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What sort of mental health problems are experienced by women in contemporary British society? What do different feminist perspectives offer as alleviation?

By Penny Halliday¹

Abstract

This essay argues that by labelling British women's mental health distress and treatment in terms of a purely medical model, underlying contributory social structures and phenomena such as gendered roles, ethnicity and poverty, have largely been ignored by the (male dominated) psychiatric profession. This labelling is historically rooted in the pathologisation of the feminine condition; therefore, women's mental ill health is substantially a social construct and a product of a patriarchal society. To fully explore a way through mental health distress - a term used by MIND to emphasise the inorganic origins of many mental health problems - labels need to be unmasked and emphasis placed upon the socio-economic contexts of women's lives. This is not to deny that men suffer from mental health distress; women and men's patterns of mental health problems differ and the reasons for this also require discussion. All strands of feminism can touch upon women's mental health. However, because of the socially constructed nature of mental health distress, particular attention should be paid to socialist and radical feminists' theoretical approaches and how they can offer alleviation through translation into policy formulation and practical action.

Keywords: Mental health, psychiatry, labelling

He always knows best
He can tell why you disliked your father
He can make your purest motive seem aggressive
He always knows best
Male power is the key

(Jennings, 'The Interrogator')

Through examining the types of mental health problems experienced by women in contemporary Britain, this piece will contextualise and put to good use my own experience of mental illness. I do not want to cast women as victims, nor to homogenise womankind. However, like Jane Ussher, I suggest that mental distress² has a universal relevance for all women and that we can learn from listening to others. I also share her profound sentiment that the unmasking of labels does not relieve the suffering many women experience. For them, the 'despair, the anxiety, the desperate misery is far more than a label' (Ussher 7). Nevertheless, it is the labelling of mental health I am interested in, particularly as it is my contention that women's psychological distress is not rooted solely in our biology but largely in the socio-economic context of our lives. I would argue that mental ill health is, substantially, both a social construct and a product of a patriarchal society that has pathologised the feminine condition. I suggest that this explains why women are more at risk of mental illness, to the extent that they are diagnosed with clinical depression at twice the rate of men.³

To explore my argument that contemporary British women's mental health problems are largely caused by social structures and conditions and madness is a social construct, I shall firstly discuss the definitions of madness and mental health problems. The categories of mental health distress that are most closely associated with contemporary British women will then be identified, prior to analysing the medical model of women's mental health distress in the context of a male-dominated psychiatric profession. I suggest that women and men's patterns of mental health problems differ and this is also largely a result of social pressures and labelling. This will be explored next, before a review of the treatment of women's mental ill health from the late twentieth century.

My research draws upon not only my own experience but also the evidence of successful projects that suggest guidelines for future strategies. With regard to perspectives that can offer alleviation, I suggest that women's mental health is something upon which all feminisms touch. However, because my thesis is rooted in socially related theories, socialist and radical feminist perspectives are the most relevant; it is upon these that I shall focus. Particular emphasis will be placed upon the significance of social and economic factors, such as sexual abuse, violence and poverty, to women's mental health distress. I have included literary references, such as the extract from Elizabeth Jennings's poem 'The Interrogator', as I suggest literature can offer the best portrayal of the suffering involved in mental ill health (e.g. Gilman; Frame). However, to fully understand the nature of contemporary female mental health distress, we need to examine the history that underpins it.

In contemporary Britain, the legacy of the Victorian era lingers. At that time, 'Madness became firmly conceptualised as mental illness under the jurisdiction of a rising medical establishment of men and close association between femininity and pathology became firmly established within scientific and popular thinking' (Kohen 41). The medical link between female sexuality and disease is exemplified by the fact that the word hysteria comes from the Greek word for uterus (Ehrenreich and English). In the early nineteenth century, the dominant (male) medical view was that women were more vulnerable to insanity than men because the instability of their reproductive symptoms interfered with their sexual and rational control. The female condition was pathologised: women (or rather middle- and upper-class women) were stereotyped as weak, suggestible, emotionally unbalanced and irrational, unable to cope with even relatively minor stress (Wilkinson and Kitzinger). This hegemonic ideology that women were more unstable than men has had extensive social consequences, becoming a legitimate reason to keep women out of professions, deny them political rights and access to education, and to keep them in the private sphere, under male and state control. No wonder they have gone mad.

Women have also been caught in a double bind regarding their mental health. In *Women and Madness*, Phyllis Chesler identifies that women have been labelled as mentally ill for both conforming to sex roles and for displaying agency by stepping, or trying to step, outside their proscribed role. Elaine Showalter sees this agency as an avant-garde struggle to redefine women's place in the social order. As the century progressed, the advent of Freud's talking cures 'urged the patient to confess her resentments and rebelliousness and then, at last to accept her role as a woman' (Ehrenreich and English 126). Psychoanalysis was based on the premise that women's

hysteria was a mental disorder, or, as feminist historian Carroll Smith-Rosenberg says, 'psychoanalysis is the child of the hysterical woman' (qtd. in Ehrenreich and English 126). Having looked at its ancestry, I shall now analyse the contemporary definitions of women's mental health in Britain.

The Mental Act of 1983, under which 'mentally disordered patients' can be compulsorily detained in hospital, defines a mental disorder as: 'mental illness - no clear definition and is a matter for clinical judgement in each case'.⁴ The *Collins Dictionary of Sociology* defines mental illness as: 'The disease of the mind, which can range from transitory depression and anxiety through to psychoses that might require hospitalisation' (Jary and Jary 379). As Geraldine Smith and Kathy Nairne have discussed, it is interesting that non-sociological definitions of depression include putting down by force, crush, press down and oppress. The concept of depression as oppression will be examined later in this essay but at this stage the discourse surrounding mental health is worth inspection. Is the depression from which women have suffered really an illness or just a natural reaction to life events and oppressive structures measured against male norms of behaviour? To investigate this question I shall list and then explore the manifestations of mental health distress that are particularly identified with women.

Classic mental health problems associated with women include eating disorders and self-harm. The latter can take the form of burning, cutting, ingesting poison and inserting harmful objects. The eating disorder Anorexia Nervosa is characterised by extreme weight loss from dieting, a greatly distorted body image and fear of being overweight. Bulimia is typified by secretive episodes of binge eating followed by self-induced vomiting (Purgold). Women's mental health problems are also characterised by higher rates of attempted suicide and by the diagnosis of borderline personality disorders.

Depression is classically associated with the hormonal and reproductive changes in a woman's life cycle, from premenstrual disorders to the menopause, charmingly labelled as 'involuntal melancholia'.⁵ Depression can be reactive – in other words a reaction to stressful events – or have the label clinical, which is often used to distinguish this condition from low mood. Psychotic and endogenous depression are more severe forms, as is the manic or bi polar diagnosis. Puerperal psychosis was once used to describe all severe medical disorders after childbirth but now postnatal depression is the most prevalent form. Since I do not wish to homogenise women, it is therefore appropriate at this juncture to highlight some of the stratification that applies to women and mental health distress.

As noted by June Wilkinson and Celia Kitzinger, those women most vulnerable to mental illness are mothers and carers, older women, lesbian and bisexual women, sex workers, women in prison, women with learning disabilities, those who misuse alcohol and/or drugs, black and ethnic minority women. Littlewood and Lipsedge (qtd. in Robinson and Richardson) have shown that British-born Afro Caribbean women are 13 times more likely to be admitted to psychiatric hospital with a diagnosis of schizophrenia than white women. Between 40 and 52% of admissions for Caribbean-born women have had the label schizophrenic, compared to 12-14% of admissions for women born in the UK. Littlewood and Lipsedge suggest that these figures reflect the fact that 'the western psychiatric model of schizophrenia pathologises the normal response of Afro Caribbean (and Asian) women' (qtd. in Richardson and Robinson 287). This theory of pathologising

normal reactions could be applied to the British female population as a whole as I shall now discuss.

It is my contention that reactions to social pressures which deviate from societal and cultural norms are regarded as deviant behaviour amongst women and pathologised as mental health problems. This is supported by the work of Thomas Szasz who argued that the concept of madness is a social construct and a means of defining behaviour that society finds unacceptable. Thomas Scheff has also argued that behaviour that contravenes society's rules and results in referral to the medical profession or the police has conveniently been labelled as madness (in Kohen).

It also appears that the medical profession has taken women's mental health distress less seriously than that of men throughout history. As discussed by Wilkinson and Kitzinger, women may be more readily labelled as mentally ill than men are but men's conditions are viewed as more serious and therefore more interesting. General Practitioners (and psychiatrists) tend to 'interpret a woman's symptoms as psychosomatic when they might consider similar symptoms in a man to be physical in origin' (Stainton Rogers and Stainton Rogers 175). Elaine Showalter sums up the situation thus: 'Changes in cultural fashion, psychiatric theory and public policy have not transformed the imbalance of gender and power that have kept madness a female malady' (19).

By the 1890s, women predominated in all types of psychiatric institutions (except those for the criminally insane) and the same pertains today. Certainly, the facts confirm that women are more vulnerable to the diagnosis of mental health problems than men, and that the pattern of women's mental health distress is different, as I shall now show.

In 1986, 29% more females than males were admitted to hospital, for all diagnoses of mental illness (Pilgrim and Rogers). Breaking these statistics down, women were diagnosed with neurotic disorders at a 91% higher rate than men. Weissman and Klerman's 1977 reviews (qtd. in Kohen) showed that more than half the women were twice as likely as men to be diagnosed with depression. (Their studies also showed that women interviewed believed it was normal for a woman to be depressed during the menopause, and as a general consequence of ageing.) This was corroborated by the findings of the 1997 Household Survey of Great Britain. In 2003, women were diagnosed with clinical depression at roughly twice the rate of men, this depression occurring most frequently in women aged 25-44. Girls entering puberty are twice as likely to be prone to depression as boys and depression is the number one cause of disability in women.⁶

Women are more likely to be diagnosed with borderline personality disorders than men and the Mental Health Alliance fear that changes to the Mental Health Act could exacerbate the situation for such women.⁷ This is because part of these proposals extends the remit of doctors to 'section' people with personality disorders, even though these are not deemed treatable. Numbers of women with mental health problems are rising. Government figures show that the number of women who have been compulsorily detained under the 1983 Mental Health Act rose by 19% between 1991 and 2002, from 9,600 to 11,400.⁸ Having outlined the facts associated with contemporary women's mental health problems, I will now turn to look at how these problems have been treated.

Women's mental health disorders have traditionally been seen as needing to be controlled and subdued by the medical profession. Wendy and Rex Stainton Rogers point out that the medical model assumes that women are passive sufferers of an illness that only experts can alleviate, usually with an over-reliance upon psychotropic drugs. By the

mid 1970s, a decade after its introduction to the drugs market, Valium, or Diazepam, had replaced Librium as the most commonly prescribed tranquilizer. By 1974, 59.3 million prescriptions were being dispensed to mainly middle-class women, who were presenting to their GPs with non-threatening depression or anxiety disorders. Literature most aptly describes the effect of this drug:

I start my day the Valium way, at 7:20 am when my departing husband brings me a mug of tea and a Diazepam tablet...I need Valium to numb my rebelling mind into insensibility...I hate taking it but am a dependent, nervous, miserable wreck without it. (Harpwood 123)

Diana Harpwood neatly sums up the addictive qualities of Valium, which had been marketed as precisely the opposite. Harpwood's protagonist cannot function properly with or without it. Though the medical profession have allegedly woken up to the dangers of Valium and the drug of their choice is now Prozac, Valium is still being used by the psychiatric profession. My recent experience of Diazepam confirms its mind-numbing, soporific effect.

The medicalisation of a natural female process can also be seen in the treatment of the menopause. Hormone Replacement Therapy is suggested as a means of 'Escaping symptoms and consequences of a perfectly natural process, bringing it under male control that plays on the fear of ageing' (Wilkinson and Kitinger 153). Even more chilling are the treatments that have been meted out for schizophrenia, which in the 1930-50s was strongly associated with the feminine condition. Insulin shock, electrotherapy and lobotomies were used with more frequency upon women than men, the rationale being that the resulting damage to memory and cognitive ability would have fewer consequences for women's lives (Showalter). Though my experience of hospitalisation was positive, I have experienced a feeling of powerlessness and frustration at my GP's lack of understanding and insistence upon treating my depression with pills rather than a combination of therapies.

Having examined the medical model, I shall now discuss feminist theoretical perspectives which provide a contextual framework. Socialist feminism emphasises poverty, lack of power, work (or lack of it), lack of choices, social exclusion and the exhaustion caused by the 'care burden' placed on women as key factors in women's mental health problems. The link between poverty and depression was highlighted in vanguard research undertaken by Brown and Harris, who discovered in the 1960s that 33% of women surveyed in Camberwell, South London suffered from measurable depression (qtd. in Kohen, 2000). The link between poverty and being female is well established: women do 90% of the world's work but own 1% of the world's wealth. Studies conducted in the UK in 1993 by Popay, Bartley and Owen show that women in all age groups are more likely than men to be living in low-income households (qtd. in Kohen).

Socialist feminists see a direct link between these statistics and the fact that women are diagnosed with clinical depression at twice the rate of men. As regards women's work, research such as that undertaken by Repeti et al. in 1989 (qtd. in Wilkinson and Kitinger) shows that employed women as a group have better mental health than those who are unemployed. However, the stresses of low-paid, low-value

work that characterise women's employment can also cause depression. Lone parenthood and the benefits trap exacerbate women's vulnerability to poverty and thus to depression. Inextricably linked with poverty are poor housing and homelessness, which affect women more than men and bring a host of problems. 'Many of the homeless have mental health problems that would be dramatically improved by dealing with the depressing conditions in which they live' (Stainton Rogers and Stainton Rogers 126). Ideological thinking that women are naturally more caring causes its own set of demands, both for women who feel constrained and for those who question their validity as they do not consider they possess what society says they should. Not only does the main burden of caring fall to women; upsetting life events may have more effect on women as they are more conditioned into caring for others and therefore more influenced by events suffered by others (Kohen).

Radical feminists go one step further in their analysis of women's mental health problems as socially created. The notion of depression as oppression is central to radical feminist thinking. Radical feminists view violence, sexual abuse, sexual harassment, powerlessness, motherhood and compulsory heterosexuality as the key causative factors for women's mental health. There is a strong statistical link between childhood sexual abuse and adult female mental illness. According to the National Women's Mental Health Strategy, over 50% of women who receive psychiatric treatment have been abused and 80% of women in secure hospitals were abused as children (Department of Health). Research recorded by Pilgrim and Rogers (1999) shows that the lifetime prevalence of psychiatric problems in those sexually abused in childhood was 34.2% for those women diagnosed with phobic anxiety, compared to 6.5% for men. For severe depression, the figures were 8% higher for women than men (21.9 as opposed to 13.8%). High-risk disorders associated with child abuse also include borderline personality disorder and psychosis (Whitfield).

Turning to women's relative lack of power, the Freudian concept of penis envy may have some resonance for radical feminists, in the sense of desiring the power that having a penis and therefore being male denotes. Contemporary British women are still expected to be submissive and concerned with their appearance, to be 'hairless, fatless and spotless' (Smith and Nairns 126). As Smith and Nairns comment, 'the paradox is that to be a real women is to wear make up, dye our hair, in other words to make a false image for the male gaze' (126).

With regard to violence, statistics would seem to corroborate radical feminist views. The World Development Report of 1993 estimated that up to 16 mentally healthy years of life are lost to women of reproductive age due to victimisation based on gender, rape, and domestic violence (Kohen). Thus women are doubly oppressed, by also internalising the oppressor, and so doubly likely to be depressed. Elaine Showalter talks of the manmade institution of marriage that has driven women mad and the National Mental Health Alliance show that married women have higher rates of depression than unmarried women.⁹ Phyllis Chesler and Luce Irigaray believe that women are conditioned into the female role, to the extent that their sexuality is determined by male parameters (Chesler). The resulting conflict, they believe, literally drives women mad. Susie Orbach views 'disordered eating' as a result of an oppressive patriarchy that wants women to take up as little space as possible.¹⁰ She also sees disordered eating, or the treatment of disordered eating, becoming an industry in its own right, controlled by men

and reinforcing women's powerlessness through brutal and degrading treatment that denies basic human rights.

Having examined the reasons why feminists believe women are being driven mad, it is now time to see what can be done about it. Though more closely associated with the type of recommendations that a liberal feminist rather than a socialist or radical perspective would offer, I would suggest that a change in the public perception, through education and more positive reporting in the media, would benefit all women. If mental health distress was de-stigmatised, the subject would not be so shrouded in fear and ignorance and those women who currently suffer in silence would no longer continue to do so. I would argue that it is the 'Differences in family and social context of men and women's lives, their experience and the impact of life events that affect the presentation and character of their mental ill health.'¹¹

Socialist feminists recognise that the differences in the family and social context of women's and men's lives need to be addressed by policy makers. A change in the status of women's work, addressing the fact that women earn 83% of men's hourly wages, would lessen women's poverty and improve their life chances. Greater financial power would mean better housing, access to better resources and thus an improvement in physical and mental well-being. However, social policy needs to change so that stronger welfare provision and services are provided and women are not caught in the benefits trap. This is echoed in the recommendations of the Depression Alliance, who believe that 'Working with women whose health has been impaired by factors such as poverty...is welcome but will be rendered meaningless unless government gives a commitment to tackle these issues at source'.¹²

Like socialist feminism, radical feminism also advocates the empowerment of women, the strengthening of laws and the promotion of women's economic independence. However, feminist theory has been criticised for 'Providing long term solutions about changing the structure of society and failing to offer immediate help to women in distress' (Kohen 49). It may be that key elements of radical feminist thinking, such as the empowerment of women, can be incorporated into governmental health policies, at a national and local level, in order to make a direct impact in alleviating women's mental health distress. I would suggest that the best way to empower women who are mental health service users would be to listen to them and to involve them in the planning of new services as described below.

A wonderful example of such empowerment that also addresses radical feminist concerns of sexual abuse is The Ashcroft project in Norfolk (Department of Health). The Ashcroft provides a highly supportive therapeutic unit for women suffering with severe and enduring emotional distress and long-term mental health problems (it is interesting to note the two distinct categories). Positive strategies have been employed by staff to enable people to be creative and better staff support is given in the core issues at the root of crises. Service users have played a key role in planning services, both in terms of consultation and by the fact that one is employed by the project. On a practical front, flats have been built (incorporating design suggestions from residents) and there are opportunities for women to meet twice weekly and attend structured sessions such as education, IT, arts and crafts. Members of the local community are able to attend and service users record that this has been a vital part in helping them to get strong again without recourse to hospital treatment. From a personal perspective, I have benefited

from being part of an ongoing educational project that encouraged adults to consider education and training as part of their way forward. Service users are encouraged to have autonomy; this helped me regain my sense of control and thus feel empowered, both vital steps in recovery. Not only have the residents of the Ashcroft project gained autonomy but they have had a direct effect upon policy making too.

The Ashcroft project should be seen in the context of a consultative paper produced by the Department of Health that aims to mainstream women's mental health issues. In many respects, through encouraging empowerment this paper espouses the central tenets of radical and social feminism. The most encouraging aspect is the fact that the voices of women service users have been listened to. All the women interviewed echoed the need to feel safe, for single-sex wards and for attention to be paid to the underlying causes of their distress and not just the diagnoses. Other recommendations included more understanding of self-harm and not just a punitive approach, access to long-term counselling and for the NHS to respond to the needs of mothers, who are the vast majority of women with mental health problems. The main message is that women want to be treated with dignity and respect by someone who values their potential and can see life after recovery, all of which are central to feminist thinking.

To conclude, this essay has shown that women's and men's mental health problems are different in nature. The link between patriarchal oppression, dependence and resultant lack of power and women's mental health has been shown, together with the long-term effect of violence and sex abuse. Socialist feminists would see policy changes that decrease women's poverty and life chances as an intrinsic part of the way forward in alleviating women's mental health distress. Radical feminists also view economic independence and empowerment as vital to prevention and cure. Some feminists have contested the sweeping nature of these recommendations and in response I have suggested that key elements of both perspectives can be translated into positive action, such as listening to service users and therefore empowering them. As MIND put it in their guiding principles for social inclusion: 'A healthy society is one that maximises opportunity for each of its members, regardless of their circumstances...and is not threatened by behaviours outside society's norms.'¹²

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² I have used the expression 'mental distress' in line with the mental health charity MIND's argument that this models mental health in terms of a continuum, and reflects the structural element as opposed to the organic implications of 'mental illness' (MIND, qtd. in Oliver).

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- ³ 15 June, 2003. www.nmha.org/ccd/support.factsheet.women
- ⁴ 15th June 2003. www.doh.gov.uk/mentalhealth
- ⁵ 22nd June 2003. www.webref.org/psychology
- ⁶ 15th June 2003. www.nmha.org/ccd/support.factsheet.women
- ⁷ 22nd January 2003 www.mind.org/uk
- ⁸ 15th June 2003. <http://news.bbc.co.uk/health>
- ⁹ 15th June 2003. www.nmha.org/ccd/support.factsheet.women
- ¹⁰ In conversation with Lauren Berlant, Lancaster University, 19th June 2003.
- ¹¹ Jackie Smith, Minister for Mental Health. 8th June 2003. <file:///epxNews%20mental%20%20health.htm>
- ¹² 15th June 2003. www.doh.gov.uk/mentalhealth
- ¹² 21st January 2003. www.mind.org/uk