Mental Health Resource and Education Network

MHREN, P. O. BOX 1082, Ashland, Oregon 97520 www.mhren.org

The two remaining workshops for 2009 are very different yet deal with important topics about which we as therapists should stay alert. Dr. Marty Klein will present his provocative, challenging material about sexual issues that we might meet in our clinical practices and Timothy Kowalski will provide us with the latest understanding of Asperger Syndrome. We are hoping that we will also have professionals from the fields of education, speech/language, and occupational therapy join us for the latter so we can all learn how to collaborate in providing the best possible services to this growing population.

We are planning our schedule for 2009 and will announce it as soon as possible. So far, we have confirmed workshops on **Dialectical Behavior Therapy with Cathy Moonshine, the return of the excellent and updated Law and Ethics with lawyer and psychologist Steven Frankel, and Working with Affairs with James A. Fogarty, Ed.D**. Other possibilities include the Level II training with **Pat Ogden**, who presented last year at one of the well-received trainings we have ever sponsored, and a NLP training. Our December newsletter will inform you of the whole schedule. **If you would like early warning of future trainings, send us your email and we will put you on a blind list used only to inform you of our workshops. Send it to info@mhren.org and put "email list" in the subject line.**

2008 MHREN-sponsored Trainings

September 19 – Diagnosis and Treatment of Sexual Issues

This workshop is for psychotherapists of all backgrounds who wish to understand and influence their clients' sexual functioning and decision-making. Participants will learn a compelling model of sexuality that focuses on its positive aspects; challenges clients' impulses to self-identify as inadequate; sees society's sex-negativity as a source of psycho-sexual pathology; and acknowledges non-traditional ("kinky") sexual expressions that are actually quite common. As a result, participants will be able to empower clients to make better sexual choices, function more as they would like to, and better integrate eroticism into their relationships. We'll examine specific clinical approaches to desire discrepancies, health and aging issues, pornography, power struggles, affairs, and inhibited communication.

Marty Klein, Ph.D., is a Certified Sex Therapist and Licensed Marriage & Family Therapist. His latest book (his 5th) was honored as **2007 American Association of Sexuality Educators, Counselors and Therapists (AASECT) Book of the Year**. For more information about him see www.SexEd.org.

November 14 - Asperger Syndrome: Diagnosis and Collaborative Treatment

This seminar will help mental health clinicians, educators, speech/language pathologists, and occupational therapists acquire practical assessment and intervention skills. Attendees will improve their diagnostic abilities and obtain skills-based techniques designed to address the social-interaction, social-communication and social-emotional concerns present in this population. Extensive recommendations designed for professionals to help these individuals succeed in the social, academic and employment settings will be provided. Case studies and an appropriate amount of time for questions and answers will be provided.

Timothy Kowalski, M.A., C.C.C., is a speech-language pathologist nationally known for his work with Asperger Syndrome.

Groups, Workshops, and Announcements

If you would like your announcement to be listed, please email information to info@mhren.org

Workshops and Classes:

***Spiritual and Clinical Issues in the LGBT Community: Queer in America* with Fanda Bender, LCSW.** Friday, October 10, 2008, 9:00-4:00, at Smullin Center at Rogue Valley Medical Center, Medford, OR. Six (6) CEUs. This workshop will explore developmental issues as they relate to the LGBT Community. Special attention will be given to clinical and spiritual issues that arise across the life span of queer people. Didactic and experiential exercises will be utilized in this training. Participants will be encouraged to explore their own internalized homophobia and heterosexism. Sponsored by the Rogue District of NASW. For registration information, email afanjet@jeffnet.org.

The 7th Annual Jackson County Courts & Community: Caring for Children and Families Conference featuring David Altschuler, Ph.D. Friday, October 24, 2008, 8:30-4:30, Smullin Center Auditorium, Rogue Valley Medical Center, 2825 E. Barnett Rd., Medford. Dr. David Altschuler is Principal Research Scientist at The Johns Hopkins Institute for Policy Studies. His work focuses on juvenile crime, justice system sanctioning, offender re-entry, and drug involvement among youth. Dr. Altschuler's presentation will be geared to professionals and community partners working with at-risk youth and families struggling with the juvenile justice system, addiction and significant mental health problems. For registration information, contact mendensj@jacksoncounty.org.

200 hour Professional Hypnotherapy Certification Course begins September 28. $2250 up to 30 days in advance. Nationally certified training. Ashland School of Hypnotherapy. Please contact us for further information at www.ashlandschoolofhypnotherapy.com 541-488-3180

The Southern Oregon Association of Psychologists will host an open workshop, ***Psychological Approaches in the Treatment of Chronic Pain*** on Saturday October 18th from 9 am - 4 pm @ Southern Oregon University (Ed/Psychology building). Learn to identify issues that contribute to pain such as personality factors, depression, anxiety, adjustment, P.T.S.D., and grief issues. Teri Strong, Ph.D. will present the physiology of pain mechanism and provide case presentations. Treatment protocols including psychotherapy, medication, and behavioral intervention will be explored. The workshop meets the new OR legislature's requirements for psychologists. Teri L. Strong, Ph.D., is the Director of Behavior Health and Wellness Programs at Cascade Health Solutions in Eugene, Oregon. A flyer and registration form can be obtained at agalia@mind.net or by leaving a message at 488-5684. *MHREN members are welcome to attend!*

Time Management from the Inside Out:

Do you have too much to do and not enough time to get it done?
Allan Weisbard L.C.S.W. will present methods for: Living a life of passion and joy, Letting Go of Perfectionism, Overcoming Procrastination, Learning to Say Yes By Saying No, Increasing Spontaneity and Creativity, Having more fun!
Monday, October 13, 7pm at the Ashland Food Cooperative Community Classroom, 195 A St. Ashland.
Allan Weisbard, L.C.S.W. has a counseling practice specializing in stress reduction located in Ashland

Announcements:

News for Licensed Clinical Social Workers: There are new CEU requirements:

The number of hours creditable in a two-year reporting period is subject to the following provisions:
(1) A licensee **must report a total of six or more hours of continuing education in ethics.**
(a) In the first biennial report required by OAR 877-025-0021 for a two-year period that ends after January 1, 2009; and
(b) In each alternate biennial report due thereafter.
(MHREN is planning a Law and Ethics workshop in 2009. We will investigate whether it will be accepted by the board)

An announcement from Ruth Codier Resch, Ph.D.

I am pleased to announce opening a practice in Ashland aiding people with in-depth work in life transitions and I specialize in catastrophic illness as well as stroke and aphasia.

I am an experienced clinician and an aphasic twenty-eight years from my stroke. From these two perspectives, I have a profound understanding of the emotional, social issues facing aphasia, stroke survivors and their families. My intent in therapy is to assist people in seeing and using the challenges of stroke and illness to live a graceful and rich life. Please contact me: 541-482-9280 or escudier@jeffnet.org and visit me at www.ruthresch.com

Office Space: Part-time basis. Negotiable, reasonable rates. Two offices, each approximately 145 square feet. Located in quiet Medford business community. Contact: Eric Morrell, Ph.D. 770-2469 or ericmorr@juno.com

Clinical Supervision: I would like to use the newsletter to inform the valley that I am available for clinical supervision for those seeking LPC or LMFT licensure. I have over 12 years experience and am AAMFT - Approved Supervisor. Both individual and group supervision is available. Contact James Brown at 541-499-7163.

Groups:

Not Straight Not Sure Youth Group will sponsor an LBGT film series between October 3rd-24th along with Scholars-in-Residence and Panel Discussions. Topics covered will include LBGT History, Youth, Religion, and Transgender topics. For specific information, email notstraightnotsure@hotmail.com or call 1 800 466 7005 x 3. The project is made possible in part by a grant from the Oregon Council for the Humanities, a statewide nonprofit organization and an independent affiliate of the National Endowment for the Humanities, which funds OCH's grant programs.

Do your clients need more social support? I'm offering consultation in the creation and deepening of small (4-8 people) support groups using Nourishing the Heart, a process I designed based on the Hakomi method. I start the group with one 2 hour consultation and a workbook and serve as an ongoing resource to get the group up and running. Send me your clients and I will get them into one of these groups. Nando Raynolds, MA, LPC, 821-6623, www.nando-r.com

Mixed Gender Process Groups – A here and now group process for personal growth in which members are brought together for the purpose of intimacy building and relieving cognitive and emotional conflicts, such as: guilt, shame, anxiety, depression and suppressed personal expression. We address reduction of personality dysfunctions while strengthening personality assets, and by changing patterns that limit growth by exploring maladaptive defenses and other self-defeating behaviors.

The groups are closed groups and run from July to December and January to June. These groups will be open to new members in January of 2009. If interested in joining or referring someone I recommend that you place your name on the waiting list on or before the 1st week in December of 2008.

Evening groups are held on: The 2nd & 4th Mondays and the 2nd & 4th Wednesdays monthly from 6:30 to 8:30 pm. Contact: Cynthia Becker White at The Counseling & Mediation Center (541) 776-9166 or Email: cbeckerwhite@charter.net

Important Notice: **We have recently had to turn away late registrants due to reaching the legal (fire marshal) capacity of the workshop venue. Please help us avoid this dilemma by registering early. If your agency is paying for you, it is your responsibility to confirm with your office that we have received payment prior to the event. We don't send out confirmation notices. Feel free to check in with us to see if your agency has indeed followed through with payment. If we haven't received payment before the day of the training, you will need to pay for the workshop and then be reimbursed by your agency.**

MHREN Membership Renewal

Professional membership dues for 2009 remain at $50 per person or $100 for organizations. Dues are based on the calendar year so, if you haven't already joined or rejoined, please support our efforts to bring you the high quality, diverse trainings and networking services we have been able to provide for 18 years. Memberships paid for after September 1st will be honored through 2009. Thanks to all our members. Fill out the form on page 9.

New MHREN members since March, 2008

(In the last newsletter we printed the names of MHREN members up to that point. These are new members. Thanks and welcome!)

Cynthia Becker-White
Sharon Bolles
Scott Bandoroff
Elizabeth Cravens
Mary Danca
Lorna Forbes
Jocelyn Gates
Dana Giffen
Elaine Hamlin
Douglas Huston
Richard Jensen
Shirley Johnson
Cathleen Katz
Jeanette Larson
Will Nuessle
Jacquelyn Pyeatt
Marcia Rodine
Kia Sanford
Diane Werich

Sexual Diversity—It's More Than GLBT
Marty Klein, Ph.D., MFT

Our profession has come a long way since the time when homosexuality was considered a mental disorder. So far, in fact, that our code of ethics specifically requires that we deal with gays and lesbians in the same way that we deal with their heterosexual cousins. This extends to all issues, from parenting to power struggles, fear of death, and sex.

So MFTs have a pretty good record on sexual diversity these days, right? Well, as long as we simply mean sexual orientation, that's true. But if "diversity" refers to the whole range of sexual interests, desires, and experiences of our client population, there is more to be done. Way more.

When it comes to sexuality, as in the rest of our practice, we may be called upon to support patients in behavior that can be healthy for them, while lying outside of our own expertise or approval. Doing so may require us to get more information; it certainly requires that we find ways to suspend our discomfort, disapproval, or—dare we admit it—prejudices.
Here then are some areas in which we need to be sensitive to and supportive of sexual diversity. Although this is just a handful of the many sexual issues we might want to notice, it's a good starting point, because these represent such a large percentage of everyone's practice.

Inevitably, by the way, any generalization about "therapists" will have its limits. As the commercials say, your mileage may vary. So don't discount the entire discussion that follows if one of its assertions about what "therapists" do or believe doesn't seem completely accurate or true for you.

Non-monogamy

MFTs are in the relationship business. These days, we know that relationships come in all shapes and sizes, such as blended families, gay couples, nursing home romances, and "friends with benefits."

One area in which some of us are not entirely up-to-date or comfortable is in the arena of monogamy (sexual exclusivity) and non-monogamy.

I'm not talking about "affairs"—clandestine arrangements in which one partner is breaking her/his contract of exclusivity by having sex with someone else. Although some situations are ethically complex or ambiguous, most therapists agree that breaking an important promise is generally a bad idea. (Interestingly, in a huge number of long-term couples at least one partner does break their vow of monogamy; our profession could be a lot more curious about this.)

Rather, I'm talking about consensual non-monogamy, which itself comes in a variety of forms.

There's "don't ask, don't tell," in which each partner does what they want sexually (typically while out of town), with the understanding that they will shield their partner from any knowledge of what goes on. This sometime develops in relationships in which one partner travels a lot, or when people want to stay together but can't find common sexual interests.

There's the "friend of the family," an individual who has sex with one member of the couple and is known to the other—in fact, is considered part of the couple's inner circle. Obviously, people have to deal with issues like jealousy and time allocation. This works best when the couple's relationship is strong, and all three people have a good sense of self. This is a common arrangement among military couples, gay male couples, and relationships in which one person is disabled.

Some couples participate in "the lifestyle," also called "swinging." They go to parties at other swinging couples' homes, perhaps make it a point to meet new sexual friends on vacation, maybe belong to one of the hundreds of swingers clubs across the country. Swingers typically have good sex with their mate, and obviously have worked out certain issues regarding jealousy. Swingers (there are several million in the U.S.) tend to be over 35, college educated, and include all body types, from absolutely ordinary- looking to seriously buff. Regardless of venue or style, when we hear about couples who have chosen non-monogamy, what do we think? Too often we make assumptions about commitment (they aren't good at it), intimacy (afraid of it), or even a diagnosis (narcissistic, low self-esteem, in denial, unwilling to grow up, etc.).

We often do the same thing when we see a non-committed couple in which one person is ready to settle down and the other isn't. Whether the people are 25, 45, or 65, don't we tend to pathologize the one who doesn't want to settle down? Don't we assume that the ultimate goal of all romantic relationships is sexual exclusivity?

Why do we do so? It's not like monogamy has such a good track record here in the United States. In most long-term sexually exclusive relationships, both the frequency and quality of sex decline dramatically over time. We may tell ourselves that this is inevitable, but almost nobody wants this outcome. Certainly, few people begin a marriage saying, "of course, the sex will decline over time, but we don't care."

So there's no reason to assume that long-term sexual exclusivity is in any way superior to another arrangement. I'm not aware of

any data that shows that people who live non-monogamously are any less grown up than people who live monogamously. Our profession's belief that monogamy is the gold standard of sexual relationships is simply a value that we have absorbed from the culture around us.

Alternative sexual expression

For most of modern Western history, being sexually "normal" has been considered very important. "Abnormal" sexuality has even been criminalized. For example, not only has "sodomy" been illegal in many countries, it was defined as any sexual activity other than penis-vagina intercourse—including oral sex. This was true in the U.S. until just five years ago.

Fortunately, most therapists now accept the "normality" of a wide range of sexual activity—oral sex, anal sex, hand jobs, playful games, and a toy or two, such as a vibrator or blindfold.

On the other hand, many therapists are still reinforcing the ideal of "normal sex," as if there is some objective standard, free of cultural influences. If you travel enough outside the U.S., or if you know a little about history or anthropology, the idea of "normal sex" quickly seems foolish or at least ill-advised.

Our ideas, for example, that pathologize group masturbation or child-child or adult-teen sex appear quite naïve in much of Europe; our acceptance of cunnilingus, on the other hand, appears quite disgusting in much of the Middle East. And our determination to shield children from seeing nude bodies or hearing adults make love would be considered bizarre in 18th century America and Europe.

Of course, you don't have to leave home (or this century) to realize you're surrounded by an enormous range of sexual behavior right in your own community. Whether you know it or not, here are some of the sexual practices in which your patients variously indulge:
Premarital sex, extramarital sex, pornography, romance novels, internet sexuality, B/D-S/M, non-monogamy, playing out fantasies, piercings of genitalia or nipples, anal sex, blood play, electrical play, commercial sex, adult entertainment, sex toys, sex games, sex clubs, erotic asphyxiation, cross-dressing, voyeurism, exhibitionism, bisexual play, risk-taking, threesomes, fetishes or paraphilias, "friends with benefits", and anonymous sex.

No MFT is expected to be an expert on all forms of sexual expression. Sex is like work, parenting, and religion: we aren't expected to know the details of all occupations, every parenting philosophy, or all religious beliefs. We are, however, expected to be able to learn about a patient's experience and understand his/her perspectives on it. Most of us would agree that it's poor clinical practice to assume that being a Baptist is "wrong," or that a patient who is a forest ranger is wasting her time. We need a similar non-pathology approach to our patients' sexual practices.

S/M (sadomasochism)

A term that's far more descriptive than "S/M" is "erotic powerplay," the conscious playing with power dynamics in erotic relationships. Millions upon millions of Americans engage in various forms of this. Many don't even have a special name for it; they call it "fun and games" or "making love." For every person who visits a dungeon on Saturday night, there are thousands who play the "hey, don't go thinking you're gonna get some of this sugar tonight! (wink, wink)" In many couples, that's code for 'let's play the spanking game,' or 'mm, I'd love to have my hair pulled during sex exactly the right amount.'

The popular stereotype of S/M is that it involves a lot of heavy equipment and physical pain. Uninformed non-participants don't realize that S/M is far more psychological than physical, and that it isn't usually a grim business in some dark basement (although, say, having your nipples or butt seriously squeezed when you're already excited can be highly arousing).

Keep in mind that eroticism, being rooted in primary process, is a set of primitive urges. Healthy eroticism includes both the desire to dominate and the desire to submit. S/M games can be a healthy way to explore and express those desires.

If S/M is primarily psychological, what's it all about? Participants typically say it's about trust, connection, sharing, and intimacy. Studies show (and the connoisseur literature encourages and illustrates this) that S/M players have a higher-than-average level of communication about sex, boundaries, pleasure, and their bodies. The expectation of communication and mutual education is something that non-S/Mers could really benefit from.

"Bottoms" say they enjoy, among other things:
* knowing their limits will be respected;
*the thrill of pushing themselves knowing that someone is caring for their safety and comfort;
* relinquishing control and responsibility within a safe space; and
* having the chance to explore the pleasures of submission.

"Tops" talk about:
* the pleasure of taking care of someone having an intense experience;
* feeling grateful to have someone's trust and body in their hands; and
* the meditation of following a bottom's breathing and subtle movements.

Some therapists assume that people involved in S/M must be reenacting childhood abuse or exploitation. There is simply no

meaningful data to support this. On the contrary, the studies that have been done on non-clinical populations show that S/M participants are no more likely to have been sexually exploited than non-S/M participants. The fact that so many clinicians continue to assume this link ("why else would anyone want to be spanked?") is a sad commentary on our profession's instinctive pathologizing of non-normative sexual expression.

Of course there are unhealthy people doing unhealthy things with S/M. Of course, the same is true with even the most "vanilla" kind of sex.

And by the way, more men want to be "bottoms" than women. The stereotype that S/M is mostly men whipping women is simply inaccurate. Interesting.

*** Pornography**

Fifty million Americans look at pornography each month. That's almost a quarter of the adult population.

This is no marginal or accidental diversion for a few lonely or angry people. Involving some $10 billion annually, Americans spent more money on pornography last year than on all the tickets for professional football, basketball, and baseball combined. Porn is mainstream entertainment.

There's no lack of mythology or feelings about pornography. It's impossible to pick up a magazine or turn on Fox News without hearing about some sex fiend busted with porn on his computer. And it's apparently impossible for a wide range of "decency" leaders to talk about American culture or behavior without telling some outlandish lie about porn leading to divorce, crime, and suicide.

Perhaps worst of all, politicians and the media are allowed to use the expression "porn and child porn" as if it had any meaning at all—when in real life, the two have virtually nothing in common. One is legal, the other isn't. Audiences for the two simply do not overlap.

When dealing with patients involved with porn (either their own viewing or their mates'), therapists need to decide if they want to operate from mythology and emotion (judgment, fear, resentment). Alternately, therapists can work from the same place of helpfulness, compassion, open-mindedness, and curiosity from which they handle other content areas all week long. This requires the therapist to know some facts and to adopt a position of neutrality.

Therapists don't always do a sufficient job of understanding porn use from the porn user's perspective. It's often relevant to inquire about the content: is it cooperative or violent (portrayals of consensual S/M are the first, not the second)? Are the actors smiling, do the characters seem glad to be there, are they responding to each other? Too many therapists assume that if something is "porn," it's either violent or ugly.

Further, why does any given patient (or patient's partner) watch porn? If you talk to people who enjoy pornography, they rarely say "I watch it in order to disrespect women, undermine my relationship, lower my self-esteem, and motivate myself to commit crime."

Rather, most viewers appreciate the portrayal of abundance. In porn there's always enough erections, enough breasts, enough time, enough competence, enough desire. When we recall how popular movies about rich people were during the Depression, the appeal of porn's depiction of erotic abundance should be easy to understand.

For better or worse, some porn consumers also enjoy having sexual experiences without feeling performance anxiety or the weight of a partner's expectations. For those in troubled relationships, a sexual experience without rancor, anxiety, history, or disappointment is not only a pleasure, it's a relief.

A certain amount of people's discomfort about pornography is discomfort about masturbation. Let's face it: most porn is consumed as prelude to, or part of, masturbation. Is that OK?

We see lots of people or couples in which one partner is satisfied with masturbation and the other feels sexually deprived. Putting aside the issue of porn—is masturbation an acceptable activity if one's partner feels sexually deprived? Therapists vary widely on this issue. Therapists have heard plenty from the partners who feel deprived; we would benefit from hearing more about this (including, though not limited to, the guilt and shame) from the partners who masturbate rather than have sex with their mates.

I cannot resist the temptation to take a clinical detour here for one moment. Many therapists approach the situation described above by discouraging the so-called "low desire" partner from masturbating. They assume (or hope) that removing this source of gratification will encourage desire for a partner. This clinical strategy hardly ever works. That's because whatever reasons someone has withdrawn from their partner in favor of pornography are not resolved by simply forgoing masturbation. For these patients, desire for partner sex and for masturbation is simply not fungible.

Are you able to treat a patient's porn use as neutral—like bowling? If a patient bowls every night and leaves her partner alone, we know the problem isn't bowling—it's the willingness to abandon a partner. The same is true with pornography: if a patient is pursuing porn while neglecting his relationship, we want to know why.

But just as no one would undermine a wonderfully intimate relationship just to go bowling, no one would leave a satisfying sexual relationship just to look at pictures or stories. So rather than blaming the porn, we need to inquire about the relationship and personality dynamics involved. If the therapist has reflexive criticism or judgments about porn, this more sophisticated investigation becomes more difficult or even impossible.

Finally, every therapist needs a healthy model of porn use. All 50,000,000 American consumers can't be emotionally limited or hostile to women (although of course some surely are). But just as we need a healthy model of civic involvement, sports participation, and parenting (all of which can be used in unhealthy ways), we need a healthy model of porn use. Without it, we are either condemning a percentage of our patients out of hand, or we're making things up as we go along—which makes us more vulnerable to counter-transference, and invites treatment failure.

So what's the point?

As therapists, how do we know what we "know"? When it comes to our clinical work around sexuality, most of us have two sources: personal experience, and cultural products like Oprah, USA Today, and Newsweek. These are the same sources of information that our patients rely on. Since our culture is essentially sex-negative, we can expect that what we "learn" from the media about sexuality will be normatively-based and pathology-oriented as well. And when our information about anything comes from the same source as our patients', it's much harder for us to notice when their "knowledge" or our "knowledge" is just a bunch of assumptions.

Information, of course, is very important in dealing with subcultures or individuals with which we have little or no personal experience. But accurate information isn't enough; we have to be genuinely accepting and curious, even while adhering to our own insights about what constitutes emotional health, growth, and satisfaction.

And even that still isn't enough. We need to feel confident that our standards of emotional health are really about our clients, and not about ourselves. When sexuality is involved, virtually all of us have had experiences of disappointment, shame, betrayal, coercion, passion, confusion, and crisis. Some of us are going through those very experiences in sexual situations today.

All professional therapists are committed to handling our own feelings, needs, and histories in ways that don't limit our ability to help our patients. We are all committed to the principle of supporting patients when they make conscious decisions using reasonable criteria to accomplish sensible goals. The actual configurations of this in one or another patient may look dramatically different from what we might choose. It is our responsibility to approach patients' sexuality with an encouraging, life-affirming attitude—no matter how much work that requires from us.

Former Supreme Court Justice Sandra Day O'Connor recently discussed her marriage in the New York Times. Her long-beloved husband now lives with Alzheimer's Disease in a facility. He rarely remembers her, and he has become involved with another woman--with O'Connor's blessing. That's love. That's devotion.

It's not monogamy, although it is fidelity. Can we accept this as a healthy arrangement for these people? If we didn't know O'Connor, would that make it more difficult? In what ways does our field need to grow in order to keep up with our patients' complex sexuality?

Dr. Marty Klein will present his MHREN workshop on September 19, 2008. See flier enclosed

Was My Mother Schizophrenic? A Search for Truth – A Transformation

by **Renée Côté** (with Afterwords by Susan Wrona and Ruth Miller, PhD.)

A book review by Jane Mara, LCSW

In *Was My Mother Schizophrenic?*, Renée Côté, a retired therapist who worked in the mental health field for many years and now lives in Sunny Valley, OR, writes an astonishing, riveting, and revelatory account of the heart-breaking story of her mother's life and her courageous search to recover it. This quest becomes Renée's heart-mending, which is aided by her mindfulness practice and her spiritual teacher, Ruth Denison, and by Family Constellation Work with Susan Wrona, a therapist in Medford.

Renée, born in 1937, was the youngest of nine children birthed in ten and a half years to Catholic parents in Québec, Canada during the Great Depression. In 1943, when Renée was six, her mother, Armande (as she is called in the book, not her mother's real name) was finally committed by doctors and her father to a psychiatric public ward, after a few short stays in a sanatorium and a private psychiatric clinic. She virtually vanished from Renée's life for she was hardly mentioned in the family afterwards. Armande was thirty nine when she was committed and was not released until 1970, when she was nearly sixty-six and Renée was a grown woman of thirty-three.

During those three decades Renée saw her mother only three times. When she was thirteen, her father unexpectedly took her and some siblings to visit without disclosing their destination until they were well on the way, and in her early twenties she visited her mother twice on her own.

All her life Renée has been obsessed with two questions, "Who was my mother?" and "Why was she put away?" Finally, at fifty-nine, she began twelve years of dedicated research, unearthing and bravely following all possible clues (in spite of active discouragement from her siblings).

Who her mother was remains elusive, for only one small black notebook and a few sentences scribbled on the back of one photograph remain. What is left of her writing, especially these words: *Women are not born to submit* and *Let them choose other families to make their men* reveal a woman forced into a life she didn't want - a life that eventually destroyed her mental and physical health. Nine children in ten and a half years! And, three years later, twins who died the same day. Armande was isolated from her parents and siblings, had to move the substantial household many times, and did not get the help she needed —certainly not from her patriarchal professional husband and only occasionally from her sisters. Armande was also dealing with compounded grief as she lost two of her sisters, a favorite brother, a 4 year-old son in addition to the twins and her father during these years. AND the family was brought to severe poverty by the depression. Can you imagine?

I can. In 1974, at thirty-two, I was in a typical heterosexual marriage with only one child, still a toddler. I was profoundly unsatisfied and unhappy as I attempted to be the wife and mother I had been trained to be. I first encountered hope of another possibility in a feminist therapy group that was part of my training as a feminist therapist. In the nurturing atmosphere of women full of mutual compassion for our struggles with patriarchal norms and institutions, I was shocked, then terrified, then profoundly relieved to hear words come out of my mouth that revealed what had been hidden under a blanket of shame and guilt: "I hate being a mother! I love Michael but I just hate this being a *mother*!"

I soon learned I was not alone. Phyllis Chesler in *Women and Madness* (1972), Inge Broverman, et al with the sexist-myth shattering study on "Sex Role Stereotyping and Clinical Judgments of Mental Health Professionals" (1973), Adrianne Rich in *Of Woman Born: Motherhood as Experience and Institution* (1976) and Jean Baker Miller in *Psychoanalysis and Women* (1977) were just some of the feminist writers of the time examining this *role* and its deleterious effects on women's lives and mental health. Deeply saddened by the stories I heard and read, yet glad to know I was in good company, in 1977 I wrote my Master's of Social Work thesis on "Post-Partum Depression and the Maternal Role Stereotype in "Normal" Women". (Please note it was the ROLE of Motherhood prescribed by patriarchy that was in question, not the acts of bearing, birthing and raising children.) I was anything but alone - and neither was Armande, although her tragic circumstances prevented her from knowing or doing anything about it.

So while Renée titles the book, "*Was My Mother Schizophrenic*?" --as the psychiatrists declared, her father accepted and her physician brother still believes today -- the content of this book suggests an alternative: *Was My Mother Used by the Catholic Church and Patriarchy as a Baby Machine?* The tension between these two possibilities provides the foundation of this work. And while viewing women as "baby machines" or believing that having a child is the solution to any woman's misery is no longer the norm in many circles, it has not, as Renée points out, disappeared, even in the mental health world. Indeed, some of the fuel for Renee's persistence in researching and writing this important book is the continuation of such misogynist and ignorant attitudes.

If there is a next edition I would like to learn more about her Family Constellation work, both content and process, as well as her experience with Ruth Denison and spiritual practice. I understand that they were both crucial to her transformation, and as a clinician I would like more of a glimpse into *how*.

Renée has created a distinctive, original form for the book, imaginatively placing documentation, memoir, art, and poetry in abundant white space. The result is a supportive and spacious container for these profoundly sad facts, for Renée's tender vulnerability and the deep joy and satisfaction of her spiritual transformation. *"Was My Mother Schizophrenic*?" is not only a valuable and unique contribution to the literature on women and madness, for clinician and lay person alike, it is also a beautiful work of art. An exceptional book.

(Jane) Mara, LCSW has a counseling practice in Grants Pass and periodically teaches classes in Buddhist Insight (Vipassana) Meditation *and* Mindful Communication *in Grants Pass and Ashland. She can be reached at 541-761-7576.*

To buy *Was My Mother Schizophrenic?* directly from the author ($24.95), or for speaking engagements, please email rcote@terragon.com or call 541-955-4636. The book can also be ordered from WiseWoman Press or from bookstores.

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