Nellie's Position on Women and Mental Health

Principles

Nellie's views Mental Health as a spectrum, unique to each woman and child. We believe that women's emotional and physical well-being are impacted by social and economic realities. We understand that women and children who experience violence and abuse develop strategies in order to survive. Violence not only takes the form of physical aggression but also racism, sexism, colonialism, ableism, heterosexism, classism and any other form of dehumanizing oppression. Women's responses to trauma are diverse and unique, and are often labeled as abnormal by those who do not understand their logic and necessity.

The current Mental Health system is rooted in psychiatry and upheld by the Diagnostic and Statistical Manual (DSM-IV), a book that lists and describes mental and personality disorders. Psychiatry and the DSM-IV rely on the judgments of normal versus abnormal behavior or perceptions, based on the consensus of a small committee, with membership exclusive to the most privileged in our society. The definition of what is normal behavior or perception changes from one generation to the next and from culture to culture. The concept of 'Mental Illness' is thereby socially constructed and a product of colonial, patriarchal, and capitalistic forces that shape North American culture, as well as a reflection of current social norms and values, rather than evidence based scientific theory. Nellie's believes this approach is flawed and that the foundation requires critical examination.

Women's experiences are shaped by a climate of misogyny, and sexism, as a function of a patriarchal society. As a result, women face violence and abuse as well as health, social and economic inequalities. Women and children are forced to adapt to the reality of their environment as an unsafe place which influences the way in which they interact with and exist in the world. Historically, women's diagnoses serve as an explanation of behaviors and perceptions we now associate with responses to trauma. We believe that 'symptomatic' behavior takes place on a continuum, with everyone experiencing them to some degree. It is only when the manifestation begins to interfere with daily living and goals of the individual, as defined by the individual, that intervention becomes necessary.

Women are disproportionately diagnosed with 'Mental Illness' despite similar presentation of behavior in their male counterparts[1] Survival strategies developed as a result of trauma are interpreted as symptoms using the DSM IV, leading to psychiatric labels and diagnoses. This labeling of coping mechanisms as 'symptoms' identifies the problem with the individual, and disregards the core issues, such as violence and abuse in women's lives. Conversely, acknowledgement of violence in women's lives is sublimated by diagnoses such as Battered Women's Syndrome (Post Traumatic Stress Disorder), which by default maintains the idea of individual defect. A more accurate analysis would find fault in the current social structures which underpin such pervasive misogyny, abuse and exploitation of women and children.

Psychiatric labels serve to oppress women and other marginalized communities and eradicates rights in order to bolster and maintain the status quo. Lesbian, bisexual and transgender women continue to be pathologized due to their failure to adhere to a hetero-normative model of sexuality and gender. The label of mental illness leaves women vulnerable to violence and

[1] WHO (2009) Gender and women's mental health: Gender disparities and mental health: The Facts http://who.int/mental_health/prevention/genderwomen/en/

abuse both at the individual and systemic level. We believe that Psychiatry and the Mental Health system inherently support forms of oppression such as racism, heterosexism, ableism, and transphobia[2].

We acknowledge that being labeled with a 'mental illness' can have negative consequences for women. A diagnosis has the potential to further exacerbate any mental suffering she is currently experiencing. She may experience stigmatization, increasing the possibility of violence, abuse and discrimination. She may also find that a diagnosis limits options and self-efficacy.

Our Position

Nellie's analysis and framework is shaped by a feminist, anti-racist, anti-oppression approach, which means we understand society as being fundamentally based on patriarchy, racism and multiple other forms of oppression on the basis of class, age, sexual orientation, ability, gender identification, race, place of origin, ethnicity, citizenship, religion, political affiliation, record of offences, marital status, family status, life experiences and appearance. Our analysis also highlights the complexity of power and privilege, including the way multiple forms of oppression intersect creating differential impacts and diverse needs and issues for different groups of women.

Systemic discrimination and oppression based on race, class, sexual orientation, family status, gender identification, age and ability, must be addressed as part of an integrated approach to addressing issues and barriers women face under the current mental health system.

There are numerous biases that can influence the process of making a psychiatric diagnosis and thereby result in compromised care. Emphasizing the brain as the target for intervention ignores the importance of the social context. Psychiatrists, who are viewed as experts, need to become critically aware of their own bias and the impact they may have in influencing the mental well-being of their clients.

The medical criteria listed in the DSM IV exist in a context inundated with white privilege, patriarchy and colonialism. Capitalist, sexist, and moralistic agendas are entrenched in the DSM IV and underpin definitions of what is normal vs. abnormal. Minorities and disenfranchised groups are most often diagnosed with an 'illness' under this model. Women constitute one of these groups. The DSM IV lists disorders that are either exclusively developed to explain women's behavior (i.e. Premenstrual Dysphoric Disorder) or applicable to anyone in principle, but in practice assigned more frequently to women (i.e. Borderline Personality Disorder and Mood Disorders)[3].

When women began making headlines for killing their abusive parents, guardians, and partners, the medical community was forced to recognize the reality of violence in women's lives as a determinant of health – emotional, mental or otherwise[4]. Psychiatry in particular drew

[2] Ali, Alisha. The Intersection of Racism and Sexism in Psychiatric Diagnosis. In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, 71-75.

[3] WHO (2009) Gender and women's mental health: Gender disparities and mental health: The Facts http://who.int/mental_health/prevention/genderwomen/en/

[4] Canadian Mental Health Association. (1995). *Women & Mental Health*. Online. URL: www.cmha.ca

correlations between persistent, severe abuse and violence and suicidal or homicidal acts. As such a new 'illness' was developed to explain women's resulting responses, behaviors and perceptions: "Battered Women's Syndrome", more recently listed under "Post Traumatic Stress Disorder". This diagnosis, while acknowledging violence as a factor in women's mental health, continues to find defect within the individual rather than the society that sanctions abuse, and violence against women. The same can be said about 'illnesses' such as 'Body Dysmorphia' and 'Anorexia Nervosa' – which say more about violence enacted on women and girls through persistent, mainstream, devaluing of their bodies, rather than an inherent defect of the brain.

The experience of discrimination cannot be easily reduced to one factor – gender. The intersection of a multitude of factors, particularly socio-economic realities, contributes to staggered and complex impacts on health and well being. For example, women are concentrated in employment areas marked by lower wages and part-time status. This renders them ineligible for health coverage, and employment supports generally extended to those in positions more valued by society. As the Canadian Mental Health Association has indicated, "limited participation in public life, restricted decision-making, devalued role expectations, poverty, violence and sexual abuse encumber the potential for mental well-being." Mental health cannot be understood in isolation from the social conditions of women's lives - the context in which a woman's 'symptomatic' behavior occurs should be considered before an uneducated diagnosis is applied.

When individuals are inferred to be 'mentally ill', we neglect alternative explanations for distress and assign values and judgment to behaviors and perceptions. Diagnosis can have both positive and negative effects on how an individual is understood by themselves and others. For many women, a diagnosis can lead to a frame of reference that allows her to acknowledge the impact her behaviors and perceptions are having on the achievement of her goals. However, the stigma of mental illness tends to exacerbate difficulties women face, leading to family discord, job discrimination, social rejection and diminished self-esteem and self-efficacy.

Research, medical advances and the current mental health system are predominately based in the realities of white men. Until the current system incorporates, and makes a priority, cultural and gender-based analytic (GBA) tools and models, which take into account the reality of being women we will continue to receive treatment and be offered supports that are oppressive, uninformed and ineffective.

Psychiatry as a practice is aligned with the capitalist, North American society, in which we, as women, are imbedded. Millions of dollars are spent each year on the development and marketing of psychiatric medications and pharmaceuticals, leading to devastating and lasting effects on the environment coupled with monumental profits for pharmaceutical companies. Government allocation of funds supports the continued research of pharmaceuticals rather than developing alternative, effective, and inclusive strategies to support women and children. We understand social determinants of health as a major factor in the deterioration of Mental Health, more so than biological pathology. We advocate that funding should be applied to consumer and community based organizations dedicated to developing holistic, effective, and diverse programs to support women. We believe that government immersion should fall on strategies to reduce societal structures underpinning the vast inequity between women and men, and the socio-economic marginalization of women and children - especially that of disenfranchised

communities such as queer, transgendered, racialized, disabled, newcomer and immigrant women.

We acknowledge the disproportionate numbers of Aboriginal women, women from racialized communities and women who have experienced violence in the criminal justice system, and recognize the correlation with overrepresentation of these women in the current mental health system[5]. We see the placement of women in systems operated and upheld by the most privileged in society, in which choice, freedom, and participation in society are severely restricted, as an opportunity to maintain the status quo.

We see the connection between intergenerational trauma, substance use and the deterioration of mental health. Cultural genocide of Aboriginal communities and the Residential School legacy continue to have a profound effect on the health and wellness of Aboriginal communities. We see the failure of all levels of government, to acknowledge the impact of such catastrophic violence against the psychological, physical, and spiritual well being of this community as negligent and unacceptable. Unique and targeted strategies are required to begin to tackle the layers of trauma and abuse present within this community and to combat the rampant racism, sexism, colonialism and continued discrimination and oppression faced by Aboriginal women. This also applies to communities that have experienced trauma, and violence as a function of war, colonialism and capitalism, such as immigrant and refugee women, especially those relocated through diaspora and ethnic extermination.

We see a flawed immigration system, hinged on oppressive policy which contributes to social and psychological stressors such as: xenophobia, poverty, racism, discrimination, isolation and reduced participation in communities and society. These elements lead to the deterioration of mental health and wellness for individuals, and families. A lack of support for newcomers and refugees, including the deficiency in accessible linguistic and employment training, further isolates these communities, especially newcomer and immigrant women who are relegated to the home due to a lack of childcare, income and transportation. Immigrant, newcomer and refugee women – most likely to have experienced violent conflict in their homeland - are thus more vulnerable to violence and abuse in their new environment and less likely to have meaningful support systems outside the home. Racism, discrimination, transphobia and homophobia further compound the experience of women already in precarious positions. We see the connection between poverty, social determinants of health and racialized, newcomer and immigrant women and their communities.

We see disability as an additional barrier to accessing support systems, healthcare, and as an avenue leading to poverty. These components lend themselves to reduced capacity to participate, vulnerability to violence and abuse, limited agency and self efficacy, lowered self esteem, severed connections with
family members and community, poor nutrition, reduced physical health, and as a result, deteriorating mental health. Women with disabilities are further marginalized upon entrance to the psychiatric system through violence, abuse, discrimination, stigmatization and the impediment of choice and access to information. Often times women from racialized communities tend to find their way into the psychiatric system through the legal system due to

[5] Caplan, P. and Poland, J. (2004). The Deep Structure of Bias in Psychiatric Diagnosis. In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, 9-23

the delay in getting the right kind of help at the right time. This adds another label and another layer of marginalization.

We see violence and trauma as pervasive and far reaching, encompassing ableism, sexism, transphobia, homophobia, islamaphobia, racism, discrimination, colonialism and all other forms of discrimination and oppression. These dehumanizing doctrines summon responses that are subsequently labeled by the current mental health system as 'abnormal', resulting in the pathologizing and diagnosis of women. We see the labeling, categorization and judgment attached to such responses as a method to maintain the status quo and assert the idea of otherness. We see that those often labeled as "ill", or "abnormal" often already hold membership in marginalized and stigmatized communities such as: queer and trans identified women, women of colour and Aboriginal women.

We see young, single, and economically displaced Mother's, and pregnant women as particularly vulnerable in the mental health system. Poverty, violence and a lack of adequate nutrition, accommodation, safety and health care, influence and expose women and children to risk of mental health deterioration. Pregnant women and Mothers are often stigmatized due to assumed Mental Illnesses and victimized within the Child Protective Services (CPS) system. Women are mandated to accept diagnosis and treatment, despite societal and environmental factors which may cause or contribute to the 'symptoms' identified by outside individuals. Women are coerced, and manipulated into consenting to diagnosis, treatment, and invasive procedures such as Electro Convulsive Therapy (ECT), in order to secure visitation, or with the illusion of being reunited with their children. Women's dual roles due to economic inequity, single parenthood, and the reality of young Mother's raising children with little to no familial, and community support leads to mental, emotional and physical health instability and deterioration. The lack of current protection for Mothers contributes to poor mental health for both Mother and Child, especially in circumstances of partner or family violence, stigmatization, isolation and CPS involvement.

Women should be seen as the expert in their own lives and supported in making informed choices. Nellie's supports women accessing the current system which informed consent, and believes that women should have access to objective information outlining their options, the implications of diagnosis and treatment, as well as the alternatives available. Women should be consulted in developing a support and treatment plan and should be the executor whenever possible. Nellie's believes that the use of Psychiatry must not be taken lightly nor its consequences underestimated. As society has grown more reliant on Psychiatry to explain and legitimatize personal suffering, it is Nellie's view that overcoming these biases is critical to addressing women fairly in all aspects of our lives including, but not limited to: health, education, housing, employment and the criminal justice system.

Women require a wider range of treatment and support options than is currently available. It is absolutely necessary for systems to be put in place that provide practical supports such as childcare, transportation, medical attention and nutrition, in conjunction with Clinical Treatments should a women chose to participate in such interventions. Women should be consulted in creating support and treatment plans, and have access to alternatives to mainstream covered by OHIP and traditional options. Consumers have identified the importance of emphasis being

placed on recovery rather than 'symptom management'[6]. Women should have the absolute right to accept or refuse medications and treatments, have full access to information outlining the benefits and draw backs of any treatment option, and have alternatives explained to them. A more holistic approach is needed in addressing women's individual circumstances.

Strategies for Change

Board, staff and clients in service will be active in strategies for change. The work will be based on the organization's mission and informed by the work we do with women and children in our programs and services.

We will work with other women's group in coalition and partnership at the Municipal, Provincial and Federal level to address the issues of women and Mental Health.

We will maintain membership in women's organizations and other organizations that address women's Mental Health from a non-medical model.

We will maintain membership in children's justice organizations that support equity and have an anti-oppression, anti-psychiatry approach to Women's Mental Health.

We will participate in Social Justice actions that identify the need for women specific Mental Health services and a diverse and individualized approach to supporting women with Mental Health diagnoses or at risk of becoming involved in the Mental Health system.

We will actively seek to involve women Consumers and Survivors as well as women at risk of becoming involved with the Mental Health system in the planning and implementation of programs and services with the intent to support women in our programs and services.

We will continue to identify the changing realities of women and their children and the impact that these changes have on Mental Health and wellness.

We will involve women Consumer Survivors in evaluation of program and services on an ongoing basis.

We will partner with Community agencies serving women with Mental Health from both a Medical/ Traditional model as well as those serving women from an anti-psychiatry/ Consumer frame of reference.

We will respect the voices and experiences of women as experts and will initiate trainings for staff, volunteers, and board members that reflect this.

We will actively educate women using our programs and services, as well as community members about Mental Health using an anti-oppression, culturally competent approach.

We will work across sectors and areas of community education and advocacy to change the

[6] Mead. S, MSW, Copeland. M.E, M.S, M.A 'What recovery means to us: Consumer's perspectives', *Community Mental Health Journal, Vol. 36, No. 3, June 2000*

social and economic conditions that perpetuate the pathologizing of women and their survival strategies.

We will ensure that in all the Mental Health discussions and work in which we are involved, we bring to the discussion a feminist, anti-oppression, framework for action. In addition, we will remain actively involved -in anti - oppression work.

We will actively lobby the Municipal, Provincial and Federal governments to provide adequate funding for Mental Health Research and Services that are women focussed and diverse in terms of approach.

The methods we will use to effect social change may include participation in coalitions, public education and media campaigns, and direct political action such as participation in protests and rallies, deputations, complaints, and refusal to participate in oppressive government programs.

We will respond with programs and services that meet the needs of the diversity of women and children who have experienced poverty, violence and oppression. Programs and services that address the needs of women and strengthen their economic, social and health positions will enable them to protect themselves and support their children.

References:

Ad hoc Working Group on Women, Mental Health, Mental Illness and Addictions. (May 2006). *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview.*Online. URL: www.cwhn.ca/PDF/womenMentalHealth.pdf

Ali, Alisha. The Intersection of Racism and Sexism in Psychiatric Diagnosis. In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, 71-75.

Barr, L., Corrigan, P.W. and Watson, A.C. (Oct 2006). The Self-Stigma of Mental Illness: Implications for
Self-Esteem and Self-Efficacy. *Journal of Social and Clinical Psychology, 25(8), pp.875-883.*

British Columbia Centre of Excellence for Women's Health. *Mainstreaming Women's Mental Health.* Online. URL: www.bccewh.bc.ca/publications-resources/documents/

Canadian Mental Health Association. (1995). *Women & Mental Health*. Online. URL: www.cmha.ca

Caplan, P. and Cosgrove, L. (2004). The Construction of Illness. In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, xix-xxxiii.

Caplan, P. and Poland, J. (2004). The Deep Structure of Bias in Psychiatric Diagnosis. In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, 9-23.

Cosgrove, L. and Riddle, B. Gender Bias and Sex Distribution of Mental Disorders in DSM-IV-TR. (2004). In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, 127-140.

Crandall, C. and Feldman, D. (Feb 2007). Dimensions of Mental Illness Stigma: What about Mental Illness Causes Social Rejection? *Journal of Social and Clinical Psychology, 26(2), pp.137-154.*

Gomel, M.K. (1997). *Nations for Mental Health: A Focus on Women.* Geneva: World Health Organization. Online. URL: whqlibdoc.who.int/hq/1997/WHO_MSA_NAM_97.4.pdf

Hankivsky, Olena. (Summer 2006). Reflections on Women's Health and Gender Equality in Canada. *Canadian Women Studies, 25 (3/4), pp.51-56.*

Linder, Meadow. (2004) The Construction of Illness. In P. Caplan and L. Cosgrove (ed). *Bias in Psychiatric Diagnosis.* New York: Jason Aronson, 3-7.

Marple, L. (2009) Beyond Pathology: 'Women and Mental Health', *Nellie's Newsletter* Pg. 2

Mead. S, MSW, Copeland. M.E, M.S, M.A 'What recovery means to us: Consumer's perspectives', *Community Mental Health Journal, Vol. 36, No. 3, June 2000*