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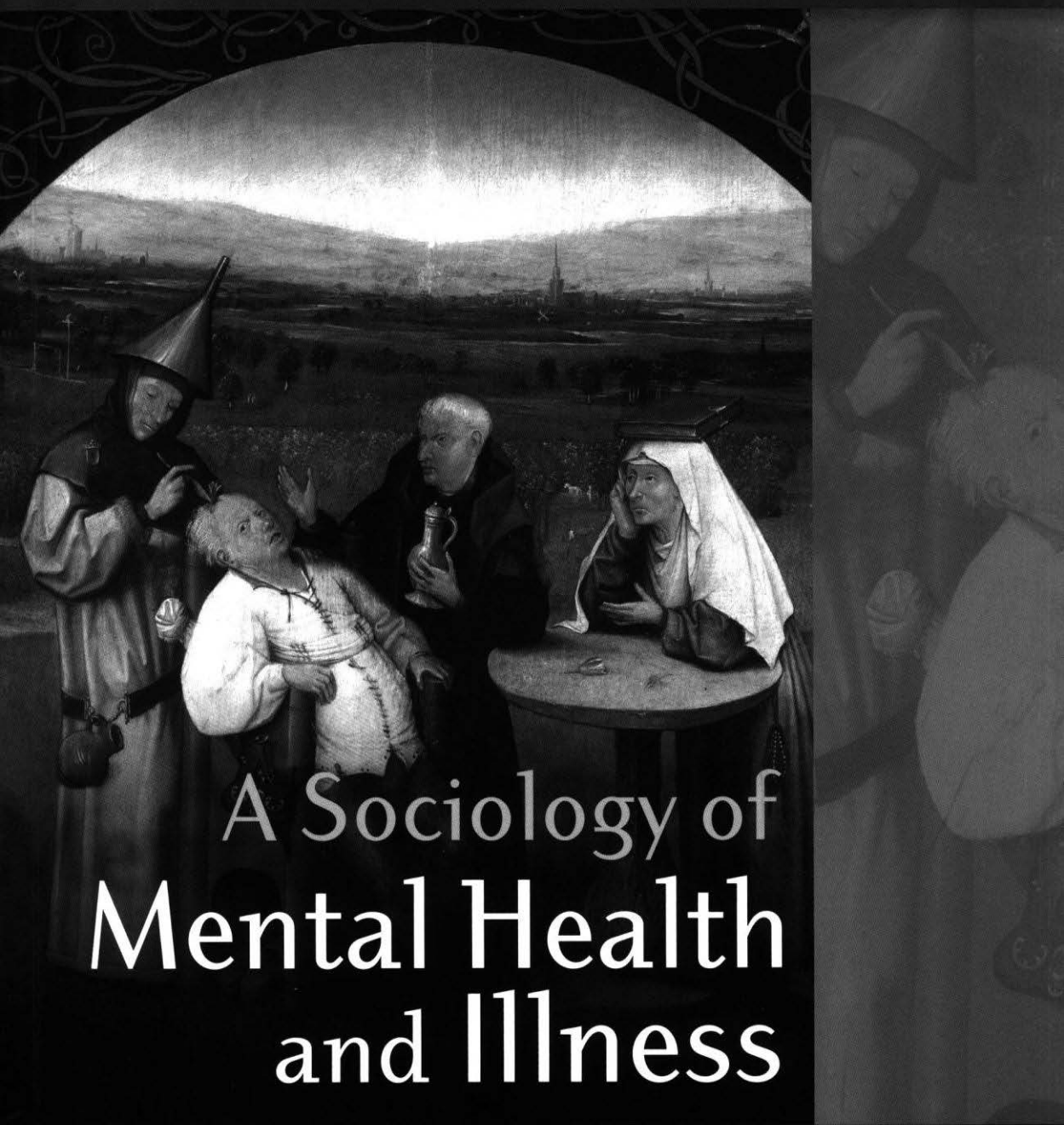

A Sociology of Mental Health and Illness

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Fourth Edition

Chapter 4

Women and men

Chapter overview

Most of the discussion about mental health and gender has tended to focus on women. This chapter reflects this in both the sociological discourse and social-psychiatric research reported. However, in addition, the question of men, mental health and psychiatry is addressed. The latter has emerged in recent sociological interest in masculinity. For example, a recent analysis of discourses on suicide has suggested a link with masculinity. In applying the concept of hegemonic masculinity Scourfield (2005) suggests that 'suicidal masculinities' result from men losing access to 'patriarchal privileges' and that important areas for understanding male suicide relate to honour, emotional literacy and control of others. The chapter will cover the following topics:

- gender bias and representation of men and women in psychiatric diagnosis;
- the question of whether society causes excessive female mental illness;
- whether female over-representation in statistics about mental health is a measurement artefact;
- whether women are labelled as mentally ill more often than men;
- men, dangerousness and mental health services;
- gender and sexuality.

The over-representation of women in psychiatric diagnosis

Although most academic attention about the topic of this chapter has focused on women and mental health, the study of gender is a comparative exercise in which the relationship of men and women to psychiatry requires exploration. Overall, women receive a psychiatric diagnosis more often than men. However, diagnosis is gendered as is the site in which it tends to take place. For example, in tertiary services, such as medium and maximum-security hospitals, men, not women, are over represented. In secondary services (acute psychiatric units in local general hospitals) gender differences are not significant. The bulk of the diagnostic practices leading to overall female representation is accounted for by 'common mental disorders'. The latter are mainly diagnosed and responded to in primary care settings. The majority of those diagnosed are not referred to specialist mental health services.

Turning from overall numbers to type of diagnosis, a gendered pattern is evident:

1 Some diagnoses are not gendered, such as those of schizophrenia and bi-polar disorder (Mitchell *et al.* 2004), though in the former case it is diagnosed on average five years earlier in young men (Gelder *et al.* 2001);
2 Some diagnoses are inevitably limited to women, such as post-natal depression and post-partum psychosis. Some of these referring to the emotional concomitants of menstruation and the menopause are contentious and some groups of women reject the label in its entirety (Edge and Rogers 2005);
3 Some diagnoses are overwhelmingly female, such as anorexia nervosa and bulimia nervosa (Van Hoecken *et al.* 1998);
4 Some diagnoses are overwhelmingly male, such as anti-social personality disorder (Tyrer 2000). The great majority of sex offenders (whether or not their conduct is classified as a psychiatric condition) are men;
5 Some diagnoses are more likely in men than women, such as substance misuse (Meltzer *et al.* 1994).
6 Some diagnoses are more likely in women than men, such as anxiety states, depression and post-traumatic stress disorder (Breslau *et al.* 1998; Fryers *et al.* 2004). Because women live longer than men higher female prevalence rates for both dementia and depression in old age also make a contribution to female over-representation.

Thus, female patients in points 2 and 3 and especially 6, account for the overall over-representation of women in psychiatric statistics. The above list summarizes the picture in North America and Europe. However, there are substantial international differences, which highlight the problem of taking psychiatric positivism at face value. For example, eating disorders are virtually unknown in developing countries (where the main challenge about food is not its refusal but its availability). In another example, in China (contra the Western picture) women are diagnosed as suffering from mental illness more often than men but in a different way. The prevalence of depression and neurotic disorders is lower in Chinese than Western women. However, the prevalence of the diagnosis of schizophrenia is significantly higher for women than men in China, which might be accounted for by the cultural

tendency in that country for women to be disvalued and coercively controlled (Pearson 1995).

In a Western context community surveys in the last 40 years have consistently confirmed point 6 on the list above. For example, Walter Gove and his colleagues, focusing on higher rates among married women than men, claim that women experience psychological distress more than men (Gove 1972; Gove and Tudor 1972). Blaxter (1990) also found that, throughout the life span, women report greater psycho-social malaise than men and the gap between the sexes increases in older people. Blaxter's self-reported factors included depression, worry, sleep disturbances and feelings of strain. A large international study using the World Health Organization Composite International Diagnostic Interview, assessed the lifetime prevalence and age at onset of mental health problems, including anxiety, mood and substance disorders. It found gendered differences in mental health in all countries. Women had more anxiety and mood disorders than men, and men had more 'externalizing' and substance disorders than women. However, the researchers also found a narrowing in recent cohorts of rates of major depression and substance misuse (Seedat *et al.* 2009).

How, then, can this apparent excess of female over male 'mental illness' be explained? The reasons for the over-representation of women in mental health statistics are highly contested, with a number of competing explanations being evident in the literature. These explanations can be broadly categorized into three main perspectives:

- Social causation – does society cause excessive female mental illness?
- Artefact – is female over-representation a measurement artefact?
- Social labelling – are women labelled more often than men?

These three questions will now be explored.

Does society cause excessive female mental illness?

That mental illness is rooted in women's life experiences has been expounded by a number of commentators. Most of these explanations have focused on the link between the 'stress' of women's lives and mental disorder. Gove (1984) and his colleagues (Gove and Geerken 1977), who have written and researched extensively in the area of women's mental health, claim that the amount and particular type of stress experienced by women results in higher rates of female psychiatric morbidity. In particular, they look at two aspects of women's societal role to explain why women experience more psychological distress than men. First, the lack of structure in women's roles (which tend to be more domestic than for men) makes them more vulnerable to mental distress because they have time to 'brood' over their problems. In contrast, men have relatively 'fixed' roles. According to Gove, this means that the necessity of responding to the immediate and highly structured demands of the workplace distracts men from their personal problems and this offers a degree of protection that is not available to women.

Citing community studies, Gove points to evidence that poorer mental health is found in situations where women are more likely to occupy nurturant

roles (e.g. divorced women who care for children have a higher incidence of mental distress than divorced men and women without children). It is hypothesized that the social demands and lack of privacy associated with this role may be a causal factor.

Evidence of social aetiology and depression among women comes from the research of Brown and Harris (1978), who identified different factors which together point to the social origins of depression. This picture of aetiology is sometimes referred to as a multi-factorial social model, where a wide selection of factors interacting with each other may be necessary preconditions for developing a psychiatric condition.

Brown and Harris draw attention to three groups of aetiological factors that need to be understood as interacting with one another to produce depression.

Vulnerability factors

Such factors might make women more susceptible to depression during a time of loss or in the face of another major negative life event. These biographical events include loss of mother before 11 years of age. Subsequent research linked this to the quality of care that followed this loss. Those with poor subsequent care were particularly vulnerable to depression (Brown *et al.* 1986). The absence of a confiding relationship with a partner also makes women more susceptible to depression, as does lack of employment (full- or part-time) outside of the home. The presence at home of three or more children is also a vulnerability factor. When the opposites of these factors were found to be present, for example high intimacy with a partner and the presence of a mother after the age of 11, they acted to 'protect' women against depression.

Provoking agents

These are factors operating in women's contemporary everyday lives, which may lead to depression, and include detrimental 'life events', such as loss through bereavement or marriage breakdown, or episodes of serious illness. Chronic difficulties as well as specific stressors are included here. The occurrence of these events determines when the depression will arise.

Symptom-formation factors

These factors determine the severity and form of depression. In Brown and Harris's (1978) research, depression was found to be more severe if there had been previous depressive episodes and the woman was aged over 50. These social factors were linked together in Brown and Harris's research with psychological variables (cognitive sets). Women whose personalities were characterized by low self-esteem were more likely to experience the onset of depression than those who had high self-esteem.

The work of Brown and Harris in the 1970s has been extended in the interim. More data has been collected and, recently, more theoretical issues have been raised by Brown and his colleagues. Brown *et al.* (1995) compared

clinical and non-clinical populations in Islington, north London. Drawing upon the work of Gilbert (1992) and Unger (1984), they elaborate their position about depression and the experience of life events. They conclude that the probability of depression increases not necessarily with loss or threatened loss per se but with the coexistence of humiliation and/or entrapment.

Gilbert and Unger note that depression is commonly associated with feeling trapped and humiliated, such that there is an assault on the person's sense of self-worth and they have a blocked escape. The latter may then make the difference between a depressive and a non-depressive trajectory. For example, Brown *et al.* (1995) suggest that a woman being told that the paralyzed husband she is caring for will not recover might become depressed, but another, able to leave her violent or feckless partner, may feel liberated. Thus, being able to 'leave the field' may head off depression or reverse it in those already distressed.

The Islington study also highlighted more details about the risk factors associated with adverse childhood experiences. A third of the depressed women studied had experienced neglect or physical or sexual abuse in their childhoods. This subgroup had twice the chances of becoming depressed in one year, compared to those without such adverse antecedents (Bifulco *et al.* 1992). These childhood events also increase the probability of anxiety symptoms. Brown (1996) suggests that this might account for the common coexistence of anxiety and depression in adult patients.

Rigorous research, such as that of Brown and his colleagues, can tell us a great deal about the possible direct and indirect influence of social factors in the cause of female mental illness. However, the extent to which we can accept the conclusions of research that suggests that women experience more mental disorder than men rests on the way in which both mental health and gender are measured. The epidemiological work of this type rests on medical constructs (Brown and Harris accepted 'depression' and other diagnoses measured by the Present State Examination). Likewise, work on prevention of mental health problems, in the wake of Brown and Harris's study, does not question psychiatric knowledge (e.g. Newton 1988). This is not the case with the next and subsequent positions, which consider that psychiatric labelling is part of wider processes of social negotiation.

Gendered power relations, and constructions of masculinities and femininities during adolescence, are important for understanding social identity and processes that might be implicated in the generation of mental health problems. Negative and positive aspects of three social processes: social interactions; performance; and responsibility appear to be highly gendered. Girls typically experience these processes more negatively, which arguably places them at greater risk of developing mental health problems. By contrast boys' greater positive mental health appears to be linked to a lower degree of responsibility-taking and the easier negotiation of cultural norms of masculinity (Landstedt *et al.* 2009).

Is female over-representation a measurement artefact?

The artefact explanation suggests that epidemiological measurement and its interpretation are faulty. From this point of view, some or all of the

excess in psychiatric morbidity is not 'real', rather it is created by the design, assumptions and interpretations operating in social psychiatric research (using, for instance, the Present State Examination and the General Health Questionnaire).

As an example of a traditional causation study subjected to an artefact critique, we can take the work of Gove (1984) and his colleagues, which has been the centre of considerable debate. This research focused on female psychiatric morbidity and marital status and claimed to demonstrate that married women have greater levels of mental distress than married men.

Gove and his coworkers take marital status as an accurate indicator for identifying differences in mental health between men and women. However, there are variations in marital relationships and the ways in which particular features of the relationship, such as the degree of role differentiation and shared power, act as a risk or a protective factor. Marital status does not lead to a unitary role outcome for men and women. For example, the notion of nurturant role assumes the presence of children in the marital relationship, yet it is also the case that 25 per cent of children in the UK are now born outside of wedlock. Similarly, a childless woman in full-time employment may have little in common in terms of role with another married woman, without employment outside of the home, who is also a mother.

The evidence of a link between gender and mental illness based on marital status may also be challenged if other comparisons are made. For example, single status makes men, not women, more vulnerable to mental health problems. With regards to the explanatory links of different stressors associated with role, Gove does not explore why the same marital female roles seem to act as protective factors in physical illnesses. While married women have higher rates of hospitalization for psychiatric illnesses, married men have higher rates of admission for non-psychiatric illness than married women.

Finally, the definition of mental illness used by Gove to support his hypothesis that women suffer from problems more than men has been subjected to the criticism that he focuses exclusively on certain types of mental disorder, such as depression and phobias. He excludes other types such as organic conditions and personality disorders (Dohrenwend and Dohrenwend 1977). A review of community studies carried out during the 1980s showed that although rates for the most common types of disorder are generally higher for women than men, rates reported by one epidemiological study (Regier *et al.* 1988) showed an almost equal sex ratio by including drug dependency and personality disorders. Similarly, in the Sedat *et al.* study mentioned above, the authors suggested that a narrowing of the gap over time in relation to key disorders might be explained with reference to the greater blurring of gender roles in wider society.

These critiques seem to point to the possibility that an apparent excess of female mental disorder may be an artefact of the construction of epidemiological research. However, subsequent research provides convincing evidence that undermines the artefact explanation and further supports the likelihood that women's greater risk of depression is a result of differences in roles and in their experience of life events. Nazroo *et al.* (1998) compared men's and women's experience of severe life events. Women were found to be at greater risk of depression than men when the event experienced involved children, housing and reproduction and where there was a clear distinction within

households in roles between men and women. This suggests that women's increased risk of depression is a result of gendered role differences which are associated with differences in the type and experience of life events.

Similarly, in relation to marital violence, gender differences in rates of anxiety (which are higher among women) have been attributed to the nature and meaning of physical abuse experienced by women (Nazroo 1995). Female perpetrators of domestic violence are now nearly as common as males (Rogers and Pilgrim 2003) but on average the severity of violence is greater when women are victims. And the latter are more likely to present with post-traumatic symptoms following victimization. Research such as this, which focuses on the meaning and context of events provides us with a deeper understanding of the relationship between key variables identified by traditional social psychiatric epidemiology.

A more nuanced look at the nature of roles and events at particular points in the life course also indicates the complex relationship with mental health problems and the limitations in generalizing about men, women and mental health. Some of the findings of research are counter-intuitive or context or time-dependent. Some events one might think are stressful do not have an impact but others do. For example, contra the researchers' presumptions, unintended childlessness and unplanned births were *not* found to be associated with psychological distress for women (Maximova and Quesniel-Vallee 2009).

Other complexity can be found in the particular circumstances of distress. For example, between those caring for disabled children compared to parents of non-disabled children, parents of disabled children experience higher levels of negative emotions, poorer psychological well-being, and more somatic symptoms. However, mothers were not found to differ from fathers in levels of well-being and older parents were significantly less likely to experience the negative effect of having a disabled child than younger parents (Ha *et al.* 2008). Also, multiple identities draw upon layers of vulnerability which are both individually and structurally shaped. Collins *et al.* (2008) suggest that inner city Mexican women (living in New York) with severe mental health problems carry multiple stigmatized statuses, including: having a mental health problem; being a member of an ethnic minority group; having an immigrant status; being poor; and not conforming to gendered expectations. In examining the interlocking domains of women's lives. The researchers found that respondents sought identities that defined themselves in opposition to the stigmatizing label of 'loca' (Spanish for crazy; e.g. as religious church goers).

Differences in the way in which men and women seek help from services may also account for their over-representation in mental health statistics – our next discussion.

Gendered differences in help-seeking behaviour

Because women report higher levels of mental distress (as well as somatic morbidity), this may result in a greater utilization of general health care. However, the relationship is more complex than this statement suggests; utilization is not a direct result of greater pathology alone. Koopmans and Lamers

(2007) found that there is not necessarily a direct relationship between experiencing symptoms and the decision to seek help. Symptoms are experienced more frequently than rates of medical consultation and admission to hospital suggest. Patterns and processes of help-seeking are influenced by people's experience of illness, the way in which services and professionals have responded to people in the past and the levels of social support and alternative health care resources available to them in the community (Rogers *et al.* 1998).

In the case of psychological symptoms, it is likely that the 'clinical iceberg' is larger than is the case with physical illness, because of the stigma of mental illness, the perceived ineffectiveness of medical interventions and a greater tendency to deny symptoms. Scambler *et al.* (1981) interviewed 74 working-class women and found that only one in 74 subjects who suffered 'nervous depression' or irritability consulted their GP, compared with one in 9 for sore throats. There is also some evidence to suggest that people with psychological symptoms delay seeking formal help for a long time. Rogers *et al.* (1993) found that the time-lag between experiencing psychological symptoms and seeking professional help was more than one year for 20 per cent in their survey of 516 post-discharge psychiatric patients.

The relationship between experiencing symptoms is further complicated in psychological distress because of the high rates of formal referral by other people. Thus, a decision to seek formal help in the case of psychological distress is a complex process dependent on both the incipient patient's and others' notions of mental health problems and the translation of the experience of these problems (e.g. tiredness, hallucinations and so on) into a willingness to contact formal agencies.

Overall, women are more likely than men to access health care, when they face minor or moderate mental health problems. As with the incidence of mental health problems discussed above, help-seeking actions may reflect not only the cultural values and expectations associated with a specific gender but also those associated with specific social roles adopted by women and men. Reported rates of symptoms in community studies may not be due to a greater incidence of mental disorder as measured by 'clinical symptoms', but a reflection of women's greater propensity to be disclosing about their symptoms.

Self-reported morbidity is determined not only by the presence or absence of clinical symptoms but also by the perception and interpretation of symptoms by the person, together with their willingness to report illness in an interview situation. This entails a willingness to label/view problems in psychological terms and to seek help once a problem has been defined. Both these interlinked processes may be influenced by differences in attitudes, norms, values and expectations between men and women. Debating this issue in the 1970s, Dohrenwend and Dohrenwend (1977: 1338) commented that:

> Sex differences in the seeking of help correspond to attitudinal differences: women are more likely to admit distress . . . to define their problems in mental-health terms . . . and to have favourable attitudes towards psychiatric treatment.

Women, then, may be more likely to recognize and label mental illness than men or, put another way, men may be less likely to view their problems as

psychiatric ones. There certainly appears to have been an assumption on the part of researchers that women are more likely to be able and willing to talk about their mental health than men. This may, in turn, account for the female focus of much of mental health research, which we will discuss later. An example of how researchers operated such an assumption is in the cited community survey of Brown and Harris (1978: 22), who are quite explicit that their choice of a female-only sample stemmed from a gender assumption:

> It also seemed likely that women, who are more often at home during the day, would be more willing to agree to see us for several hours . . . most of the women we approached were willing to talk to us at length about their lives and appeared to enjoy doing so.

Women may also be more likely to act on their mental health symptoms than men by seeking professional help. Women are approximately twice as likely as men to refer themselves for psychiatric treatment. Men, on the other hand, have been found more frequently to seek help on the advice of others. Community studies suggest that, for those considered to be suffering from severe psychological distress (measured by the General Health Questionnaire) sex ratios for primary health care consultations are almost identical. However, in terms of overall rates of consultation with a GP, women appear to consult more than men (Williams *et al.* 1986; Rickwood and Braithwaite 1994).

It seems unlikely that this higher propensity to seek help is due to women having more spare time to visit the doctor than men. Women who combine maternal, domestic and employment roles have less time on their hands than employed men or housewives, and housewives work longer hours than employed men. There is some evidence that being in a professional or employed working role is an important influence on the decision of women and men to seek or not to seek medical care for mental health problems. Holding the role of worker tends to foster the use of psychological services in women, especially in married women (Drapeau *et al.* 2009). However, Verbrugge and Wingard (1987) argued that women's roles, as part-time workers or housewives, may allow them greater flexibility (not time per se) to visit the doctor.

Because of gendered assumptions about caring, women also make contact with GPs when taking their children to be seen for minor ailments. There is also some evidence to suggest that women with young children may put their children's health needs before their own, which inhibits them entering the sick role (Brown and Harris 1978; Rogers *et al.* 1999). Additionally, it may be that higher rates of consultation are not due only, or mainly, to the active help-seeking actions of women. Women's own accounts of stress, anxiety and depression seem to suggest that women normalize the mental health problems they report (Walters 1993), which is not commensurate with problem recognition associated with help-seeking from formal services.

Moreover, a study of women's pathways to care in post-natal depression suggests that only one-third of women considered to be depressed by primary care professionals believed they were suffering from the condition. Over 80 per cent had not reported their symptoms to any health professional (Whitton *et al.* 1996). This suggests that contact with health services for other reasons, such as the seeking of health care for children, may allow for

increased detection of problems which may contribute to seemingly higher consultation rates for female mental health problems.

Are women labelled as mentally ill more often than men?

A different explanation for female over-representation in mental health statistics is proposed by some feminist researchers, influenced both by labelling theory and constructivist frameworks. From this viewpoint, patriarchal authority, which seeks out and labels women as mad, is responsible for the over-representation. Women become vulnerable to being labelled mentally disordered, when they fail to conform to stereotypical gender roles as mothers, housewives, and so on or if they are too submissive, too aggressive or hostile to men. During the 1970s, feminist writers began to argue that there is both a general cultural sexism, which renders women vulnerable to psychiatric labelling, and a specific sexism from professionals. For example Chesler (1972: 115) asserted that: 'Women, by definition (sic), are viewed as psychiatrically impaired – whether they accept or reject the female role – simply because they are women'.

More specifically, medical discourse is deemed to be patriarchal and misogynistic by feminist critics. For example, Chesler's analysis has much in common with those of other feminist writers on health and illness who have viewed male doctors as defining illness with reference to women's emotions (e.g. English and Ehrenreich 1976). The profession of psychiatry is, according to Chesler and others, numerically male dominated and permeated by patriarchal stereotypes of female inferiority. This situation has arisen as a result of a historical legacy. As medicine, including psychiatry, successfully professionalized during the eighteenth and nineteenth centuries, so women healers became marginalized and excluded from positions of power. This male domination influences the way in which psychiatric diagnoses are applied to women as well as the types of diagnosis and the rates at which they are applied.

There was evidence at the time of Chesler's writing that these patriarchal assumptions were not confined to psychiatry but operated in other parts of health services. Barrett and Roberts (1978) found that male GPs construed their middle-aged female patients to be overly neurotic and requiring minor tranquillizers more than male patients. The doctors also often thought that the distressed women who worked would be better off resigning and they expressed a greater sympathy for male counterparts. Goldberg and Huxley (1980) also found that GPs were less likely to identify psychological problems in male patients. Milliren (1977) studied older patients and found that male GPs diagnosed women as suffering from anxiety symptoms more often than men. When the latter were diagnosed they were offered minor tranquillizers less often than women by the GPs.

Subsequently, Sheppard (1991) provided further evidence that GPs discriminate against women. Doctors were found to be more likely to refer women as candidates for compulsory admission than men. According to Sheppard, this reflects the sexist practices of GPs, because their decisions were not always confirmed. That is, many of the female referrals were not subsequently deemed suitable for compulsory admission by Approved Social

Workers (social workers specially trained in mental health law, a role in the UK subsumed in that of the 'Approved Mental Health Professional' since 2007). Social work is a predominantly female profession. This was considered by Sheppard to be evidence of women workers being able to counteract the sexist practices of the predominantly male group of GPs.

However, others found evidence of sexist stereotyping of female roles among social workers in relation to women with severe mental health problems (Davis *et al.* 1985). This suggests that having a predominantly female profession might not eliminate sexist practices. Similarly, Chesler's theoretical position rests on the premise that in the psychiatric profession women are massively outnumbered by men. Yet, statistics on the number of medical graduates embarking on psychiatry as a career suggests that psychiatry is rapidly becoming a less male-dominated system in terms of the ratio of male to female practitioners (Parkhouse 1991). This casts some doubt on the assumption that a numerically male-dominated psychiatric profession is solely responsible for sexist psychiatric practice.

It is likely that sexism in psychiatry has its roots in, and can be transmitted in, the type of knowledge, diagnostic categories and practices followed by the profession as well, which can still be called 'patriarchal' even when used by women doctors. Another dimension of feminist analysis has drawn attention to the assumptions inherent in the ideology of psychiatry. Disordered behaviour is defined according to what is considered normal or 'ordered' mental health. (The term 'ordered' offers an odd quality to the reader because 'disorder' elicits more interest in daily life; we notice when 'things go wrong' – see Chapter 2.)

Research by Broverman *et al.* (1970) provided evidence of bias in the construction of notions of mental health and illness. This research showed that behaviour defined as 'male' was viewed by psychiatrists to be congruent with healthy behaviour, while behaviour defined as 'female' was not. Healthy women were in comparative terms considered to be more submissive, less independent and adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, seen as having their feelings more easily hurt, being more emotional, more narcissistic about their appearance and less objective than healthy men. Women were couched in primarily negative terms, even images of healthy women were perceived as less healthy than men. Fabrikant (1974) reported that male therapists rated 70 per cent of 'female' positive.

Those interested in gendered labelling emphasize that it is shaped by new technologies (not just psychiatric diagnosis per se). For example, the new SSRI antidepressants have played a role in expanding existing categories of mental ill health among women. Metzl and Angell (2004) studied the impact of these new drugs on popular notions of women's depressive illness. What were previously seen as ordinary life events now had become categories, such as 'premenstrual dysphoric disorder'. The enlarged notion of gender-specific mental health problems was also found to be disseminated in the mass media. Examples of negative stereotyping can be found even in biographical forms of psychiatric knowledge, such as psychoanalysis. Masson's (1985; 1988a) historical investigations of psychoanalysis reveal psychotherapists disbelieving reports from female patients of incestuous assaults on them, and compounding their distress through new abuse during treatment.

Gendered notions of mental health and illness seem to be prevalent among lay people as well as mental health professionals. Jones and Cochrane (1981) found from responses to a series of scales made up of terms depicting opposite personal characteristic (e.g. 'outgoing' versus 'withdrawn', 'sensitive' versus 'insensitive') that respondents clearly differentiated in the adjectives they chose to describe the differences between mentally ill men and women. In contrast, the terms used to describe normal women and mentally ill women were similar.

So far, a picture has been presented of how others have sought to define mental illness in a feminized way. As well as professionals and lay people constructing problems in this manner, there are also indications that patients conceptualize their problems in a sex-specific way. Rogers *et al.* (1993) found that women were more likely to identify marital stress as the source of their difficulties. By contrast, men reported work stress to be of relevance three times more often than did women. This suggests that relationships in the domestic arena seem to take on a greater meaning for women than men. Women were also found to share their difficulties with others more readily than men. Women were more likely to choose their lay network of friends and neighbours as their first attempt to seek help. There is some evidence to suggest that this willingness to disclose is reversed once contact has been made with professionals. A Dutch study (de Boer 1991) noted that problem formulation in therapeutic encounters is a product of the interaction of two different discourses – that of the therapist and that of the patient. Sex differences in 'problem formulation' were found in so far as men appeared to be more able to account for their problem in a therapeutic situation than women, who appeared to be more diffident. As a result, male influence on the definition and formulation of a problem at this stage may be greater than the influence of women.

A caution needs to be introduced about generalizing the willingness of women to disclose and seek voluntary primary care or outpatient contact compared to men. This picture seems to hold true for white patients in European and North American clinical settings. However, the literature on ethnic minority women suggests a tendency for them to under-utilize such voluntary service contact opportunities (Padgett *et al.* 1994). The latter US study found that black and Hispanic women had a lower probability of accessing outpatient services than white women from similar class backgrounds. Overall, if race and class differences are ignored, women use outpatient mental health services more than men (Rhodes and Goering 1994) but within the female picture are racialized subgroups which are treated differently. For example, when young black women do have service contact they are offered less psychological treatment than white women (Cuffe *et al.* 1995).

There has been a tendency to view the social causation and the labelling explanation as contradictory, i.e. the over-representation of women is caused by either women's social situation making them sick or the pathologizing of women by a male-dominated mental health service. However, to argue that the phenomena which have historically come to be constituted as mental illness have their roots in the difficulties of women's lives is not inconsistent with the view that the social nature and social consequences of defining a woman as mentally ill need to be emphasized.

The effects of labelling secondary deviance – women and minor tranquillizers

We introduced the notions of primary and secondary deviance in Chapter 2 when discussing labelling theory. Whatever the reasons why and how women enter the sick role in a psychiatric sense, a consequence is that they are subjected to more frequent medical and professional attention than men. They also tend to seek help and are diagnosed more frequently than men when suffering from problems that are dealt with by GPs. It is here that a controversy arose over the way in which women's problems are viewed and treated. In particular, attention has been directed towards the prescription of minor tranquillizers because of their dependency-inducing properties. Women consume psychotropic drugs in far greater quantities than men (Olson and Pincus 1994a). This is despite evidence which suggests that women express a strong antipathy to using drugs to solve their problems (Gabe and Lipshitsz-Phillips 1982).

By 1980, the excess of the female rate of consumption was estimated as 2:1, with four-fifths of this consumption being attributed to minor tranquillizers and sedative hypnotics (both types of benzodiazepine) (Cooperstock 1978). Although the dangers of benzodiazepines were well known by 1980, by the end of that decade the prescription rate was still over two-thirds of that a decade earlier, despite both litigation/campaigning from addicted users and cautions from professional bodies such as the Royal College of Psychiatrists (Medawar 1992).

The prescription of minor tranquillizers and antidepressants can be seen as a medicalized response to personal troubles. From this vantage point the benefits of a medical response are to remove personal responsibility from the individual for their problems. For example, the guilt and unhappiness associated with depression can be dealt with simplistically if it is framed as an illness, which can be relieved by mood-altering drugs, rather than the responsibility of the individual's actions and their social circumstances.

However, from a different perspective, the prescription and use of such drugs can be viewed as a means of 'social control' because they transform social problems into medical ones. The social effects of treating personal problems by medical sedation were highlighted by Waldron (1977), who pointed out that the treatment of individual 'pathology' disguises its social causes and deflects attention from the need for political change to ameliorate the oppression of women.

Gabe and Thorogood (1986) found that women were most likely to find benzodiazepines to be a 'prop' in the absence of other means of support, such as paid work, adequate housing, leisure activities and so on. This was particularly so in the case of middle-aged women, who were less likely than other women to have access to resources with which to manage their everyday lives. Women tended to express ambivalent views about taking minor tranquillizers: on the one hand, they expressed the view that they gave them 'peace of mind', and on the other, they emphasized the dangers and dependency-inducing aspects of taking these drugs.

Paradoxically, perhaps, in publicizing the dangers of addiction, women who have been prescribed such drugs have been subject to what labelling theorists refer to as 'deviance amplification'. The media, in taking up the problem of minor tranquillizer dependency, has tended to reinforce images of women as

helpless, dependent and passive victims of addictive drugs (Bury and Gabe 1990). Not only did their original behaviour or primary deviance expose women more frequently to an addictive prescribed drug but the consequent addiction then became associated with their gender.

Does this additional labelling of women imply that they are subjected to medical control more frequently than men? Their greater contact with services and the minor tranquillizer problem being labelled as a 'women's problem' might imply that this is the case. Certainly feminist scholarship has been instrumental in gaining a wider recognition of the ways in which women have been oppressed by being labelled as mentally ill. This in turn has led to the setting up of alternative services for women. According to Scambler (1998), these women's services retained a collective notion and awareness of the social by providing group support aimed at re-socializing women to reject a subordinate position within domestic and social life.

However, as Scambler points out, being outside of state-provided services means that access to the voluntary women-only mental health services may be denied to those in most need. Moreover, Pilgrim (1997a) has argued that even feminist therapies retain the power discrepancies between therapists and patients inherent in all styles of psychotherapy and they retain many patriarchal elements intrinsic to the psychoanalytical legacy. (The main theoretical position underpinning women's services has tended to be psychoanalytical in orientation.)

As we noted in our introduction, generalized claims about the *overall* predominance of mental disorder being an essentially male or female phenomenon are risky. The nature and construction of mental health problems differ according to diagnostic category and cultural context. However, the discussion of male mental disorder is, compared with the feminist literature on women and mental health, rare. This corresponds to a more generalized tendency in the sociology of health and illness to focus on female rather than male health disadvantage (Cameron and Bernardes 1998).

An exception to this has been research conducted into male unemployment and mental health. There is evidence to suggest that the experience of unemployment is detrimental to men's mental health because of the dissonance this gives rise to between a masculine self-image and social expectations of men being in full-time paid employment (Hayes and Nutman 1981). Studies have also taken as their focus the variation in male mental health according to wider economic and employment opportunities (Warner 1985). However, if we put to one side these studies looking at unemployment, the sociological discourse about gender and mental health is female dominated. Let us look at two examples of the different considerations given by both psychiatrists and sociologists to men and women with regard first to dangerousness and then to sexuality.

Men, dangerousness and mental health services

Men's behaviour is more frequently recognized as being dangerous than women's. It seems that being the recipient of intimate partner violence, sexual

violence, and peer/school violence has a much larger psychological impact on women than men (Romito and Grassi 2007). Thus men who are victims of violence speak from that experience less than women. However, overall it is not in doubt that men are violent more often than women in society. As a consequence though, all men (including non-violent ones) may be subjected to stereotypical expectations. Just as all women are at risk of being stereotyped as weak and ill, all men may be stereotyped as being violent.

Comparisons are sometimes made between the statistics, which show women to be over-represented in mental health populations and men in prison populations. This may be related to the type of social judgement made about 'rule breaking'. The recognition both of mental disorder and of criminality involve judgements being made about a person's state of mind and their conduct. In conditions such as depression, the judgement being made is more about a person's anguished and irrational state of mind, judged by their social withdrawal and 'motor retardation'. By contrast, a criminal act is more about a person's self-interested motivation, judged by the manifest gain made from their offence. However, both entail judgements about the relationship between mind and conduct – and weighing up the nature of this relationship decides whether the deviance ascribed is of a criminal or psychiatric type. As we noted in Chapter 2, these distinctions between rational or goal-directed, and irrational or incomprehensible, rule breaking are not always clear cut in the minds of either professionals or of lay people.

The connection between these considerations and gender is that men's conduct has been more associated with public antisocial acts, violent and sexual offences, drunken aggressive behaviour and so on. In contrast, women's behaviour has been associated more with private, self-damaging acts, where aggression is directed at the self rather than others. Depression, parasuicide, eating disorders and self-mutilation together summarize this tendency. Men are more likely to indulge in behaviour that is antisocial, and to be labelled as criminally deviant more than women. This is then reflected within psychiatry, in that men are more likely to have labels which refer to and incorporate the threat of their behaviour.

The notion of 'danger to others' is more frequently ascribed to male than female patients. The question of 'danger to self' is more complicated. Although women attempt suicide more frequently then men, the figures for actual suicide are consistently higher for men than women. However, a Finnish study of parasuicidal behaviour suggested that men make more gestures of suicide, as well as committing suicide more often (Ostamo and Lonnqvist 1992). Of course, suicidal and parasuicidal behaviours are ambiguous – they may be adjudged to be either self-injurious or antisocial or both. This may account for the prevalence being split between the two sexes and the contradictory findings about the ratio of such a split. Female problems are more likely to be dealt with at the 'soft' end of psychiatry since, as we have already seen, they tend to be labelled with the type of problem that is usually dealt with in primary health care settings. Although such management is by no means always benign, as demonstrated by the negative effects of the reliance on minor tranquillizers discussed earlier, it more rarely requires compulsory admission. By contrast, men are more likely to be dealt with at the 'harsh' end of psychiatry as mentally disordered offenders in secure facilities.

Thus, once a label has been affixed, overall as a group, men are dealt with

more harshly than women. This is especially the case at the interface between psychiatry and the criminal justice system. It is mainly men who are over-represented in the most stigmatized and policed part of the mental health system, the 'special hospitals'. Though many in these institutions are there for sex offences and other violent crime and their behaviour or threat to society might have warranted such a response, many have not been convicted of a criminal offence. The effect of such management can be seen not only in the negative media stereotypes portraying the inmates of such hospitals as 'animals' and 'monsters' but also in recurrent government inquiries into the mistreatment of special hospital patients. With regard to psychiatric referrals from the police, under section 136 of the Mental Health Act 1983 there is evidence to suggest that men are subject to arrest more frequently than women. Moreover, the police use handcuffs and detention cells more frequently for men than women (Rogers 1990).

Even where the differences in the rate at which a diagnostic label is attached are not great, the negative consequences of a label may be greater for men than women. This can be seen in the case of schizophrenia in Western countries, where, overall, there is little difference in incidence between men and women. There are, however, wide differences between the sexes in the incidence of the illness at different ages. It has been estimated that the occurrence is twice as great for men aged 15–24 than for women of the same age. For women the peak age is between 25 and 34 (Warner 1985: 231). This may reflect career- and work-related stress upon men at this stage in their lives.

Because men are diagnosed younger, when they are physically at their strongest, this may induce more coercive actions from professionals during an inpatient crisis. (We will return to the handling of aggression in black male patients in Chapter 5.) Additionally, a greater prevalence of 'schizophrenia' in males has been reported for many developing countries. Just as the domestic role has disadvantages associated with it, as pointed out in the study by Brown and Harris, in other contexts it can be seen as a protective factor for women. One possible implication of this is that as the proportion of women in the labour force rises, so we can expect an increase in 'schizophrenia'.

The course of 'schizophrenia' is also, in some ways, more benign for women than men. Warner (1985: 142) reports that, historically, the proportion of patients discharged as recovered is consistently higher for women. Differences in prognosis have also been noted. In the World Health Organization (1979) international study of schizophrenia, proportionally fewer women were in the worst outcome group at follow up, and more were in the best outcome category. In industrialized countries women tend to have shorter episodes of schizophrenia.

If we look at other disease categories, then the male/female distinction drawn by feminist analysis above is only applicable to a Western social context. In other places, men do worse than women. For example, some cross-cultural studies of depression have shown a slightly higher proportion of men than women suffering from depression (Carstairs and Kapur 1976). While women take sick leave for minor psychiatric problems more often than men, the latter tend to be off work for longer periods (Hensing *et al.* 1996). These studies suggest that it is the *context* of people's experiences that influence the type and rate of mental distress, rather than anything intrinsic or constant

about being a man or woman. In some contexts, work outside the home can be a threat to mental health, just as the domestic environment can.

Gender and sexuality

Both gay men and lesbians present with more mental health problems than do heterosexuals and are more likely to abuse substances (King *et al.* 2003). Gay and bi-sexual men are four times more likely to commit suicide than their heterosexual equivalents (McAndrew and Warne 2004). This may reflect the stress created by homophobic reactions and the discrimination and violence that ensues in hate crimes (Huebner *et al.* 2004). It may also reflect developmental challenges. Girls and boys growing up with an emerging realization about their homosexuality may struggle with a particular identity problem, over and above the general one when shifting from childhood to adulthood. In Britain the demonization of a gay identity in schools has sometimes been an explicit educational policy (for example, the introduction of Section 28, which made it illegal for teachers to discuss homosexuality).

Thus the ascription of a form of devalued sense of self or 'otherness' to young gay people can operate at both lay and 'official' levels. The rates of depression anxiety and suicidal ideas amongst gay people compared to heterosexuals are not only higher but they vary significantly across place and country. Epidemiological data suggest that whilst there are a high rates of poor mental health outcomes in the United Kingdom and large gay-heterosexual variations in the Netherlands, in Canada (Vermont and British Columbia) there are lower and improving rates of risk and outcomes. Such disparities in recorded mental health can be accounted for by local policy making, mental health programme responses, and the ways in which sexual minorities are discussed and responded to in different localities (Lewis 2009).

The psychiatric response to homosexuality in one sense has differed from responses to other types of 'problem' behaviour. During the mid-twentieth century homosexuality was designated as problematic by psychiatrists (it was a form of mental disorder under DSM). During the nineteenth century its assumed biological determination led not to active physical intervention (as was the case with madness) but with a fatalism, which prompted little therapeutic interest (Bullough 1987). It was only when psychoanalytical and then behavioural therapeutic methods were introduced during the twentieth century that psychiatrists began to interfere with homosexuality and aspire to 'cure' the condition. At the end of the century, the gay liberation movement opposed and undermined this pathologization but did not eliminate it. The very optimism encouraged by these environmental/psychological theories of mental disorder prompted professionals to be more interventionist with homosexuals. Moreover, both male and female homosexuality were problematized by psychiatry because they were problematized more widely in Western society. As Al-Issa (1987: 155) noted: 'Deviation from gender role expectations is traditionally considered abnormal'.

Leaving aside psychiatry's response to homosexuality, have gay men and lesbians been treated equitably? Certainly differences in society are discernible. Since the nineteenth century, male not female homosexuality has been designated as criminal. In Great Britain it is no longer criminal but until 2001

when the age of homosexual consent was reduced to 16 it had a higher age of consent than heterosexuality (21 not 16 years). Once more, as with dangerousness, differential legal and cultural assumptions about homosexuality seem to associate maleness and antisocial behaviour and lower such an expectation of women. This is also reflected in the therapeutic discourse on homosexuality. While most therapeutic schools have clinical reports, and even research on treatment outcomes, for both gay men and lesbians, male problems are alluded to more frequently or given a greater priority.

This prioritization of men as 'suitable cases for treatment' was at its most exaggerated in the late 1960s and early 1970s, when behaviour therapists attempted to 'cure' male homosexuals using electric shock aversion therapy. More benign behavioural methods were used for lesbian patients requesting reorientation (such as desensitization and assertiveness training) but men were singled out for the aversion treatment. The latter not only failed to induce a shift of sexual orientation in gay men, it merely induced phobic anxiety and impotence in some of its recipients (Diamont 1987). However, subsequently, some psychiatrists still pursued a form of 'therapeutic optimism' about re-orientating homosexual desire and identity (Spitzer 2003).

Another way in which male homosexuals suffer especially restrictive or punitive attention from the mental health system links to the point made earlier about secure environments. Because there are more men than women in secure psychiatric provision, this means that there are more gay men than lesbians living in closed systems. In such systems, homosexual behaviour is constrained by the lack of privacy permitted for sexual contact. Thus, advocates of women's rights in secure provision understandably complain of the plight of those lesbians who are incarcerated at the 'harsh' end of psychiatry (Stevenson 1992). However, it is logical to deduce that the infringement of homosexual rights must occur with a greater regularity for men than women, as the latter are under-represented in secure provision.

However, the more frequent constraints on male, rather than female, homosexual rights in secure provision need to be considered alongside the greater vulnerability of women, once they are in such environments. Those women who do find themselves in secure provision are more vulnerable than male patients to sexual harassment and assault, from both patients and staff. Such predatory attention from men is particularly relevant given the type of women appearing in conditions of maximum security. For instance, Potier (1992) reported that 34 out of the 40 female patients with a diagnosis of psychopathic disorder at Ashworth Special Hospital had been sexually abused in childhood or adolescence. Outside of secure services there is evidence that the mental health needs of gay people, which extend into mainstream health and social care, are marginalized or under-acknowledged due to discrimination (Addis *et al.* 2009).

Having addressed the question of dangerousness and sexuality, we can now see why men are treated more harshly than women by psychiatry more often, though the small ratio of women at the secure end of psychiatric services may suffer individually more than men. Thus the focus on the over-representation of women in psychiatric statistics and the relative absence of men from the sociological discourse may gloss over important questions of gender, which are about *both* women *and* men.

Discussion

The concentration on women and mental disorder is a relatively new phenomenon, arising in the late twentieth century. Gove and Geerken (1977) found that of the 11 pre-Second World War studies reviewed, three showed higher rates of mental disorder for women, while eight showed higher rates for men. Following the Second World War, studies showed higher rates for women while none showed higher rates for men. Recent research also points to the volatility of this finding which may be related to changing and overlapping roles between men and women, social identity and structural changes such as employment and the impact of legislative change.

How might these changes be accounted for? They may be a result of changes in women's social situation and psychiatric practices. A further possibility is that feminist scholarship itself may be a factor in constructing women and mental health as an object of study. Put another way, the shift towards identifying higher rates of mental disorder in women may be the result of a change in discourse. As the discourse changes, so too do the objects of attention.

Identifying women as an object of study, in itself may accentuate the 'female character' of mental ill health, establishing it as an essentially women's problem. For example, the work of Brown and Harris is often cited in texts as evidence that depression is a female problem. From this it may be inferred that the same problems are not experienced by men. However, Brown and Harris did not set out to study men, who were excluded from the research design at the outset. Therefore, from this study we do not know anything about the nature of *male* depression. If research is directed at women, to the exclusion of men, it is likely to produce evidence that links depression to women's experiences and social roles. Also, in attempting to make women more visible, some feminist scholars may have made men relatively invisible.

Feminists make much of the social disadvantage under which women suffer. Indeed, socio-economic indicators do demonstrate unequivocally that, overall, women suffer greater material deprivation than men. Notwithstanding such evidence, it is clear that particular groups of men are also subject to social disadvantage. There may be substantial evidence that men make women mentally sick, by stressing and labelling them more often than vice versa. However, the existence of a large number of men who are mentally disordered and particularly disadvantaged means that an exclusive focus on women and mental health precludes a full picture of the relationship between gender and psychiatry.

Rather than focusing on men or women and psychiatry, comparative analyses of men and women along a range of dimensions, including treatment, behaviour and portrayal of images of abnormality, are needed. In addition to gender, other variables need to be taken into consideration in understanding the mental health of women and men. What is clear in understanding gender and mental disorder is the need to focus more on the context and meaning of the cause and experience of mental health problems.

As we have argued elsewhere, a close relationship with social psychiatry had created one form of sociological analysis, following Durkheim, of treating mental health problems as social facts. Useful as this may be at showing the

social origins of mental health problems, an understanding of the relationship between agency and structure, when considering the gendered nature of mental health problems, is also required. A recognition of meaning and context is also relevant to responding to the differing needs of men and women using mental health services. We return to this issue in the chapter on treatment. As will be seen in the next two chapters, gender as a variable in mental health is overlain by age and race.

Gender and mental health have been considered extensively by sociologists. However, there has been an overwhelming focus on women. Paradoxically, this may have contributed to a discourse linking women and psychological vulnerability. It also runs the risk of understating those underlying social processes, which make some men particularly vulnerable to coercive psychiatric treatment. Despite the continuing interest in gender and mental health, there is still not a clear sociological account of why women are over-represented in the way they are in psychiatric populations. This chapter has rehearsed some factors which can be seen as additive or competing in this regard.

Questions

1 Which factors might explain why women are over-represented in mental health statistics?

2 How are psychiatric diagnoses gendered?

3 Provide a socio-historical account of psychiatry's response to homosexuality.

4 What has the *Social Origins of Depression* (Brown and Harris 1978) taught us about gender and mental health?

5 Why do women take more psychiatric drugs than men?

6 Why might men be overlooked in sociological studies of mental health?

For discussion

Consider arguments for and against the notion that women are less mentally healthy than men.

Further reading

Barnes, M. and Maple, N. (1992) *Women and Mental Health: Challenging the Stereotypes*. Birmingham: Venture Press.

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Nazroo, J.Y., Edwards, A.C. and Brown, G.W. (1998) Gender differences in the prevalence of depression: artefact, alternative disorders, biology or roles? *Sociology of Health and Illness*, 20(3): 3112–30.