Women and Mental Health: A Brief Global Analysis

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Abstract

For the purpose of this essay I set out a context by describing the diverse research areas and opinions that attempt to explain the poor `mental health` of women globally. Paltiel (1993) is then followed, as a structural template to identify some of the risk factors and social causes. These include the inequitable gendered division of labour and family responsibility, women's devalued social status, the impact of poverty and the scope and effects of violence against women. I go on to describe and analyse the way women are perceived and treated through the practice of psychiatry by drawing on a range of feminist writers who argue that psychiatry may be a major risk factor to women's `mental health` because gendered notions of normal female behaviour shapes the construction of mental disorder. I then offer reflections of the psychological impact of gendered socialisation on my own experience as a male. In conclusion, I argue that the evidence suggests that gender, as a social construct, symbolizes and influences significantly the unequal and subjugated position of many women globally.

Context

The World Health Organisation (W.H.O.) estimate that 450 million people globally are affected by` mental disorder` with gender being perceived as the critical determinant and strongest correlate of risk for different categorised types (W.H.O., 2001, National institute of Mental Health, 2000). The bio-medical evidence across nations, cultures and ethnicities suggests that women are 1.5 to 3 times more likely than men to develop depressive and anxiety disorders (Ustun, 2000).

Current research and opinions seeking to explain epidemiological gender differences of `mental disorder` focus on genetic, biological, psychological, psychoanalytic, social, cultural and environmental risk factors with aetiology attributed to interactive or individual variables (Kendler, 1998, Ustun, 2000, Klages, 2000, W.H.O., 2001 Willenz, 2002)

Some writers claim that despite three decades of research on gender identities and a wide range of risk factors, none can fully explain or single handedly account for gender differences in `mental disorder` (Nolen-Hokesma, 2001, Segal, 2001). A fundamental conflict between different ideological positions appears to emerge depending on the epistemological assumptions used to explain poor `mental health` (Russel, 1995). According to Ustun (2000) "Much remains to be understood regarding the incidence of depressive disorders in women and men"(p7).

In contrast, Prior (1999) states it is now accepted that explanations must be located within the social milieu, she cites Weisman (1991) "epidemiological difference is not reducible to biological factors or methodological artefact but

can be traced instead to extrinsic features of the social milieu and inequities with respect to cultural domains of power and interest"(p279). A range of feminist writers also argue that the poor `mental health` of women can be explained by the socially constructed nature of gender with women being seriously disadvantaged and oppressed through inequities in the distribution of power in all areas of living (Chesler, 1972, Faludi, 1991, Lee, 1998).

In addition, the nature and validity of the concepts, `mental health`, `mental illness` and `mental disorder` are also controversial and subject to sustained and growing criticism for being empiricist, reductionist and inadequate in explaining the lived experiences of women and men (Prior, 1999, Linnett, 2001, Cooke, 2002).

To proceed, I will follow Paltiel (1993) who suggests that the key risk factors for women globally are simply and disturbingly "everywhere women are overworked, over-looked and undervalued, and that poverty, discrimination, violence and powerlessness are pervasive features of women's lives" (p197). According to Dworkin (1988) it is the inequitable realities and oppression of women's experiences that constitutes "the real shit…of women's lives all over the planet" (p133).

Overworked: Women's Assigned Roles

Across all socio-economic levels the multiple roles that women perform throughout all societies places them at greater risk of developing diagnosable mental disorders (WHO, 2001). Specifically, many women globally face multiple and chronic burdens associated with their low social status and assigned roles, their life circumstances usually feature an around the clock taken for granted care function involving the responsibilities of being wives, mothers, carers and cleaners for others (Paltiel, 1993). According to Miles (1988) it is the unending nature of these demanding tasks that can lead to poor `mental health`.

Women are increasingly being expected to sandwich family responsibilities with difficult long hours of labour, in "one-quarter to one-third of households they are the prime source of income" (WHO, 2001, p41).

A recent study in Africa (Afrol.com, 2001) found that women performed all the domestic tasks and worked three hours longer than men. Jacobson (1993) presented evidence that women not only work longer hours than men in the majority of countries but for less money and without a reduction of duties at home.

Nolen-Hoeksema et al (1999) recently measured chronic strain in developing countries by grouping inequities in workload, power difference in decision-making and heterosexual relationships into a single variable and claimed this predicted increases in depression over time. Consistent findings of unequal gendered disparity in the division of labour and family responsibility globally prompted Paltiel (1993) to state, "Women were sick and tired of being sick and tired" (p197).

According to Lee (1998) who reviewed the evidence of cross cultural studies, allocation of work loads stems from ideological and cultural assumptions around gender-appropriate responsibilities and the greatest disparity occurs in countries where there is a "rigid division of labour along gendered lines"(p106).

Overlooked and Undervalued

A number of feminist writers have highlighted that women are comprehensively devalued through gender inequality and social norms. For example, Eichenbaum and Orbach (1985) pin this down to a socially constructed and obligatory deferment to others "she must always be connected to others and shape her life in accordance with a mans…this often leads to a lack of confidence and…isolation"(p8).

The other side of the deferment coin can arguably be found in a recent book called `powerful women`, Lee (1998) describes the construct as the stereotypical women as object myth. The book states, "Being young, female, intelligent and pretty gives her the ingredients to defy conventional routes to business success" (Parkhouse, 2001, p1). These attributions focused on a woman entrepreneur who co-founded a company worth £750 million. The male chief executive stated that he is happy to let her be the public face because "The brand has a sexy image and she is prettier than me" (p12).

However, regarding women's rights to safe sexuality and autonomy in decisions relating to their reproductive health, this "is respected almost nowhere" (afrol.com, 2002, p1). In many developing countries social, educational and political disadvantages have been claimed to combine and create the view that a young women's role is " to bear many children, preferably sons" (Jacobson, 1993, p20). According to Paltiel (1993) A lack of access to reproductive health information and contraception is a major concern and the exact mental health consequences of repeated premature pregnancies remain largely unexamined.

Globally, women's rights and social status are also reported as being "systematically undervalued…almost any measure will reveal it" (United Nations Population Fund, 2000, p1). Current data sets such as the gender equality index (GEI) include and reveal struggles for women along the following indicators, autonomy of the body, autonomy within the household, political power, social and material resources, employment and income and time to sleep (Wieringa, 1999).

Consistent evidence from global studies supports the view that women are also particularly disadvantaged in terms of education and income (Lee, 1998). According to Blue et al (1995) cited in the W.H.O. (2000) fact sheet, women living with low socio-economic status and associated income are much more likely to develop `mental disorders` and the combined impact of gender and social causes were found to be critical determinants of women's `mental health`.

There is a recognition of the importance of social causes in the development of `mental disorders` (WHO, 2000). However, women's `mental health` issues are claimed as still being marginalized because of dominant acontextual ideologies. Davar (2001) highlights this issue " Questioning the politics of inequity and the social causes of psychological suffering, and advocating collective change are held to be incompatible with scientific goals of individual change" (p90).

Poverty

The World Heath Organisation (2000) has stated that it is essential to recognise that "socio-cultural, economic, legal, infrastructural and environmental factors affect women's mental health"(p2). Going a step further, the evidence also points to socio-economic factors as a cause of mental distress rather than individual vulnerability (Busfield, 1996, Grove, 1999).

Currently women account for 70% of those living in absolute poverty and generally people suffering from `mental disorders` are economically poor and face more severe life events (United Nations Development programme, 1997, Ramon, 1996). The W.H.O. (2001) highlight that priorities in terms of services are directly linked to government budgets and that the treatment gap in poor populations is "indeed massive" (p14).

Kennet (2001) analysed the global economic expansion of capitalist markets and the polarisation of economic wealth. She cites evidence from the United Nations Development Programme (1999) to highlight the economic spread, " The assets of the three top billionaires are more than the combined gross national product of all 43 least developed countries and their 600 million people" (p10). The knock on effects of this economic polarisation and decline in per-capita income globally has "brought into sharp relief the social, economic and political dimensions of women's health" (Jacobson, 1993, p6).

This increasing lack of global public resource and equality, combined with reductions in food subsidies mean that many women are forced into a dangerous balancing act in trying to support their families and end up "working harder, eating less…[and] are increasingly susceptible to falling ill" (Jacobson, 1993, p8).

Gender and Psychiatry: A Form of Discrimination?

A number of writers have claimed that the way women's experiences have been medicalised and treated constitutes a major risk factor to their `mental health` (Barnes and Maple, 1992, Russell, 1995). Women are more likely than men to be prescribed electro-convulsive therapy and psychotropic medication even where the evidence suggests that the main conditions they are diagnosed with (depression/anxiety) have strong social origins (Busfield, 1996).

Recently Bracken (2002) describes the dominant treatments for depression " As a doctor I was expected to do something with the patients brain with drugs or ECT…if the first drug used did not work I should try another, and sooner or later use ECT…if the first course of ECT did not work, I was expected to use another, and if necessary another. Now, twenty years later little has changed"(p7).

Cooke (2002) reviewed the growing archive of service user literature in the UK and highlighted further problems associated with the use of the concept `mental illness`. Her review included an examination of the psychological affects of being labelled `mentally ill`. Findings suggested that labelling can lead to a "sense of hopelessness and decreased confidence, a stigmatised social role, a decreased sense of ownership and agency and denial of the meaning and positive aspects of experiences"(p1).

Consequently, an understanding of how and why gender bias may influence the construction of `mental disorder` is seen as crucial. Busfield (1996) cites

Ehrenreich and English (1979) to highlight the progress of the evolving feminist critique

" The general theory which guided doctors…was that women were, by nature, weak, dependent and diseased" (p92).

Many feminist writers have also consistently argued that gender is strongly embedded in the construction and categorisation of `mental disorder`. For example, Showalter (1987, p4) claims

"While the name of the symbolic female disorder may change from one historical period to the next, the gender asymmetry of the representational tradition remains constant". Prior (1999) argued, again, that this happens because of gendered notions of what constitutes normal female behaviour and that the aspects of women's lives that need social change, instead, become individually medicalised.

In Busfields (1996) sociological approach there is an attempt to move on from the discourse centred on gendered care and control to an appraisal of psychiatric regulation in terms of the values at stake and " their relation to the individuals interests and power"(p234). This author examined the global epidemiological data and concluded that when disaggregated a complex gendered landscape appears "in which some diagnoses are linked to women and some to men"(p30).Davar (2001) recently pointed out that in the process of deconstructing psychiatric diagnosis, layers of sameness and difference emerge depending on the range of epistemologies used to understand `mental disorder`.

However, in contrast, to scientific realists who believe that `mental disorder` is identifiable and treatable through psychiatric diagnostic paradigms, some feminist's doubt whether a scientific discourse can adequately represent women's psychosocial experiences of mental distress and merely adds to their oppression (Chesler, 1972, Russell, 1995).

Violence: Scope and Affects

Violence against women, as an extreme form of gender based inequality, has been described as themost pervasive but least recognised human rights abuse globally and causes very negative and extensive `mental health` consequences (Heise, 1993, W.H.O., 2001).

The W.H.O. (2001) Department of injuries and violence prevention unit (V.I.P.) reports that measuring the true prevalence of violence across international communities is a complex task because of under reporting by victims due to fear of reprisal or shame and the lack of consistent survey methods. The scope of violence (more than 20% in most countries) inflicted on women and female children includes, " Battering, sexual abuse, marital rape, dowry related violence, female genital mutilation, forced prostitution and physical, sexual and psychological violence"(W.H.O., 2001, p3).

The most endemic form of violence against women in developed or developing countries is domestic violence, global prevalence ranges from 16%-50% (W.H.O., 1997). For example, "Men may kick, bite, slap, punch…burn, stab or shoot…rape them with body parts or sharp objects…or throw acid in their faces… the nature of violence has prompted comparisons to torture" (W.H.O., 2001, V.I.P., p3).

Numerous studies have found that domestic violence places women at a greater risk of developing a variety of `mental disorders` (Heise, 1993, W.H.O., 2000). Specifically, comparative studies in Australia, Nicaragua, Pakistan and the US have found that battered women were six times more likely to develop depression, anxiety and phobias with physical abuse being identified as the key risk factor (Roberts et al, 1998).

Sexual assault against females in childhood or adulthood has also been identified as the most likely trauma event resulting in post traumatic stress disorder (P.T.S.D.), studies in France, New Zealand and the US revealed that between 50%-95% of women raped will develop P.T.S.D. (Darves-Bornoz, 1997).

Researchers globally are increasingly drawing on ecological frameworks to try and understand the risk factors that can combine and interact to increase the likelihood that men may violently abuse women. The Centre for Health and Gender Equity (1999) cite numerous studies that agree on the following risk factors. These include child abuse or witnessing marital violence, male control of family decision making, cultural attitudes that promote the concept of masculinity as being associated with dominance and societies that legitimise male violence.

According to Herman (1992) Psychological trauma, as a major risk factor to mental health, is an affliction of the powerless and occurs " when neither resistance or escape is possible" (p34). This author highlights that although the severity of psychological trauma cannot be measured on simplistic quantifiable dimensions, the identifiable experiences that increase harm include physical violation of the body or injury. Kardiner in (1947), Cited by Herman (1992) describes a possible consequence " The whole apparatus for concerted, co-ordinated and purposeful activity is smashed".

Personal Reflections

As a male and long-term analysand of a senior Philadelphia Association analyst I have worked through deep emotionally internalised patterns of gendered socialisation.

As a boy I was not allowed to feel scared, if I reported bullying I was punished for tale telling and for not physically fighting back. If I cried or broke down I was a `sissy` not `a man`. My father was lost at sea when I was nine years old, I was informed by my grandparents and uncles that I was now the `man` of the house, had to be `strong`, `keep my chin up` and look after `the women`- my mother and sister. This conditioned fixing of gender identity and consequent inappropriate responsibility, combined with the forced denial of the experience of grief was impossible for me to cope with. The ensuing and obvious failure caused me great emotional distress and psychological damage.

Now as a male therapist and service development facilitator, my own experiences ground and helpme realise the value and importance of attuning primarily to a persons own frame of reference, respecting and acknowledging fully the lived realities people face in regard to race, gender and social inequality.

Conclusion

Brundtland (2000) the Director General of the W.H.O. has stated "mental health depends on some measure of social justice" (p4). However, the evidence presented here indicates globally that in many aspects of women's lives there exists serious disadvantage and oppression in comparison to men. Gross inequalities in the gendered division of labour and family responsibility, the impact of poverty and the high level of violence women are subjected to are arguably just some of the risk factors that may account for the poor mental health of millions of women.

Gender, as a social construct and fixing of identity appears to influence significantly the symbolic, material and unequal position that women are consistently and forcibly subjugated to in most countries.

The dominant discourse through which `mental disorder` is treated remains within psychiatric paradigms with claims that a strong gendered pattern in the construction and categorisation of `mental disorder`, a "differential regulation" exists (Busfield, 1996, p232). There are also arguments whether a scientific discourse adequately represents the psychosocial experiences of women globally with pure epistemology being called a "fantasised ideal" (Davar, 2001, p20).

Consequently, there are increasing calls for distress and despair to be understood at the lived siteof struggle rather than located as individualised symptoms outside of the wider socio-political context.

Brackens (2002) recent analogy highlights this central issue, in my opinion, perfectly

" Attempting to deal with depression by changing brain chemistry is akin to someone trying to change the storyline of Eastenders by interfering with the wiring of their television set"(p11).

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