A Talk on Women and Psychiatry

for Women's Health Symposium : 22nd June

Images of Women in our culture, and in psychiatry

Psychiatry reflects the images of women that are defined by our culture and serves to educate and socialize women. Currently, it is one of the instrumental modes of transmitting the cultural status quo. Psychiatry has a vested interest in proliferating its influence. As Naomi Weisstein points out psychiatry provides women with an"inconsistent, emotionally unstable," image of themselves as "lacking in a strong conscience or superego, weaker, nurturant rather than productive, intuitive rather than intelligent, and normal, if suited to the home and family". [1] This image reinforces the cultural status quo.

At the same time, psychiatry helps to bolster the economy as masses of politically disenfranchised women continue to consume not only the services offered by the psychiatric industry; but also the products of multi-million dollar industries which thrive on women who accept a traditional role; such as clothing, cosmetics, home products, and more insidiously, pharmaceutical industries. The consumption of excess products is integral to the economy of our country, and women are integral to this ethic. Though women are, for the most part, disenfranchised, we have access to purchasing power through men. Only 1percent of the total US population of women earns more than $10,000 per year. Interestingly, women also have access to a male-dominated psychiatric industry primarily through men - their husbands, or fathers.

Naomi Weisstein has collected some observations on women from prominent male psychiatrists. These views indicate to us how women are viewed by male mental health professionals, and frequently, how other women clinicians view their sisters:

"We must start with the realisation that, as much as women want to be good scientists or engineers, they want first and foremost to be wom anly companions of men and to be mothers." [2](Bruno Bettelheim)

"Much of a young women's identity is already defined in her kind of attractiveness and in the selectivity of her search for the man (or men) by whom she wishes to be sought." [3] (Erik Erikson)

Women's somatic design harbors an "inner space" destined to bear the offspring of chosen men, and with it, a biological, psychological, and ethical commitment to take care of human infancy."[4] (Erik Erikson)

Sadly, the psychiatric industry, reflecting the culture we live in, is deeply committed to proliferating images of women as passive partners for men, functional primarily as housewives and mothers; whose youthful concerns evolve around making herself an attractive product so that she can be consumed by a husband, elevated to the non -political status of housewife, and henceforward, serve the culture which exploits her as a means of reproduction and as a domestic labourer.

Woe falls upon the woman who cannot cope with such a role; married or single. She may become incompetant under pressure in her home environment, or have difficulty at work; she may reject her friends, husband, lover, children; exhibit symptoms of anxiety, acute depression, and horrors of horrors, even become violent. Too frequently she is prompted to seek psychiatric assistance. If her male benefactor can afford to send her for private treatment then she comes under the authoritarian, role-reinforcing, partirarchally-oriented influence of her male psychiatrist; because psychiatrists are, for the most part, male. If she has no male benefactor, or one who cannot afford private treatment, then she is shunted off to a mental institution where she is dually oppressed; first as a woman, and second, as a mental patient. In mental institutions the same partriarchal psychiatrists and other men are the most influential authority figures; with women hospital employees ranking very low on the scale, indeed only just above the dispossessed patient.

In both spheres, as psychiatric private patient and as incarcerated mental patient, women are exposed to treatment, little more than methods of social control, which attempt to re-informce and refuel their tired and confused batteries. For example, recently a 26 year old woman pharmacist living in Vancouver went to her GP with an ailment in her back. Her male doctor decided that her symptoms were psychosomatic, that she was in an acute state of stress, and need psychiatric hospitalisation. But he did not inform her of this; rather he told her that she was going to hospital for observation. She was wholeheartedly in favour of this since she wanted her medical disorder diagnosed. When she found herself in a psychiatric unit, threatened by commitment to a mental institution, understandably she became quite frantic. Because she was a pharmacist, she recognised that the attending nurse was feeding her a placebo to quieten the pains she complained of so she continued to complain; as soon as was possible she contacted a woman friend to bring her some knitting materials and hair rollers because she was aware that if she took some interest in her appearance, and occupied herself with things that are traditionally feminine such as knitting, the doctors would make a more favourable judgement on her mental condition. It worked. She was discharged shortly thereafter, and able finally to seek the medical attention she so sorely needed for a severe spinal disorder.

There is no doubt that traditional therapy, from Freud to modern times, reinforces and refuels women's social roles within our culture. But to do this effectively it must perpetuate images of women as inferior and emotionally unstable doll-like infants who are acceptable and mentally healthy only if they understand this role, and perform well in it. This is the image that most male psychiatrists have of women; and this is the image which has been successfully marketed to women. Unknowingly, women consumers have bought this image and most still believe in it.

But as Weisstein point out in"Psychology Constructs the Female" the psychiatric industry has only been able to do this by isolating crucial social factors from their study of personality. The trend in therapies has been oriented almost exclusively around the study of the individual's inner dynamic and only rarely looks at the social contexts within which people live. On this basis a women is mentally healthy if she responds well to her natural, biologically-determined function. If she rebels or even mildly protests, then for convenience's sake she is too often diagnosed as suffering from some variety of mental illness. Traditional therapy

does not question the status quo; it questions the individual. It is reluctant to consider the significance of social realities because such an advance might predicate the collapse of the psychiatric industry in its present form; along with the collapse of many of our current cultural values and institutions.

If a woman is not crazy because she does not desire to be a housewife or mother, because she does desire to have economic and political power, because she does not wish to be a consumer of excess frivolous products, because she does wish to be a healthy, thriving, self-governing member of the society in which she lives; then she constitutes a serious threat to the psychiatric profession and to her society. Joseph Rheingold, a prominent psychiatrist at the Harvard Medical School expresses this anxiety on behalf of his profession.

"Woman is nurturance...anatomy decrees the life of a woman...when women grow up without dread of their biological functions and without subversion by feminist doctrine, and therefore enter upon motherhood with a sense of fulfillment and altruistic sentiment, we shall attain the goal of a good life and a secure world in which to live it..."[5]

Not surprisingly, the re-fuelling of the feminist movement in the sixties which calls for autonomy for women,and not for oppression due to anatomy as suggested by Rheingold, has created a backlash of discontent from the psychiatric professions, as well as from the culture at large. Alarmingly, the female psychiatric patient ratio has escalated in the last quarter-century, and there is reliable reason to believe that the mental health professions have been engaged in a campaign to cultivate the psychiatric patient.

The Female Psychiatric Patient: Increased Private Treatment and Public Institutionalisation.

Lanny Beckman, one of the founders of the Mental Patients Association in Vancouver has written a paper which explores the educational campaign carried out on our continent in the last quarter century to cultivate the psychiatric patient. It began as a campaign to teach the public to recognise and take responsible actions toward the mentally ill. Using mass media advertising to promote the slogan "Mental Illness Is An Illness Like Any Other" it has only succeeded in stygmatising mental illness and in promoting another message, "Mental Illness Is An Illness That Requires Mental Health Professionals."

Beckman points out that "deviant behaviour qua mental illness is thus transformed from everyday moral, social and economic problems into a technical, medico-scientific ones which only the mental health expert is equipped to handle."[6]

Beckman proposes that the results of such an educational campaign is "ultimately designed to enlarge the psychiatric clientele. to increase the ranks of mental health experts (especially at the lower levels),and to expand the fiscal scope of the mental health empire."[7]By hanging on to its concept of mental illness, psychiatry increases its referrals. Laing has called such a promotion of the psychiatric mission "pan-clinicism", and Szasz has called it "psychiatric imperialism."

There has been a tremendous burgeoning of the mental health professional, and the private and institutionalized psychiatric patient. Phylis Chessler points out that the US National Institute of Mental Health (NIMH) has estimated that the total number of psychiatric incidents of care has more than doubled since 1955 to the extent that one out of every three beds in America is a psychiatric bed.[8] NIMH also has estimated that the cost of promoting the mental health enterprise in 1968 was 21 billion dollars. The figure is modest, and has accelerated since then.

The mental health industry is big business, and women are its largest consumers of services. Chessler examined the NIMH statistics to 1968 looking as much as possible at resitavism to care facilities as to first admission statistics; and her findings reveal that more women than men have been involved, directly or indirectly, in private psychiatric hospitals, in state and county psychiatric hospitals, in inpatient psychiatric wards in general and Veterans Administration hospitals, and general and Veterans Administration outpatient psychiatric facilities.[9] She reports that in 1968 alone 50,363 more women than men were psychiatrically hospitalised and treated; and this figure excludes those women involved in private treatment, or in in and outpatient clinics in community mental centres. Although the total number of residents in state and county mental institutions has decreased over the last decade, Chessler points out that the number of first admissions and readmissions has been steadily increasing, along with the number of people being serviced in community mental health centers. Clearly, the campaign to educate the public to identify mental illness, and to refer persons to mental health professionals has been very successful.

In Canada, no such study has been carried out as yet; but I imagine the trend would follow the US pattern described by Chessler in Women and Madness. Canadian Mental Health Statistics do not account for rates of return to hospital either. But according to the 1970 statistics on first admissions to Riverview Hospital more men than women received treatment. Yet these figures indicate that at age 25 and upwards, the female first admission ratio is higher.[10] Interestingly, the average age of marriage in Canada is 22; and the average age of admissions of women to mental institutions is 24.VGH emergency admissions in recent years have shown that persons receiving a lower income and living in lower income areas have a higher degree of "psychiatric problems".[11] It would be interesting to see the male/female ratio of admissions to Canadian psychiatric facilities of low-income persons; as well as of middle and upper income persons.

As was mentioned earlier, women in America earn very little. Only 1 percent of American women earn over $10,000. Yet if Chessler's book is anything to go by, it would appear that women are the largest consumers of the mental health industry. Therefore, women would not be likely to afford treatment through their efforts alone. Except in the cases where a province or state provides freee delivery of mental health services, women must receive these services through the hands of a benefactor, usually male. As was mentioned earlier, conventionally this is a husband or a father, or a state-run patriarchally determined institution. So as the young bride is handed from father to son-in-law; the housewife is handed from husband to male psychiatrist. Where there is free delivery of mental health services, it is totally inadequate in terms of delivery of service; but more importantly, it is patriarchally-determined, and often (though not in all instances) of very little use to women in our culture.

Role-Conflict and Re-inforcement of Role-Conflict Through Therapy

It is my belief, shared by other more experienced feminists, that much of the increase in the female psychiatric patient population both privately treated, and in mental hospitals, is largely due to conditions in society which make it exceedingly difficult to operate as a non-traditional female as defined by the patriarchal culture. As Chessler and others have pointed out, the degree to which a woman accepts or rejects her female role in the culture, to a large extent, determines the degree of her psychiatric problems. Traditional psychiatry, not allowing for the inclusion of social, political and economic factors in treatment, largely ignores the realities of a woman patient's world. At the same time, there is no existing theory of human personality based on feminist ideologies; neither is there a feminist approach to therapy; more particularly to psychoanalysis, which has formed the basis of our modern thinking.

I'd like to talk briefly about two women who faced a similar problem; one was treated privately by psychoanalysis, the other was committed to a mental hospital. I feel that their stories quite clearly indicate the desparate need for a feminist evaluation of therapy, and for a consolidated feminist movement.

The first woman has been under psychoanalysis for seven years and is still in treatment at the present time. At puberty she began to systematically and compulsively pull out her hair. She was sheltered by her family and friends who guarded her secret by informing persons that she had a hair condition which produced her baldness. From age thirteen to twenty-one she plowed her way through various psychiatrist's offices, and availed herself of numerous therapies including behavioural science; all of which proved totally ineffectual. Finally, she decided to explore psychoanalysis. In many respects, psychoanalysis has been quite helpful to her. She has had the opportunity to explore her relationships with her parents via the inevitable transference to her doctor. However, seven years later she is still very much in the dark and she still pulls out her hair.

She knows that her father pulled out grey hairs from her mother's head to prevent her from aging; that her grandmother celebrated the orthodox jewish ritual of shaving her head and wearing a wig; that she harbours repressed sexual desire for her father; that she rivals her mother and sister for her father's love; and so on. All of this has something to do with her condition; yet she still pulls out her hair. It is my feeling that psychoanalytical theory itself limits her perspective on her situation because of the nature of that theory. The woman claims she wants to marry and form a lasting relationship; yet she has rejected all possibilities for such a happening. The idea of her therapy is to take her to being able to fulfill the goal she has identified - a relationship and marriage which will occur when she stops pulling out her hair. Psychoanalysis, like most therapies today, is not attuned to the nature of women at all; it treats women and men indiscriminately as though they were both receiving the same cultural conditioning, and had very much in common. In fact, thier needs are quite disparate.

Shulamith Firestone in The Dialectic of Sex points out that Freud did not carry his theories far enough. Firestone does not believe that sexual envy is at the root of our hang-ups. Firestone applies a feminist analysis to freudianism and comes out with something like this. The child, male or female, identifies with the mother at birth and loves the mother because she

provides the child with nurturance, and not because the mother is female. At a later date, the child, male or female, begins to realize that the mother is oppressed and powerless, and that the father has all the power. Understandably, the child does not wish to continue its alliance with this impoverished powerless woman. The child rejects the mother, guiltily of course, because the child is sensitive to the plight of children as powerless as their mothers in this world, and identifies with, desires, and fears the father's power; not his penis alone, as Freud would have it. If the child is to be successfully analysed as an adult then he/she would, as a result of analysis, be able to repress the original repression, the envy of the father's power/penis (power vested in sexuality is only one aspect of power),; as Firestone would have it. Clearly Firestone's version explained in terms of power envy makes more sense. Yet if one were to hold with Firestone's analysis; then the end result of psychoanalysis and of most other therapies derivingso much of their ideology from Freud couldn not possibly benefit women. For women would have to successfully repress their desire for power and autonomy in order to be able to function in this world. They would have to overcome their desire for their father's power/penis because this is, according to Freud, an infantile fixation. Women must, according to Freud, become mature fulfilled adults by transferring this desire to another man, preferably a husband; and not try to continue to rival the mother for the father's affections, or seek to attain the father's power/penis.

Let us return to the case of the women who pulls out her hair, and substitute some of Firestone's hypotheses for the tenets of psychoanalysis. Is it preposterous to think that the woman may pull out her hair, not because she is repressing a sexual desire for her father; but because she is rebelling against her own powerless role as a woman. Perhaps she does not wishe to be a woman at all. Her father has demonstrated quite clearly to her that women are a commodity to be devalued with age; hence he would pick out her mother's grey hairs to prevent her from aging. Indeed, she does not wish to be a woman at all' she wishes to be a powerful person like her father. Hence her bald head, which prevents her from becoming involved in a male-female permanent relationship which might lead to a similar enslavement to that of her mother. Logically, she cannot be"cured" by accepting her sexual attraction to her father as a fixation, and growing up by rejecting that notion. Her actions are powerful indictments of the role to which she has been culturally educated. She wants her father's power and she should have it. But she doesn't need to seduce him, or another man; or rival her mother, or another woman for this power. This is not maturity. This is insanity. Her therapy seeks to re-inforce her role-conflict because it does not recognize role-conflict at all. This woman needs to develop her own power and autonomy and authority in order to become a mature adult. How can she ever chose to stop pulling her hair out, and stop denying herself the possibility of relating to another human being more fully, if she does not understand this.

As yet there is no therapeutical provision for understanding the problems of women in terms such as these. Increasingly, women are facedwith similar role conflicts which frequently lead to unbearable mental stress and breakdown; evidenced by the mean age at which women enter mental institutions or seek psychiatric help - 24 - either two years after marrying, or perhaps, on realizing that they are alone and unmarried in a society which gives social sanction only to women who function as wives and breeders. As Chessler points

out, "our culture rewards women for breeding more than for any other activity."[11] If a woman cannot accept her social role, she will be lonely and alienated. If she is lonely and alienated, she will suffer and need help. Her only available resources at the present time are largely male-dominated psychiatric professionals and patriarchally-run mental institutions which cannot possibly treat a problem which they do not recognize as a problem - the powerlessness of the female condition.

The first woman was treated privately, primarily because of the economic advantage of her family. She is really very fortunate; despite her lack of success in treatment. She is oppressed; but she is free. Another woman was not so fortunate. At the same age (puberty), she began to exhibit the same symptom - pulling out her hair. Her family did not have a tolerant attitude; neither did they have any money. In this environment she became overtly depressed and retiring. Her access to the private psychiatric industry was limited. At fourteen years of age she was involuntarily committed to a mental institution by her parents. She was subjected to shock treatment and chemotherapy for prolonged periods of time; she was released periodically for short periods of time, and recommitted again and again. All attempts to rechannel her into the female mold of a patriarchal culture have failed. Her problem was never even given the luxury of analysis. Today she has become a chronic mental patient - a situation largely perpetrated by the treatment afforded at mental institutions.

She is not free on two counts; she has been incarcerated and abused by the mental hospital; and her behaviour has been diagnosed as pathological when it would seem far more likely that she, like the first woman, was making a powerful, symbolic and desparate gesture of definace by pulling out her hair at puberty. Her protest has been totally obliterated by drug therapy, shock treatment , and inhumanity; she has been dismissed under the stygmatizing label of a pathological disorder. The cases of both women and countless others I have met, are very moving. They move me to question conventional psychiatric and institutional models particularly with reference to the treatment of women.

Presently, the psychiatric industry does not understand women. It does not understand the conflicts women endure in their traditional roles. A patriarchal society has demanded women to be used primarily as breeders and this is fast becoming an obsolete notion in female consciousness. Too frequently, the psychiatric industry confuses psychopathology in women with the revolt of an oppressed class. Thank goodness for birth control, even in its unadvanced state; finally women are capable of taking control of their bodies, of defying their supposed biologically-determined roles, of coming into personal and political power. We need a consolidated feminist movement, and we need feminist therapy - iconoclastic and revolutionary.

Eve-Lynne Rubin
Mental Patient's Association (Vancouver)
June, 1974.

Footnotes

1. Weisstein, Naomi, "Psychology Constructs the Female. or, The Fantasy Life of the Male Psychologist" in Norton Reader, 3rd ed (New York: Norton, 1973), p 394.

2. Weisstein, p379

3. Weisstein, p. 379

4. Weisstein, p. 379

5. Weisstein, p.379

6. Beckman, Lanny,"Attitudes Toward Mental Illness: A Mental Patient's Liberation Perspective ",to be published in Bedlam, a quarterly journal now being prepared by the Mental Patients Publishing Project, off-shoot project of the Mental Patient's Association.

7. Beckman.

8. Chesler, Phyllis, Women and Madness , (New York: Avon, 1973) , p 304

9. Chesler, p. 304

10. CMH statistics, 1970

11. In a Nutshell, monthly pulication of Mental Patient's Association. Vol.

11. second footnote 11 is really 12.

12. Chesler, p 249

* I apologize for spelling Phyllis Chesler's name incorrectly in the paper. Also, for the sloppiness of the footnotes - but I was pressed for time.