

Women and Mental Health



The issues

The illnesses

What women want from services

Prepared by the Women's Health Services Mental Health Community Outreach Program

The Issues

Women represent 65 percent of patients in mental institutions. Twice as many women as men are prescribed psychotropic medications.¹ There are two common explanations for the over-representation of women in the mental health system:

Social Factors

Women are more likely to be diagnosed as mentally ill because of sex role stereotyping, which assumes that women are more prone to emotional distress because of social factors specific to their gender role. This leads psychiatry to expect and encourage women to behave and feel in 'feminine' ways. Those who deviate from the norm of their ascribed role are more likely to be treated as mentally ill.

It is more socially sanctioned for women to seek help for mental distress than it is for men, and more acceptable for women to use psychiatric services and medications. Further, there have been criticisms of a tendency to medicalise and pathologise women's reproductive health and hormones, but not that of men.

Disadvantage

The second explanation for women's over-representation in the mental health system is that if women are more depressed, anxious or fearful, it is because they have more to be depressed, anxious or fearful about.² Women's generally disadvantaged social status (as mothers, workers, wives and in relation to violence) creates relatively greater levels of mental health problems. This kind of social perspective looks at the circumstances of women's lives as a context (not always a cause) for their mental illness.

How is it that women have managed to grab any [mental health] at all? Women do two-thirds of the world's work, receive 10 percent of the world's income and own one percent of the world's property . . . across the world 100 million young women are being sexually assaulted by adult men, day after day, week after week, year after year.³

A focus on mental health symptoms only, will result in distortion of women's experience and their needs. A number of different factors, psychosocial and environmental contexts need to be taken into account to get an accurate picture.

Women with Children

Until relatively recent times, children were regarded as the property of the husband. If the mother was seen as unfit to raise "his" children, they could be removed from her influence. Also until recently, people with mental illness could expect to spend long periods of time in institutions. Producing or raising children was not an option for women with mental illness. If a woman did become pregnant, often she would be forced to relinquish her child at birth. Being a parent was simply not an important factor in the treatment of women with mental illness. Even now, the Health Department of WA does not record the parenting status of psychiatric patients.

Now however, with an emphasis on community-based treatment and rehabilitation, women with mental illness can often have children and parent them. At the same time, it is recognised in law that children have a right to a continuing relationship with both parents wherever possible. These two developments have revolutionised the lives of mothers with mental illness. But they have created a dilemma for a society which still stigmatises mental illness. On the one hand, parenting has been shown to benefit the recovery and stabilisation of women with mental illness.⁴ On the other, they may need a high level of support at certain times. If the problem was a broken leg, that support would be taken for granted, but because mental illness is still shrouded in negative images and stigma, women may have great difficulty finding the right kind of help when they need it. As a result, parenting without help can create stress and contribute to relapse.

Women's Health Care House implemented the Mental Health Community Outreach Project to help deal with this dilemma. By offering a variety of community-based supports for mothers with a severe mental illness, the project can help women to gain more positive experiences from their parenting role, and at the same time minimise the stressful aspects.

The Illnesses

Mental illnesses usually involve some physical dysfunction in the brain, but many other psychosocial and environmental factors play an important part. Often, a mental illness is triggered by a stressful event. For many women, their psychiatric symptoms may be a fairly natural response to some adverse event or situation in their lives, such as violence.¹ There are different types of mental illnesses. They are most often transient or episodic rather than continuous. Sometimes an episode of mental illness will occur only once. Treatments vary according to the individual and the illness. However, women frequently complain that they are offered drug-based treatments only, when they require an informed choice including psychosocial management.¹ Mental illnesses fall into two main groups: psychotic and non-psychotic. Within these groups are a number of different illnesses.

Psychotic Illnesses

Psychoses involve losing touch with the shared reality. People with psychoses have their own parallel or alternate reality that is exclusive to them. What they see, hear or feel will be different from what those around them experience. People with psychoses may have delusions. These are false beliefs, usually of persecution, guilt or grandeur. Their delusions or hallucinations are likely to result in a good deal of fear and confusion for the person suffering the illness, and may be difficult for those around them to cope with. Psychotic illnesses include schizophrenia and bipolar disorder. Most can be treated with medication and psychosocial therapies, so that those affected can live successfully in the community.

Non-psychotic Illnesses

These are largely disorders of affect, or feelings: uncontrollable or exaggerated feelings of great sadness, anxiety, panic, depression, tension or fear. For many, these illnesses become so severe that normal day-to-day activity is a major challenge, or not possible at all. Non-psychotic problems include phobias, depression and obsessive compulsive disorder. Often, the symptoms of these illnesses are not evident to other people, but they cause great distress to those affected.

The Major Diagnostic Categories

Schizophrenia

It is an illness that causes a person to have difficulty in deciding what is real and what is not real. One in 100 Australians is diagnosed as having schizophrenia – equal numbers of men and women. There is no known cause or cure for the illness, but symptoms can be treated and controlled. Symptoms include:

- Major changes in behaviour and feelings,
- Disordered thoughts,
- Delusions,
- Hallucinations,
- Withdrawal, and
- Loss of initiative, energy and motivation.⁵

Until recent years, people with schizophrenia could expect to spend much of their lives in hospital, as this was the only treatment. Now, they can live at home and function in the community as long as their symptoms are controlled with medication and community support. The group of drugs used to manage schizophrenia are called neuroleptic or anti-psychotic drugs. They include Modecate, Melleril, Serenace and Stelazine. They often have troublesome side effects which can be treated with other medications. Short periods in hospital may be necessary at times, when symptoms worsen. People can choose to go into hospital, or be referred by a doctor. However, if they become a risk to themselves or others, they may be admitted as an involuntary patient.

Bipolar Disorder

This illness was formerly called manic depression. It involves alternating episodes of mania (a euphoric, hyperactive state) and depression (deep sadness or emotional flatness,

low motivation). Mood swings can occur over months, or as often as several times in the course of a day. Symptoms of mania include:

- Feeling uncontrollably high,
- Feeling irritable,
- Talking a lot, and very quickly,
- Fast flow of ideas,
- Not needing or wanting to sleep,
- Insensitivity to others,
- Overspending, and
- Lowered perception of danger.⁵

Symptoms of depression are the same as for unipolar depression (see below). Bipolar disorder can include an element of psychosis if the person experiences delusions, disordered thinking or hallucinations.

Treatment focuses on stabilising the extremes with medication. Lithium carbonate is the most common and successful drug for stabilising the highs and lows and controlling manic symptoms. Lithium can have a number of side effects. If the dose is too high, toxicity can occur.

Depression

This is thought to be the most common mental disorder, affecting an estimated one in four. Twice as many women as men are diagnosed with depression. Depression has two primary features:

- An overriding feeling of sadness, negativity, and
- Loss of interest in things previously enjoyed.⁶

As well, people with depression can expect to experience at least three of the following symptoms:

- Loss of energy *or* physical agitation,
- Changed sleeping patterns,
- Changed eating habits,
- Poor concentration, difficulty making decisions,
- Feelings of guilt,
- Lowered self-esteem,
- Low motivation, and
- Not wanting to live.

It may not be obvious to others that someone is depressed, but the disorder is distressing and debilitating. It can result in suicide.

A variety of effective treatments are available. If the depression is mild-moderate, psychosocial treatments can be very successful. These include counselling, lifestyle changes leading to better self-care and reduced stress. For more severe depression, medication can lift the mood to allow effective use of psychosocial interventions. The common antidepressant drugs are Prothiaden, Aurorix, Prozac, Sinequin and Tryptonol. Antidepressants are not addictive but they often have side effects.

Anxiety Disorders

This group of problems is characterised by feelings of fear or anxiety about aspects of life that are not a problem for most people. It includes panic attacks, phobias, obsessive-compulsive disorder (OCD), and generalised anxiety. AS many as one in three people may suffer an anxiety problem. It affects twice as many women as men, and is more prevalent among the poor and the elderly. Common symptoms include:

- Jitteriness, tension,
- Feeling tired,
- Dizziness, feeling faint,
- Sweating, trembling, heart palpitations,
- Sleeplessness,
- Difficulty concentrating, and
- Hyper-vigilance.

Treatments include a variety of psychosocial interventions. Tranquilisers are the most common medication prescribed for anxiety problems, particularly the benzodiazepines which include Librium and Valium. They are highly addictive. The over-use of benzodiazepines (benzos) is still a problem for Australian women. In 1990, 10.6 million prescriptions for this group of drugs were dispensed. An estimated 330,000 Australians were using the drugs daily for six months or more in 1989-90. Most were women and the elderly, and a large proportion of them became physically addicted.⁷

Generalised anxiety is a pervasive feeling of fear and anxiety which is generally present, and does not relate to a specific cause.

Panic attacks are a sudden unanticipated feeling of terror and helplessness. An attack may last seconds, hours or even a few days. People are likely to develop anticipatory anxiety – fear of having a panic attack – which can severely disrupt their lives.

Phobias are an intense fear of a specific objects or situations. People with phobias usually organise their lives to avoid the feared situation.

Obsessive-compulsive disorder is characterised by repetitive thoughts (obsessions) and acts (compulsions), such as hand washing, counting, checking and rituals. The prevalence of OCD is difficult to determine, as many people hide the problem from others. It affects equal numbers of men and women.

What Women Want From Services

“You need a place to go where you won’t be judged or labelled and where you can talk about what is really happening for you and not fear repercussions if people know how you really are.”

This statement is from a recent study in Victoria which surveyed 200 women with mental illness about what they wanted from services they used.² Following is some of their findings.

“Women want services to respond to their needs within a system which offers them dignity, safety, control, practical assistance, quality care, choice and respect as individuals.”

Women want sensitivity to gender issues. Many had been sexually assaulted, and saw their violent past experiences as central to their problems. Often they had difficulty talking to male medical staff about this issue. They want privacy and security. They want to be shown respect regardless of their state of mental health. They want confidentiality respected. They want to know who will have access to their files, and for what reason. They want information about their medications, and informed choice about treatment methods. They want to know what all the alternatives are. They want holistic health care, including their physical problems as well as their mental issues. They want continuity of care, through long-term commitment of workers. They hate telling their story over and over again. They need to be able to build a relationship and develop trust with workers, and this takes time. They want choice about their workers, and they want workers who are honest, direct and caring.

References

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