Women and the mental health system: the social impact of the biological model

Thesis

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Women and the Mental Health System: The Social Impact of the Biological Model

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Chapter Four -

Discrimination in the Statutory Mental Health Services

Introduction

In chapter one I reviewed literature which suggested that psychiatric service provision itself contributes to the oppression of women mental health service users (see sections 1.7 and 1.8). In this chapter I present the findings of my research in relation to the women’s experiences of discrimination within statutory mental health service provision. For the purposes of manageability I have divided this chapter into separate sections concerning issues relating to gender (4.2-4.4); sexuality (4.5); age (4.6); disability (4.7); class (4.8); and race (4.9). This does represent something of an artificial separation however, as the issue of discrimination is a complex and multi-layered ground. For example poverty is not the same as class; race is not the same as ethnicity or nationality, and all of these factors can give rise types of discrimination. Different categories overlap, and one form of oppression can inflect in significant ways with other forms (Phoenix 1994, Frye 1983, hooks 1981, Wittig 1980).

Furthermore, it is sometimes not possible to clearly differentiate the impact of each characteristic in a woman’s experience of discrimination (Phoenix 1994).

4.1 An overview of the women’s reports of discrimination occurring within the statutory mental health services

In this research I define ‘discrimination’ as the provision of less favourable treatment to an individual than would otherwise be provided, specifically because that individual is identified as belonging to an oppressed group within society (I define an ‘oppressed group’ in section 2.3). Although the interviewees may not always have
used the word 'discrimination' themselves; wherever interviewees indicated that a less favourable service was provided by mental health professionals specifically because of a service users' race; sexuality; sex; class; disability; age; or a combination of these characteristics, I have interpreted this as evidence of discrimination.

In this research, fifteen women (43%) reported encountering discriminatory attitudes from statutory service providers specifically because they are women (section 4.2); two (6%) because of their sexuality (section 4.5); six (17%) because of their age (section 4.6); five (14%) because of health problems (section 4.7), and three (9%) because of their social class (section 4.8). One woman reported encountering racist attitudes from service providers because she was married to a black man and had mixed race children (section 4.9). Other women reported witnessing discrimination against fellow service users, and these reports are discussed in the relevant sections. As I noted in section 2.12, my research has significant limitations in examining the racism that black women may experience in the mental health services, as only one interviewee was black. In addition, there were no women participants in my study who were over sixty years of age, and only two lesbian participants.

4.2 Sexist attitudes towards women service users

Overall, fifteen women (43%) reported sexist attitudes amongst mental health service providers. Eight women reported encountering sexist attitudes from one or more GPs (24% of the women who had consulted a GP). To some extent this appeared to transcend the gender of GPs (five male and three female GPs were singled out for being sexist in their attitudes). Six women (24% of those who consulted them) reported encountering sexist attitudes amongst psychiatrists (all of these psychiatrists were male). Two women (18% of those who consulted them)
reported sexist attitudes amongst Community Psychiatric Nurses (one male and one
female CPN were singled out for criticism).

Jade said:

"I felt I was treated differently by GPs and male psychiatrists. Mainly GPs, treating
me as if I'm just the neurotic woman, sort of thing."

In section 3.2 I discussed a recurrent criticism of GPs made by many women
in the study, which was that they often disregarded the women's concerns about their
mental health issues. Several women reported that their GPs had made sexist
references to 'women's troubles' as a way of dismissing their concerns. For example,
Heather was told by her GP that her feelings of depression would be cured if she
decided to have another baby.

"Some of the comments I've had, awful comments especially when I was
young...he'd say something like 'all she wants is another baby' or 'why don't you take her to
the Bahamas for six weeks, that'll put her right'. You know those sorts of comments, not
taking me seriously at all."

Isabel, who approached her GP whilst severely distressed because she had
been sexually abused as a child by her mother, was told by her GP that her feelings
were nothing to do with the abuse and had more to do with the fact that she was
menopausal. Discrimination according to her gender and her age were clearly
indicated in the response of her GP.

"Well my doctor keeps trying to give me hormones and stuff, he says it's my time of
my life and things like that. That's it... he says yes you've had a nasty experience with your
mother but you've managed all this time so it's your hormones now, it's your time of life. It's
all these other things now, he doesn't want to know."
Vicky approached her GP when she was suffering with depression after the birth of her first child. She said that her family GP had a very dismissive attitude towards her and did not offer her any assistance. Vicky believed that her GP would have treated a man differently. She said:

"Whether if I’d have seen a woman [GP] it would have made any difference I don’t know. But I’m pretty sure if I’d have been my husband going in there with the same symptoms they would bloody well have done something about it, I’m sure of that. I’m sure it made a difference."

It has been suggested that some GPs avoid making a formal diagnosis of a mental health problem altogether where they are dealing with conditions they think are not serious. Instead they attempt to reassure their patients and may prescribe a course of antidepressants and/or tranquillisers (Foster 1995, Miles 1988). As some of the women in this study described, the reassurances which GPs provide can be unhelpful, as they often involve explaining the women’s distress as ‘merely’ a manifestation of women’s reproductive processes, such as childbirth, menstruation and menopause (see also Miles 1988). This explanation can involve an oppressive trivialising of the women’s feelings of distress, by utilising references to female biological processes as a means of dismissing their concerns. As Miles indicates, some women may link their problems themselves to their reproductive processes, but they think that their concerns should be taken seriously rather than being disregarded (1988:120). The dismissive attitude of some GPs can also be seen as indicative of the belief that women are inevitably prone to experiencing minor mental illnesses, as mental illness is perceived to entail a loss of rationality, and women are sometimes believed to be inherently prone to irrationality (see section 1.1 and 1.7). Of GPs, the majority who were criticised for expressing overtly patronising attitudes towards their female patients were male (five). There were, however, reports of female GPs
(three) refusing to take the women’s concerns seriously. For example, Sarah said that she will not see a woman GP because of the bad experiences she’s had with them in the past.

“All my mental health problems stem from a bad marriage and physical illness [endometriosis]. I was never out of pain from 11 years old... But I do not want a woman GP ever. I have had them in the past - no good. I don’t know about mental health but if a woman has got period problems especially ones as bad as with endometriosis and you go to a woman GP who has never had period problems, you are in dire straits I tell you, because she doesn’t want to know... My feedback from women GPs is not good.”

Jane also said that the female GPs she had seen had expressed dismissive attitudes towards her. In fact when I asked her whether she thought that she had ever been discriminated against in mental health services because she is a woman, she answered:

“By women doctors, yes. I felt like they were like an old auntie who knew everything and the attitude was ‘oh I’ve been through worse than you!’ You know, ‘fuss and bother!’”.

This attitude contrasted with that of the male GP she now sees. During her first consultation she was relieved to find that he took her seriously and did not tell her to ‘pull herself together’ as her previous female GPs had done.

Sarah said that the male community psychiatric nurse (CPN) she saw had a discriminatory attitude towards her, which contrasted with the attitude he had towards her husband who is also a mental health service user. In describing what was happening, Sarah became very distressed and broke down in tears as she explained that the CPN’s sexist attitudes are particularly painful because they remind her of the domestic violence she suffered during her first marriage.

“I have to find the words to put this. Because he [the CPN] turns everything I say round on me it’s like having mental cruelty. And it shuts me up. Because of my past I can’t
go past that. When he goes sometimes I think that’s a feeling from the past. Because I’m just not being heard and then I try to explain it’s all just thrown back at me.”

Six women (24% of those who had consulted psychiatrists) described encountering sexist attitudes amongst the psychiatrists they had seen. All of these psychiatrists were male. For example, Justine said that her psychiatrist had displayed a particular dislike of treating women patients. She said:

“He used to make me feel like I was lying. He’d go ‘uh-oh another woman’. He was all smiles when my husband came in, but he was a pretty horrible fella. We didn’t hit it off very well… I think that if you’re a woman, they go ‘oh here we go, another one of them’.”

Charlotte said that she would have liked to have a woman psychiatrist because she did not feel comfortable talking to a man. However, when she requested this she was told that there weren’t any available, and was accused by her male psychiatrist of being sexist.

“My psychiatrist always comes across as very patronising but whether that comes down to sexism or whether he’s patronising to everyone I don’t know! I did say to him that I had asked to see a woman and he accused me of being sexist. Yes, he said don’t you think that that’s sexist. And I said no, without explaining... The thing is when you’re feeling vulnerable anyway, to be confronted with someone who you’ve got absolutely nothing in common with is not good. He [the psychiatrist] just seemed like a patronising git. It’s very difficult. I deliberately asked if I could see a woman when I went to see my GP and he informed me that there were no women practising psychiatry in the area.”

The power dynamics inherent in statutory mental health services are revealed by the fact that psychiatrists in particular are predominantly male, and from a middle class background (Johnstone 1989). The lower down the medical hierarchy the more varied become the social characteristics of medical professionals. It would be wrong however to assume that there is any simple correlation between the gender of a service provider and their efficacy at helping women to deal with issues of mental
distress. For example, Jane said that although she had needed to see a woman professional to talk about her experiences of abuse, her relationship with the woman CPN she was allocated had not been a successful one, and in some respects had been damaging for her because of the CPN's stigmatising attitude (see section 3.4).

Nevertheless many women said that they would like to have more choice in deciding the gender of their service providers. I explore the reasons for this in the following section.

4.3 The significance of the social characteristics of mental health professionals

Sixteen women (46%) said they would prefer to talk to women GPs, psychiatrists, psychologists, counsellors and community psychiatric nurses. For example Elaine said:

"I'd rather see a woman. You can talk, tell a woman everything, she knows everything about women's problems don't she? You can tell her everything - you couldn't tell a man could you?"

Vicky said that she could not properly discuss with a man her feelings about the depression she experienced after the birth of her first child. She said:

"I know men are parents and fathers and whatever but I just don't think they've got the same insight into it. I could speak freely to a midwife friend or to women that haven't got children. I know that they'd understand, but I just don't think that a man would. Because my husband tried to understand and couldn't. And I think that that's because he was a man. It was sort of pull yourself together, you know."

Jane pointed out that for her, being able to see a woman professional to talk over her problems had been very important. She said that she would not have been able to talk in depth about the problems that were bothering her, if she had had to see a male CPN.
"I think it's very important to be able to choose the sex of the worker. Because I had so many sexual things I had to talk about that's why I chose a woman first of all. I think it was good for me even though I only talked to her a couple of times, she was the first official person I had sat down and told about certain things. So I think it was easier for me to tell a woman first of all...But it was very hard to talk to that one bloke I seen to get the referral. Because he had to work out who I was going to see, so I couldn't just skim across the surface. I had to tell him things that had happened and it was really hard to tell him."

Many women service users who would like to see women specialists are prevented from doing so however. This is sometimes because there are no women available; psychiatry for example is an overwhelmingly male dominated profession. This is less of a problem where there are more women working, such as in psychiatric nursing for example. Nevertheless, some women are still prevented from seeing a woman because they have been automatically allocated a male nurse and are not given the option of choosing the gender of their worker themselves. Judy, for example, found her male CPN to be totally unhelpful to her, because she believed that he simply didn't listen to what she had to say. She decided to tell the manager of her daycentre that she had 'women's problems' and needed to talk to a woman in the hope that they would permanently replace her CPN. Their response was to allocate a woman for a few sessions on a temporary basis. They told her that she could have the woman from time to time if she needed to talk about 'women's problems' but she would still have the male CPN as her primary worker. As this tactic was unsuccessful, Judy made a direct complaint about him and asked for a woman CPN. He was still not replaced however and she stopped using the CPN service altogether.

For some women however, the gender of a professional may be as, or even less important, than other social characteristics they may have. For example, as a black woman, Diane said that she would prefer to see a black psychiatrist (see section 4.9). Kim, a lesbian, said that she would prefer to see a lesbian psychiatrist (see
section 4.5). Kate, a working class woman, said that she would prefer to see a woman psychiatrist who herself had come from a working class background (see section 4.8). Gillian, a forty-nine-year-old woman, said that in order for her to have talked about the domestic violence which was key in her experience of emotional distress, she would have had to have seen a woman of a similar age (see section 5.2). Isabel, Jade, Sheila and Justine had all experienced child sexual abuse, and said that they would like to see professionals who had themselves been abused (see section 5.6). In all of these cases the characteristics the women most wanted in a professional were those they identified as being a particularly important source of oppression for them.

It could be argued that this desire to share identity with service providers is a somewhat essentialist position. However several feminist researchers (for example Davies 1996, Kitzinger and Wilkinson 1996, Roseneil 1996) have argued that issues of shared identity are crucial in the politics of liberation and there is nothing inherently essentialist about this as identities are themselves socially constructed and therefore contingent.

In examining the question of shared identity it became apparent that issues relating to safety, trust, empathy\(^1\), understanding, the ability to listen, and the possibility of encountering discriminatory attitudes, were of central significance. Safety was an especially important issue for women who had experienced male violence in the past. Thus many stipulated that they would have to consult a female professional in order to feel properly safe. The reasons for feeling unsafe with male service providers included a fear of being misunderstood, blamed for their abuse, or

\(^1\) I use the term empathy to mean the ability to ‘stand in someone else’s shoes’, that is, the ability to understand a situation from the vantage point of someone else’s concerns.
otherwise revictimised in that relationship\textsuperscript{2}. Because they did not feel safe they chose not to talk to male professionals about their experiences of abuse, even where they recognised these experiences as being significant in causing their mental health problems.

Associated with the issue of safety is the issue of trust. Many of the women explained that a shared ‘insider identity’ (of being female; black; lesbian; working class; older; an abuse survivor, for example) would, from the outset, provide rapport and help to establish the trust necessary in the building of an open confiding relationship. They also believed that this ‘insider identity’ would lead the professional to be better at listening to their experiences and more empathic in their approach.

A major criticism for many women was that the professionals they consulted did not have adequate listening skills. Listening skills are a pre-requisite in the establishment of an empathic relationship. Listening is an active rather than a passive process and there are a range of signs both verbal and non-verbal which indicate whether someone is listening or not. Previous research has indicated that because of a purely scientific training doctors are often ill-equipped to discuss emotional issues with their patients (see section 1.3).

However the question of whether one is able to listen extends beyond the issue of whether someone possesses formal counselling skills. A service provider’s own unfamiliarity with, or aversion to, the issues which are being raised might render them unable to listen in a meaningful way. It is understandable that many women hold the expectation that a service provider who shares certain characteristics of oppression in common with them will be better able to listen because of their own

\textsuperscript{2} These were not always unfounded fears. I discuss this issue in further detail in chapter five on abuse survivors experiences in the mental health system.
personal experience in that area. Thus there is an assumption that because they are familiar with this territory on a personal level, they will be more understanding when discussing it with their clients.

Although in many cases this might be the case, and shared experiences may enable a professional to become a better listener through increased familiarity and understanding of the issues in question, it is also possible that in some circumstances a shared identity might cause someone to listen less well. For example, in the course of interviewing one woman, an abuse survivor, it became apparent to me that for a short period of time I had mentally ‘switched off’ from what she was saying to me. During this brief period of time, although I continued to behave as if I was listening, my mind had wandered so that I was not actually actively listening. When I went home I listened to the tape of the interview and noted the section where my attention had wandered. I was somewhat ashamed to find that I had disengaged from her when she was describing an aspect of her abuse experience. I concluded that it was not a simple accident that my attention had wandered at this point, as this issue was particularly painful to me in my own experience of abuse. Paradoxically, it was my own ‘insider identity’ which contributed to the willingness of some of the women to talk to me about sensitive issues relating to their mental health problems (see section 2.9), however, in this particular instance my ability to listen was hampered by the very identity we had in common.

Of course, in order for professionals to exercise any listening skills they may have, service users must feel able to begin to establish trust with them so that they can take the (not inconsiderable) risk of speaking openly about their mental health problems and the experiences which may have given rise to them. For this reason, it would seem advisable that, wherever possible, women service users should be able to
exercise some choice in deciding the characteristics of the professionals who will treat them in order to facilitate a process in which they can feel comfortable enough to speak freely.

There was a clear assumption amongst many women that because of a shared identity of oppression the professional would automatically be 'on the side' of the woman herself and would not side with the oppressor group. Thus they would be less likely to repeat the discriminatory treatment which had been an important source of their distress in the first place. In discussing this it became apparent that some women were (at least to some extent) eliding the issue of shared identity with that of shared understanding. It is possible that professionals who share social characteristics with their clients could also hold oppressive, discriminatory or otherwise unhelpful attitudes to their clients (see for example Sarah and Jane (section 4.2) who accused female service providers of displaying sexist attitudes towards them). Beyond the question of shared identity there is the crucial issue of the particular theoretical analysis a service provider holds towards women experiencing mental health problems. Thus it is quite possible that although a service provider does not share characteristics of oppression in common with their clients, the theoretical and political approach which they adopt equips them with the necessary skills to interpret their clients' experiences in a way which is both enabling and empowering. Conversely, sharing social characteristics whilst subscribing to a theoretical analysis which ignores issues of oppression can lead to an approach which is experienced as disempowering.

Thus allowing women more choice in determining the characteristics of the professionals who treat them will not of itself ensure that women receive effective non-discriminatory treatment within the mental health system. On a practical note, the
majority of psychiatrists are male and middle class, and so women will not always be able to access psychiatrists who have the social characteristics they are looking for (although professionals lower down in the hierarchy are drawn from a wider range of social backgrounds). A further crucial point however, is the issue of the theoretical approach adopted by service providers in their treatment of women users. The biological model of mental illness does not adequately address issues relating to the social oppression experienced by service users in wider society (section 1.1 - 1.3). In addition, issues relating to the social construction of mental health problems, such as the discriminatory labelling of some service users within psychiatry, are not usually acknowledged by proponents of the biological model (sections 1.2 and 1.7). Furthermore, as psychiatrists are placed at the top of the hierarchy of statutory mental health services, the biological approach evinced by psychiatrists has a tendency to dominate the work of other service providers (Johnstone 1993). Previous research (Scheff 1984) has indicated that involvement in the psychiatric establishment can have a deradicalising effect on individual service providers lower down in the hierarchy of service provision, as the structure of the establishment encourages a conformity of approach.

4.4 Additional problems for women with childcare responsibilities

As women are usually the primary caretakers of children within the family (Barrett 1990), a significant way in which some women may experience indirect discrimination within mental health services is in terms of the lack of childcare facilities which are made available. Twenty four women (69%) in my study had children. Sixteen of these women (67%) reported that a lack of childcare facilities in mental health services was a significant problem for them in accessing the services.
Women who did not report problems with childcare usually had other family members who were willing to look after their children, or their children were old enough to be left at home on their own.

Kate described how a lack of childcare facilities contributed significantly to the distress she felt when she was admitted to a psychiatric hospital. Kate was experiencing domestic violence and was suffering acute emotional distress such that, in her words, she was “completely in a different reality”. She was turned away from a Women’s refuge because they said they didn’t have any room for her. Subsequently Kate was arrested by the police when she was found wandering around a shopping centre in a confused and distressed state with her daughter. She was taken by the police to see a psychiatrist who asked her if she needed ‘a rest’. She told the psychiatrist that she did, as she desperately wanted to get away from her home environment which was the major source of her problems. She did not realise that the ‘rest’ that was being offered her was admission to a psychiatric hospital. She was taken in a police car with her daughter and not told where they were going. Once inside the hospital she realised where she was and that her child was going to be taken and put into local authority care. She tried to leave then, and was forcibly restrained by male nurses, injected with major tranquillisers and detained in hospital under a section of the Mental Health Act. Her child was taken and she collapsed.

"My little girl went to a foster family then and it wasn’t until the third day, you know, that I was able to talk to a social worker... I know the child obviously can’t stay with you all the time but they should have something like a double room or something where they can stay in tow with someone the child knows. Because my little girl was three at the time and it’s very young to be taken away from me and not know what was happening, you know? I mean because we talked about it afterwards and she’d gone to stay with a family and they had three little boys. And she was sick when she got there - she was sick because she was - she
didn’t know what was happening. So I mean I feel very strongly about that, I think they should have some kind of facility.”

When Kate was describing her experiences of mental health service provision, the issue of childcare was the priority consideration for her. Having her child taken into care added to her distress considerably and has had repercussions for her since. She has felt a lot of guilt about what happened to her child, a feeling which has been encouraged by her ex-partner.

“One of the things I feel you know, very very strongly about is that there was no support for keeping my two children in the area where I was hospitalised and so I didn’t see them for about six months. I feel that if there were properly designed mother and baby units to which I could have been admitted with my baby and emergency nursery care for my toddler son, I would have been far less traumatised by what happened and they would have been as well. You know they would have had wonderful care from the nurse looking after them...To have to cope with one of the two major psychotic illnesses and then have to fight to keep your children is one of the most traumatic things that can happen to you.”
Although women are often the primary caretakers of children within the family, and women are over represented within the mental health system (see section 1.7), mental health services usually do not provide childcare facilities for service users (Darton, Gorman and Sayce 1994). Previous research reports have asserted that many women with young children are faced with a choice of either accessing a mental health service; or fulfilling their parenting role (Francis 1994, Good Practices in Mental Health 1994, Beckert 1987). It has been asserted that some women may avoid seeking assistance with a mental health problem altogether, in case their children will be taken into care (Rickford 1996, Darton, Gorman and Sayce 1994, Gorman 1992, MIND 1992a). In an attempt to remedy this situation, the user group MIND, has mounted a campaign for the provision of childcare facilities throughout statutory mental health service provision (Darton, Gorman and Sayce 1994). The provision of childcare facilities was a major concern for sixteen women who participated in my study, as they found that a lack of such facilities was a major problem for them in accessing services. Indeed, a lack of adequate childcare provision comprised an additional source of emotional distress for many of the women who had young children when they were using mental health services.

4.5 Discrimination against lesbians within statutory mental health services

The two women in the study (Kim and Stephanie) who identified themselves as lesbians both reported being discriminated against within statutory mental health services because of their sexuality. Stephanie had encountered homophobic attitudes from her GP and Kim had encountered homophobic attitudes from psychiatrists and psychiatric nurses.
Kim has been a psychiatric service user on an inpatient and outpatient basis for several years. She has been hospitalised on two occasions. She said that a major source of her emotional distress is the homophobia which she has experienced in all aspects of her life.

"To spend a whole life unable to express myself as a lesbian - it's more than the soul can bear. And that's the reason for mental illness - the soul is falling apart, the situation is so intolerable. I'd be a totally different person if I could express myself as I am."

Medical staff have not helped Kim to deal with the homophobia she has experienced. In fact, they have sometimes displayed the same homophobic attitudes which have been the source of so much distress for her.

"They were very obstructive, particularly because they knew I was a lesbian. Being a lesbian alienated me from everything and all I could do was sneak off into a corner somewhere and lick my own wounds because there was no-one there prepared. And that is what this system does to lesbians. There is no-one to go to. You are on your own no-one wants to know. Homosexuality frightens medical staff to death, it frightens nursing staff to death... They really do hate lesbians and dyke lesbians particularly - 'oh my god what is this thing here which looks like a bloke'."

When she was in hospital Kim requested a lesbian psychiatrist so that she could discuss the issues around sexuality which were important for her. Her psychiatrist did not respect her request however.

"They have no facilities for lesbians at all. If we have to have psychiatrists and psychologists they should be lesbian psychiatrists and psychologists... I wanted a lesbian psychiatrist but she [the psychiatrist] said she didn't want to know any."

Stephanie said that she too had encountered homophobia in the attitudes of her GP. She said that her GP would not acknowledge her relationship with her partner because Stephanie is a lesbian. Her partner was also her full time carer, and
because Stephanie’s GP was uncomfortable with lesbianism, she chose to ignore the role that her partner was playing in looking after her.

“I was telling my doctor that I couldn’t walk, I couldn’t feed myself, I needed help to go to the toilet and I couldn’t do anything for myself and that my partner was catering to my every need... the doctor could have recommended DLA [Disability Living Allowance] or Social Service intervention but she didn’t and I was too ill to think about those things. I think because my partner was a woman and she didn’t really think of us as a couple - she sort of ignored our relationship and ignored all the work that my partner was doing and didn’t think of us as an item.”

In considering the homophobia which lesbians encounter both within and outside the mental health system, Kim argued that mental health services should specifically address the needs of lesbians. She said that sexuality should be a fundamental consideration when organising service provision.

“We need services for lesbians, bisexuals whatever. Because the world revolves around sexuality whatever people say. We shouldn’t be lumped together because we’re not lumpable.”

Other research reports have indicated that lesbians are discriminated against within the mental health system (see for example Barnes and Maple 1992, Martin and Lyon 1984, Perkins 1991, Diamant 1987). Lesbian relationships are often not recognised by medical staff, as Stephanie described. In addition lesbians have no legal rights to make decisions relating to the hospital care of their partners. Mental health services commonly assume heterosexuality among users and staff which is a form of homophobia in itself. Furthermore mental health services often make the assumption that it is a woman’s lesbianism which is the cause of her problems, as homosexuality is often still perceived as being evidence of a psychiatric disorder even though homosexuality was removed from the official list of psychiatric disorders twenty
years ago (Perkins 1991, Diamant 1987). The diagnostic category ‘ego dystonic homosexuality’ is meant to be applied to a condition in which homosexuals are unhappy with their sexual orientation (American Psychiatric Association 1994). However, treatment for them is aimed at encouraging heterosexuality, rather than on addressing issues relating to the oppression of homosexuals in wider society (Diamant 1987).

4.6 Age discrimination in the statutory mental health services

Mental health problems amongst people aged over sixty years are commonly diagnosed as ‘senile dementia’. This is usually thought to be caused by Alzheimer’s disease, which is a biological illness of the brain. (Pilgrim and Rogers 1994). In Wales in 1998, people over the age of sixty-five represented the largest age group receiving inpatient care (7,865 in the age group sixty five and over, compared with 3,335 in the age group forty five to sixty four - Welsh Office 1999). As I noted earlier, there were no women interviewed as part of this study who were over sixty years of age and no women who had received a diagnosis of senile dementia (see section 2.12). This inevitably limits my exploration of age discrimination in the mental health services. However, seven women (20%) in my study said that they had witnessed the poor treatment of older users of statutory mental health services. Many of the observations that were made relate to a general lack of concern for elderly patients. For example Kate described the treatment of some older people on the ward where she was a patient:

“You know there were quite a few old people in there and they weren’t very nice to them... There was this old woman and she used to fall asleep in her chair, and they just used to pick her up in the chair to take her to bed. They’d always be dropping her out of the chair onto the floor whatever, and she’d bang her head, and they’d just shove her back on, and
carry her in and dump her on the bed. I'm not saying they were all like that, some of them were OK. But some of the male nurses were just like bouncers really."

Margaret was also concerned about the treatment of older people on the ward. She thought that some of the older patients were neglected by staff members, and so tried to intervene in order to assist them in ways which staff members did not.

"I did help the older ones quite a bit. I suppose I just subconsciously thought 'what if that was my mother there?' I wouldn't like my mother to be sat there for half an hour with a glass of orange juice, with people saying 'well if you don't drink that we'll have to put a drip on you'. I think I just thought well, blow this, I'm going to do something... There was one lady that couldn't drink so I spoon fed her. Once she started, she started drinking then, and she started to get a bit better. I had one old chap crying on my shoulder for about five minutes, and I thought perhaps I'm in the wrong job!"

As regards age discriminatory attitudes towards women who are under sixty years of age, six women (17%) in this study reported how they were not taken seriously because of a combination of their age and gender. For example, Diane, Cerys and Vicky all thought that that they were not taken seriously specifically because they were young women in their teens and early twenties. Sarah, Isabel, and Heather described how their concerns were disregarded by mental health professionals because they were middle aged and their problems were all ascribed to the menopause (see also section 4.2). Five women (14%) referred to combination of ageist and sexist attitudes amongst GPs and two (6%) referred to a combination of ageist and sexist attitudes amongst psychiatrists.

Previous research has indicated that people over the age of sixty may be particularly negatively affected by the dominance within psychiatry of biological explanations for mental health problems. Psychotropic drugs are prescribed to older women more than any other patient group (Williams et al 1993). It has also been indicated that older women are most at risk from the side effects of prescribed
medication, but they are the least likely to be provided with counselling or psychotherapy (Williams et al 1993). Elderly women may also be more likely to be treated with ECT, despite the greater risk for them of damaging side effects (Foster 1995, Barnes and Maple 1992). Because of the dominance of the biological model of mental health problems, social support for older women who are experiencing mental health problems is eschewed in favour of physical treatments. In discussing the treatment of older women service users, Foster (1995) asks the following questions:

"Is a course of ECT really the best solution to the complex range of problems faced by very elderly women in today’s society? Or could it be that a course of ECT is simply a more cost effective and more capitalist compatible form of intervention than the provision of adequate income and social support which so many elderly women lack?" (Foster 1995: 100)

Over 60% of women over sixty five live below the official poverty line in Britain (Williams et al 1993) and there is an established link between poverty and mental ill health (Bruce et al 1991, Gabe and Thorogood 1986, Hollingshead and Redlich 1958). In previous research, it has been argued that many older people have been misdiagnosed with senile dementia and/or Alzheimer’s disease, because distress due to poverty; elder abuse; loneliness; bereavement; and discrimination, is ignored (Barnes and Maple 1992, Pilgrim and Rogers 1994).

4.7 Discrimination due to disability within statutory mental health services

The Disability Discrimination Act 1995 defines disability as “a physical or mental impairment which has a substantial and long-term adverse effect on ability to carry out normal day-to-day activities” (quoted in the Disability Rights Handbook 1997:10). In my study however, definitions of disability differed between the women who took part. Some women were unsure whether a mental health problem could be described as a disability and if so under what conditions it could be labelled as such.
Two women (6%) defined themselves as disabled because of their mental health problems. They had both been diagnosed with manic depression. The other women who had received the same diagnosis did not define themselves as disabled and preferred to define disablement as applying only to physical health problems (see section 2.12, table 7). Seven women (20%) defined themselves as disabled because of a physical condition.

If mental health problems are defined as a disability, then a discussion of issues relating to disability discrimination would also entail the exploration of discrimination against people with mental health problems. In section 3.4 I discuss the stigmatisation of mental health issues. This stigmatisation can be seen as a form of discrimination against people with mental health problems (Sayce 2000) which sometimes affects women when they are using mental health services (see section 3.4 for a discussion of this).

Of the nine women who defined themselves as mentally or physically disabled, five (56%) reported encountering discrimination because of disability within the mental health system. Of these, three women (33%) reported discrimination because of a physical disability. Two women (22%) reported experiencing discrimination within statutory services because of a mental health problem. Three women (33%) accused GPs (one female GP, three males) of discriminating on the grounds of their physical health problems. Two women (22%) accused CPNs (one male CPN, one female) of discriminating on the grounds of a mental and/or physical health problem (see also section 3.4).

Heather reported that because she has been diagnosed with a mental health problem (manic depression), when she visits her doctor complaining of a physical illness he refuses to take her seriously.
"When you're diagnosed with a mental illness when you go to the doctor with another complaint they don't take you seriously and properly investigate. They say that it's all psychological. That's my epitaph, I told my husband, 'she's not really dead, it's all psychological'."

Sarah made a similar criticism. She accords her mental health problems to the domestic violence she suffered in her marriage, and chronic endometriosis which had remained undiagnosed for thirty years. Before the diagnosis of endometriosis was made, Sarah was put on hormone treatment which drastically worsened her condition. Sarah had told her GP that she suffered with mental health problems and that these were largely due to the domestic violence she had suffered for many years. However this fact was held against her when she tried to get treatment for her physical condition. She went to several GPs, repeatedly asking for help to deal with the severe pelvic pain she was experiencing. They all told her that her problem was psychosomatic. Consequently she was prescribed antidepressants and tranquillisers. Eventually her physical condition was properly diagnosed, but not before she became seriously ill; as the endometriosis was aggravated by the hormone treatment. By this time she had also become addicted to the medication she had been prescribed.

Sarah also reported experiencing discrimination against her because she is disabled with arthritis. She said that she does not get adequate help from social services to help her deal with the condition. Her CPN also does not acknowledge the mobility problems she has, and the impact these have upon her mental health. When Sarah was discussing the issue of discrimination, she described how she had faced discrimination because she is a woman, because she has a disability, and because of her age. Sarah described how the variety of oppression she has experienced has served to compound her emotional distress significantly.
"Even the period problems created part of the mental health problem - I was told that every woman had periods and I had a very low pain threshold. In actual fact I had a very high pain threshold because even pethidme didn't work. Endometriosis pain is devastating...I was made to believe that I was neurotic - I was making fuss because everyone had a period - twenty nine years of that...Now I feel that my CPN doesn’t give me the consideration I should be having because of my disability...You get to 50 and everything is because of your age. From 40 to 50 everything that I ever went through I was told was because of my age. They’re trying to say that everything’s the menopause.”

Sarah’s testimony indicates that in women’s lived experience, different forms of discrimination can inflect together at specific points in time to produce a complex web of oppressive attitudes.

4.8 Discrimination according to social class in statutory mental health services

As I observed in section 2.12, women from middle class and/or highly educated backgrounds are over represented in terms of the number of women who participated in my research. Of the thirty five women interviewed in total, fifteen (43%) have studied at university level. Overall ten women (29%) reported that they were treated differently by staff because of their social class, occupation and/or levels of educational achievement. However, predominantly this figure is made up of women who thought that they had received better treatment than other service users, because of their level of education. Eight women (23%) thought that because of the job they did at the time, or the educational qualifications they had, they had received better treatment than other service users not similarly qualified. Three women (9%) reported that they had been discriminated against specifically because they are working class. Of these, two women reported that their psychiatrists (one male psychiatrist, one female) had a discriminatory attitude towards them, and one
reported that her psychologist (male) had a discriminatory attitude towards her, because of social class.

Sheila, who was working as a kitchen assistant, described the discriminatory attitude of her psychologist. When she approached him for help with the distress she felt at having been sexually abused by her father in childhood, she was told that her distress was caused by the fact that she hadn’t had enough education.

“He thought that my problem was that I’d left school without qualifications and basically I didn’t have enough up there [taps the side of her head] to - how can I say - I didn’t have enough to keep me occupied so I kept thinking about the past and my problems. Whereas if I had books to read and an education I wouldn’t, I wouldn’t think about things like that then.”

Kate said that although she was not actually discriminated against, she thought that her psychiatrist could not assist her adequately, because she is working class and her psychiatrist obviously came from a very middle class background. She said:

“I saw a woman [psychiatrist] but if I’m being honest with you I think she doesn’t have a bloody clue. We’re from different backgrounds and everything, I think she wouldn’t be able to relate to me and help me in any kind of way. She seems like she’s come from a middle class kind of background, I’m not saying there’s anything wrong with that but I don’t know, she just seems really straight laced and, to be honest, she didn’t seem like she had a clue... It just makes me think, you know, that these psychiatrists, they don’t really know what people need.”

I asked Kate whether she thought that if her psychiatrist had had a more working class background she would have been able to relate to Kate better. She answered:
“Oh yes definitely, definitely. I think that’s one of the things that’s important, you’ve got to make sure you’ve got the right sort of person for you, otherwise you can’t come out with your experiences can you?”

Charlotte a middle class service user thought that she received better treatment in hospital because she was a university student.

“I think the fact that I was a student and I was obviously intelligent influenced things. I think perhaps I wasn’t treated as patronisingly as other patients were. And when the professionals would talk to me - I think it influenced the way that I was as well, because I feel much more as an equal against people that I talked to, as opposed to the others.”

Heather thought that those with a better education would receive better treatment in mental health services, but she also thought that it could count against you as some doctors would perceive it as a threat to their power over a patient.

“I’m sure that you are treated better in all these things if you are well educated and articulate. Being a teacher I was able to speak for myself. But on the other hand you can get the authoritarian type of doctor whose attitude is that ‘just because you’re educated, you think you’re as good as me’, sort of thing.”

Gail, a working class service user, thought that her social class has been important when doctors have prescribed her treatment. Gail had two courses of ECT while an inpatient in hospital. This was in addition to major tranquillisers and antidepressants which were prescribed for her. Each course of ECT comprised two treatments a week for eight weeks. She refused a third course because it was causing significant memory loss and she could not perceive any therapeutic benefit from it.

“I actually refused it the third because it was affecting my memory, I couldn’t remember things. But the staff said ‘oh well that doesn’t really happen, it doesn’t really cause you memory problems - it’s all for the best’. And I said ‘well I would have ECT willingly if it cured you, but it doesn’t cure you.’ You know, I think it makes them feel better because they think they’re helping you.”
Because Gail refused a third course of ECT, her psychiatrist applied considerable pressure on her to have a leucotomy. At first Gail did not know what the procedure was and her psychiatrist did not provide with any detailed information about it. She was seriously considering consenting to the operation when she spoke to her nephew who is a social worker. When she discovered that it would entail the surgical removal of parts of her brain so that she would be permanently brain damaged, possibly incurring seriously deleterious effects in terms of her personality, feelings and day to day functioning she returned to her psychiatrist and refused to go ahead with it. He applied more pressure and told her if she did not consent then she would have to have further courses of ECT. The psychiatrist threatened Gail with sectioning and enforced ECT if she did not voluntarily choose either of these treatment options. Gail was devastated by her psychiatrist’s abuse of his powerful position over her. A few weeks later her psychiatrist took up a post in a different area and her new psychiatrist, a woman, reassured her that she did not have to consent to either procedure if she did not want to. When I interviewed her, Gail had been taking major tranquillisers and antidepressants for many years. She saw little therapeutic benefit in them, but thought that they were probably “better than nothing” in helping her to deal with the distress she felt. What she would have really like to do, she said, was to have a course of counselling provided. This had so far been denied her, and she was firmly of the opinion that this was because she is working class. She said that if she was middle class she would have been offered counselling instead of the purely physical treatments which she has been offered so far, namely medication, ECT, and leucotomy.

"Basically working class people get given ECT and middle class people get offered psychotherapy... Even now, my psychiatrist says when I’m really bad ‘are you coming in for
some ECT? No way! If it helped I would have it. They even wanted me to have this operation where they cut into your brain...I was told to go to London to see the people about it and I refused...They said 'you should have it, it's highly recommended that you should have it'...And he got a bit narky when I refused. Because he said 'well how can we keep on helping you if you're not going to try to help yourself?' Well I said I am helping myself, I'm doing all I can for myself...He said 'well if you're going to refuse that then you have to accept ECT when it's offered.' And I said 'no I don't, I'm not accepting that'. And I was quite brave actually, because I'm a bit of a coward. And I sat there and I said I'm not accepting that. I said I need help...I mean he used to say to me 'well it isn't normal for people to be up at two o'clock in the morning polishing their furniture'...He made me feel like a right freak.”

In previous research it has been asserted that where counselling is available, working class people are often thought to be inappropriate to receive it, because of their supposed deficiencies in language skills (Coleman 1998, Penfold and Walker 1984). Of course any ‘talking cure’ which is provided working class people would have to take account of the fact that the working class are disadvantaged economically (see also Penfold and Walker 1984). Indeed, as I noted earlier, a link has been suggested between poverty and mental and physical ill health (see Bruce et al 1991, Gabe and Thorogood 1986, Hollingshead and Redlich 1958). In a study carried out with sixty working class women, Gabe and Thorogood (1986) found clear evidence that inadequate resources such as bad housing, a lack of leisure options and a lack of, or unsatisfactory paid work, made many women more likely to approach their doctors for assistance with the psychological distress they felt. Many of the women in their sample had become long term users of minor tranquillisers in order to manage their everyday lives. As I observed in section 3.2, some GPs may be aware that their patients distress is caused by social problems, such as poverty and bad housing. However, the dominance of the biological model of mental health problems within the statutory mental health services, means that the only assistance which is usually made available to service users comprises of physical treatments. Indeed, the
dominance of the biological model within psychiatry means that the largest share of available funding for the mental health services is allocated to medical treatment, rather than social support (Goodwin 1993 - see also chapter six).

4.9 Discrimination against black women within statutory mental health services

In my study there is only one woman who defined herself as black (Diane). Another participant, Isabel, was initially unsure as to how to identify her race as her grandmother was black, but because of her appearance she is usually identified by others as white rather than black, or mixed race. She therefore decided to describe herself as white in the study, although this was a source of uncertainty for her. As I noted in section 2.4, the lack of involvement of black women in my research does represent a significant limitation in the scope of my findings. Isabel reported encountering racist attitudes amongst GPs and psychiatrists (all male doctors). Diane did not report encountering any overtly racist attitudes amongst service providers but felt that her (male) psychiatrist had been patronising towards her because of her age and gender.

Isabel was married to a black man, and they had two children together. She said that she has frequently encountered racist attitudes towards her family. However, the racism which she experienced in her everyday life was not addressed in the mental health services she used, and in fact was repeated in the attitudes of some service providers.

"A lot of people can’t handle that you’ve married a black man or that you’ve got a bit of race in you. Or even if you just married a black man, you know, they reckon it’s bad to marry a black man and have half caste children. So there’s lot of issues all involved, it’s the world isn’t it? And we can’t do nothing about the world.”
Diane first approached statutory mental health services when she was feeling distressed due to family problems and the pressures of coping with racism in her everyday life. She was engaging in self harming behaviour which was both a coping mechanism for dealing with the stress she was under, and also an additional source of distress for her. She eventually sought referral to a psychiatrist.

"I wanted to be put on some medication. I think I wanted to opt out. I would rather have labelled myself as ill than have to cope with what was going on... I was thinking people were staring at me which at the time I wanted to put down to some psychiatric disorder that a psychiatrist could sort out, when in retrospect I think that it's just that people do stare at me. But I didn't want to face up to the reality that because I'm black people stare at me. I would rather think no, they're not staring at me, I only think that because I'm a bit loopy, and someone's got to help me. So I went to see a psychiatrist at the hospital."

Diane saw the psychiatrist three times in total and decided not to return for further appointments. She thought that the psychiatrist had a very patronising attitude and did not take her concerns seriously. She believed that because she wasn't displaying behaviour which could be labelled as manic depression or schizophrenia, he didn't know what to do to help her. Her psychiatrist did not ask about her experiences of racism and whether she thought that this had any relevance to her feelings of distress.

"Racism has certainly happened to me. I don't think in any obvious sense the services have helped me deal with that. Because they don't address it and they don't want to. I imagine they'd positively discourage it...From what I've seen they're notoriously unwilling to accept the influence of social factors in their diagnosis of mental illness anyway so racism would just be another social factor that in their eyes wouldn't constitute a reason for going mental. I mean certainly no-one in the course of all this has ever asked me 'do you think, I mean is this causing you problems.' Which, to my mind would be an obvious question to ask someone that I thought was depressed or whatever. I would ask, you know."
I asked Diane whether she had experienced any racism in the mental health services she'd used. She thought that her GP did not discriminate against her because of her race. With the psychiatrist she thought that although he was unhelpful, this was probably not specifically because of her race.

"I was inclined to think that he'd be like that with most young women. I would certainly think that it wouldn't have helped him to take me seriously. But on the other hand so far as I am aware racially prejudiced psychiatrists would be more likely to say you were more mad rather than less mad. And he certainly wasn't doing that, he was just bemused."

Diane said that visiting the psychiatrist was helpful to her, but only because his lack of understanding and inability to assist her made her realise that she would have to do something practical about her problems herself. She thought that as he did not have an understanding of, or an answer to her problems, she would have to find them herself.

"In a way it did help me. Not how it should have helped me, but it did make me realise that you know, everyone isn't superior to me, isn't more intelligent than me and this bloke's a nutter and he can't help me at all. I think it kind of jolted me a bit into thinking well I would have to help myself because there isn't any easy cop out by putting myself in the hands of someone like that, who didn't have any analysis of what my problems were."

Diane said that initially she would have preferred to label herself as mentally ill rather than acknowledge the impact which racial prejudice had upon her. If she was diagnosed as suffering with an illness it would provide an 'easy answer'; she could then be prescribed medication which would serve to ease her distress. When her psychiatrist did not assist her, she made the decision to acknowledge and address the sources of her distress, including her family problems and the far reaching impact which racism has upon her life.
Stephanie told me how she observed the discriminatory treatment of a black woman who was held involuntarily under a section of the Mental Health Act in hospital for several months. She was unable to communicate with doctors and nurses because she did not speak any English. She was very distressed, angry and fearful, but, no efforts were made to establish communication with her. Stephanie said that every week this woman was carried into the bathroom by male nurses and forcibly stripped and washed by them. She also was regularly injected with major tranquillisers against her will.

"I've seen the way that black people are treated in hospital. One particular instance is completely horrifying - a woman never being addressed in her own language and no effort is being made to get an interpreter, no efforts being made to find out what was really wrong with her. Being subject to further racist harassment in hospital which is probably a big part of the reason why she was there in the first place."

Racism impacts upon the lives of all black people in British society. A refusal to address racism as an inevitable issue for all black service users, serves to perpetuate racism in society. One way of improving this situation would be to recruit more black professionals at all levels of mental health service provision (but see also section 4.3 on the limitations of this suggestion as a way to significantly improve service provision across the board). Another way of improving the situation for black users, would be to establish self help groups specifically for black people experiencing mental health problems. Indeed, Diane said that she could only really be comfortable talking to other black people about the racial discrimination she experiences.

"I think definitely self help groups are needed because from my point of view if I am a victim of racism I want to talk about it with other black people and it's totally useless to be going to a white middle class doctor and be trying to explain this to him because he won't
know what I’m talking about. Or at best what you’ll get is someone over reacting horribly and going ‘oh my god that’s so dreadful’ and you know that it’s their own guilt or something and you don’t want to hear it. You need to talk to people who know what it’s like because only they can react in an appropriate way anyway... Presumably for some people or at some times those problems become so severe that they kind of tip you over the edge. And then a self help group once a week isn’t going to be enough and you may be forced to have to be in some kind of full time care. But obviously the desirable thing would be if people found themselves in that position, say you ended up in hospital because of repeated racial attacks or something and it flipped you out, that there would be for a start a black doctor in there, but more to the point that somebody would want to hear about that, that something practical was going to be done when you got out to make sure this didn’t happen to you again.”

Mental health services do not provide services which are geared to the specific needs of black users whether this in terms of addressing racism, providing self-help groups; access to black staff; or in providing interpreters for those whose first language is not English. Previous research has indicated that the racism which black people face in society is not addressed in mental health services and can often be repeated (see for example Torkington 1991, Littlewood and Lipsedge 1989). Admission statistics in the UK reveal that people of Afro-Caribbean descent are more likely to be admitted to a psychiatric institution than white people and are more likely to receive a diagnosis of schizophrenia (Coleman 1998, Torkington 1991, Littlewood and Lipsedge 1989). It has been suggested that the high level of diagnosed mental health problems among black people is the result of a high level of emotional distress caused by continued racial and economic discrimination (Gallagher 1987). This viewpoint has been challenged however (see for example Torkington 1991). Rather than a simple reflection of emotional distress, the over representation of black people in the mental health system is at least partly due to discriminatory labelling by the police, courts and medical profession (Coleman 1998, Torkington 1991, Littlewood and Lipsedge 1989, Hill 1983). In fact the number of people of Afro-Caribbean
descent who are detained in psychiatric hospitals under section 136 of the Mental Health Act 1983 (a police referral) indicates that there is a high degree of racism operating within the mental health system which affects both male and female service users (Torkington 1991). Mental health services further discriminate because access to interpreters for those whose first language is not English is very limited indeed (MIND 1992b).

As Diane indicated, in order to provide adequate assistance to black users, the impact of racism on issues of mental health needs to be addressed within the statutory mental health services. Because of the dominance of the biological model, however, the impact of social issues, such as racism, on the well being of service users is not addressed within the mainstream psychiatric services. In addition, because of the medicalisation of mental health issues, predominantly the only assistance which is usually provided service users comes in the form of physical treatments. Practical assistance in dealing with the social factors which can cause distress is not usually provided.

In view of research indicating widespread racism against black service users, it has been argued that psychiatry represents a form of “institutionalised racism” (Sashidharan and Francis 1999). This claim has come from two psychiatrists working within the discipline who have asserted that

“...any attempt to deal with racism would necessitate a reappraisal of not only the general procedures of psychiatry but also the Eurocentric bias of our theories and a commitment to change the professional culture that is based on pathologising differences. Psychiatry comes closest to the police among medical specialities in pursuing practices and procedures that explicitly discriminate against minority ethnic groups in the United Kingdom. Unlike in other branches of medicine, the racial bias in treatment and outcome that is evident in psychiatry cannot be understood fully by an examination of procedures, practice, or policy governing service delivery. The theories and assumptions of psychiatry are problematic when
they are applied to people who are socially excluded or culturally marginalised.” (Sashidharan and Francis 1999: 254).

Indeed, there is evidence to suggest that, historically within Western cultures, the development of psychological theories relating to mental and health illness have been imbued by an ideology of black and ethnic minority inferiority (Torkington 1991). Consequently, Sashidharan and Francis have called for a full national enquiry into the issue of race and mental health, which would set out to address racism in the conceptual basis of psychiatry, as well as in the policies, practice and procedures in service delivery.

Conclusion

In this study there were reports of sexist; racist; homophobic; ageist; and disableist attitudes, amongst statutory service providers. For some women, the discriminatory attitudes which they identified as being key in causing their mental health problems was actually repeated within the mental health services themselves.

In accounting for the discriminatory attitudes prevalent in mental health service provision it has been argued that psychiatrists simply reflect the prejudices which are widespread in the rest of society.

"...Many user/survivors...state that discrimination begins inside the mental health system. Staff attitudes can reflect those of the wider culture rather than marking a break from it." (Sayce 2000:64)

In reviewing the literature which indicates widespread discriminatory practices, Hill observes:

"Again, we are faced with the question of whether we should expect our mental health professionals to be any less prejudiced than the sexist culture which bred them, which
decided that the vast majority of psychiatrists should be male, and to which they aspire to have their predominantly female patients adjust.” (Hill 1983:264)

Broverman et al (1970) make a similar observation (see also section 1.7):

“...we see the judgements of our sample of clinicians as merely reflecting the sex role stereotypes, and the differing valuations of these stereotypes prevalent in our society.” (Broverman et al 1970:7)

Psychiatry as an institution reflects the power imbalance of wider society certainly. However, a material or extra-discursive reality of oppression, is, to some extent sustained and reproduced within discursive networks within the mental health system. Medical consultations can be seen to have a political character in the sense that they involve an unequal distribution of cultural and material capital (see also section 3.5). Thus the medical professional has both greater medical knowledge and the possession of the material resources necessary to diagnose and treat mental health problems. As a profession, psychiatrists have the power to play some role in articulating the ideological norms of behaviour within society. In this way psychiatry does more than simply reflect the prejudice in wider society. Psychiatry has established a set of norms to which all members of society are expected to adjust if they are brought either voluntarily or involuntarily within the remit of psychiatric medicine. It has been suggested that these norms relate closely to the characteristics most readily associated with the white, middle class, male, heterosexual. Individuals who deviate from these standards, are sometimes seen, almost by definition, as being closer to mental illness than those who do not (see also sections 1.7 and 1.8).

Within modern psychiatry women are discriminated against directly, in terms of sexist treatment, for example. They are also oppressed however, in terms of the explanations which are provided for their emotional distress. Oppression according to
race; poverty; gender; sexuality; age, and disability, are frequently ignored as possible sources of mental health problems (see also Coleman 1998, Darton et al 1994, Barnes and Maple 1992, Diamant 1987, Penfold and Walker 1984). In fact, most clinical staff are not trained to understand any of the social problems which service users encounter, and which may have contributed to their mental health problems (Johnstone 1993).

Mainstream psychiatry offers a means of understanding psychological distress which is inherently conservative (Penfold and Walker 1984). Within the biological model of mental illness, the notion that societal structures and social processes play a role in the aetiology of psychological distress, is often ignored in favour of the study of the biological functions of the brain. Thus the role of bad housing; poverty; racism; sexism; domestic violence; sexual and physical abuse; ageism, and other social problems concerning inequalities in power, are often ignored within mainstream psychiatry in favour of the study of brain chemistry. At the material level psychiatry serves to maintain the dominance of the pharmaceutical industry - one of the richest and most influential multinationals in Western capitalism (see section 1.4).

I consider the power relations inherent in mainstream psychiatric service provision in further detail in the following chapter, which concerns the specific experiences of women survivors of abuse in the mental health system.
Chapter Five -

Women Abuse Survivors in the Statutory Mental Health System

Introduction

The majority of women who participated in my research said that they had experienced some form of abuse in their lives. This included reports of domestic violence, and of child sexual and/or physical abuse. In this chapter I first provide a brief overview of the women abuse survivors experiences within the statutory mental health services (section 5.1). Previous research has claimed that due to the prevalence of abuse experiences amongst women mental health service users, a failure on the part of professionals to ask whether women service users have been abused amounts to malpractice (section 5.2). Therefore, I investigated whether the women who participated in my research had themselves been asked about abuse (section 5.2). In section 5.3 I describe some of the attitudes of mental health service providers towards women abuse survivors and go on to examine the treatment that was provided the women abuse survivors in my study (5.4). In previous chapters I have argued that sometimes statutory mental health service provision actually repeats the oppressive experiences which have caused women’s psychological distress. In section 5.4.2 and 5.5 I discuss this specifically in relation to the women abuse survivors in my study who reported having been sexually abused whilst they were using statutory mental health services. In the final section of this chapter (section 5.6) I discuss the women’s suggestions for the development of mental health services which would be useful in assisting women abuse survivors who are experiencing emotional distress.
5.1 An overview of the experiences of the abuse survivors who participated in the research

In my research twenty four (69%) women said they had experienced some kind of abuse during their lives. Of these, twenty (83%) said they had experienced sexual abuse as children, ten (42%) said they had experienced domestic violence as adults and five (21%) women reported having experienced physical abuse as children. A number of these women had experienced more than one form of abuse. The majority of this abuse had been committed by close family members including husbands, fathers, brothers, uncles, grandfathers. The majority of the abusers were male, although two women described being physically abused in childhood by their mothers and one woman had been both sexually and physically abused by her mother.

Of the twenty four women that disclosed abuse, twenty (83%) said that they had started using mental health services specifically because of the emotional distress they felt in connection with their abuse experiences. The sort of distress they described included feelings of anxiety; depression; low self esteem; phobias; panic attacks; self harm; feelings of unreality; of being cut off from the outside world; attempted suicide; substance abuse; and eating disorders.

Overall, thirteen of the women (54%) who disclosed abuse said that statutory mental health services had been totally unhelpful to them. Eight women (33%) who disclosed abuse reported mixed experiences in the system, describing how some professionals had provided them with adequate assistance while others had been completely unhelpful, and even damaging in their attitudes. Only three women (13%) said they had found statutory mental health services to be generally helpful to them. The criticisms which the women made included reports of negative attitudes
amongst service providers (see section 5.3), a predominance of physical treatments within the system (see section 5.4) and a general lack of mental health services in the statutory sector which are geared to the specific needs of abuse survivors (sections 5.2, 5.4, 5.6). An extremely disturbing problem described by some women related to further sexual abuse and harassment occurring within statutory mental health services themselves (see section 5.5).

5.2 The women's experience of being asked about abuse in the mental health services

Several research reports have indicated that a history of physical and sexual abuse is the cause of many conditions which receive a diagnosis of a severe mental health problem (see for example Darton et al 1994, Herman 1992, Barnes and Maple 1992). Dissociative feelings in particular (feelings of being cut off from the outside world), are often diagnosed as the symptoms of a psychotic mental health problem (see Herman 1992). In a report published by the user group MIND (Darton et al 1994) it has been estimated that the majority of women inpatients, and half of all women who consult a psychiatrist on an outpatient basis, have been the victims of child sexual abuse.

Due to the prevalence of abuse amongst women mental health service users, Williams, Watson, Smith, Copperman and Wood (1993) argue that service users should be asked whether they have experienced any abuse when they first access health services. They have asserted that:

"Unresponsive mental health services replicate and perpetuate women's previous experiences of their abuse not being recognised and accepted by others. This, in turn, may lead to the maintenance of substance abuse, psychotic symptoms or self-harm on the part of the woman, and high use of mental health services. Given what is now known about the incidence of abuse and its implications for women's mental health, neglecting to enquire
about a history of abuse is clearly malpractice.” (Williams et al 1993:14)

In 1998 the British Medical Association produced a report which called upon medical practitioners to play a greater role in identifying women who have experienced abuse (British Medical Association 1998). It acknowledged domestic violence as a health issue and asserted that health care professionals should constructively assist women to disclose instances of abuse and then ensure that they receive effective advice and support on how to deal with their experiences, including referral to Women's Aid groups and other agencies. Similarly, in 1992 the American Medical Association issued guidelines recommending that all doctors should routinely ask women whether they have experienced any form of abuse (Richardson and Feder 1995).

I asked all of the women who took part in my study (not just those who described themselves as abuse survivors) whether they had been asked about abuse when they were using mental health services. Only two women (6%) said they had been asked about abuse when they were using statutory mental health services.

Jade said she had been asked by a male psychiatrist, but had at first denied that she had experienced abuse as she didn’t feel safe confiding in him. His inquiry came only after many years of regular service use including long periods of hospitalisation. She said:

“I’d been seeing different doctors and psychiatrists and all that for years before then and I don’t think anybody had asked anything. I got the impression that they all thought it was in my head or whatever you know? Some neurotic paranoid woman who just wants a bit of attention.”

Jade said that the psychiatrist’s inquiry represented a turning point for her, even though she did not feel able to tell him the truth. He introduced her to another woman patient in hospital who was receiving counselling for sexual abuse. Jade
struck up a friendship with her, and was able at last to confide in someone that she too had been sexually abused by her father.

Kim said that she had been asked about abuse but had also denied that she had been abused because it was a male psychiatrist who asked her. She said that she would never confide in a man that she had experienced abuse, as it was a man that had abused her in the first place. She said:

"You don’t take your illness back to the one that’s made you ill... You have to be careful because a lot of males get off on hearing about sexual abuse - ‘and what did he do my dear?’ that sort of thing. I have to feel in control, it’s very important for women to feel in control, even of their abuse, even if they may be falling apart at the time."

Gillian said that she was never asked about abuse despite the fact that she was seeking help from psychiatric services specifically because of the distress she felt at being married to a man that persistently abused her. She said:

"The psychiatrist came about twice a week - he asked me to have ECT because he reckoned that I was suffering from endogenous depression. I wasn’t talking about my marriage... If somebody had taken the time with me, sat me down and got my confidence then I would have spoken about it. The psychiatrist specialised in neurotic women in their forties, he was into that kind of psychiatry. Nobody did talk to me, well there was a charge nurse that was nice and did talk to me. But I wasn’t comfortable talking to a man... Maybe if I’d met somebody of my own age and a woman I would have talked."

Many women service users are not asked about the social experiences which may have caused their emotional distress, including abuse (see also chapter three and four). In any case, if women were asked by male workers, many, like Kim, Jade and Gillian would not feel safe confiding in them about the abuse they have experienced (see also section 4.3 on the importance of the social characteristics of service providers).

One of the reasons why women are not asked about abuse when they begin to use mental health services is that the services themselves are often not geared to
deal with distress caused by abuse (see section 3.4). Gillian, who works as a nurse herself, made this observation when she said that the reason why no-one is asked about abuse in psychiatric hospitals, is because the staff simply would not know what to do about the fact that a woman has experienced abuse. Indeed, many women who approach mental health services for assistance are open with service providers about the fact that they have been abused and do not wait to be asked. In my study for example, Sheila, Cerys, Isabel, and Jane had all told service providers that they had experienced sexual abuse as children when they first sought assistance from statutory mental health system. None of these women, however, had been offered help which was specifically geared to the needs of child sexual abuse survivors. Indeed, all of them had encountered extremely unhelpful attitudes from the service providers they had approached. I consider issues relating to the negative attitudes of some service providers in the following section.

5.3 Attitudes of service providers to abuse survivors

A central criticism made by the majority of women who disclosed abuse relates to the negative attitudes towards them expressed by some service providers. The attitudes they encountered included disbelief; shock; dismissiveness; lack of understanding, and the abuse not being named or acknowledged.

Isabel had been both sexually and physically abused in childhood by her mother and brother. She had also experienced sexual and physical abuse from a violent ex-husband and his brother, and had been sexually abused by a male nurse in hospital. She has seen various GPs, a psychiatrist and psychologist, and has spent some time as an inpatient in a psychiatric hospital. Isabel said that these services have all been completely unhelpful to her, and that the treatment she has received has in fact contributed to her distress significantly. She said:
“It’s crazy really, because it’s people that you’ve met on your travels have made you like this as well. It’s the actual doctors and nurses.”

Isabel singled out the attitudes of service providers as being particularly damaging to her. She said that she felt further distressed by these attitudes, but because of her powerless position as a service user in the system, there were no avenues that she could turn to in order to improve the situation. She said:

“They didn’t get it half right and I jacked it in. The reasons why I jacked it in they don’t know, I could have told them it was because of this and that, but then you think what am I? I’m nothing, oh well.”

Isabel’s accounts of the abuse she has suffered have sometimes been met with shock and disbelief by service providers. Her disclosures that she was sexually abused by her mother, in particular, have led to her being described as ‘hysterical’ and ‘attention seeking’. Although her present GP believes that she was abused by her mother, he will not offer her any assistance with that specifically, because he believes that her distress is caused by the menopause and not by her abuse experiences (see also section 3.2 and 4.2).

Sheila described the attitude of her GP when she approached her for help with the distress she felt at having been sexually abused by her father.

“She seemed very shocked and very ‘oh my god’, you know and she said ‘is your son his’, as if it [the abuse] was only 12 years ago. I don’t think she knew which way to handle it and she is the senior doctor in the practice, she’s the one that’s been there the longest and with the most qualifications ... She was the first doctor I told and she just didn’t know how to handle it to be honest. And she referred me to the psychologist.”

Sheila found that the psychologist to whom she was referred had an even more damaging attitude to abuse survivors. He completely dismissed her concerns and even appeared to suggest that it was permissible for men to sexually abuse their
children. She said:

"His attitude to me was so bad that I just wanted to walk out in the middle of the session. He turned round and told me 'oh well, men did that in those days, if they couldn't have sex with their wives, they just turned on their children, that's just something they did then'...Oh it was appalling, you know just 'so what, that's what men did in those days, that's the way they behaved'. He sounded like it was acceptable - telling me it was OK for them to do that."

Her psychologist then went on to tell Sheila that the real reason why she felt distressed was that she has no educational qualifications (see also section 4.8 on the discrimination experienced by working class service users).

Jane described how her Community Psychiatric Nurse initially set out to provide her with counselling, but did not continue providing this because she was unable to deal with the anger Jane feels about her abuse experiences. The CPN did not understand that anger is a common emotion experienced by many survivors of abuse. She was clearly afraid that Jane would become violent towards her and consequently stopped visiting Jane without providing any explanations for this or referring her to any other service (see also section 3.4 on the stigma affecting service users).

A further important issue relates to the naming of abuse within the statutory mental health services. A key aspect of feminist approaches to the issue of violence against women has been the naming of women's experiences (Kelly 1996b, 1988a, 1988b, Kelly and Radford 1996). Prior to the influence of feminism there were literally no names for a whole range of violent acts towards women and children. Lacking names meant that this violence could not be talked about, acknowledged and women's experiences validated. As the range of sexual violence towards women and children has been documented, feminists have introduced new words and phrases into the language in order to name these experiences, such as 'child sexual
abuse', 'domestic violence', and 'sexual harassment'. These names have posed a challenge to dominant definitions which did not reflect women's experiences (Kelly 1988a 1988b). Although the women's movement has placed the issue of violence against women squarely on the agenda, there is some evidence to suggest that this analysis has not yet filtered through into the mainstream of mental health service provision, so that abuse is often unrecognised and unaddressed as a source of women's mental health problems.

For example, Sarah indicated that in several years of consulting mental health service providers, no-one had helped her to identify herself as a woman experiencing domestic violence even though they knew she was being abused by her husband. Instead she had been prescribed a variety of medication to ease her feelings of distress. She said that she had a "half life" because of the deadening effects upon her emotions of this medication. Sarah had blamed herself for the abuse she was suffering, and had not made the link between that and the mental health problems she was experiencing. She said that the turning point for her came when she approached a housing charity for advice on seeking alternative accommodation. She said:

"When I walked into her [the advice worker's] office she thought I was disabled but it was only that I'd been beaten the night before. And she was clever enough to actually to bring that out. And when she did see the bruises she picked up the phone and said I'm getting you into a refuge right now. I said 'you can't do that, my mother's dying in hospital - you can't do that'. She said 'because you're a battered wife!' I said 'I'm not a battered wife!' I didn't know I was. Because I'd been through that mental health system and nobody had told me, nobody had labelled me...But I was an intelligent person and if somebody had said to me 'do you know that what you are is a battered wife' it would have upset me no end but at least I would have been able to think about it. Or if somebody had said to me 'do you know that what is happening here is mental cruelty' - no-one told me what mental cruelty was. They're just words unless someone tells you what it is."

Sarah then entered a Women's Aid refuge where she received counselling
specifically for the abuse she had suffered. She said that this counselling was invaluable to her, as it was only then that she could begin to come to terms with the abuse she had experienced.

Of the twenty four women who had experienced abuse, nine (38%) had been diagnosed with a neurotic mental illness. Eight (33%) had been diagnosed with a psychotic mental illness and seven (29%) had not been told a diagnosis (although one might have been made - see section 3.5). Amongst the diagnostic labels which are available to psychiatrists there are very few which explicitly indicate that social factors have been significant in the aetiology of mental health problems (such as exogenous depression for example). However, names are necessary in order to provide the meaning, reality, and recognition of any given phenomenon. As Dale Spender in her influential book ‘Man Made Language’ indicated:

“In order to live in the world, we must name it. Names are essential for the construction of reality for without a name it is difficult to accept the existence of an object, an event, a feeling...By assigning names we impose a pattern and a meaning which allows us to manipulate the world.” (1980:163)

The naming of abuse within mental health services is crucial in order to provide an effective service for abuse survivors. A medical diagnosis is a way of naming and classifying mental health problems. A lack of appropriate labels to reflect and describe mental health problems caused by abuse experiences can be seen as inherently disempowering. Failing to name abuse by applying a diagnosis which instead indicates a biomedical problem in itself serves to devalue, and divert attention from, social explanations of women’s distress.

Overall, three (13%) of the women abuse survivors who participated in my study said that they had encountered helpful attitudes overall from the service providers they had approached. They described how they were believed when they
reported they had been abused, and their disclosure was met with a warm and concerned attitude on the part of service providers. They also described receiving treatment which they thought was appropriate to the causes of their distress. I explore issues relating to the medical treatment of abuse survivors in the following section.

5.4 The treatment provided abuse survivors

Amongst the women abuse survivors who were dissatisfied with the treatment provided them, there were two recurrent themes. These relate to a predominance of physical treatments within the mental health system and a lack of skilled counselling being made available. Twenty three (96%) of the twenty four women who had experienced abuse had been given psychotropic medication. Two (8%) had been given ECT. Most of these women had not been offered any other form of treatment or assistance.

Cerys said that she approached her GP to tell him about the sexual abuse she had experienced. After only two minutes in consultation with him however, she was prescribed a course of minor tranquillisers.

"I didn’t find him very helpful at all. I went to see him when the abuse came out and I wanted someone to talk to. My mum sent me down to the doctors and I went down expecting a chat whatever. I went in, I was there for about two minutes, he said ‘you’ve got problems? You’re depressed?’ I said ‘yes’. He said ‘I’ll prescribe you some Valium’ and then he sent me out. And I was only sixteen at the time, it was three years ago when I was sixteen. Giving me Valium at sixteen! So that was not helpful at all.”

Pauline said that when she approached a GP for help, he was also only interested in making a diagnosis from her presenting symptoms and did not ask her about the possible causes of her distress. She was diagnosed with anxiety and prescribed medication to suppress the distress she felt at having been sexually
abused by a member of her family. Pauline went back to another GP to request counselling but he would not take her concerns seriously and would not refer her to any other service.

Jade described how she had approached several GPs and had been referred to a variety of specialist service providers, but had not received assistance which she had found useful in dealing with her abuse history. Various diagnoses were made including 'personality disorder' and she was prescribed with tranquillisers and antidepressants. As I described in section 5.2, the turning point for her came when a psychiatrist asked her if she had experienced child sexual abuse. She said that it was then that she started to think about the effects which her abuse experiences had had upon her feelings of distress. Thereafter she joined various self help groups, including one specifically for abuse survivors, which she had found to be very helpful to her (see also section 5.6 on the services the women identified as being useful to them). She said:

"Drugs was all the help I got. And looking back now I don't consider it as help...I feel it's such a waste, you know? If I could have been prescribed the therapy years ago which I needed, I could have started my life years ago, instead of prolonging the agony. Because that's all the drugs have done is prolong the agony...They've just kept me functioning as best I could from day to day while all the shit that's causing it all is still there."

Overall, amongst the women who disclosed abuse there were varying reports of the usefulness of the medication that was prescribed. Some thought that it had worsened their health problems, while others thought that it had been useful in easing feelings of distress. Gillian, for example, a survivor of domestic violence, said that the antidepressant medication she had been prescribed had been useful in helping her to deal with her feelings of depression. She said however, that the tranquillisers she had been given had actually made her worse. Gillian said that she
had been given ECT during a hospital stay and despite the fact that it had caused her serious side effects, she thought that it had helped in lifting her feelings of depression. However, she said that the side effects of the medication and the ECT she was prescribed were never explained to her.

"At one stage I was on 30 mg of Valium a day and largactil. I was on everything. I went from being totally withdrawn to being hyper. I couldn't sleep day or night. And then the largactil was making me sleepy and like a zombie with no concentration. I had six ECTs and they were bilateral. Nobody explained the side effects - the memory loss, there was none of that...I had shaking, headaches and blocks of memory which to this day have been totally destroyed. You know when I went home and things the kids would say to me 'remember when we went to so and so'. I'd have no memory of ever going to some places. It became a family joke - oh she's having one of her lapses you know, because I'd forget all these different things."

Seven women (29%) who had experienced abuse said they had been offered some kind of counselling in statutory services. Three women (13%) had seen a professional counsellor working within the NHS. The others had received some form of 'talking therapy' from a CPN or a psychologist. There were varying reports of the effectiveness of this counselling. Some women reported that their counselling was unsuccessful because their concerns were disregarded and/or their counsellor did not appear to be aware of the specific issues affecting abuse survivors. For example, Sheila described how she had tried to access effective counselling through NHS psychiatric services. Although she was referred to specialist service providers for this, she said that the practitioners she encountered did not seem to have understand the distress experienced by child sexual abuse survivors. Eventually Sheila decided to pay for a private counsellor. She was on state benefits at the time and incurred substantial financial hardship in order to access the counselling she believed she needed. She said:
“It is a shame that you can’t get that help you need, you know on the National Health and you should be able to... I shouldn’t have to pay for the counselling I need. It should be there available, because I mean this isn’t an isolated problem you know. It’s widespread, there should be somewhere that you can get the help you need without having to pay for it. There’s a counsellor attached to the doctors surgery and they told me well if you need help you can see her. But I’ve been to quite a lot of counsellors on the National Health and I’ve had bad experiences and I haven’t found them helpful, you know...You don’t get the specialised help you need through the National Health.”

Cerys said that she had tried to talk to the two counsellors employed at her GPs surgery, but stopped attending after a couple of sessions with each of them. She said the surgery counsellors had been nervous about counselling an incest survivor and they had told her that they did not know how to proceed.

“The counsellors I went to, they both said they hadn’t had much experience of dealing with sexual abuse and they didn’t quite know how to go about it, and they were asking me ‘well how would you like to go about this?’ And I was saying ‘well I don’t know!’ They didn’t have much of a clue what they were doing .”

When I first spoke to her, Cerys had recently joined a self help group for survivors of sexual abuse. When the interview took place however, she had made the decision to leave the survivors group. She explained that she felt guilty that she wasn’t making enough input into the group because of her difficulties in talking about herself in meetings. Having evaluated what had happened to her in the mental health system, Cerys made it clear that one outcome of her negative experiences with mental health professionals is that, despite the fact that she would like to talk someone about it, she no longer feels able to talk about the abuse she has suffered. She said:

“A lot of problems you have when you’re older stem from things that happened to you when you were younger. The problem is probably there when you’re younger but as you get older it gets more and more and more. I just feel if I could have talked about it then, I would have been - not alright, but it would have been more helpful I think. Because I
would have felt a lot more able to talk about it then than I do now. Because at the time I wanted to talk about it and they just weren't willing to listen at all. And it carries through until you think 'well I don't really want to talk about it, no-one's interested'."

In order to explore in further depth issues relating to the treatment of abuse survivors within the statutory mental health system, in the following sections (5.4.1 and 5.4.2) I describe in detail the contrasting experiences of Mandy and Joy. Both are mothers, survivors of child sexual abuse and have also experienced abuse from male partners. However, Mandy has received assistance which she thought was extremely helpful in assisting her to deal with her abuse experiences. Joy, on the other hand, has not experienced the services as useful, and had actually experienced further abuse within the system.

5.4.1 Mandy's experience of statutory service provision

Mandy's experience of statutory mental health service provision was exceptional in the context of this research overall. Although two other women who had experienced abuse said that the statutory services had usually been useful (and three others who said they had not experienced abuse), only Mandy was unequivocally enthusiastic in her praise of the services. Mandy described how her abuse was named within the services; she was believed; listened to; validated that she was not alone; and was given a combination of practical social support, skilled counselling and medical treatment.

Mandy said that the help she has received from her GP, counsellor and social services has combined to improve her life situation dramatically. She pointed out that the assistance she received and continues to receive is invaluable in helping her to maintain her own well-being, and in helping her to look after her children. She said:
They've kept me and my family together because if they hadn't have stepped in, I would have ended up killing myself and the children, you know... I was quite surprised by how helpful they were. They offered me all sorts of help, all sorts of people and then it seemed like there were people coming from everywhere. It seemed as if I wasn't alone at all then. In fact there were so many people coming in and out, I didn't get any time to myself at all you know what I mean! It went from one extreme to the other - I found myself wandering round the house thinking what can I do now? Before I had ninety million jobs and now I'd got three and I don't know what to do with them. But yes they were very good and they still are."

Mandy explained how, when her mother died and her violent partner left her, she began having flashbacks and recovering further memories of being sexually abused as a child. She was also living on her own on state benefits, with three young children, the youngest of whom had severe learning difficulties. Mandy approached her GP for help and he prescribed a course of tranquillisers and also referred her to the surgery counsellor. Mandy said she found the woman counsellor (who also ran a private practice in which she specialised in counselling women abuse survivors) to be extremely skilful in helping her deal with the trauma in her past as well the issues in her present which were causing her distress. On the advice of her counsellor Mandy sought additional help from social services via a GP referral. She said that initially she thought the only option for her would have been to ask social services to take her daughter into care, because she felt she couldn't cope. When she discussed this possibility with them, however, Child and Family social workers offered to provide her with a high level of practical support in looking after her youngest daughter so that she could keep custody of her. They organised respite care, babysitting; and social activities for her daughter, such as horse riding, swimming and trips out. They also referred Mandy to a self help group for survivors of sexual abuse. Mandy saw her counsellor on a weekly basis for nine months. She also attended the self help group for a year. She stayed on tranquillisers for two and a
half years, until her GP told her that she ought to start cutting down on them with a view to stopping them altogether. Mandy was annoyed by this at the time, as she wanted to continue taking them. Now however, she feels grateful that he took this approach, as she says she would certainly have become addicted to the medication over the long term, if he had not.

Comparing herself with other women she has met who have not received these levels of assistance when they have experienced an emotional crisis, Mandy attributed the success of the situation to the fact that she has a daughter with learning difficulties. She says that a major incentive for service providers to assist her, was that to do so would avoid the necessity of her youngest daughter being taken into care. A social worker told her that the only reason the money could be made available from the social services budget to help her was because it had been earmarked specifically for children with disabilities. Mandy says that the only significant drawback in this situation is that her other two children can often feel that they are missing out, as they do not have the opportunity to engage in the social activities that are provided for her youngest daughter. Occasionally this can be a source of guilt for Mandy, as she cannot afford to pay for the other two to do similar things, and she tries to compensate them with treats within the limitations of her budget. This highlights the one area where Mandy is not being adequately assisted. As she is on state benefits, financially things are difficult for her, and this can be a significant source of stress. The question of her state benefit levels is of course beyond the remit of mental health services. Mandy said:

"I think if I hadn’t had a child with a disability I think I wouldn’t have come so far, maybe things would have been different. But I think they’ve rallied around to help me to keep my family together and I hope they continue to do it because without their support I would really have nothing, I’ve got to be honest.... But I think if I hadn’t have had a handicapped child they might not have been so quick into keeping me sane. And I also look
at it money wise as well. It would have cost them hundreds of pounds to put her in a home every week whereas I just get a measly pittance on the dole. I mean how much would it cost to put her in care? I mean they'd have to pay someone 24 hours a day to care for her. It's much cheaper to support me... But I still think it should be available to people who haven't got handicapped children. It should be available to everyone, everyone should be equal, everyone deserves a chance.”

Mandy’s case illustrates that in order to be properly effective services would need to address the whole of a service users’ situation. What is needed is a recognition of a full range of social, psychological and biological factors, and how these inflect to produce mental health problems. Of course the pressures of a single mother on a low income cannot be resolved in the mental health system under the present system of organisation. However, a combination of practical, emotional and medical support can be effective, at least to some degree, in assisting the individual to deal with these circumstances.

5.4.2 Joy’s experience of statutory mental health service provision

Like Mandy, Joy is a mother, a survivor of child sexual abuse and has been in a relationship with an abusive male partner. She also indicated that these experiences have been a significant cause of distress for her. Unlike Mandy however, she said that overall the statutory mental health services she has used have considerably exacerbated her distress. The main reasons for this are that the abuse was not named; not acknowledged as important; she was not listened to; she was detained involuntarily in hospital for many years; she lost custody of her children; she had physical treatment forcibly administered; and she was sexually abused by a male nurse whilst in hospital.

The process of interviewing Joy was a dramatically different experience from that of interviewing the other participants in the study. Unlike the other
participants in my study, Joy did not want to follow the question/answer/discussion approach in describing her experiences. My initial attempt to follow through my interview schedule as a means of facilitating discussion were unsuccessful and I asked Joy if she wanted to continue with the interview, as she did not appear to want to answer my questions. Joy said that although she wanted to talk to me, and participate in the research, it was far too distressing for her to answer my questions directly. Initially I was unsure as to whether to proceed because of this, but I decided that because Joy did seem keen to take part, I should let her carry on and tell me what she wanted to in her own way.

Joy talked a lot about her religion and then moved on to describe many of the experiences she had had in the mental health system. She did this in an unconventional manner however, moving around the room a lot and sometimes singing songs which she asked me to join in with. I was aware that such unconventional behaviour is often perceived to be symptomatic of psychotic mental health problems. Nevertheless, the content of what Joy had to say was perfectly intelligible in itself.

Joy said that she had spent eight of the last ten years in hospital, most of which time she had been detained involuntarily. When she came out of hospital, her husband left her and she lost custody of her two children. Losing her children had clearly been a significant source of distress for her. Her initial contact with psychiatric services had come about because her husband had applied to have her detained in hospital, when she was extremely distressed. When she was taken into hospital she said that she was singing a song in which she had changed the lyrics in order to describe how she was being mentally abused by her husband. Joy had been diagnosed with a range of psychotic illnesses, including manic depression and schizophrenia. She said that despite these diagnoses, she did not believe that she was
suffering with a biologically induced mental illness; but rather, she believed that she had been extremely distressed because of the negative experiences she had had with her husband. However, the doctors and nurses at the hospital did not listen to what she had to say about this, and the manner of communication she had adopted in order to convey her experiences (i.e. singing a song), was used as evidence of her insanity. Consequently she was diagnosed as suffering with a biologically induced psychosis. Because she had been diagnosed with a severe mental illness, Joy was prescribed with several courses of ECT and many different types of medication. She said that she had suffered a damaging array of side effects from this treatment (see section 3.6 on the effects of medication and ECT). She did not want to undergo this medical treatment but because she was a ‘sectioned’ patient for much of this time she had the treatment forced upon her.

Joy told me that whilst she was detained in hospital, she had been sexually abused by a male member of staff. She was kept in a padded room and repeatedly raped by him. She said:

"On my first occasion in the padded cell and believe me there was one then, although they denied there was... it was known as ‘the box’ and I was abused by a male nurse much younger and heavier than myself, because I was very pretty and I had a nice figure. I was stripped off without a woman being present and felt utterly degraded and deprived of all dignity. I thought no-one has a right to do this to me because I have two children. I am a mother and I am married. I felt at my lowest ebb and then I thought you mustn’t let this get to you - so I sang... I went through every song, I went through a complete repertoire and if anybody deserved an Oscar I did. But I didn’t really deserve it because that was how I got through it."

Furthermore, she was not believed when she attempted to report this abuse. Indeed her distress at what was happening to her was used as further evidence of, and a justification for, her diagnosis of psychotic mental illness.

After describing this, Joy was understandably very distressed. She went on to
convey her concerns about the treatment of child sexual abuse survivors in the mental health system. She communicated these concerns to me in the form of a play in which she acted out all of the parts, adopting different voices for each of them. At the beginning of this play Joy denied that she was herself an survivor of child sexual abuse. However, when she had finished enacting the play she broke down into tears and disclosed that she had in fact herself experienced sexual abuse as a child.

Joy asked me to send her a written copy of her play and asked for a promise that I would include it in my research findings. I include an excerpt from the play below and include the full transcript of the play in appendix a.

In her play, Joy described the experiences of a fifteen year old girl called Mary, who had been sexually abused by her father. Joy said that Mary had told her mother about the abuse; but her mother did not believe her and took her to see the doctor. In the following excerpt from Joy’s play I indicate in which character’s voice Joy was speaking, by inserting and underlining their names.

“Doctor - Now well come come Mary there’s nothing wrong with you at all. You have what we call a psychosis or something of that nature. What has happened is that you’re confused in your mind. You really want a boyfriend don’t you, and all that that entails but your father is so important to you. He’s the most important man in your life and you’re getting a little bit mixed up you see and you’re identifying what you really want with your father and getting it all wrong in your head...you’ve got it all wrong really haven’t you Mary dear. This isn’t really happening is it? You’re out of touch with reality aren’t you?
Mary - I suppose so Doctor. Can you help me?
Doctor - Yes indeed I can Mary, we’ve got a lovely little unit near here for adolescents and in this unit we’ve got computers and televisions, all sorts of things that a young person can use - discos and counselling, the most marvellous medication. You’ll take a tablet and then you’ll forget about everything, and then you’ll take another one at night and you’ll sleep like a log and in no time you’ll be just like you used to be. As right as rain.
Mary - Is that the truth Doctor?
Doctor - Would I lie to you Mary?
Mary - When can I go?
Doctor - That’s what I like to see somebody that really does want to get better. You do want
to get better don’t you Mary? And you know you’re ill don’t you Mary?

Mary - Yes doctor.

Doctor - Well you can, in fact, go today. There is a vacancy and if you get there by six o’clock tonight you’ll meet a lot of nice young people. And perhaps you’ll meet a nice young man which is what you want really isn’t it Mary? A nice young man of your own...[I’ll put you down for six months and] and then you’ll come home to Mum and Dad and then everything will be just as it was...

[Final Scene - Mary’s home several days later ]

Mary’s Mother [answering the telephone]... Hello - yes, yes this is Mrs Jones here - this is Mary’s mother - nothing the matter with her is there? I beg your pardon - what did you say then - did I hear you correctly - Dai!

Mary’s father - oh what’s the matter now?

Mother - Dai, it’s about our Mary.

Father - Oh what’s she gone and done now. Has she gone and made trouble has she?

Mother - Dai, our Mary’s dead.

Father - Dead? They killed her?

Mother - Oh don’t be so soft Dai.

Father - Well what happened then?

Mother - Well she pretended to one of the older boys that she smoked and she borrowed matches and she went into the toilets see Dai, and she set her clothes on fire. And by the time they heard the screaming and knocked down the door, our Mary was burned to death. And she left a note.

Father - A note? A note? It didn’t say nothing about me did it?

Mother - No don’t be so silly Dai. It said the funniest old thing.

Father - Well what did it say?

Mother - It said ‘I only wanted somebody to listen’.”

I found Joy’s play to be extremely moving, as the central message of it, and everything else that Joy said during the interview was that she simply wanted someone to listen to her, believe her and take her seriously. Indeed, Joy seemed very desperate to talk and have someone listen to her, which is why she had volunteered to participate in my research in the first place. Joy dedicated her play to the Samaritans, who, she said, are amongst the few people who have been prepared to listen to her. As I left after the interview, Joy held on to me and pleaded with me to hurry and finish my research so that the findings could be publicised and people
would know about some of the abuses which occur within the mental health system.

Joy’s experience indicates that the treatment provided by statutory mental health services can further exacerbate the distress of women abuse survivors. When Joy was first taken into hospital in a very distressed state, she was not listened to when she attempted to communicate about the abuse she was experiencing from her husband. Her concerns were disregarded by staff as the symptoms of a biologically induced psychosis. The psychosocial reasons for her distress were neither acknowledged nor addressed in favour of an exclusive focus on the biological aspects of her mental health problems.

Joy said that the diagnoses, medication and ECT which she has been given, have not helped her in any way. In fact, the treatment which she has been given have been key in disempowering her further in relation to her husband and the rest of society. Joy was rendered almost completely powerless when she was detained in hospital; she had physical treatments forced upon her and suffered damaging side effects from this treatment. A male nurse took advantage of her powerless position and repeatedly sexually abused her. The fact that she had been diagnosed with a psychotic mental illness meant that she was not believed when she tried to report this abuse.

Joy’s mental health problems were dealt with through a process of medical diagnosis and treatment which did not acknowledge nor address her experiences of male violence as causative factors in her distress. In this way, the treatment she received served to significantly compound and exacerbate the mental health problems which had driven her to be hospitalised in the first place.
The fact that some women experience sexual abuse when they are using mental health services is the most disturbing finding that has emerged from my research. In the following section I explore this issue in relation to the other women who participated in my study.

5.5 Sexual abuse and harassment within the statutory services

In the preceding section I discussed the experiences of Joy, who had been sexually abused whilst an inpatient in a psychiatric hospital. This was not an isolated report however; indeed eight interviewees (23%) described incidents of sexual harassment and sexual abuse occurring within statutory mental health services. These ranged from a report of a psychiatrist’s apparently salacious interest in the sex life of a woman user, to repeated rape of women hospital inpatients by male professionals and male patients. Some of the women who talked about this had had first hand experience of this kind of abuse; others had witnessed attacks against fellow women service users.

Three women (9%) who participated in my study were sexually abused themselves whilst using statutory mental health services. All three of these women were incest survivors and had also experienced domestic violence; experiences which they describe as key in them seeking help from the statutory services. The fact that they were further abused when they were seeking help was experienced as an enormously damaging betrayal of trust. Two women, Joy and Isabel, were sexually abused by male nurses; Isabel was also sexually harassed by a male psychiatrist. Jade was sexually abused by another patient.

From the interviews with the women who had been abused by professional staff, it was not possible to ascertain whether their abuse histories were significant in the fact that they were sexually revictimised within the system. Thus it was not
possible to find out whether the fact that these professionals had known they were already abuse survivors had played a role in their revictimisation.

A further issue is that women's definitions of sexual violence can and do alter over time (Kelly 1988a). There is often a tendency for some survivors of sexual violence to forget, minimise and refuse to define some forms of coerced sexual contact as sexually abusive (Kelly 1988a). Sexual abuse may be redefined as such according to numerous factors, such as encountering further incidents of sexual violence, talking over with other people what happened, and recovering memories of previously forgotten incidents of abuse (Kelly 1988a).

Two of the women (Jade and Isabel) who had been sexually revictimised within the system had also been members of a women's self-help group for sexual abuse survivors. These groups appeared to play a 'consciousness-raising' role relating to sexual violence and this may have been a factor in their recognition of further forms of sexual violence, such as sexual harassment, as sexually abusive.

For example Isabel said of her psychiatrist:

"All he wanted to know is whether you've got any sexual problems - that was utmost in his head. How was my husband, did I have any sexual problems and was I satisfying my husband...I don't think that psychiatrists can handle abuse... Really they are raping you - I felt like I was being raped because he wanted to know about this and that and it felt like he was taking over from the abuser...If I complained they were only going to say it's me and not him and that's the frightening part. So the system is absolute crap, I felt raped by it."

When Jade was an inpatient in a psychiatric hospital, a male patient got into bed with her. She complained to the staff but they did not take her distress seriously, and for the next few days kept laughing and remarking to her and other patients that she had 'a new boyfriend'.

Both Jade and Isabel identified these incidents as sexually abusive. It is
unclear whether other women in the study who may have had similar experiences would necessarily have identified them as abusive, given a tendency amongst some women to employ a coping strategy in which they deny, minimise or forget incidents of sexual violence. Thus it may be possible that other women in the study had had similar experiences but did not choose to define them as abuse; or they may have chosen not to disclose their experiences to me.

Kim said that when she was working as a psychiatric hospital nurse she became aware of the systematic sexual abuse of female patients by male members of staff working on the wards. She says that other members of staff, herself included, did not address what was going on even though they knew what was happening. Kim eventually left the psychiatric nursing profession because she could no longer tolerate the abuse of patients.

“When I first went in as a nurse in the seventies they still had padded cells and things like that. Although they weren’t used that often. I saw them used as a form of punishment. The things I saw were so horrendous. And sexual abuse of women - it was common knowledge what was going on, on nightshift, male staff abusing female patients...I think if I’d have been able to prove it I would have done something about it, but I took the cowardly way out and got myself out of the profession. It goes on continuously - especially with patients on drugs. This went on during the night shift. There’d only be a couple of nurses on at night.”

Kim was an inpatient in a psychiatric hospital herself when she found herself in the position of trying to protect a fellow patient on the ward who was being repeatedly sexually assaulted by a male patient. The staff did not take her complaints seriously even though they agreed that the sexual assaults were taking place.

“They wouldn’t do anything about it. They told me its a natural thing for people to be attracted to each another. I said yes, but you damn well know that she is a lesbian. Then it happened again with someone different...Mixed wards are a scandal and woman are getting hurt because of it. I hated it as a lesbian. I was never ever respected in that way.”
The staff on the ward refused to remove either her friend or her friend’s attacker from the ward. Because they did not help in this situation Kim tried to protect her friend from further assaults. She sat outside her bedroom door at night to make sure she was not attacked. She also helped her with dressing and eating as her friend was having difficulty doing these things for herself, and the staff would not aid her. This became an enormous source of stress for Kim and she experienced a further emotional breakdown.

Diane also had a female friend who was being sexually assaulted by a male patient whilst in a psychiatric hospital. She too complained to the staff but they refused to do anything about it.

"Another patient sexually assaulted her and the doctors didn’t want to know about it... We went and told them and they just got very antagonistic with us... They just became very unhelpful and pinned us down as troublemakers for saying this and just point blank refused to move him, or her, for that matter. They wouldn’t do anything... There was no protection for her."

Most wards in psychiatric hospitals in the National Health Service are mixed so that men and women patients use the same dayrooms, TV rooms, kitchens and dining rooms and sleep in connecting dormitories. This system of organisation is a source of abuse and harassment for many women patients, but despite campaigns by user groups (such as MIND) to provide single sex wards for all of those who require them, the vast majority of wards in NHS psychiatric hospitals are mixed gender (Gorman 1992, Darton et al 1994).

In responding to the criticisms made by user groups, the Royal College of Psychiatrists has issued guidance that patients should be allocated to a single sex ward, where possible, if they request it (Royal College of Psychiatrists 1999). This guidance is not binding however, and there are still very few single sex wards
available in psychiatric hospitals in Britain.

Overall, sixteen women (46%) objected to mixed wards in psychiatric hospitals because of the possibility of being sexually abused by male patients. Of the nineteen women who had been inpatients themselves, all supported single sex provision (although some said mixed wards should be available for other women who might prefer them). Thirteen (68%) of the nineteen women who had been inpatients said that mixed sex wards should be removed and single sex wards made compulsory. For example, Isabel said:

"I think mixed wards are awful, I really do. I think it's very degrading. I think that's where a lot of trouble happens and a lot of abuse happens. I've seen that happening. I've seen it happening in there. I used to work as a voluntary worker there too and I saw that. It's happening now and it's pretty rife. It's terrible. People say oh things have changed. But it's just more clever again and it's hushed up in a different way."

When Gillian was first hospitalised she was placed in a single sex ward. When she became an inpatient again several years later, mixed gender wards had become the norm. In comparing the two systems she thought that a single sex ward was most conducive to her safety and that of the other women patients on the ward.

"The first time I went in they were separated and then when I went back it was mixed. I found it quite frightening to some extent because some of the men were quite violent. I felt vulnerable... You were always worried because there were a couple in there that were sexually interested in every woman that came through. Even in the dormitories you were always that little bit worried that they'd come in. They wanted to touch and that sort of thing. So really I wasn't happy with it. Because I was a vulnerable person. When it was separated it was much better."

Nine women (26%) said they had no particular views on mixed wards as they had not been psychiatric hospital inpatients. One woman, Sheila, who had not herself been an inpatient, said that she thought that men and women should be in mixed sex wards together, as they would benefit from mixing socially with each
other.

I have argued that statutory mental health service provision sometimes actually repeats the oppression which women have already experienced. Nowhere is this more evident than in the experience of women who are sexually abused whilst using statutory mental health services. Some of the explanations which have been provided within psychiatry for the retention of a mixed ward system, in the face of evidence which has indicated that women are at risk of sexual abuse on the ward (see for example Batcup 1995, Gorman 1992, Darton et al 1994), indicate that psychiatry can sometimes play a reactionary role in maintaining and reproducing the social status quo. There has been a clear acknowledgement in some sectors of the psychiatric profession that mixed wards are helpful for male patients and for members of staff. Professor Brice Pitt, Public Education Director of the Royal College of Psychiatrists, said in defence of the mixed ward system:

"When male psychiatric patients are kept together you do not get a high standard of hygiene and there are none of the homely touches which women naturally bring. The women had an ameliorating effect on the men. They calmed down and started to take more interest in themselves." (Quoted in Darton et al 1994)

Psychiatrists have argued that retaining a gender mix on psychiatric wards is desirable because it provides a 'homelike environment' (Darton et al 1994). This is a sexist and homophobic attitude however, as many women, particularly lesbians, do not choose to live with men. In my study, the majority of women who had experienced abuse (whether as adults or children), had been abused by close male family members. This abuse was cited as a significant source of the women's emotional distress. Numerous other research reports have indicated that women and children are at significant risk of sexual abuse, violent assault and murder from men within their own families (see section 1.7). Because of the oppressive power
relationships that are enshrined within the heterosexual family, trying to reconstruct a heterosexual family environment as a place where women can find safety is likely to fail many women. Another reason for the retention of a mixed ward system despite increasing pressure from user groups, relates to the financial savings which can be made by mixing the sexes in this way (Darton et al 1994). However the cost to women’s mental health of pursuing this policy would appear to be very high indeed.

Mainstream psychiatry does not overtly set out to challenge the oppression of women. On the contrary, as the controversy surrounding the mixed ward system indicates, psychiatry sometimes engages in recreating and perpetuating the exploitation of women by men within its own structures. These oppressive power relationships operate at various levels - between male and female staff in which it is men who usually hold the most powerful positions as psychiatrists, for example (Samson 1995, Johnstone 1989 - see also section 3.3), and between male and female patients, in which the abuse of women is sometimes disregarded when compared to the benefits which accrue to members of staff and male patients.

The prevalence of sexual abuse within psychiatric services is one of the most important findings in my research. It is an outrage that women who seek help from mental health services, many of whom have already experienced abuse, are at risk of further abuse within that system. The use of medication and ECT, and the legal mechanisms for compulsory detention and treatment, mean that women patients are in an extremely powerless position in relation to male patients and staff members (the power relationships within psychiatric hospitals are further examined in section 6.3). The sexual abuse of women is one significant reason why assistance which is provided women in emotional distress, particularly where this is provided within a residential setting, should as far as possible be provided on a woman only basis (in
terms of both service users and service providers - see also section 6.5).

To date, the full extent of sexual abuse within the statutory mental health services remains unclear. As I mentioned earlier there may be a tendency amongst some women to cope with sexual violence by denying, minimising or forgetting it. In addition, information relating to the problem has usually been gathered by researchers asking questions of mental health service providers rather than of women service users themselves (Ussher 1991, Masson 1989). This will inevitably reveal far less evidence of sexual abuse than if the studies were directed at the users of services. User groups have indicated that many women patients in psychiatric hospitals are too frightened to report incidents of sexual abuse and harassment (Darton et al 1994). However, as my research indicates, even when a service user attempts to report an assault they are often not taken seriously and the incidents are not acted upon (see also Darton et al 1994, Altounyan 1993, Gorman 1992). In addition, previous research has provided evidence to suggest that the publication of material relating to the extent of sexual contact between mental health service providers and service users has been dismissed and suppressed within psychiatry (see for example Ussher 1991, Davidson 1984).

5.6 The women's suggestions for developing services for women abuse survivors

I asked all of the women who took part in the research what developments in service provision they thought would be useful to help women who had experienced abuse. The women who described themselves as abuse survivors were understandably most vocal about this issue; the other women in the study usually said that they didn’t know, or wouldn’t like to say, what would be suitable for abuse survivors.
In the suggestions that were made, there were ten main themes. These included accessibility; counselling; understanding; the need to be listened to; believed; understood; validated; the need for safety; mutual support and a place of asylum.

Several women said that self-referral to specialist services was needed in order to provide ease of access. This was suggested either because their GPs would not take their health concerns seriously (see section 3.2 and 4.2) or because they did not feel comfortable talking to their family GP about their problems, as he or she had such close links with the rest of their family.

One of the most frequently made suggestions was the provision of effective, free counselling by practitioners who understand the specific issues facing abuse survivors. Other women, like Joy and Isabel indicated that what they would like to have is not counselling per se, but simply the opportunity to talk to someone who would listen to them, understand, and believe what they had to say. Isabel said:

"You've got to have someone to talk to about it. You can talk for hours and think Jesus that's not even half of it... You feel like you want to be put into a room and have one to one - not counselling, [but just to be able to say] this happened and this happened, like writing a book... If I was offered the opportunity to have it on a one to one basis I'd take it. But I don't want counselling. They're going to counsel me on what they think is right. I don't think they know exactly. I want me to say, them to ask and just like you are doing, they can learn from that. And maybe some feedback of some kind, but just being there and listening."

The setting up of more self help and/or therapy groups for abuse survivors was another frequently made suggestion. Six women (25% of those women who disclosed abuse) were, or had been, members of groups for survivors of child sexual abuse. These were three separate groups from different areas. All were women only; one had been set up on a voluntary basis with no professional involvement; one had been set up by a woman university counsellor who facilitated group meetings and
the other had been set up by a woman psychologist who sent two CPNs to facilitate meetings.

All of the women who had participated in these groups described benefits from their involvement. The groups provided validation that they were not alone in having been abused, and they provided a safe space for them to talk over their feelings with others similarly identified. Stephanie said that meeting other incest survivors had had lasting benefits for her.

"It was the first time that I'd met anybody else who'd been abused, to my knowledge. It was the first time that I realised that I wasn't the only one. So that has a tremendous effect on your mental health because it stops you feeling so weird. It stopped me feeling that there was something wrong with me because it had happened to me and it stopped me feeling like I was imagining the whole thing or making a fuss about nothing. It really gave me such a boost... I was like a completely different person to who I'd been before. Much more self confident and I was so much more in touch with myself and I just stopped thinking there was something wrong with me." (Stephanie)

Isabel said that the self help group for survivors of child sexual abuse which was organised on a voluntary basis outside the statutory services was the only service she had used which had been helpful in any way to her. She pointed out that the pressures of running the group were sometimes difficult though.

"I've got four or five different things out of it. Some has been anger and some has been real love, I have felt the love. I've liked the honesty there. Then I have found it hard because people are getting tired and pissed off. I find that everyone has their own needs... It hasn't worked out the way I wanted it to, but it's better than nothing. But I wouldn't like to think what it would be like without the group. Because if I didn't have that then I don't know what I'd have. There is still no avenues for me to turn to. But I wish there was someone there [in the group] guiding us more, because we're all more or less in the same position. I think there should be something there that should be more structured, someone there for us, helping us all out, so it would relieve us as well of that." (Isabel)

Unfortunately shortly after the interview Isabel told me that the incest
survivors group had been wound up because of lack of attendance at meetings. The difficulty of organising and running a small group without more structured support had been one reason for this.

Jade, Isabel, Sheila and Justine who had all been in self help groups for abuse survivors, argued that services for women abuse survivors would be particularly effective if they were provided by women who had themselves experienced abuse (see also section 4.3). Sheila said:

"I used to phone an incest helpline and the women on the phoneline were all incest survivors themselves and I found that tremendously helpful. It was the first time I’d talked about it to anyone...that helped a lot knowing that the women on the other end of the phone were actually incest survivors themselves - that they understood when you were talking to them, they understood everything you were saying, they understood how you felt. In my experience when you’re talking to someone that hasn’t had any experience with incest survivors or isn’t an incest survivor themselves there’s no level of understanding. It’s a very hard thing to say but you’ve got to experience it to actually understand and to know."

Ten of the women (42%) who had experienced sexual abuse as children suggested that a woman only residential service was something which was needed, as this could provide a safe place for survivors to address their abuse issues. The women explained that sometimes they needed to leave their homes to find asylum, a safe place to stay when they could no longer cope at home. Other women who participated in my study, who did not identify themselves as abuse survivors, also referred to the need for an alternative place to stay when they were experiencing a mental health crisis. I explore this idea in depth in section 6.5.

Conclusion

In my research twenty four of the thirty five interviewees (69%) disclosed some form of abuse; whether this was experienced as children and/or as adults in abusive relationships with male partners. Previous reports have indicated that the
majority of women mental health service users have experienced abuse in their lives and that this abuse has been significant in causing their feelings of distress (see for example Darton et al 1994, Williams et al 1993, Herman 1992). All of the women in my study who disclosed abuse indicated that their abuse had caused them considerable distress; and the majority of them identified this abuse as causing their mental health problems. Some women however, particularly survivors of domestic violence who had been diagnosed with a psychotic disorder, were unsure as to what degree their abuse experiences had contributed to their mental health problems, given that their doctors had told them that they had a biologically induced mental illness. Various commentators have indicated the widespread diagnostic mislabelling of abuse survivors (for example Herman 1992).

Overall, the women who had experienced child sexual abuse were more likely to reject the medical discourse and adopt an alternative discourse based on the recognition of the harmful effects of child sexual abuse. One reason for this may be the accessibility of this alternative discourse - women’s groups have campaigned long and hard to put the issue of male violence against women and children squarely on the agenda. The long term negative effects for many women of experiencing sexual abuse during childhood have been well documented (see for example Hall and Lynch 1998, Mullen et al 1996, Browne and Finkelhor 1986, Ciba Foundation 1984). Increased media attention on the issue of child sexual abuse and the setting up of self help groups and counselling helplines have assisted many women to make the link between their present feelings of distress and the abuse they experienced as children. Less attention has been paid to the long term effects for many survivors of domestic violence and adult survivors of child physical abuse.

It is vital that the prevalence of abuse against women and children is acknowledged in order to create responsive mental health services. The report issued
by the BMA in 1998 is certainly to be welcomed, especially as it acknowledges that domestic violence is a health issue. It provides constructive guidance for medical practitioners on how they should respond to women disclosing abuse and recommends that the women are referred to appropriate agencies specialising in assisting women abuse survivors. Its implementation would represent a considerable improvement for women who choose to disclose abuse to their medical practitioners.

However, a further problem is that the diagnoses which are provided by some medical practitioners (particularly psychiatrists) often indicate a biologically based disease in which the impact of abuse is ignored. In order to provide an effective service for women, abuse must be named and acknowledged as a possible causative factor in a whole range of women’s mental health problems. Women must also be believed when they report instances of abuse regardless of the type of diagnosis they may have received (which currently may tend towards undermining their credibility). Their experiences should be listened to in an empathic way and they should be validated that they are not alone, possibly by being provided the opportunity of meeting other survivors in the context of a self-help group, and/or by being referred to Women’s Aid agencies and other groups specifically set up to assist women abuse survivors. The principles of belief, validation and mutual support amongst women, are ones that women’s liberation groups (including Women’s Aid organisations) have functioned upon over the last thirty years.

Even where abuse is acknowledged as a source of distress, often the assistance that medical practitioners provide comprise of physical treatments, and far less commonly counselling. Although many women want to take medication to help deal with their distress and many also want to access counselling, these may not in themselves provide effective assistance to abused women. Medication eases feelings of distress, but it can also bring with it serious side effects, especially when taken in
the long term. Therapy may be useful for many women, but in order that women are not further disempowered when they seek assistance, the political reasons for their distress should provide the cornerstone of any analysis of their problems. For example, in my study one woman was told by a counsellor that she must learn to forgive her abuser or 'she would never properly recover'. Another was told that she must not blame her abusive father for what he did because 'he must have had a deeply unhappy childhood'. Such comments indicate that the counsellors involved were not willing to challenge the oppression which their clients have faced and whether intentionally or not, were further entrenching the power relationships between women abuse survivors and their abusers.

This research provides some evidence that abuse survivors can become involved in destructive interactions within the mental health system which replicate the dynamics within abusive families (see also Darton et al 1994, Gorman 1992). Many survivors have strong feelings of guilt stemming from their abuse experiences. This can make them particularly vulnerable when professionals do not provide them with adequate help. In talking to Cerys for example, it became obvious that she had blamed herself for her counsellors' lack of expertise. Particularly worrying is that some women abuse survivors experience further sexual abuse and harassment, from male service providers and/or male service users. Some of the explanations which have been provided within psychiatry for the retention of a mixed ward system in psychiatric hospitals have indicated that psychiatry often seeks to make women adjust to the dominant ideological norms of behaviour, regardless of the cost to their emotional well being.

The way in which the issue of child sexual abuse is currently dealt with by the medical establishment illustrates the reactionary role of much mainstream psychiatry (see also Kelly 1996a, Armstrong 1991). Feminists campaigning within
the women's liberation movement have been responsible for highlighting the issue of child sexual abuse and domestic violence. This political movement provided the context in which the abuse of children and women could be addressed. The psychiatric establishment broadly responded to this issue however, by bringing it in within the remit of medicine. Instead of a social problem which requires a social resolution, the issue of child sexual abuse has been transformed into a problem of individual illness which may be amenable to 'cure' through medical treatment. This medicalisation has frequently affected both abusers and their victims. Women who have experienced abuse are often labelled as ill and in need of medical treatment, usually provided by medication and less commonly therapy. Males who sexual abuse children have frequently been labelled as 'paedophiles': people affected by an illness in which their primary sexual attachment is to children (see Kelly 1996a). The cure for this illness is medication and/or therapy. The fact that many men who abuse children are in fact related to those children and also engage in sexual activity with adult partners is often ignored. In this way the whole issue of the male abuse of children has been depoliticised.

The prevalence of child sexual abuse suggests that the present system of social organisation is deeply flawed. As long as medical explanations of abuse are substituted for social ones, the power relations associated with the abuse of women and children remains unaddressed and unchallenged. In this way, the medicalisation of child sexual abuse can be seen, at least to some degree, as a source of disempowerment for women and children. Indeed, it has been asserted by several commentators that the medicalisation of social problems is a technique which serves to individualise and depoliticise social issues (Lyon 1996, Calvert 1985, Conrad 1981).
Chapter Six -

The Women’s Perspectives on Asylum and Community Care

Introduction

The majority of women who participated in my study had experience of being a psychiatric hospital inpatient (see section 6.1). In previous chapters I have discussed issues relating to the sexual abuse of women whilst they are hospital inpatients (see section 5.5), the lack of childcare facilities for women patients (see section 4.4) and the discriminatory attitudes expressed by some hospital staff (see chapter four). However, there are additional issues relating to the system of hospital care for women service users which warrant investigation. In this chapter I consider the women’s views on the power relations within psychiatric hospitals and examine the impact upon these power relations of the prescription of physical treatments within the hospital environment (section 6.3) I also discuss issues relating to the need for ‘asylum’, an alternative place to stay for women experiencing severe emotional distress (sections 6.2 and 6.5). I investigate to what extent hospital based provision fulfils an ‘asylum’ function for women service users (sections 6.2 and 6.3). Finally, I discuss the women’s views on the care in the community policy and present their suggestions for the further development of community based services (sections 6.4 and 6.5).
6.1 An overview of the women's perspectives on hospitalisation and community care

Nineteen of the women (54%) who participated in my study had been inpatients in a psychiatric hospital. Seventeen women (49%) had been in hospital more than once, and six (17%) had had five or more inpatient stays. Six (17%) women had experience of being compulsorily detained under a section of the Mental Health Act 1983 (HMSO 1983) on at least one of their hospital stays. A further five (14%) had been told by medical professionals that if they did not consent to enter hospital on a voluntary basis, they would be compulsorily detained.

I asked all of the women who had been in hospital whether their stay had been helpful to them. Ten women (53%) said that overall their inpatient stay had been unhelpful to them; five women (26%) said that overall they had had mixed experiences; and four women (21%) said that although there had been some problems, they would say that overall their inpatient stays had been helpful to them. Of the women who had mixed or unhelpful experiences, ten (67%) said that they had needed to go into hospital because they could no longer continue to cope within their home environment, but that the treatment they had received whilst in hospital had often been inappropriate to their needs. The problems the women described included a general lack of care and concern by staff (section 6.2), over-medication on the ward (section 6.3); and a failure to address the social problems which inpatients face in their daily lives (section 6.3). Other criticisms which they made of psychiatric hospitals, I have described in previous sections of the thesis - these included sexual abuse and harassment in hospital (sections 5.4.2 and section 5.5); the mixed sex ward system (section 5.5); discriminatory attitudes being expressed by staff members (sections 4.2. - 4.9); and a lack of childcare facilities (section 4.4).
four women who had found a hospital stay to be helpful thought that their admission to hospital had been necessary considering the extreme distress which they were experiencing at the time. They also believed that they had received reasonable treatment and care whilst in hospital.

Twenty nine women overall (83%) were critical of the current policy of care in the community policy for failing to provide adequate levels of service provision for mental health service users (section 6.4). Thirty two women (91%) opposed the programme of psychiatric hospital closure entailed by the policy of care in the community (section 6.4). Thirty three women (94%) suggested the development of an additional range of mental health services within the community which they thought would provide a more effective service than is currently provided (sections 6.4 and 6.5). Their suggestions include the provision of homebased services; self help groups; access to skilled counsellors on the NHS; non-medical residential crisis services with childcare facilities; and the introduction of a twenty four, seven day-a-week telephone helpline through which assistance can be sought from mental health services.

6.2 Hospital as a place of asylum

Amongst the women who identified some positive aspects associated with hospitalisation, there were five recurrent themes (some of which were closely linked together). These were that the hospital provided them with asylum; that it offered respite; mutual support; validation; and a place of sanctuary in which they were able to openly express their feelings.

Of the nineteen women who had been hospitalised, ten (53%) said that they had become inpatients because they needed to get away from their home environment. A significant reason why some women needed to leave their home was
because they were experiencing sexual and/or physical violence from male members of their families. They felt unsafe in their homes and needed to access an alternative place to stay in order for their mental health to improve. The hospital represented a place of asylum as it was perceived to offer far greater levels of safety than that available at home. For example, Gillian was experiencing abuse from her husband, when she was admitted to hospital. She said:

"I needed to go into hospital to be honest. Maybe there are some conditions that you can deal with at home but I needed to get out from that home environment. I really needed that break from it. You do literally need asylum. You need to be safe somewhere - not to be pressurised. Because I would never have got over that at home. I don't know how I could have, to be honest with you. I needed a safe place where people couldn't get at me day and night."

Another positive aspect associated with hospitalisation was that it offered the women respite from stressful family responsibilities. Women are usually the primary caretakers of children within the family and also often bear the responsibility of caring for family members who are ill or infirm. Many women play a caring role within the family whilst also engaging in paid employment (see sections 1.6. and 1.7). Becoming a psychiatric inpatient during periods of acute emotional distress meant that they had the time and space to focus on their own needs, without the pressures of having to look after other family members.

A positive aspect of hospitalisation for nine women (47%) was the mutual support which patients provided each other in hospital. Being able to talk openly about their feelings with people who had shared similar experiences was welcomed, particularly as the stigma associated with mental health problems meant that many women did not feel comfortable talking about their feelings with those not similarly identified. Some women also described how they felt validated by talking to other service users who were experiencing similar mental health problems. For example,
Kim said:

“All the therapy went on between the patients. And it was good therapy because we were all in such a position that the barriers were thrown down. We would sit in the smoke room and talk about suicides. ‘Well I tried to take this that and the other’ - ‘Did you? Well I thought of hanging myself one time but I don’t think I could do that’. What should have gone on between therapists and whoever went on between patients. Because really it was the ideal situation. You could say it and it didn’t cause any drama between us. It was just what we did. You could actually talk about it.”

A further positive aspect of the hospital environment was that it provided an environment in which they could be open about their mental health problems. Several women commented that they had felt pressurised to conceal from family and friends the levels of emotional distress they were experiencing. This concealment was felt necessary so that they wouldn’t upset, or be blamed by, the other people in their lives. In hospital however, they were able to openly display their feelings of distress. The hospital environment thus provided a place of sanctuary in which they were safe to acknowledge their feelings to themselves and the people around them. For example, Muyesha said:

“It was my safe haven when I couldn’t think anymore and I was going crazy because I didn’t know what was going on anymore, because of the confusion from the incest. At least there I could say I’ve lost it, I’ve had a breakdown and then everybody [outside] would leave me alone.”

In commenting favourably upon the hospital environment as a place of sanctuary Kim said:

“You need to scream, you need to shout, you need to tell everyone how fucking done down you are and why can’t you see what I need, and I feel so sorry for myself because no one is listening to me, please listen. That’s what you need, and you need to go into madness if necessary ...I had such a need to cry and just be mad. I needed to act who I was right then.”
Amongst the women who had had unhelpful experiences associated with hospitalisation there were seven recurring themes. These included a lack of safety; feeling objectified; insufficient support being provided by staff; a lack of attention being paid to the psychosocial factors that affected them; a predominance of physical treatments; the power relationships in the hospital environment, and the experience of institutionalisation.

Although ten women said that they needed to leave their homes and be admitted into hospital in order for their mental health to improve, six of these (60%) thought that the hospital environment did not provide the place of safety they were seeking. As I noted in section 5.5, the mixed ward system was a source of concern for many women, because of the risk of sexual abuse from male patients. Overall, eight women (23%) reported incidents of sexual abuse and/or harassment carried out by male members of staff, or male patients within psychiatric hospitals (see 5.4.2 and section 5.5).

A further issue of concern for some women was that although they got support from some patients, they felt frightened of other patients who had been diagnosed with psychotic conditions (see also section 6.4). Three women (16%) made this observation and they had all received diagnoses of a neurotic mental illness (such as depression). For example Margaret said:

"It was frightening...I think mixing schizophrenics and people who are depressed is a silly idea...I'm not sure but it seemed a funny mix because you might get someone doing something really silly if they're out of touch with reality...I didn't feel very secure in that sense. The longer I stayed there the more I felt that well this is not all that safe to be, I'm just as safe at home, you know."

Comments like these indicate that the women were not a homogenous group in terms of the types of mental health problems they had experienced and the
diagnoses which they had received (see also section 3.4). Some women who had
been diagnosed with neurotic forms of mental illness were often concerned not to be
' lumped together' with people who had been diagnosed as psychotic. In some cases
they found people with the more severe forms of diagnosed mental illness
frightening because of the disturbed behaviour they exhibited. Although none had
directly experienced any form of violence or harassment from those diagnosed as
psychotic, three women appeared worried that these individuals might pose a threat
to their safety. Understandably, some women may be frightened by people who
appear to be extremely disturbed. It may also be the case that the 'moral panic'
associated with the stigmatisation of people diagnosed with psychoses as prone to
violence contributes to this fearfulness (see for example Debbie section 3.4). The
desire to increase the effectiveness of mental health services in relation to the
provision of a safe environment was a significant reason why these women
suggested the establishment of a needs specific range of services which would aim
to address different levels of support needs amongst users.

A further reason for dissatisfaction with the psychiatric hospital was that the
treatment they received whilst inpatients made them feel objectified. A lack of
warmth, empathy and understanding amongst clinical staff, as well as a reliance on
standardised medical treatments made them feel that their individuality as people
was not being respected. Heather said that many hospital staff were cold and clinical
in their manner and did not appear to be concerned with how the patients felt. She
said:

"In both those [hospital stays] I felt like I was an object more than a person really. I
felt like I was on a conveyor belt and I got pushed off at the end."

An exclusive focus on symptomatology; a neglect of their personal feelings
and social concerns; not being properly listened to; a lack of information and not being allowed participation in decision making processes relating to their diagnosis and treatment all contributed to the women's feelings of objectification (see also section 3.3). To some extent this sense of objectification is exacerbated by a psychiatric discourse which "is based on the medical, the scientific, the 'objective' and the rational, with emphasis in relation to treatment being placed predominantly, but not exclusively, on drug therapy" (Fawcett and Featherstone 1994 - see section 3.3). Indeed, a medical gaze which entails a preoccupation with isolating the signs and symptoms of disease in order to prescribe standardised physical treatments can contribute towards feelings of objectification (Foucault 1973 - see also section 3.3, 3.5 and 3.6)

Nine women (47%) criticised hospital staff for not showing adequate care and concern towards their patients. For example, Margaret and Kim said they felt they had to look after other patients who were not being properly cared for by staff members. Kim said that the pressure she felt at trying to protect another patient from sexual assault led to her experiencing a further mental health crisis when she was discharged from hospital (see section 5.5).

Although for ten women hospital provided an escape from the stresses of their home life; whilst they were inpatients no attempt was made to address the interpersonal and social problems which they described as key in becoming hospitalised in the first place. All of the women who had been hospitalised had been treated with medication and/or ECT, and none had received any formal counselling or social support. Justine said that since no attempt was made whilst she was in hospital to help her address the problems she faced in her life, she would encounter these problems once again when she was discharged. She said:
"I don’t mean to sound bitter because I needed the rest - for that time at least I got somewhere away. But it frightened me being expected to go back out with still the same load. Yeah I’d had a rest, but how long was it going to be before I was back there?"

Kate made a similar criticism. She observed that:

"Basically when you go into hospital they just drug you and maybe you’re lucky if you see a psychiatrist once or twice but you don’t get any help, you don’t get any aftercare help either. I think you should get counselling when you’re in there so they know why you’re in there and you don’t go in again. Get them in there, drug them up and shove them back out again. And you’re obviously going to end up back there again unless you get help... I know that the drugs help you to a certain extent but they don’t solve the problem do they?"

Despite this criticism, however, these women did not want hospitals to close down, as there are so few mental health services available outside of a hospital setting. For example, Muyesha said:

"I would say that the majority of people in the psychiatric system that need care are there because of problems that have been heaped on them, and they don’t have the skills or the support to figure out how to resolve the situations. And so they end up in hospital because that’s the only thing that’s available to them. But it’s better than nothing at times, because at least there’s some extension of aid available."

The hospital regime is dominated by psychiatrists and as such is predominantly concerned with treating patients within a biological model of mental illness. Although not all women are diagnosed as suffering with a biologically induced mental illness when they become hospital inpatients, the hospital is structured according to the biological model. Consequently, hospital staff are often not trained to assist service users in dealing with the social issues and personal concerns which may have caused or exacerbated their mental health problems (Johnstone 1993, 1989). Physical treatments are the treatments most commonly
provided service users. Twelve (63%) of the nineteen women who had been hospitalised expressed dissatisfaction with the almost exclusive reliance on drug treatment which they encountered in hospital (see also section 6.3).

A study carried out in Canada by Miedema and Stoppard (1994) into women's experiences of psychiatric hospitalisation, also found that whilst the hospital provided an important asylum function for many women; the women were critical of the care they received whilst they were inpatients. The researchers interviewed twenty seven women and found that the hospital provided a respite from abusive relationships and stressful family responsibilities. However, Miedema and Stoppard reported that the women who participated in their study had experienced a lack of control over decisions affecting them and felt disempowered by the psychiatric system (see section 6.3 as this issue relates to my study). Abusive family relationships were not addressed by medical staff while they were in hospital and most of the women were prescribed medication without being offered other forms of assistance. Some participants in Miedema and Stoppard's study were also fearful of having to return to the family environment which had caused their problems. One reason for the similarity between these research findings and those in my study, is that in Canada, as well as in Britain, the biological model of mental health problems is prevalent within psychiatry (Burstow and Weitz 1988). Although Miedema and Stoppard do not analyse the effects of this model, it is my contention that many of the criticisms the women made about the treatment they received in hospital in both studies, are outcomes of the biological model of mental health problems. The provision of medical rather than social support, a predominance of physical treatments within the system and an inability to address the social causes of mental distress are among these outcomes (I discuss this in detail in chapter three on the impact of the biological model on stigma, diagnosis and treatment, and chapter five
on the particular experiences of women abuse survivors).

In the next sections I explore criticisms of the hospital regime which relate specifically to the power relationships between staff and service users within the hospital environment and the effect upon these relationships of the prescription of physical treatments.

6.3 Power relations within the hospital environment and the prescription of physical treatments

The power relationships between staff and patients were a major source of concern for ten of the women (53%) in my study who had been psychiatric hospital inpatients. The abuse of women inpatients can be seen as one outcome of this extreme power imbalance between service users and providers (see also section 5.4.2 and 5.5). The prescription of medication in hospital was described by eight women as both symbolic of, and instrumental in, the control which staff exercise over patients. Most of the women were not allowed participation in decisions relating to their treatment and were not informed of the possible side effects of the drugs they were prescribed (see also sections 3.5 and 3.6). Over-medication was cited as a significant problem, particularly in connection with the prescription of major tranquillisers in hospital (see also Brown and Funk 1986). Both Kim and Kate argued that overprescribing was carried out intentionally by medical staff in order to control patients on the ward, rather than for any therapeutic reasons. However, within the approach adopted in mainstream psychiatry, it is not easy to make a clear distinction between the therapeutic use of medication and its use as a means of control. Within psychiatry, lack of conformity is sometimes perceived as evidence of a mental health problem (see section 1.2 and 1.7). Therefore inducing conformity through the prescription of medication can be seen as both therapeutic and as a
means of control.

For women who are detained in hospital under a section of the Mental Health Act (HMSO 1983), the power of medical personnel is almost absolute. Service users who are compulsorily detained can be locked into wards, and have medication forcibly administered. This medication can entail serious side effects, and in some cases can even induce fatalities (see sections 1.4 and 3.6). ‘Sectioned’ patients cannot leave the hospital ward without permission, and if they do, the police can be sent to bring them back. In this study, six women had been compulsorily detained on at least one of their hospital stays. For example, Kate was detained in hospital and treated with major tranquillisers, when experiencing a mental health crisis she identified as being caused by violence from her male partner. She said:

"I know I needed something to calm me down - but not as much [medication] as they gave me. It was like every mealtime I had to take tablets ...And once after that they forgot to give me the side effects drug and I bit my tooth off because your jaw just goes stiff...I used to black out all the time. I used to fall over and hit my head, you know. I could walk but only in a jilting kind of way. Basically it just turns you into a zombie...[but] if I refused to take any medication they’d drag me into the toilets and do it, inject me with it...And you feel really really trapped because you’re locked into the ward and you can’t wander around anywhere unless they’ve got a nurse that can take you out and that sort of thing...I didn’t feel safe, not at all. I just used to sit by the door waiting for someone to come and visit me and hoping they would let me go outside for a bit.”

At present, compulsory treatment can only be legally administered to patients detained in hospital because they are thought to present a danger to themselves or others (HMSO 1983). Currently the Mental Health Act 1983 is under review. Amongst the suggested revisions to the Act is a system of compulsory treatment for service users living within the community (Scoping Study Committee 1999, Sayce and Pilgrim 1998). The idea that compulsory treatment outside hospital may be required has arisen in response to the controversy surrounding the current care in the
community policy; particularly the focus on acts of violence carried out by ex-psychiatric inpatients (see also sections 1.4 and 3.5). The widespread belief that psychiatric service users and ex-users are particularly prone to violence, has been fuelled by increased media attention on violent incidents involving ex-service users (see also section 3.4). However, there is evidence to suggest that people who have been diagnosed with a mental health problem are no more likely to commit violent acts than other sections of the community (Sayce and Pilgrim 1998). Sayce and Pilgrim pose the issue most aptly in the following terms:

"Is it justifiable that someone with mental health problems can be locked up, without trial, for a crime they may commit in future, yet someone who regularly beats his wife up cannot be? If preventative detention is ever justified, surely it should apply where the risk is greatest?...While some people with mental health problems are violent, the link is so statistically weak that it is impossible to use diagnosis of mental illness as a predictor." (Sayce and Pilgrim 1998:8)

Existing legal mechanisms for the compulsory detention and treatment of people though to be suffering with a mental disorder inevitably produce an extreme power imbalance between mental health service users and service providers. Even though only six women (17%) had been held in hospital on a ‘section’ themselves; all of the women who had entered hospital on a voluntary basis were aware of the possibility that they could be detained, and have physical treatments forced upon them. Indeed, five women (14%) had been told by service providers that if they did not consent to enter hospital on a voluntary basis, they would be ‘sectioned’. Thus whether or not women had been detained themselves, they were well aware of the possibility that they could be held in hospital involuntarily, and have treatment forced upon them.

Previous research aimed at investigating psychiatric inpatients views of hospital services (carried out by McIntyre, Farrell and David in 1989), concluded
that "the thing psychiatric inpatients value most about being in hospital is their ability to leave" (1989: 160). They asked ninety nine hospital inpatients to rate ten items on a structured interview schedule in order of helpfulness. The women who participated in the study rated a 'free pass' (which enables the holder to leave the hospital grounds) as the service most helpful for them - more so than talking to doctors, nurses, or receiving medication. This finding is significant, especially as only twenty four members of the sample group were being detained compulsorily under the Mental Health Act (HMSO 1983). The item rated as the second most helpful aspect of the patients' hospital stay was the experience of receiving visitors. Of the care provided, talking to doctors and nurses was regarded by the women as more helpful than drug treatment. According to the study, however, doctors spent less than one hour per week in talking to their patients. The reason why participants in the study made these responses is not discussed by the researchers. Although they assert that more attention should be paid to providing 'talking therapy' in hospitals, they also conclude that "patients need help to understand the benefits of their drug treatment" (1989: 160). Thus rather than criticise the negative aspects of hospitalisation and the prevalence of drug therapy in the mental health system, the researchers suggest that patients should be 're-educated' in their attitude towards receiving medication. In this way the researchers appear to dismiss the genuine concerns which many psychiatric in-patients have about receiving treatment in hospital.

Because of the power relationships within the hospital environment, Batcup (1995) has indicated that attempting to carry out research with women inpatients can be problematic, as they may not feel able to speak freely and criticise the hospital regime. Furthermore, some women may not feel able to complain to staff about the negative treatment they receive whilst in hospital, in case this is seen as further
evidence of their illness. In view of the power relationships within psychiatric hospitals, one participant in my research, Pam, suggested that there should be an independent confidential body to which inpatients could make complaints. She said:

"I felt that when it was your word against the staff, the staff would always win...Because you're a patient you don't have a say really. And they don't ask you enough. And it doesn't matter who you are, what colour, race or anything else, they are right. They take over your mind and in the end you don't think logically for yourself. In the end they seem to think for you."

Because of the level of control which is exercised over the activities of patients, three women (16%) described how they believed they had become institutionalised after even relatively short hospital stays. They also described how they felt particularly stigmatised by the experience of having been a psychiatric hospital inpatient which made it difficult to adjust to life outside hospital (see also section 3.4). For example Elaine said:

"When you come out then you feel so strange you know...everybody looks at you, don't they, they go past - 'oh look at her funny bugger'. Or if they see you sitting on the seat they think you've got two bloody heads anyway...You haven't seen nobody, you've only seen the people you know in there for months...And when you go out ooh it's weird, you think well I haven't got that security now, I don't want to go out and I don't want to do this and I don't want to do that."

Pam had experienced similar feelings when she was discharged from hospital. She said:

"When I started to go out I felt 'oh, everybody's looking at you'. I felt institutionalised. I felt it hard to get back into people again. I felt it awfully hard to be doing normal things again. Because [in hospital] you can't make a cup of tea when you want to. Because I thought I was pretty normal, really, even though I had problems. But you do get institutionalised so quickly...It was an education going in there - one I don't want to have again."
Kim worked as a psychiatric nurse for several years before becoming a psychiatric service user. She has been in a psychiatric hospital twice over the last ten years, and from her experience on both sides of the user/professional divide she observed the power relations which form part of the day to day running of psychiatric hospitals. She said:

"People that work in mental hospitals are just looking out for themselves. I did. I had to because I was expected to keep up a status because I was expected to fall in with the crowd. They separate themselves purposely from the patients because they can't cope with them. And that's where the drugs come in. Stuff them up with drugs and we can control them. They just had nothing. Patients are usable for status, to make yourself look good, jab them a few times, give them what you want. In other words it's a simple power thing, a control thing."

The majority of interviewees who had been psychiatric hospital inpatients expressed concern about the power relationships between hospital staff and patients. The over-prescribing of medication was described as being both a result of, and instrumental in, maintaining this power imbalance. The lack of information that was provided in hospital about the possible side effects of medication and ECT was a particular source of concern for many women (see also section 3.6). The mechanisms which exist for the compulsory detention and treatment of service users in hospital has a significant effect in establishing and maintaining the imbalance in power between service users and providers within a hospital setting. The introduction of compulsory treatment of service users outside hospital, as part of the reform of the 1983 Mental Health Act, may serve to further disempower users of mental health services in Britain.
6.4 The women's perspectives on care in the community

For the last century and a half, large psychiatric hospitals located within a remote geographical setting have provided the central location for psychiatric treatment (Pilgrim and Rogers 1994). The establishment of asylums for those who were deemed 'mad' in the eighteenth and nineteenth centuries, paved the way for the establishment of psychiatry as a medical specialism (Rogers and Pilgrim 1996, Foucault 1967, 1961). Thus the rise of the psychiatric profession has been closely linked to the development of the psychiatric hospital system. During the last twenty years, however, there has been a desire amongst psychiatrists to relocate the profession to the general hospital alongside other medical specialisms. There has also been considerable concern relating to the cost of funding psychiatric hospitals and the damaging effects of institutionalisation upon patients (see section 1.6.1). The policy of care in the community which has been pursued by successive governments (see section 1.6) has led to the rundown of psychiatric hospitals and the development of small psychiatric acute units attached to general hospitals, interdisciplinary community mental health teams and daycentres.

The closure of psychiatric hospitals in line with the policy of care in the community was an issue of concern for many women in my study. Thirty two women overall (91%) opposed the programme of psychiatric hospital closure. Most of the women supported the idea of developing mental health services within the community, but thought that this should not be done at the expense of cutting back on hospital care.

Twenty nine women (83%) criticised the policy of care in the community policy for failing to provide adequate levels of service provision for mental health service users The majority of women who took part in my study said that in their
experience there was actually no such thing as ‘care in the community’ as the only service which was made available to them (apart from visits to their GP or an inpatient stay in hospital) was an infrequent and brief outpatient appointment with a psychiatrist. When I asked Sarah about her experience of care in the community, she became very distressed and began to cry. She said:

“There isn’t community care - it’s as simple as that...Both me and my partner with mental health problems and I don’t know what the community mental health team does...It’s a joke, community care is a joke. I mean agree with the principles of it ...But there’s no way I should have been allowed to deal with it on my own, the way I’ve had to. There must be community care - there has got to be, if they’re not going to put people into hospital to get treatment...To get anything is such a fight...Most people can’t do it and then they’re just left. They say the help is there but you just can’t get it - it’s not available.”

Isabel pointed out that the only service that was available was a psychiatric hospital stay if you were severely distressed and in danger of harming yourself or other people. Otherwise you couldn’t access any help at all. She said:

“[If] you’re not suicidal and you don’t want to hurt anybody then you can’t get the help and if you say you are suicidal and you want to hurt someone they’ll have you in [hospital]. It’s so wrong. So they need to have more facilities in lots of ways. More places, smaller places. Something should be done, more. The Health Authority haven’t thought this through, not at all.”

Thirty three women (94%) suggested the development of a range of different mental health services within the community, which would provide a broader, more needs specific service than is currently provided. However the women pointed out that these services were needed in addition to, rather than instead of, hospital provision, because there were occasions when they would need to live in an alternative environment for their health to improve (see also section 6.5). For example Gillian said:
“Care in the community is OK if you’ve got a supportive partner. I couldn’t cope in
the community. I needed to be taken away because basically that was my stress. I needed to
be removed far away from it. To have that pressure taken away from me. I went home and I
suddenly went right back down again. I took another overdose and I went back into
hospital”

Kim, however, disagreed that services should be developed in the
community. She said that hospitals should be kept open and should instead be run by
patients and staff who have not received any specialist medical training. She said:

“You certainly need hospitals as asylums…. I needed to get away from that crowd
that was doing it to me, into a place where people were willing to talk to me on the level. I
learned a great deal there about me… And the others did too. What are you going to do, put
them into the community? Community is just another word for society. Society is just going
to beat them down again. Society is the baddest place on earth.”

It has been asserted that the move towards care in the community would
reduce the stigma experienced by many psychiatric service users (see section 1.6).
However, three women (9%) who participated in this study argued that, in view of
the stigma attached to service use, if they had to go into hospital, they would prefer
to become inpatients in an acute unit which was not located within their own
community. This was because they did not want their friends and neighbours to find
about their mental health problems. Sarah said:

“No one in the Manic Depression group want the hospital to close. They say they’re
going to set up another unit in the grounds of the [general] hospital. But everyone says we
don’t want that - people seeing us when we’re at our worst. We want grounds that we can
walk around in solitude where no one is going to notice us. Why isn’t all of this being taken
into account?”

These women suggested that psychiatric hospitals should be established as
places of sanctuary that are geographically isolated from the rest of the community.
An isolated location would help them to conceal their service use from friends and
neighbours, and since people would be less likely to know they were patients, they might be able to escape much of the stigma associated with a stay in a psychiatric hospital. A remote setting was also perceived as offering greater safety and security because of the exclusion of ‘outsiders’ - people who did not understand and had not experienced mental health problems themselves.

In contrast, four women (11%) argued that if mental health services across the board were relocated to the community, it might help to destigmatise service use. The two reasons offered for this concerned anonymity and normalisation, respectively. As they would be smaller than the old Victorian psychiatric hospitals, community based services might tend to be more anonymous, and this anonymity would mean that service users could escape some of the stigma associated with psychiatric hospitals. Thus service users might tend to be less stigmatised as it would be less commonly known that the places they were attending were specifically mental health service premises. By contrast, it was argued that relocating services within the community, specifically alongside other health services (such as psychiatric acute units attached to general hospitals), might mean that the services themselves would come to be seen as equal to, and an extension of, the range of other health services (see 3.4).

There is some evidence to suggest however, that the move towards relocating services within the community has actually led to an increase in the stigma experienced by psychiatric service users (see also sections 1.5 and 3.4). The media emphasis on the violence carried out by ex-psychiatric inpatients in the community, has led to situation whereby the development of community based services is often

1 Geographical remoteness was an intentional component in the original establishment of ‘lunatic asylums’ in the eighteenth and nineteenth centuries. They were originally perceived as a retreat to which individuals could go for rehabilitation (Scull 1996).
hindered by the activity of local residents opposed to their creation within the locality (Sayce 2000, Prior 1999, Mapp 1994). Thus in some ways the move towards community care and the objections raised to the policy, have tended to intensify the stigma associated with mental health problems. The fact that someone is a psychiatric service user means they are now, possibly more than ever, perceived as an essentially dangerous and threatening ‘other’. Thus if it becomes known that a service is to be opened in the community catering specifically for people with mental health problems there is often widespread opposition.

Rebecca referred to this issue, when she said:

"I think the community care thing is a load of bollocks and once again a cop out by our government, because it just completely reinforces the social stigma without perhaps realising itself to be doing so. I think it’s wiping their hands - it’s trying to put the responsibility into the community, but the community doesn’t give a shit anyway; because the community is completely influenced by what the media tells them. And what the media tells them, is what the government in so many ways has told them also. It’s like a knock on effect. We’re not ready to deal with people in the community. We haven’t got the skills, we haven’t got the social awareness to be able to treat people with care and respect...So community care is an extremely bad move; it’s very premature."

The community based service development which was suggested by the women in the study included non-medical residential services, more community psychiatric nurses; more counselling being made available; and more self help groups covering a wider range of issues (see also section 5.6). Several women referred to the need for a twenty four hour, seven-day-a-week telephone crisis line, through which assistance could be sought from mental health services. Sarah said

"There’s got to be a twenty four hour service - there needs to be a crisis one and there needs to be a befriending one...There’s got to be someone that can go out to a carer or a user when they need it, when they’re feeling so lonely at the time...Someone that gives you validity even if they can’t come right then - that can say ‘try this, this, and this and I’ll be with you as soon as I can’. Just something, because there’s nothing there at the moment "
Developing services which would be provided to users in their own homes was perceived as a good idea by thirty one of the women participants. Seven women (20%) referred to problems with childcare which made it problematic or completely impossible for them to leave the home to visit mental health services (see also section 4.4). Two women (6%) specifically referred to emotional difficulties in leaving their homes when they were severely distressed, which had made it difficult for them to access services outside the home. The services which the women suggested they would like to see provided at home, included counselling; visits from community psychiatric nurses and occupational therapists; consultations with psychologists; help with housework and childcare, and advice on complementary therapies, as well as general information sharing. Three women (9%) said that just having someone visit who was approachable and would be willing to talk things over with them would be very useful. Debbie said:

"Visits from someone who’s down to earth, who knows what the problems are about…that’s dealt with a lot of people that’s been there and seen the outcomes, and can advise on alternative medicine, and the help within the health service…just having someone to talk to once a day for an hour, or twice or three times a week for an hour, would be amazing, especially when you’re on the ceiling and you can’t tell anyone why you’re ill because they think you’re mad and you’re a loony."

However, nine women (26%) asserted that providing homebased services would not be appropriate for some women, as the pressures of family life contribute significantly to emotional distress. Diane thought that social class would be significant for many women in whether homebased services were experienced as useful. She said:

"If you’ve got a nice spacious home and your kids are in the nursery and so on then yes it’s very nice to have someone come to your home. But if you’re living in a council flat and your kids are screaming then you’d probably rather get out and see somebody."
Most of the women who participated in my study suggested the development of a broad range of mental health services which could provide a needs specific service to users. Amongst these suggestions was a residential service which would provide a place to stay when they were experiencing severe emotional distress. Many women had become inpatients in hospital in order to achieve asylum but had been critical of the medical treatment they received there (section 6.2). In the following section I explore the women's suggestions relating to the development of residential services which are not based within a psychiatric hospital or acute unit attached to a general hospital.

6.5 The development of alternative residential provision

In discussing the move away from residential service provision directed by the policy of 'care in the community', Jane Ussher (1991) argues that many women may benefit from a residential service which would provide them with asylum.

"Therapy may be part of women-centred services, but so may the traditional (and often vilified) asylum: space away from family, from society. For many women it is a welcome relief, and the move to the community in psychiatric care often denies this. To acknowledge the need for asylum does not mean that we should lock women in 'mad houses' for expressing their pain, that we should allow women to become institutionalised. We need safety without coercion." (Ussher 1991: 305)

In a report issued by Williams, Watson, Smith, Copperman and Wood (1993) it is also argued that the provision of only homebased and/or non-residential day services, is unlikely to meet the needs of a significant number of women. They assert that for women who have suffered domestic violence and/or racial harassment it is important that they receive accommodation in which they can feel completely safe. In addition, they assert that in view of the violence against women which is
committed within a family setting, many women will require an alternative safe place to live in order for their mental health to improve. Therefore they assert that there is a need for safe houses in the community, particularly for women who have been sexually abused (see also section 5.6). In Britain currently, however, there are very few residential services provided outside of a hospital setting (Good Practices in Mental Health 1994). In the South Wales area, there are supported housing projects which offer tenants accommodation with some emotional and practical support provided, but these schemes do not provide an alternative to hospitalisation for women experiencing a mental health crisis, as they do not provide immediate access, and often do not cater for women with high support needs. Women’s Aid refuges provide an alternative supported place to stay for women experiencing emotional, sexual and/or physical abuse, but most are clear they do not have the facilities to provide the high levels of support needed by someone experiencing an acute mental health crisis.

I asked all the women interviewees whether they perceived a need for a residential service which was not provided within a hospital setting. As all but one of the women in my study had not actually used a non-hospital based residential service, their comments were informed by the gaps which they had perceived in the services which they had used, and not by any direct experience of this kind of service.

Thirty three women (94%) said that there was a need for a residential mental health service which was not a psychiatric hospital or acute unit. With one exception, this was perceived by the women as something which would be useful in addition to, rather than instead of, current hospital provision. Many of the women said that a non-hospital based residential service would fill a gap in service provision which at present has not been addressed in the organisation of mental health
In discussing issues relating to the establishment of a residential service, there were eight themes which emerged from the women's suggestions. These included the need for asylum; respite; accessibility; validation; support; the need for attention to be paid to psychosocial factors; not wanting to be compelled to accept physical treatments; and the provision of childcare facilities.

Of the women who supported the establishment of a residential facility, twenty (57%) said that such a service would be useful if it could provide them with asylum, a safe place to be when they could no longer cope at home. In discussing the concept of asylum and why this was needed, seven women (20%) mentioned specifically the pressure of their caring role within the family, and six (17%) mentioned the need to leave the home in order to escape abuse by family members. Others thought it was needed by women who had not specifically experienced abuse.

"I think sometimes women do need a refuge. Not just because they've suffered violence or abuse but they need somewhere safe to be. It would be lovely to see more places like that. Where perhaps they don't need medical help but time out. Professionals and the middle classes are more able to do that, you know you can book your weekend in the Cotswolds or whatever but if you're living on a housing estate on benefits I don't know how you get that time. So I say - health farms for all!" (Rachel)

In order to effectively provide a place of asylum any service would have to offer women a high level of safety when they were using the service. Fourteen women (42%) said that a residential service should be single sex in order to effectively provide this place of safety for women. This was in part an acknowledgement of the problems associated with the mixed wards system in hospital (see section 5.5). Six women (17%) said that the service should be run only by women members of staff, in order to avoid the possibility of any sexual harassment or abuse from professionals within the service (see also section 5.4.2 and
Thirteen women (39%) suggested that a residential facility should provide complementary therapies for users. These included aromatherapy, homeopathy and hypnotherapy. Overall this reflected the popularity of complementary therapies amongst the women who took part. In the sample as a whole, twenty three women (66%) had used some form of complementary therapy instead of, or in addition to, the treatment which they had been prescribed by medical practitioners (see table 1, section 2.12.

The issue of accessibility was important for many women. Twelve women (36% of those who supported the idea of a residential facility) indicated that a system of self-referral would be required, so that access would not be blocked by unsympathetic GPs or other mental health professionals. This relates to the criticism that GPs, acting as the gatekeepers to specialist mental health services, were sometimes obstructive in their attitudes and refused to refer some women to specialist service provision (see section 3.2).

Another feature which was described as desirable was the opportunity to be with other people who were also experiencing a mental health crisis. Being able to talk openly about their feelings with people who had similar problems was welcomed as a validating and empowering process. In particular it provided the opportunity for a woman to feel that she was ‘not the only one’ so affected. Veronica said:

"I think it would have been very beneficial if I could have gone away for a short time, perhaps only a couple of days and been with people who had similar problems and just be away from the family. Away from the responsibilities of having to be a mother and a wife so that perhaps I could concentrate just on my own problems....I can’t think of the word for it in English, ‘illoches’ it is in Welsh. Some sort of shelter, not where you’re receiving medical help, but just where you can go away and rest, and just talk to others."
A further issue relates to the type and levels of support which were perceived as desirable within a residential service. Acknowledging the validating and empowering aspect of interacting with other users, nine women (26%) said that a residential service should have some element of self help, either in the form of self help groups which were made available within the service, or that the service itself should be run by users in association with staff. This, in part, reflects the effectiveness of self help groups for many of the women who have participated in them. For example, Isabel said:

"It would do good. You would get a better effect with that. You could go to a self help group in the afternoons. I think that would be instantaneously helpful, if it was in a complex like a health farm."

Ten women (29%) said they thought that to be properly effective a residential service would need to provide childcare facilities, so that users would not run the risk of losing custody of their children when they used the service (see also section 4.4). Three women (9%) suggested that a residential service should set out to provide non-discriminatory treatment to service users. This represented an acknowledgement of the discriminatory treatment which sometimes occurs in other mental health services (see chapter four).

All of the women who supported the idea of establishing a residential service, except one (Jade), suggested that such a service should be provided in addition to, rather than instead of, hospital provision. They suggested that it should not provide the medical intervention characteristic of a hospital setting but instead should complement hospitals by concentrating on providing social care and support. They envisaged that such a service would be useful for women who were not in such a state of distress that they posed a danger to their own safety, and who therefore did
not require intensive support, medical care and treatment. Seven women (20%) said they thought that if social, rather than medical, assistance was provided in a residential setting at an early stage in the development of a women’s mental health problem, many women would not become so distressed that they would have to be hospitalised in the first place. Charlotte said:

“When I was totally off my head I think that hospital was the most appropriate place. I was really in danger of hurting myself as well. But when I was rational enough to be not quite at that point but finding it very hard to escape the idea of suicide then something sort of halfway where you can be with people who understand that and who’ll let you be in your own space would just be heaven. So something more sort of halfway... just a house somewhere with 24 hour staff cover. Somewhere safe to be, somewhere you can make your own food, but there are people there - just there, and you can take your children. Yes, I think there’s a need for both a hospital environment and something sort of halfway like that.”

Similarly Margaret observed that:

“There needs to be somewhere else other than mental hospitals. I’m not sure of the percentages but I’m sure there can’t be that many people who are so psychotic they need to be put in hospitals. I mean if you’re going to kill your baby or do harm to yourself fair enough. But a lot of people aren’t that stage they are at somewhere in the middle.”

In contrast to this position, Jade suggested that a non-medical residential service should be provided as a constructive alternative to, rather than adjunct of, psychiatric hospital provision. Jade was the only woman who had herself been in a residential facility which was not a psychiatric hospital or acute unit. She had been diagnosed with a personality disorder and a neurotic mental illness (anxiety and depression). She is also an abuse survivor, and a recovered alcoholic and drug addict. The service she had used was a voluntary sector organisation set up specifically to offer a high level of social support and counselling (rather than medical treatment) to women with mental health problems who had also been addicted to substances. After many years of service use, Jade said that entering this
facility was when her recovery really began:

"I feel that we need that break from the home just to completely get away from everything and everyone. Just to have time to ourselves to deal with what we need to deal with... I just think if there were more places like that available to women it would cost less in the long run. Because I spent years seeing so many different psychiatrists, psychotherapists, psychologists, GPs, different clinics, hospitals, surgeries, different drugs... Even though it could take money to build these places, get them organised, get staff in and that, it's going to save people in the long run. Because that's what I needed was to get to the root of it all and deal with it all, instead of just beating about the bush. And just plodding along and not really getting it sorted out."

Jade was firmly of the opinion that most mental health problems are caused by psychosocial issues and she felt strongly that her years of medical service use had actually worsened her condition rather than helping her. Thus she supported the idea of developing a non-medical alternative to psychiatric hospitalisation which aimed at addressing psychosocial problems amongst users.

One woman, Mary, took up a polar position to Jade and said that she did not perceive a need for a residential service outside of a hospital setting. She had been diagnosed with manic depression and was a member of the Manic Depression Fellowship. Her major concern during the interview was that people suffering with serious mental illnesses be admitted into a psychiatric acute unit as soon as possible when they become ill. She asserted that in terms of residential crisis care the most important requirement is for properly equipped psychiatric acute units which service users can access in order to get appropriate medical treatment.

"The old idea of asylum was a place of refuge for someone who is seriously ill and needed to come to grips with a mental illness. I would like to think that if I was seriously ill with manic depression again I could be brought into a well designed acute unit and have the best provision of services. I don't think that somebody who is hypomanic can be dealt with adequately in their own home... And I honestly think these old hospitals have got to be demolished but the money from these old hospitals has got to put into developing acute
units within the community. Not isolated out from the centre of the population and there should be more of them. They should be much smaller and they should be well staffed.”

Like Jade, Mary’s views were significantly influenced by her conceptualisation of mental health issues. Mary subscribed to the approach adopted by the Manic Depression Fellowship and the psychiatric discourse in conceptualising many mental illnesses as being caused by biochemical processes which require physical treatments.

Four women (11%) said that despite the potential usefulness to them of developing a non-medical residential service, such a development would be highly unlikely given the financial constraints which affect mental health service provision. There was a broad consensus of agreement among the women in the study that mental health services are seriously underfunded. Many of the women were aware that the rhetoric concerning community care did not match their experience of service use and that regardless of the actual needs of service users, the development of services outside of psychiatric hospitals has not actually occurred. For example Isabel said:

“At the moment there is nowhere. Nowhere. But we can’t even get baby-sitting at the moment - we’re not going to get this are we! I suppose we could win the lottery or something, you never know. No, it’d be a good idea if we had somewhere to go.”

Diane indicated that financial constraints would not be the only obstacles to developing this kind of service. She said that because of the dominance of psychiatry within the present system of mental health services, it would be highly unlikely that the development of non-medical services would be supported. She said:

“There isn’t the funding and there isn’t the attitude anyway that’s going to provide something better than the hospitals were. I mean of course ideally there would be some sort of residential places in the countryside that were more like hotels than hospitals where you could chat to anyone whenever you wanted and you weren’t going to get assaulted. And
Many women thought that the development of a residential service would be particularly useful if it could provide an additional service to that of psychiatric hospitalisation for women experiencing an emotional crisis, and could be organised to avoid many of the problems associated with hospitalisation. The core elements in the women’s suggestions for this service development relate to the need for asylum; respite; safety; support; validation; alternatives to physical treatments and the provision of childcare facilities. Although psychiatric hospitals were perceived as useful in providing asylum, a key aspect of asylum is safety. Several women criticised hospitals for not providing the level of safety they were seeking (see also section 5.5). The women also criticised the predominance of physical treatments and a lack of childcare facilities within inpatient hospital care. The dominance of the biological model of mental illness within mainstream psychiatry means that the major share of the available funding for mental health services is allocated to medical treatment, rather than social assistance for service users (Goodwin 1993).

Conclusion

In the development of the policy of care in the community, many large psychiatric hospitals have been closed down, but alternative, community based, provision is still seriously underfunded. The majority of women who participated in my study said that in their experience there was effectively ‘no such thing as community care’. The women who participated in this study did not want a simple either/or approach to service provision in which the central choice is between becoming a psychiatric hospital inpatient, or seeing a medical practitioner on an outpatient basis. Rather, a range of service provision was seen as desirable, in which
women could access different forms of provision according to their particular needs at specific points in time. The majority of women indicated that the development of a wide range of mental health services would be most useful, with different forms of provision catering for different types of problems and levels of support needs. Amongst the suggestions were the establishment of a non-medical residential service; more self help groups; greater access to complementary therapies; the provision of more NHS counselling services; a twenty four telephone line through which they could access help from mental health services; and the provision of CPNs; counsellors; and psychologists, who would be able to visit service users' in their own homes. These developments were perceived as being desirable in addition to, rather than instead of, hospital provision. A core element in all of the women's suggestions was the provision of support in a safe environment.

One of the problems identified with current hospital provision was a lack of social and personal support and a lack of safety on the ward. Hospitalisation often provides a respite for women in emotional crisis, where they can escape from the pressures and responsibilities of their everyday lives. It can provide a space in which they feel free to express their feelings of emotional distress and in which they can gain asylum from domestic violence and abuse. There is a serious cause of concern however as to the treatment which is offered some women psychiatric inpatients. The main areas of concern expressed by the women related to the sexual abuse which some women have experienced on the ward; oppressive attitudes being expressed by staff members; compulsory detention and treatment; the mixed ward system; an over reliance on physical treatments; a lack of care and concern by staff; feelings of objectification; a lack of childcare facilities; and a failure to address the social problems which inpatients face in their daily lives. Because of these factors the hospital environment was experienced as disempowering for many women.
Despite these criticisms many women thought, however, that hospitals should not be closed down, as for women experiencing a very severe mental health crisis it was appropriate to be treated in hospital. For women experiencing a less severe mental health crisis it was often perceived to be a service which was ‘better than nothing’.

The development of a non-medical residential service was seen by many of the women in the study as a way of achieving a place of asylum which does not also incur the problems associated with hospitalisation. An emphasis on social, rather than medical, care was identified by the majority of the women in the study as being desirable within this type of residential setting.
Chapter Seven -

Conclusion

Introduction

In this chapter I conclude my research by bringing together the main themes I have developed in this thesis (section 7.1). I then go on to discuss issues arising from these themes relating to the improvement of the organisation and provision of mental health services for women (section 7.2).

7.1 The social impact of the biological model of mental health problems upon women mental health service users

As I discussed in chapter one, mental health professionals in Britain utilise a variety of different approaches in understanding and treating conditions perceived to be indicative of a mental illness. However, despite this eclecticism, the biological model is the dominant means of conceptualising mental illness within psychiatry. Psychiatrists are placed at the top of the hierarchy of mental health services in Britain and their approach to understanding and treating mental health problems comprises the most significant influence on the way that service users are treated within the statutory mental health system (section 1.1).

In the biological model, mental health problems are conceived to be indicative of an illness which is caused by biological factors - such as biochemical processes and/or genetic features within the structure of the brain and body. Some proponents of the biological model claim that social factors play a role in the genesis of mental health problems, but only to the extent that they play a role in ‘triggering’ the development of the illness in individuals who already have an organic
‘predisposition’ to the disease (section 1.1).

Due to the dominance of the biological model, the vast majority of research into the causes of mental health problems aims to discover the biological factors which are presumed to be key in their aetiology. Despite a plethora of research in this field there has not been a great deal of progress made in identifying the precise biochemical or genetic features which are theorised to be key in the aetiology of diagnosed mental illnesses (section 1.1). The majority of this research is funded by pharmaceutical companies who manufacture psychotropic medication which is supposed to provide a ‘cure’ for mental health problems. The prevalence of the biological model within psychiatric thinking across the Western world means that pharmaceutical companies which manufacture psychotropic medication are amongst the most profitable industries in the world (section 1.3). The fact that psychotropic medication does not in fact provide a ‘cure’ (as opposed to the temporary amelioration of symptoms) for many mental health problems and can promote physical and psychological dependency amongst users is one reason for the financial success of these industries (section 1.4).

In defence of the biological model it could be argued that it is not practically possible to intervene at a social level in treating people diagnosed with mental illnesses. Thus although environmental factors may ‘trigger’ illnesses, it is not possible to screen out these factors as most will be beyond the control of medical practitioners. All mental phenomena are accompanied by physiological processes in the brain and the body, and intervention at the level of physiology means something immediately constructive can be done to ameliorate individual feelings of distress. This argument tends to lead to a reductionist position however, in which socio-political issues in the aetiology, analysis and treatment of mental health problems are overlooked.
Although physical treatments can, and often do, assist an individual to deal with their mental health problems there are distinct social and political issues which need to be addressed in order to provide effective, comprehensive mental health services for women. These include issues of gender oppression; racism; homophobia; poverty; class oppression; ageism, and discrimination against those with a disability. All of these factors can contribute to an individual's experience of mental health problems, and issues of oppression may also relate to the construction of the diagnostic categories within scientific psychiatry (see 1.7, chapter four).

Although some of the women in my study had found physical treatments to be useful in lessening feelings of distress (despite the side effects they may have experienced), many were dissatisfied that they were the only treatments they had been provided with (section 3.6 and 5.4). Intervening at the chemical level sometimes produces a relatively quick amelioration of painful feelings. This accounts at least in some measure for the popularity of minor tranquillisers and antidepressants among mental health service users. The other reason for their popularity however is that they are, in the majority of cases, the only assistance offered by GPs and psychiatrists. Many of the women who participated in my study said that they would like more counselling made available; more self help groups; social support such as the provision of childcare facilities; and access to complementary therapies (sections 4.4, 5.6 and 6.4).

The majority of women who participated in my study criticised psychiatrists because they appeared to be exclusively concerned with isolating the symptoms of their distress and then prescribing physical treatments such as major and minor tranquillisers, antidepressants, and less commonly, ECT (section 3.3). They believed that their psychiatrists were not willing to discuss with them their personal concerns, and this led to some women feeling like they were treated like objects rather than
people. Indeed, many women said that the attitudes of their medical practitioners (both GPs and psychiatrists) were characterised by coldness; a lack of empathy; an unwillingness to discuss the concerns they had about their mental health issues, and a preoccupation with prescribing medication (section 3.2 and 3.3). One reason for these findings can be accorded to the biological model of mental illness as this entails an exclusive focus upon isolating, classifying and treating the symptoms of the biological condition which is often thought to be causing a woman’s mental health problem (section 3.3).

GPs were also criticised by the women because many adopted a dismissive attitude towards their women patients and refused to refer them to specialist service providers (section 3.2). In particular there were reports of patronising references to women’s biology being made as a way of dismissing the women’s concerns about their mental health (section 4.2). This attitude may be indicative of the belief that women by their very nature are more liable to experience minor mental illnesses, as mental illness is perceived to entail a loss of rationality and women are sometimes believed to be inherently emotional and irrational. The dismissive attitudes evinced by some GPs also reflects the widespread ideology that female biological processes such as menopause, childbirth, and menstruation, tend to make women more psychologically unstable than men (section 1.7). Attitudes like these can be seen to reflect and perpetuate an oppressive ideology of women’s natural biological and psychological inferiority to men.

There is evidence to suggest that the medical discourse itself may contribute to the objectification and disempowerment of women service users. The psychiatric consultation has a micropolitical character in that psychiatrists are often drawn from an elite group in society (usually male and middle class), and they have an unequal access to the material and intellectual resources necessary to analyse and treat
mental health problems. The medical discourse favours the medical practitioner using it, as in the context of a consultation they are seen as the 'expert' in terms of their understanding and use of this discourse.

Several women commented that they did not understand the medical jargon used by their doctors and no attempt was made to explain it to them in layman's terms. It has been argued that the use of jargon, and the withholding of information generally, serves to mystify medical practice and so intensifies the power relations between doctors and their patients. Thus medical consultations may maintain the esoteric nature of psychiatric knowledge which reproduces a hierarchy based on expertise. Interestingly, the women who were members of the Manic Depression Fellowship described how the group had explained the medical discourse to them in accessible terms, and because of this information sharing they felt able to engage with their doctors on a much more assertive level.

All of the women who participated in my study thought that they needed an explanation of why they had experienced mental health difficulties. Some women thought that they had developed, or had been given, a satisfactory analysis as to why they had experienced these mental health problems (section 3.5). Several women who had been treated by GPs and/or psychiatrists had neither been told a medical diagnosis, nor had any other explanation for their distress provided by medical practitioners - they were simply prescribed physical treatments which they were told would make them feel better. Many of these women thought that they did not have an adequate understanding of why they felt as they did and criticised their medical practitioners for being unwilling to discuss with them the possible causes of their mental health difficulties. Indeed, a major complaint amongst the women was a lack of information sharing, and a lack of participation in decision making processes relating to their diagnosis and treatment.
A further issue which emerged from the interviews was that many women actively adopt a range of strategies to treat their mental health problems and/or to explain to themselves and others why they are experiencing mental health difficulties. Overall, twenty three women (66%) had used some form of complementary therapy (aromatherapy, hypnotherapy or homeopathy). Some women subscribed to the dominant medical discourse in discussing their mental health problems, whilst others rejected all or part of this discourse. Some accepted their diagnoses (where they had been given one) and concomitant physical treatments; others rejected their diagnoses whilst accepting medication to ease their feelings of distress, and some women rejected both their diagnoses and the physical treatments which had been prescribed to them. The decision to reject or accept the medical discourse relate to its potential to make sense of a woman’s experience, the accessibility of alternative discourses and the advantages which may accrue in choosing one discourse over another. This is a complex issue however as what may be advantageous in one context may bring with it disadvantages in others.

There is enormous stigma attached to mental health problems (sections 1.5 and 3.4). In terms of stigma, some women who participated in my study thought that a psychiatric diagnosis was helpful because it signified that they were suffering with a illness which was not their fault. They thought that the stigma they experienced because of their diagnosis (even where this denoted a psychosis) was preferable to that they would have experienced had they been perceived to be attention-seeking, or badly behaved, instead of ill (section 3.5). For these women it appeared to be a straight choice between understanding and explaining their distress as symptomatic of a medical illness; or being blamed (by themselves and/or others) for being wilfully troublesome. Although they welcomed their diagnosis, these women were also critical of their doctors exclusive preoccupation with studying their symptoms
and with the predominance of physical treatments within the services. Inevitably, however, within the biological model, a psychiatric diagnosis entails physical treatments which are meant to cure, or at least control, the illness which has been diagnosed. As I noted earlier, within psychiatry as a whole, the dominant means of explaining and understanding women's distress is in terms of a biologically induced illness. This does not mean that all medical practitioners believe that their patients are suffering with a biological mental illness (see section 3.2). However, the dominance of this model means that psychosocial approaches to understanding women's mental health problems are confined to the periphery within the mental health system (Johnstone 1993, 1989 - see also section 1.3). In the absence of any alternative explanations being offered them, it is unsurprising that many women when they are told they have a biological illness, accept this explanation (as at least it means that their distress is not voluntarily chosen by them) even if at the same time they express a great deal of dissatisfaction with the effects of the label in terms of the attitudes expressed, and treatments provided, by mental health professionals.

Whether they chose to accept or reject the medical discourse all of the women indicated that service providers should respect their individuality and treat them with a degree of warmth, empathy and understanding. Those who subscribed to a biological understanding of their mental health problems also identified social and personal factors which impact upon their mental health problems and felt that these should be accorded some attention. They also wanted a degree of participation and consultation in matters relating to their diagnosis and treatment.

Many of the women who disclosed experiences of child sexual abuse chose to reject the medical discourse when discussing their mental health problems. The accessibility of an alternative discourse (introduced by feminist campaigners) in which abuse is named, acknowledge and recognised as a source of women's mental
health problems was key in this process. However, alternative discourses which do not adhere to a Western scientific biomedical model tend to be subjugated and marginalised within the doctor-patient encounter. The doctor assumes control within this interaction by permitting only the use of the diagnostic categories of scientific psychiatry. Currently there are no diagnoses which specifically refer to the range of mental health problems which are experienced by women survivors of male violence.

Only three of the twenty four women (13%) who identified themselves as abuse survivors had received any kind of statutory service provision which was specifically geared to the issues of physical and/or sexual abuse. The assistance offered was referral to NHS counsellors apparently knowledgeable about abuse issues and a self help group for abuse survivors in the statutory sector. Some women had actually experienced further sexual abuse and/or harassment from male service providers or male patients when they were using statutory services (sections 5.4.2 and 5.5). Thus the very oppression which these women identified as being key in causing their feelings of distress was actually repeated within the statutory mental health services.

In this research I found evidence that some mental health professionals display discriminatory attitudes towards social groups who also experience discrimination in wider society (chapter four). There were reports of sexist, homophobic; racist; ageist, and disableist, attitudes amongst service providers. The medical discourse itself may serve to disempower women, as within this discourse many social problems key in the experience of mental health problems are individualised and medicalised. Thus an explanation for them is provided which tends to obscure their socio-political origins. The diagnoses and treatments (medication, ECT and less commonly counselling) offered often do not name or
address the prevailing systems of social oppression within society. By locating the source of the problem with the individual service user rather than with broader socio-political processes, the medical discourse individualises collective social problems and may serve to mystify their origins.

Micropolitical interactions between mental health professionals and service users can in some circumstances repeat and reinforce macropolitical structural patterns of domination and subordination. This does not mean that mental health professionals consciously conspire to reinforce structural systems of oppression. There is a gender hierarchy based on professional expertise which affects mental health workers as well as service users. Women make up the majority of service users overall (Prior 1999); women often predominate in support roles as nurses¹ and occupational therapists, and men tend to predominate as qualified psychiatrists. Furthermore, mental health professionals are participants in a particular set of social relations which is dominated by a discourse that individualises and pathologises many socio-political issues. The psychiatric profession, through its construction of diagnostic categories, has some power to articulate what is normal and abnormal behaviour in a given context. Individuals are expected to adjust to these norms of behaviour in order to be perceived as psychologically healthy. However, it has been claimed that individuals and groups who deviate from the standards articulated in these diagnostic categories (standards most readily associated with the behaviour of white middle class males) are often pathologised as mentally ill (see chapter four, sections 1.7, 1.8). The historical development of Western psychiatric discourse has

¹ Although there tends to be relatively more men in posts as psychiatric nurses than there are in other sectors of the nursing profession. This may relate in part to the specific history of psychiatric nursing. Historically, it was predominantly unskilled working class men who were recruited to work in 'lunatic asylums'. They were selected for their physical strength and ability to restrain inmates.
taken place in a social world which is stratified along lines of race; class; gender; age; sexuality, and disability. Ideological oppression against these groups has sometimes found expression within the diagnostic categories of psychiatry. Thus successive revisions of the DSM (1994) have dropped certain diagnoses (for example homosexuality per se) which were named as discriminatory by oppressed groups and their advocates within the mental health professions.

Mental health service users' groups have indicated the dissatisfaction of many service users with dominant psychiatric practice (section 1.5.2). I have argued in this thesis that the biological model of mental health problems underlies many of the problems that mental health service users encounter. However, there are vested power interests in maintaining the biological model of mental health problems. This way of conceptualising mental distress provides a secure power base for psychiatrists within the medical profession and also provides a highly lucrative industry for drug companies (section 1.3). The biological model of mental health problems, will not easily be supplanted however. In the following section I discuss the possibilities for improving the provision of mental health services for women service users.

7.2 Improving the provision and organisation of mental health services for women

In this research the majority of women service users found the service offered by their GPs and psychiatrists to be unhelpful. However, for most of the women the only mental health services which they could access on a regular basis were consultations with medical practitioners. In order to improve mental health service provision, the women in the study suggested that a broad range of service options need to be developed. Their suggestions included the development of more
self help groups; greater access to skilled professional counsellors within the NHS; access to complementary therapies such as homeopathy and aromatherapy; the provision of mental health services in users' own homes; and a system of self-referral to specialist services. In addition, several women referred to the need for a residential service which provides social rather than medical help, and operated as an alternative to psychiatric hospitalisation for those who did not have such high support needs that they posed a danger to their own safety. Several women suggested that such a facility should have childcare facilities; and should be run on a woman only basis (in terms of both users and providers) in order that they could access a safe environment when they were experiencing emotional distress (section 6.5). An element of self-help was also identified as desirable by some women, given the validating effects of interacting with other users to provide mutual support.

The majority of women opposed the closure of psychiatric hospitals, despite expressing serious criticisms of the hospital regime. The reason why many women do not want psychiatric hospitals to close is because the hospital can provide an alternative environment in which to stay when they cannot cope at home (section 6.2 and 6.3). Several women indicated that the pressures of caring for other family members and/or abusive experiences within their home environment meant that they required an alternative place to stay when they were experiencing an emotional crisis. Retaining psychiatric hospital provision was seen as particularly important as the majority of women indicated that there are still a dearth of community based services which would provide an alternative to hospitalisation for women experiencing severe emotional distress (section 6.4). The women made a range of suggestions for improving psychiatric hospitals which would increase the safety and effectiveness of the hospital environment. These included not being compelled to accept physical treatments; the provision of women only wards; the provision of
childcare facilities; the introduction of an independently run complaints procedure; 
and the development of an approach amongst staff in which the social problems 
which inpatients face in their daily lives are acknowledged and addressed (section 6.3).

The central theme in the women's suggestions for service development is the 
 provision of a range of needs-led services which would cater for a wide range of 
support needs and types of mental health problems. Core requirements within this 
 service provision included the need to be listened to; to have safety; support; 
validation that they are not alone; alternatives to physical treatments; attention paid 
to psychosocial factors, and information sharing, consultation and participation in 
relation to diagnosis and treatment.

In this research I have argued that many of the problems associated with the 
women's experiences arise from a biological approach to treating mental health 
problems. It could be argued then, that in order to radically improve mental health 
 service provision for women, the dominance of the biological model as the basis on 
which women's distress is understood should be challenged and overturned.

Indeed, it is my contention that the biological model of mental illness should 
be replaced by a model which is informed by a radical political analysis of the 
psychosocial, as well as the physiological, mechanisms which are significant in the 
construction and experience of conditions commonly diagnosed as mental illnesses. 
To date, there has been a tendency in much research to adopt an either/or approach, 
in which the focus is placed either with biology (as within psychiatry), or with 
 psychosocial factors (as within sociology and much social psychology). To some 
extent this dichotomy is understandable, as much social science research has been 
implicitly or explicitly attempting to counter the biological 'bias' within psychiatric 
research (as indeed I have attempted to do in this study). However, it could be
argued that to radically increase the understanding of the aetiology and treatment of mental health problems, what is needed is a model which acknowledges biological, social and psychological factors as interacting in a dynamic way to produce mental health problems. A truly 'biopsychosocial' model, which aimed at synthesising each of these factors equally, might tend to imply that organised forms of social and emotional assistance are needed in addition to, rather than instead of, medical treatment. As I have previously argued, medication can be useful for many women. However, without the provision of social assistance which seeks to address the interpersonal and political issues which may be key in the aetiology of many women's distress, medication merely serves to keep some women functioning in oppressive social situations at a further cost to their mental and physical health.

Throughout this research I have been concerned to analyse the effects of the biological model of mental health problems upon service users experiences as this is the dominant approach utilised in psychiatry. The biological model provides the most widely used conceptual framework for understanding the causation and treatment of mental health problems within psychiatry and as such it has the most significant impact on the organisation of mental health services within the statutory sector. In my analysis I have indicated that the biological model of mental illness problems has a socially oppressive effect upon many women service users and to a certain extent, also plays a role in reproducing and reinforcing the socio-political status quo within society generally. By focusing my criticisms upon the biological model, however, I do not mean to imply that competing models of mental health problems (such as the behaviouraal and psychodynamic models which are less commonly used within the psychiatric services), cannot also have negative effects upon women service users. Indeed it has been argued by some commentators that other models can entail oppressive effects; particularly where they concentrate
exclusively upon the individual and do not take into account the broader social processes affecting service users (see for example Busfield 1996, Penfold and Walker 1984). As the ideology of individualism serves to obscure social problems; any model of mental health issues which confines itself to theorising about the individual, inevitably ignores collective social problems. Thus although many of the women who participated in my research said that they would like access to free counselling, any form of ‘talking treatment’ which is provided should take account of the political and social mechanisms of oppression within society and the effects which these can have on women’s mental health.

However desirable it may be (from a feminist and socialist perspective), the replacement of the biological model of mental health problems by a politically radical social model of mental health issues is unlikely to occur within the statutory mental health services within the current political climate. There are vested power interests for psychiatrists and the pharmaceutical industry in maintaining the biological model of mental health problems (section 1.3). The proliferation of user groups has indicated widespread dissatisfaction amongst the users of service themselves, but successive governments have still relied on the views of psychiatrists when reorganising mental health service provision. Psychiatrists are drawn from an elite group in society and have a vested interest in medicalising mental health problems, as this accords them status as members of a profession which is believed to be expert in the medical treatment of mental health problems. Many psychiatrists thus continue to campaign for the medical treatment, rather than the social support, of service users. Such vested interests can effectively serve to block the development of alternative, more radical approaches to the understanding of mental health issues and to the organised assistance of service users within the statutory sector. In addition, the biological model can be seen to serve a social
controlling function within wider society, as it inevitably diverts attention from oppressive social processes. The inherently conservative analysis in the biological model tends to discourage the acknowledgement and exploration of oppressive material, social and ideological practices within society.

It is my belief that a radical social movement would be needed to effectively challenge the medicalisation of issues of emotional distress in general and the biological model of mental illness in particular. Throughout my research I have attempted to show that the analysis and treatment of mental distress is inevitably political. Mental health service provision can be seen as a locus of political struggle both at the individual and at the collective level. This struggle ranges along a continuum from a service users' 'non-compliance' with medical treatment, to the political activities of organised mental health service users groups.

Any improvements in the provision of services for women must be informed by, and take support from, broader political movements in society. Radical critiques of psychiatry have always been developed by individuals who have been informed by a radical political movement, which in turn has provided a community in which their research has been supported and propagated (see for example Herman 1992). Although there has been a proliferation of mental health service user groups in the last fifteen years which have campaigned for change within the organisation of mental health services, they lack unity in terms of their political analysis of mental distress and so, as yet, cannot effectively organise to provide a real challenge to the psychiatric status quo. Nevertheless, the users' movement has seen the proliferation of small, user-led, mental health initiatives which have sought to provide assistance which does not entail some of the oppressive aspects found within the statutory sector. However, without the support of a powerful and cohesive social movement, advocates of progressive means of understanding and assisting women service users
often find it difficult to make significant inroads into the statutory sector. The initiatives set up by feminists, and user groups like MIND, have taken place within the voluntary sector and although they do extremely constructive work with users, such projects often suffer from a lack of funding and a consequently insecure outlook in terms of their long term future. Although user groups are right to campaign for the immediate introduction of reforms in the provision of statutory mental health services for women (such as MIND’s campaign for single sex wards) I believe that it is only through a wider political struggle that the oppressive mechanisms of mainstream psychiatry can be acknowledged and eventually overturned completely. For this to occur, alliances have to be forged between the currently fragmented political groupings which seek to address issues of oppression - for example feminists, Marxists, black activists, disability rights activists, lesbian and gay activists and mental health users’ groups on the left. In addition the political analyses of all these groups would have to expand to recognise the links between mental health issues, the discriminatory labelling which sometimes occurs within psychiatry and the broader political and social issues facing members of oppressed groups. Collective political action is vital in order to overturn oppressive societal structures. However unlikely the prospect may seem at present, it is only through a political struggle which involves the radicalisation of mental health service users and other oppressed groups, that a political climate can be created which would sustain a real challenge to mainstream psychiatry.
Appendix a

'Adding Incest to Injury' -
the play Joy enacted during her interview

"Very many of my friends, some of whom are no longer alive, have been the victims of incest. Which is the most unforgivable crime because it is a real betrayal of trust. I have never encountered it myself but I have decided to dramatise it into a small piece of dramatic work called either 'Adding Incest to Injury', or 'Suffer Little Children to Come Unto Me'. It is set somewhere in the Welsh valleys... I use familiar voices to me.

[I indicate in which character's voice Joy was speaking, by inserting and underlining their names.]

**Mother** - Mary! Mary! Horrible girl you are, I don't know what's gone wrong with you, you used to be nice you did, you used to be a real sweet little thing but the last two years, well you've gone right off the rails. You're up in that room of yours in the dark, playing dark old music, you don't ever smile and I can tell you something else our Mary - you're being bullied aren't you?

**Mary** - No, Mam.

**Mother** - Don't tell you're rotten filthy lies! I know you're being bullied, because when you were in the bath the other day and I went in to use the toilet, I saw bruises on you.

**Mary** - No you didn't, Mam.

**Mother** - I saw bruises around your middle region.

**Mary** - No Mam, you didn't.

**Mother** - Don't tell lies to your mother, you're being bullied in school aren't you Mary? Now tell me the truth!

**Mary** - Don't make me, I'm not being bullied Mam.

**Mother** - You tell me the truth, or you will know what I am going to do to you, right!

**Mary** - Oh Mam, don't make me tell you.

**Mother** - Tell me the truth.
Mary - I am being bullied Mam.
Mother - I thought so, you're being bullied in school aren't you Mary?
Mary - No, Mam.
Mother - Where are you being bullied then, if not in school?
Mary - Oh you won't like it Mam. Please don't make me tell you Mam.
Mother - WHERE - ARE - YOU - BEING - BULLIED?
Mary - Here, Mam, in my house.
Mother - Oh Mary don't talk nonsense, who's bullying you here? There's only me and your father here, and I certainly don't bully you and I know your father doesn't bully you.
Mary - He does Mam.
Mother - What are you saying? That your father who works all day for you to go to University, though there's little chance of that now, I suspect, would bully his own daughter?
Mary - Oh Mam I know you won't like it, just leave it alone Mam.
Mother - Tell me the truth!
Mary - Well Mam you know when I started my periods and you told me there were certain things that mothers and fathers do to make children, like you and Dad made me, well, oh Mam [hysterical now] the thing that he should be doing with you - well he's doing with me Mam! I don't like it and I tried to stop it and he's bigger and strong - and I told you you wouldn't like it.
Mother - God alive Mary what's coming out of your mouth? You're psychiatric that's what you are! Psychiatric! I'm taking you to the doctors!
Mary - Alright Mam, I told you you wouldn't like it.
Mother - You go and get you're coat on my girl. Do you want to go to the doctors?

The next scene is the doctor's surgery and Mary and her Mam are in front of the doctor.

Doctor - Hello Mary dear what is the matter with you? You used to be such a pretty sweet little thing and your mother tells me you're all mixed up and saying such dreadful things about your father that loves you so much, and saying that you're being bullied.
Mother - That's right you tell them our Mary, you're being bullied in school aren't you?

Mary - Yes I'm being bullied in school.

Doctor - Well why are you being bullied then dear?

Mary - Well I - I'm not like I used to be Doctor, and nobody likes me anymore. I don't like myself very much. Even my favourite teacher says I need to pull myself together and she doesn't like me any more.

Doctor - Well what does she say you're doing?

Mary - She says I'm only doing this to draw attention to myself. And in a funny kind of way I think she's right.

Doctor - Now well come come Mary there's nothing wrong with you at all. You have what we call a psychosis or something of that nature. What has happened is that you're confused in your mind. You really want a boyfriend don't you, and all that that entails but your father is so important to you. He's the most important man in your life and you're getting a little bit mixed up, you see, and you're identifying what you really want with your father and getting it all wrong in your head. You're young and you're pretty what are you now?

Mary - I'll be fifteen next birthday Doctor.

Doctor - Well you're at the age when you're ready for a boyfriend. You really want one of your own and you've got it all wrong really haven't you Mary dear? This isn't really happening is it? You're out of touch with reality aren't you?

Mary - I suppose so Doctor. Can you help me?

Doctor - Yes indeed I can Mary, we've got a lovely little unit near here for adolescents and in this unit we've got computers and televisions, all sorts of things that a young person can use - discos and counselling, the most marvellous medication. You'll take a tablet and then you'll forget about everything, and then you'll take another one at night and you'll sleep like a log and in no time you'll be just like you used to be. As right as rain.

Mary - Is that the truth Doctor?

Doctor - Would I lie to you Mary?

Mary - When can I go?

Doctor - That's what I like to see somebody that really does want to get better. You do want to get better don't you Mary? And you know you're ill don't you Mary?

Mary - Yes doctor.
Doctor - Well you can, in fact, go today. There is a vacancy and if you get there by six ‘o’ clock tonight you'll meet a lot of nice young people. And perhaps you'll meet a nice young man which is what you want really isn't it Mary? A nice young man of your own.

Mary - I don't know Doctor but I'd like to go as soon as possible.

Doctor - Well I expect your father would -

Mary - No doctor, can I have an ambulance?

Doctor - Oh now Mary your teacher is right isn't she? You do like to draw attention to yourself don't you?

Mary - I don't want to go with my father.

Doctor - I quite understand, you’re embarrassed Mary about all the wicked things you've said about him. Well how about a hospital car alright, how would that be?

Mary - I'd like that doctor.

Doctor - Your mother and father will come and see you tomorrow.

Mary - No, no, it's time I grew up, see doctor, I'd rather try and handle this on my own.

Doctor - Well so be it. What you must do now, you must pack up all your lovely little feminine dresses and those pretty cardigans that your mother knits for you, and your ladies needs, you know what I mean. And make yourself look pretty and get ready and then we'll take you there.

Mary - Can I stay there doctor. Can I stay there for a long time?

Doctor - Now Mary, the maximum period is six months, which I'll put you down for. But you'll be out long before that I can assure you, and then you'll come home to Mum and Dad and then everything will be just as it was.

Mary - I don't think so Doctor.

Doctor - Well so be it, but I can guarantee you won't be there for six months. You're far too bright and pretty for that.

Mary - Alright Doctor, I'll go tonight Doctor.

Doctor - That's a good girl. You be a good girl now and go home and do everything I said. I'll pop in and see you myself it's not far from here.

Final scene - Mary’s father who is a puny man, with a weak moustache and glasses, is sitting watching the television in an easy chair in front of the fire. He's got
a bottle of cider in one hand and a cigarette in the other. Mrs Jones is putting curlers in her hair when the telephone rings.

**Father** - Glad! Glad! Our Glad, be a lovely girl and go and answer that telephone, I'm tired see and I'm having a nice little rest and this film is good. No harm in it, a bit of sex, a bit of violence but no harm in it. And I'm enjoying it see, I'm tired.

**Mother** - Oh you are a boy aren't you! Well just for you I'll answer the telephone. Hello - yes, yes this is Mrs Jones here - this is Mary's mother - nothing the matter with her is there? I beg your pardon - what did you say then - did I hear you correctly - Dai!

**Father** - Oh what's the matter now?

**Mother** - Dai, it's about our Mary.

**Father** - Oh what's she gone and done now. Has she gone and made trouble has she?

**Mother** - Dai, our Mary's dead.

**Father** - Dead? They killed her?

**Mother** - Oh don't be so soft Dai.

**Father** - Well what happened then?

**Mother** - Well she pretended to one of the older boys that she smoked and she borrowed matches and she went into the toilets see Dai, and she set her clothes on fire. And by the time they heard the screaming and knocked down the door, our Mary was burned to death. And she left a note.

**Father** - A note? A note? It didn't say nothing about me did it?

**Mother** - No don't be so silly Dai. It said the funniest old thing.

**Father** - Well what did it say?

**Mother** - It said ‘I only wanted somebody to listen’.

And that is my personal tribute to the Samaritans...It's a combination of the stories of everybody in hospital I've ever loved.” (Joy - see section 5.4.2)
Appendix b

Biographical data of the women who took part in the study

Cerys is nineteen years old, white, heterosexual and able bodied. She is single and works as a childminder. She has not been given a diagnosis and has been a service user regularly over the last three years.

Charlotte is twenty-four years old, white, heterosexual and disabled. She is married and has one child. Charlotte is an undergraduate student at university. She has been diagnosed with manic depression and has been a service user for the last five years.

Debbie is thirty-five years old, white, able bodied and heterosexual. She is employed as a care assistant. She is married and has one child. She was a mental health service user for a period of a year, fifteen years ago and was diagnosed with anxiety. She is not currently a service user.

Diane is twenty-seven years old, black, heterosexual and able bodied. She has a partner and one child. She is not in paid employment at the moment but used to work as a welfare rights advisor. Diane has been diagnosed with depression and has been a service user over the last six years.

Elaine is forty-two years old, white, heterosexual and able bodied. She is married and has never been in paid employment. She has been diagnosed with paranoid schizophrenia and has been a service user for the last ten years.

Evelyn is forty-two years old, white, heterosexual and able bodied. She is single and is not in paid employment at the moment. She used to work as a local government officer. She has been diagnosed with manic depression and has been a regular service user for the last five years.
Fran is thirty-five years old, white, heterosexual and able bodied. She is married and has three children. She is not in paid employment at the moment, but used to work as a clerical officer. Fran was diagnosed as suffering with anxiety. She has been a service user for the last year and a half.

Gail is forty years old, white, heterosexual and able bodied. She is married and has two children. Gail is not in paid employment at the moment but used to work in a cash and carry as a stock controller. Gail was diagnosed with manic depression and has been a mental health service user for the last nine years.

Gillian is forty-nine years old, white, heterosexual and able bodied. She is currently employed as a general nurse. She is divorced and has three children. Gillian has been diagnosed with depression. She has been a service user for the last eighteen years.

Heather is fifty-four years old, white, heterosexual and disabled. She is not in paid employment at the moment but used to work as a teacher. She is married and has two children. Heather has been diagnosed with manic depression and defines herself as disabled because of her mental health problem. She has been a mental health service user since she was a teenager.

Isabel is forty-eight years old, white (although defining her race was a source of some uncertainty for her - see section 4.9), able bodied and unsure about her sexuality. She is not in paid employment at the moment but used to work as a cleaner, and a hairdresser. She is married and has three children. Isabel has not been told a diagnosis. She has been a service user since her childhood.

Jade is thirty-one years old, white, heterosexual and able bodied. She is living with her partner and is not in paid employment at the moment. She used to work as a supermarket cashier. Jade has been diagnosed as suffering with a personality disorder. She has been a user of mental health services since childhood.
Jane is twenty-two years old, white, bisexual and able bodied. She is single and is not in paid employment at the moment. Jane has not been given a diagnosis. She has been a mental health service user for the last year.

Joy is forty-five years old, white, heterosexual and able bodied. She is divorced and has two children. She is not in paid employment at the moment but used to work as a teacher. Joy has been diagnosed with manic depression and schizophrenia. She has been a mental health service user for the last ten years.

Judy is forty-three years old, white, heterosexual and disabled. She is not in paid employment at the moment but used to work as a domestic in a nursing home. She is married and has four children. She has not received a psychiatric diagnosis. She has been a mental health service user for the last seven years.

Justine is thirty-five years old, white, heterosexual and able bodied. She is not in paid employment at the moment, although she used to work as a kitchen assistant. She has not been given a diagnosis and has been a service user for the last three years.

Kate is twenty-nine years old, white, heterosexual and able bodied. She has a partner and one child. She is currently a full time student in further education. She has been diagnosed with acute psychosis. She has been a service user sporadically over the last eight years.

Kim did not wish to disclose her age. She is white, lesbian and able bodied. She is single and is not in paid employment at the moment. She used to work as a psychiatric nurse. She has been diagnosed with manic depression and has been a service user for the last three years.

Laura is thirty years old, white, heterosexual and able bodied. She has one child. She is not in paid employment at the moment but used to work as a nurse. She has been diagnosed with depression and has been a service user for the last five years.
Mandy is thirty-two years old, white, heterosexual and able bodied. She has a partner and three children. She is not in paid employment at the moment but used to work as a butchery assistant. Mandy has not been given a diagnosis and has been a service user for the last five years.

Margaret is forty-five years old, white, heterosexual and able bodied. She is not in paid employment at the moment, but used to work as a school teacher. She is married and has two children. She has been diagnosed with depression. She has been a service user sporadically over the last twenty-one years.

Mary is fifty-seven years old, white, heterosexual and able bodied. She is divorced and has two children. Mary is a retired school teacher. She has been diagnosed with manic depression and has been a service user for the last thirty years.

Muyesha is forty-four years old, white, heterosexual and has a physical disability. She is married and lives with her partner and their four children. She is a research student working for a masters degree. Muyesha was diagnosed with manic depression. She has been a mental health service user regularly over the last thirty years.

Pam is forty-five years old, white, heterosexual and disabled. She has one child. She is not in paid employment at the moment but used to work as a nurse. She has not been given a diagnosis and has been a service user for the last two years.

Pauline is forty-one, white, heterosexual and disabled. She is married and has two children. She is currently an undergraduate student. She has not been given a diagnosis and has been a service user for the last fifteen years.

Rachel is thirty-three years old, white, bisexual and able bodied. She has a partner and works at a mental health daycentre. She has not been given a diagnosis and has been a service user for the last two years.
Rebecca is twenty-nine years old, white, heterosexual and able bodied. She works as a temporary administration assistant. Rebecca was a service user for six months, two years ago. She has not received a formal diagnosis and does not currently use any mental health services.

Sarah is fifty years old, white, heterosexual and disabled. She is married and is not in paid employment at the moment. She used to work as a shop assistant. Sarah has been diagnosed with depression and has been a service user for the last fifteen years.

Sheila is thirty-six years old, white, heterosexual and able bodied. She works as a kitchen assistant and has two children. She has not been given a diagnosis and has been a service user for the last two years.

Sian is twenty-one years old, white, heterosexual and able bodied. She is single and is not in paid employment at the moment. Sian has been diagnosed but did not wish to disclose what it was. She has been a mental health service user for the last two years.

Stephanie is twenty-six years old, white, lesbian and able bodied. She has a partner and is employed as a housing support worker. She was diagnosed with ME by one GP but this was changed to depression. She has been a mental health service user for the last six years.

Val is forty-nine years old, white, heterosexual and disabled. She is not in paid employment at the moment but used to work as a shop assistant. She is living with her partner and has one child. She was diagnosed with depression and has been a service user for the last three years.

Veronica is fifty-five years old, white, heterosexual and able bodied. She is divorced and works as a researcher in higher education. She has one child. Veronica was
diagnosed with a biologically induced depression following a car accident in which she was injured. She is not a service user at the moment.

**Vicky** is twenty-seven years old, white, heterosexual and able bodied. She is married and lives with her partner and their two children. She works as a midwife. Vicky was diagnosed with postnatal depression after the birth of her first child. She is still involved with a self help group for women suffering with postnatal depression.

**Wendy** is forty-four years old, white, heterosexual and disabled. She is married and has two children. She is not in paid employment at the moment but used to work as a shop assistant. She has been diagnosed with depression and has been a service user sporadically over the last twenty years.
Appendix c

Information letter for the women who agreed to participate in the interviews

Dear Interviewee,

Many thanks for volunteering to provide an interview for my research. I am working on a PhD project, funded by the University of Wales Institute Cardiff. The aim of the research is to investigate what women think of the mental health services they have used; whether they found staff helpful or not; and also whether they think the treatments provided are useful. I would particularly like to know what kind of mental health services you think should be developed.

You might have consulted a GP about a mental health issue, been admitted to hospital, seen a psychiatrist or psychologist as an outpatient, attended a self help or therapy group, attended a daycentre, received counselling, stayed in a women's refuge or supported housing scheme, or received alternative treatments such as aromatherapy, homeopathy, hypnotherapy, acupuncture and so on. Whatever services you’ve used, I am interested in your opinions. I am particularly interested in whether you are satisfied with the services you’ve received and whether you think there is room for improvement in the range of mental health services available.

If you do not want to answer any of my questions, that’s fine, you can just ‘pass’ and we’ll go on to something else. Of course if you want to end the interview at any time, for any reason, that’s no problem.

I am not associated with any social services, medical or health authority, and I am the only person who will ever have access to the original interviews. I can assure you of the strictest confidentiality. No one, except myself, will ever know your name, or address. As I mentioned earlier, I hope to tape the interviews so that I can make notes from them afterwards. As soon as the research has finished the tapes of the interviews will be
completely wiped clean. In the meantime they will be kept in a locked cabinet to which I have the only key. Of course, if you don’t want me to tape the interview, then I can take notes during the interview instead.

I intend to talk to around thirty five to forty women. I will use the comments they make to find out how the range of mental health services can be improved. I will use this information to write my PhD thesis. When the research is finished (in about two to three years time) I intend to publicise the research findings. Short passages from the interviews may be published in order to back up the research findings. If they are, I will not reveal your real name, or where you come from in South Wales, so that you will remain anonymous. By publicising the research findings hopefully people can become more aware of the sort of mental health services that many women find useful; and the sort of developments that women would like to see in the mental health system.

I would like to send you a summary of the research findings. If you would like one I will send one out to the address on your consent form. If you move house in the meantime, please give me a ring, or drop me a note at the Institute so that I can send them on to you.

If you have any queries at all about the research please do not hesitate to contact me.

Thanks again for agreeing to help with the research,

Yours Faithfully,

Zoë Thomas
Researcher
Appendix d
Consent and monitoring forms

CONSENT FORM

I give my consent to allow an interview to proceed with Zoe Thomas, research assistant at Cardiff Institute of Higher Education.

I understand the purpose of the interview, that it will be used by her for research purposes and that certain passages may be published as part of the research findings. I understand that my name and address will be kept strictly confidential, and neither myself nor the centre(s) I attend will at any time be identified.

I understand that I can refuse to answer any question during the interview, and I can end the interview at any time.

Signed............................................................................................

Full name..........................................................................................

Address (in block capitals)................................................................
...........................................................................................................
...........................................................................................................
...........................................................................................................
...........................................................................................................

delete as appropriate - I want/ do not want to receive a summary of the research findings when they become available (in approx. 3 years)
Monitoring Form

I would like to collect some details about the women who have volunteered to take part in the research, but if you do not want to answer any of the questions, just leave them blank.

1. What is your age?
   16-19  20-29  30-39  40-49  50-60  over 60

2. Are you: (Please tick whatever applies to you)
   single/ not living with your partner
   living with your partner
   married
   divorced/separated
   widowed

3. How would you describe your ethnic origins?
   Black - Welsh  White - Welsh  Asian
   Black - GB  White - GB  Chinese
   Black - Other  White - Other  Vietnamese
   Irish
   Other (please specify)

4. Do you have a disability?
   Yes
   No

5. How would you describe your sexuality?
   Lesbian / Gay  Bisexual
   Straight/heterosexual  Other  Not sure
Appendix e
Interview Schedule

1. How old are you?
Are you employed at the moment? If not, have you ever been in paid employment?

2. Do you have any children? How old are they?

3. What mental health services have you used or are you using now? [Check when they were used:]
   GP - Hospital admission - Psychiatrist - Psychologist - Medication - ECT - CPN/CMHT -
   social worker - occupational therapy - self help group / therapy group - Daycentre -
   Counselling - Women's refuge - Drop in centre - User Groups (MIND, NSF etc) - Supported
   Housing - Alternative treatments (eg. Aromatherapy, Acupuncture, Homeopathy,
   Hypnotherapy etc.)
   Anything else?

4. Why did you use this service? [Check each one]

5. Do you use this service regularly? [Check each one]

6. Do you think it is helpful or not? Why? [Check each one]

7. When you used this service did you feel that you were listened to and respected? [Check each one]

8. Did you feel safe using these services? [Ask whether she has any particular views on the
   sex of professionals; what she thinks of mixed wards in hospital]

9. Do you think any of the following had an effect upon the way you were treated in the
   mental health services you've used? Not all of them might be relevant to you, but I ask the
   same of everybody - being a woman - your race - any disability you might have - your age -
   your religion - the language you speak - your sexuality - the job you do, or did at the time? If
   yes, how?

10. Have you ever received a medical diagnosis? Was it helpful?
11. How did you arrange someone to look after your children when you used mental health services?

12. Do you think that mental health services should provide childcare facilities?

13. Do you think that there is any stigma attached to the use of mental health services? If so, why do you think that is? Do you have any ideas on what could be done to reduce this stigma?

14. Have you any ideas as to how the present range of mental health services could be improved? Is there anything you would alter about the services you’ve received?

15. Do you feel that there are any gaps in the provision of mental health services? Is there anything that should be provided which isn’t, at the moment?

16. Of course you can pass on any question, if you don’t feel comfortable answering, but I am interested in whether mental health services help women who’ve experienced racism, physical abuse, sexual abuse, harassment and domestic violence. Have any of these things happened to you? If so, did the services you used help you to deal with your experiences?

17. Do you have any views on the sort of services which should be provided to help women deal with these sorts of experiences?

18. Were you asked whether you’d experienced abuse when you used mental health services?

19. Again feel free to pass if you would prefer, but I’d like to find out whether any women have experienced harassment when they were using mental health services. Have you experienced any physical or sexual abuse, racism or harassment when you were using mental health services?

20. In your opinion, is there a need for homebased services - mental health services which are provided to a woman in her home? If so, why? What sort of services should be provided?

21. In your opinion is there a need for services in your local area such as mental health daycentres, self help groups, therapy groups and so on? If so, why?
22. In your opinion is there a need for a residential mental health service for women?

Somewhere women can stay, and receive support away from the home? If so, why do you think it might be useful? what sort of facilities should it provide?

23. In your opinion is there a need for psychiatric hospitals? If so, why do you think they are needed? What do you think of the current care in the community policy?

24. Given the purpose of the research is there anything you think I should have asked? Are there any burning issues that we haven't discussed?
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