

Women and Psychiatry

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ABSTRACT/RESUME

La psychiatrie est très redevable au mouvement des femmes du fait que cette dernière a appelé l'attention sur les répercussions du conditionnement social des enfants du sexe féminin, lequel tend à faire accepter la soumission, le manque d'autorité, le manque d'indépendance émotive ou financière, le manque de latitude pour l'originalité, la créativité, les réalisations et le succès, ouvrant ainsi la voie à l'angoisse et à la maladie.

Une étude scientifique objective menée par Broverman chez les travailleurs du domaine de l'hygiène mentale fait état d'une double norme de l'hygiène mentale. On perçoit les hommes comme étant normaux et adultes et les femmes comme n'étant ni normales ni adultes si elles possèdent les qualités qu'on est censé trouver chez les femmes sérieuses bien adaptées aux exigences de la société.

Dans une analyse psychosociologique, Dorothy Dinnerstein a prouvé que la division artificielle des qualités humaines en deux groupes, tel que le veut le partage traditionnel des fonctions entre le secteur masculin et le secteur féminin, est malsaine. Il

faut trouver un nouveau type d'hygiène mentale à partir d'une intégration des qualités humaines.

On a procédé à un premier travail de recherche de la ville de Hamilton, en vue d'obtenir des données au sujet de la tendance de la pratique privée en psychiatrie. Les malades du sexe féminin l'emportaient en nombre sur ceux de l'autre sexe, dans une proportion de 3 à 2. Dans le cas de quarante-cinq pour cent des femmes on a diagnostiqué la dépression. On a constaté une corrélation entre la dépression et le mariage; venait ensuite une corrélation entre la dépression et le mariage; venait ensuite une corrélation entre la dépression et le veuvage ou le divorce. Les femmes célibataires semblaient moins exposées à la dépression que les femmes mariées. Toutefois, les femmes célibataires étaient plus sujettes à un diagnostic de troubles de personnalité que ne l'étaient les hommes célibataires. Il y avait en outre une corrélation entre la dépression et la situation en matière d'emploi, alors que la plupart des femmes déprimées étaient soit des ménagères, des assistées sociales ou des personnes travaillant à plein temps dans des emplois de bas niveau.

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traitement des principaux troubles mentaux ont été quelque peu exagérées dans le cas des femmes. Toutefois, contre toute attente, on n'a pas constaté qu'il y avait abus de tranquillisants et d'antidépresseurs de la part des psychiatres soit à l'endroit des hommes, soit à l'endroit des femmes.

On a constaté une différence importante dans la durée de la psychothérapie. Les hommes l'emportaient en nombre sur les femmes dans le cas de thérapie à court terme alors que les femmes étaient plus nombreuses que les hommes à suivre des traitements de thérapie d'une durée de plus de six mois.

To say that women are treated differently from men by psychiatrists generally would be true, just as it is true that all of society treats women differently. Psychiatrists tend to reflect society's values. Psychiatrists are not in the vanguard of social change; they respond to societal changes but probably faster than the other medical specialties. The Canadian Psychiatric Association has had a Task Force on Women's Issues for four years. The American Psychiatric Association has had its counterpart for over six years. Attendance at these conferences are suddenly including very pregnant mental health workers and babies in Snugglies; events previously unheard

of at a professional conference. Discussion on topical issues of rape, wife-battering, child abuse, alternate life styles and sociopolitical issues as they affect the practice of psychiatry, have become a regular feature at such national meetings of psychiatrists. I have not found to date any comparable demonstration of social and political awareness at conferences of other medical specialties. I have shown one of the psychiatric convention's programs recently to a feminist obstetrician friend of mine who gasped at seeing some of the items and said: "it would be unheard of at an OBGYN conference," and promptly attended a political analysis of wife-battering in Toronto.

Of course, the psychiatric profession is not free from sexism but it can be said that psychiatrists are trying to become aware of it. A considerable amount of change has taken place already, and it continues to happen. The attitudes and awareness of younger psychiatrists change quicker than those of the older ones, but I doubt there are many psychiatrists today who have been left untouched by the influence of the Women's Movement.

Psychiatry owes much to the Women's Movement. It has drawn attention to the poverty of knowledge about female psychology, female psychosexual development, sex role stereotypes and their contribution to psychiatric mor-

idity, by which I mean emotional distress and illness. It has also emphasized the role of socialization of female children that tends to lead to the acceptance of submission, lack of power, lack of emotional or financial independence, lack of power, lack of emotional or financial independence, lack of scope for originality, creativity, achievement and success. This is the "slave mentality," as some might call it, with the devastating price it costs in terms of identity and selfhood, self-esteem and the respect of others.

I would like to emphasize some of the work done both by psychiatrists and non-psychiatrists that has had a major impact on the principles and practices of psychiatry and which has led to further research and findings. The book that has changed the course of my career as a psychiatrist was Phyllis Chesler's Women and Madness. (1) I have never seen mental illness in the same way since I read Chesler. The Broverman study, (2) now a classic, also had an impact with its objective scientific survey that pointed out the double standard of mental health. Mental health workers of various disciplines, ages and both sexes were asked to score qualities and characteristics provided in a list that would be appropriate for a normal adult male, a normal adult female and a normal adult sex unspecified. Scores of normal adults were practically the same as those of normal adult males--while quite different from the scores of

normal adult females. The inconsistency has brought to public attention the fact that only males are seen as undisputedly normal and adult. Females are seen as not normal, nor adult if they have the qualities expected of mature, well-adjusted females in the society. This is a clear case of a double bind. If a woman is well-adjusted to her social role, as is expected of her, she cannot be regarded as a normal adult person; if her qualities, however, approximate the normal adult's, she cannot not be regarded as well-adjusted or feminine, and so will misfit her expected social role. She cannot be right or well however hard she tries to be.

As a result of the Broverman study much attention has been paid to sex roles, especially of women's sex roles. There followed an increased acceptance of a much broader range of "normal" or acceptable behaviours in women. Perhaps psychiatrists have been more cautious in declaring "abnormal" the housewife-mother if she happens to be happy in her role. This is I think a welcome correction for the swing of the pendulum, which is a result of the momentum of social change in women's roles, but which put the occasional happy housewife in still another double bind, making a lot of women feel that unless they went out in search of a career they were abnormal.

Dorothy Dinnerstein, a New York analyst, published a book in 1977 called The Mermaid and the Minotaur - sexual arrangements and human malaise.(3) In an excellent sociological-psychological analysis, she demonstrates the inherent unhealthiness of both the traditional male and female roles. The sickness is not in the particular qualities of either male or female, but rather in the artificial division of human qualities into two highly polarised, very different sets. Such splitting and polarisation is basically neurotic and adherence to either role demands suppression of some qualities and exaggeration of others--both resulting in neurotic characters. Male and female have to be mutually dependent on each other in such a system, forstering a basically infantile attitude in both. Hence men do not take women seriously--"women are silly;" and women do not take men seriously--"men are such children." Dinnerstein's major contribution is the statement that the "healthy adult" model we have thought healthy and adult is, in fact, neither healthy nor adult.

A new model of mental health has to be found and the basis of it is an integration of human qualities, to undo the previous polarisation. Human beings possess the potential for all human qualities and the development of human potential is what is healthy. After being human, people are male

and female, because they are born that way, not because they cultivate stereotyped, often stilted, behaviours. People should be recognized as individuals with their unique blend of potentials, rather than as masculine or feminine, because they role-play what society expects of them and hence what they expect of themselves.

These studies have had an impact on my own research conducted last year in the city of Hamilton.(4) My aim was to obtain data about the patterns of psychiatric private practice. Thirteen of the nineteen psychiatrists in private practice have co-operated in the study, two female and eleven male psychiatrists.

All were requested to fill out one brief questionnaire about each and every patient seen over a four month period. The questions included the age, sex, marital and occupational status of the patient; also the diagnosis, the form of treatment, and the date of first contact and the date of discharge in order to obtain some idea about the length of treatment. The total number of patients over eighteen was 1448; of those 880 were women and 567 were men.

The most important findings have been that women patients outnumbered the men patients by a ratio of 3 : 2. Forty-five percent of women were diagnosed as depressed, making depres-

sion the single most frequent diagnosis. A correlation was found between depression and marriage, the next highest correlation between depression and widowhood and divorce. Single women were less often depressed than those married. Another interesting correlation was found between depression and job status. Most of the depressed women were either housewives on welfare or employed full-time in a low-paying low status job. Although there were depressed women in high status jobs as well, the proportion of the depressed was much lower in this group than the proportion in the housewife, low status job or welfare group.

Another interesting finding was that the diagnosis of personality disorder was found with roughly similar frequencies in single or married men. But single women, including the divorced and the never married, were diagnosed as having personality disorder about 30% more often as single men were. This finding provokes the question as to whether non-marriage in women may be seen by psychiatrists as a sign of deviance and so receive the diagnosis of personality disorder.

Some differences in the treatment of men and women patients were also found. Although more men than women were diagnosed schizophrenic (8% :

7.5%), about 9% of women received antipsychotic drugs as opposed to only 5.5% of the men. Also, psychotic depressive illness including manic-depressive illness was diagnosed in 3% of both men and women, yet about 4% of women patients were prescribed Lithium to about 2% of the men. Thus, the drugs for the treatment of major mental disorders were slightly overprescribed for women.

Contrary to expectations, tranquilizers and anti-depressants were not found to be overprescribed by psychiatrists for either men or women. Other studies such as that of Ruth Cooperstock from Toronto Drug Research Foundation, (5) show a definite overprescription of tranquillizers and anti-depressants to women, and the prescribers are shown to be family doctors. Electroshock treatment, although seldom used by private psychiatrists, was given to about 3% of women as opposed to 1% of men in the sample.

Other important differences in treatment were found in the length of psychotherapy. Men outnumbered women for consultations by 16% to 12%. There were slightly more men seen in short term therapy of less than six months' duration, and more women than men in the six to twenty-four months length of treatment. There were twice as many women as men in the small group who were in treatment for more than two years.

Carl D'Arcy's group from Saskatchewan, studying the patterns of psychiatric illness and psychiatric care in that province, have confirmed most of my findings.(6) He has an additional interesting finding that would be worth looking into in Ontario as well. He found that 80% of psychiatric treatment is rendered by family

physicians; less than 7% of the patients are treated by psychiatrists and the rest receive treatment by hospitals and other agencies.

There is clearly a necessity for more research in all these areas.

NOTES

1. Chesler, Phyllis, Women and Madness, (New York: Doubleday, 1970).
2. Broverman, Inge K. et al, "Sex role stereotypes and clinical judgements of mental health," Journal of Consulting and Clinical Psychology (1970), Vol. 34, pp. 1-7.
3. Dinnerstein, Dorothy, The Mermaid and the Minotaur (New York: Harper & Row, 1976).
4. Cooperstock, Ruth, "A review of women's psychotropic drug use," Canadian Journal of Psychiatry, Vol. 24 (February, 1979), pp. 29-34.
5. D'Arcy, Carl, Schmitz, J.A., "Sex differences in the utilization of health services for psychiatric problems in Saskatchewan, Canadian Journal of Psychiatry, Vol. 24 (February, 1979), pp. 19-27.