. Yet, reading below the surface points not only to the authors' unspoken, possibly even unacknowledged agenda; it also suggests a way out of their paradigmatic and discursive dilemma. To begin with, although it

seems self-evident, I cannot refrain from the simple observation that merely stating that one does not blame victims does not make it true. To be credible, a claim must have evidence to support it.

Gabbard and Gutheil (1992) set out three axioms in support of their contention that they are not blaming the victim. Beyond these "axiomatic proofs," however, the authors fail to provide any supporting evidence to substantiate their claim. Such evidence would include, at the very least, a fair representation of the opposing position that says that they do blame the victim. But as I have shown, Gabbard and Gutheil mischaracterize and then falsely ascribe that position to the women who oppose their formulation. What they refute, and finally implicate (blame) as an impediment to prevention, is nothing but a "straw woman."

Ultimately, Gabbard and Gutheil's contention that they do not blame victims rests on what amounts to a word game. In a series of axioms, the psychiatrists assert that they see the victim of sexual exploitation as "accountable" but not to blame for her role in the abusive relationship. Their argument requires the reader to accept a supposed distinction between the words "accountable" and "blameworthy."

According to Gabbard and Gutheil, the word "accountable" carries no notion of blame. At first glance, one might think that the *American Heritage Dictionary* (1980) supports the psychiatrists' contention that the word "accountable" connotes no blame: the first definition for the word "accountable" — "answerable, capable of being explained" — appears relatively neutral. However, closer examination shows that "accountability" actually does connote culpability, since the word "account" is defined as "a written or oral explanation, *as of blame* or cause" [emphasis added]. In common usage, one speaks of "being called to account," an expression that clearly suggests culpability. Thus, once one gets beyond the pretense of distinction, there is little actual difference between the words "blameworthy" and "accountable."

Yet even if, for purposes of argument, we accept that Gabbard and Gutheil (1992) presuppose no blame, their suggestion that victims must "account" for themselves is still highly problematic. For how is the survivor to give her account when psychiatry refuses her even the opportunity to speak; or when, at best, it allows her "to name (her) truths" only "in (the) alien language" of psychiatry (Rich, 1977, cited in Russ, 1991, p. 207)?

Gutheil (1989a), in his article on "borderlines," never presents a single survivor voice. All of the women survivors are *spoken for,* that is, objects subordinated. I think it is for this reason, possibly more than any others, that Gutheil so inflamed his feminist critics. In all of the writings discussed here, Gutheil refuses not only victims, but even their advocates, the right to speak for themselves. Instead, he translates their voices, making them speak in his language, not their own. In the "borderline" article, Gutheil does not even

state whether the survivor experiences he narrates were told to him directly, or if he heard them from the victims' (possibly offending) therapists. If the latter, then Gutheil's translation of these women's statements would be an interpretation of a prior and possibly even more biased interpretation. And, as has been demonstrated here, Gutheil is not a neutral translator.

This last observation calls into serious question the validity of his and others' descriptions of the victim–survivors as "seductive" and "provocative." It also reminds us that, if the psychiatrists are truly as concerned as they say they are about the harmful effects of stereotyping women, they would be well advised to avoid using words that do hurt us. Statistics from the FBI reveal, for example, that a woman "provokes" a man to beat her every 18 seconds, and "seduces" a man into rape every three minutes (cited in Dworkin, 1983). Women's and girls' "seductiveness" has been invoked to explain every kind of bad male behavior, as well as nearly every human problem beginning with Eve's supposed "accountability" for "man's" fall from grace in the Garden of Eden. The term "seductive" has become so coded with associative meaning that it is practically useless to describe women's behavior. It is a word that usually conveys more about the perceiver than about the agent of the behavior being described.

A Call for Systemic Prevention

Yet Gutheil (1990) raises a legitimate question when he asks how we should "teach trainees and colleagues to avoid . . . (these) tragically common" boundary violations in a way that truly does not blame the victim (p. 130). I would like to respond because, like Gutheil, I am deeply concerned about preventing this problem's occurrence. Moreover, as he does, I think that the victim's psychology is important. Each woman organizes a personal meaning system of the socio-political, cultural, family, and other structures she lives in. The coherence, stability, and resiliency of these internal schemata do play a role in her vulnerability to victimization.

It is important that both therapists *and* clients understand this. Prevention education for all clients, but particularly for women with abuse histories, is necessary and useful. Such education should inform clients of what they can realistically expect from psychotherapy and psychotherapists. It should unequivocally delineate the limits and boundaries of competent, ethical therapy. The possibility that a therapist of either gender can exploit a client of either sex should be explained, but the fact that male/female exploitation is the most common pattern — as well as the sexist implications of this pattern — should be articulated.

Prevention for vulnerable women should both educate and empower them. Explaining that women with sexual abuse histories are at high risk and

teaching compensatory skills can help to accomplish this. Such interventions should explore how a woman's personal history and societal position can contribute to her possibly feeling overpowered by, or giving away her power to, or seeking to draw on, or to wrest away the power of, her male therapist.

On the other hand, prevention should include better training for practitioners. Academic and continuing professional education must "downplay . . . the androcentric medical model in which the authoritarian therapist must gain power and control" (Walker, 1989, p. 700). Education for professionals should also provide non-sexist perspectives on women's development, psychology, and common problems, such as sexual violence. Psychotherapists do need to understand that women clients, and particularly incest survivors, may be especially vulnerable to sexual exploitation, may even ask it of their therapists. But instructions to prevent misogynous behavior couched in misogynous terms are clearly doomed to failure. Instructors should describe these clients' behaviors in terms that truly are neutral and free from obvious and excessive androcentric bias. (For an instructive example, see Russell, 1986, pp. 165–173.) Moreover, the professions should guard against using diagnoses that vilify or stigmatize women. At least one psychiatrist (Herman, 1992) has said that the term "borderline" is more often a "sophisticated insult" (p. 123) than a useful clinical descriptor. Psychologist Robert Phillips (1993) was perhaps more direct when he identified borderline personality disorder as "that diagnosis we give to patients we don't like."

Even more importantly, prevention efforts must not stop at the level of individual client and therapist. Prevention must be comprehensive to address the professional, institutional, and societal factors that generate and support sexual exploitation. A growing literature on prevention of mental health-related and social problems suggests that changing social attitudes and values, through policy and broadly based normative-reeducative efforts, is at least as important as strategies that focus on individuals (Albee, 1990; Hunter, 1990; National Mental Health Association, 1986). At the Second National Conference on Sexual Misconduct by Clergy, Psychotherapists and Health Care Professionals, William White (1992) advocated for such a systemic prevention strategy. Because survivors were a strong and vocal presence, the Conference itself represented a model of the absolute necessity of including survivors' voices in comprehensive prevention efforts.

Toward A More Fully Human Approach

Gutheil's (1989a) poor translation of the survivor voice, and Gabbard and Gutheil's (1992) defense of that translation speak eloquently to what Dale Spender (1985, cited in Reinharz, 1992) has called the "politics of naming." Historically, men have held the power to define and give meaning to social

reality. Consequently, women's experience has been represented from a male position outside that experience. But it is precisely a reversal of this situation, one that empowers the other half of humanity to speak, that holds the potential not only for preventing sexual exploitation by psychotherapists, but also for beginning to heal the injury that patriarchal thinking in psychiatry and other social institutions has caused all people.

Feminist analysis views male privilege as only one of many negative expressions of power. Regardless of the specific form it takes, power to oppress maintains itself through the same patterns of domination (Adair, 1992). Recognizing this, feminist analysis ultimately calls for a social revolution that allows for true cultural diversity and full human expression. Feminist theorist and cultural critic, bell hooks (1992), has observed that "feminist struggle is not defined as a conflict between women and men . . . [but rather] . . . by resistance to a politic of patriarchal domination that is perpetuated and maintained by nearly everyone in our culture" (p. 113). Understood this way, "feminist thought and practice liberates us all" (hooks, 1992, p. 117). Feminist struggle acknowledges the critical importance and absolute necessity of including the voices not only of women, but also of ethnic minorities, members of diverse socio-economic classes, gay men and lesbians, people with disabilities, children, the aged, and all other oppressed groups.

In *The Creation of Feminist Consciousness*, historian Gerda Lerner (1993) closes her chapter, "The Right to Learn, the Right to Teach, the Right to Define," by citing the wisdom of the inspirational educator, Anna Julia Cooper. Even the double stigma of being an African American and a woman could not silence so powerful a voice. Though first uttered over one hundred years ago, Cooper's (1892) words (cited in Lerner, 1993) speak eloquently to the problems of today:

> So long as woman sat with bandaged eyes and manacled hands, fast bound in the clamps of ignorance and inaction, the world of thought moved in its orbit like the revolutions of the moon; with one face (the man's face) always out, so that the spectator could not distinguish whether it was a disc or a sphere. . . . I claim . . . that there is a feminine as well as a masculine side to truth; and that these are related not as inferior and superior, not as better or worse, not as weaker or stronger, but as complements — complements in one necessary and symmetric whole. (pp. 218–219)

Enabling women survivors to speak in our own voice will not be easy for the mental health institution. It will require acts of immense good faith and tremendous courage, for the establishment will rightly hear our speaking as a challenge to its very foundations. But I think that the rewards will more than compensate. For, as Lerner says, it is only in the voice that admits both the male and female, our collective human voice, that we are able to tell "whether the moon is a disc or a sphere."

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