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Women With Severe Mental Disorders

Issues and Service Needs

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The existence of sex bias in mental health treatment is a long-standing and probably still unresolved issue. For example, early research by Broverman et al.¹ identified the negative perceptions of women held by clinicians and the double bind in which women were placed, in that the expected characteristics of a "healthy" adult varied markedly from those for an adult female. Clinical and practice research has found gender biases in diagnosis² and in treatment, which serve to demean women (as dependent, passive, seductive, hysterical, etc.), foster traditional and limited sex roles, and respond to women patients as sex objects.³

An awareness of how such biases might affect services to women with long-term psychiatric disabilities is of more recent origin. Test and Berlin⁴ were apparently the first to point out that in terms of differential service provision, the "chronically mentally ill are regarded as almost genderless" (p. 136). However, their early review was able to identify research establishing numerous significant differences in major domains of life functioning. While several authors have since elaborated on these problems,⁵⁻⁷ systematic attention to researching gender differ-

ences among persons with long-term mental illness is still clearly lacking. A prior review documented failures to specify the gender composition of research samples or to report on gender differences for several major mental health journals.⁸

In this chapter, we review the most recent literature concerning women with long-term, severe mental illness (SMI), using Test and Berlin's⁴ topics as an organizing framework. We begin with a summary of gender differences in demographics and clinical characteristics, and then move on to discuss problems in major areas of life functioning: instrumental roles; interpersonal roles, including social, sexual, marital, and family roles; and physical health, including medications. We then review the literature on two major problem areas for women with SMI: substance abuse and victimization. Finally, we end with some implications for mental health administrators and practitioners, framed from a public health perspective.

GENDER DIFFERENCES IN DEMOGRAPHICS AND CLINICAL CHARACTERISTICS

It seems to be common knowledge for most mental health providers that women far outnumber men in diagnoses of major affective disorders, especially depression. The lifetime prevalence for major depressive episodes in women is 1.67 times that of men—affecting a staggering 21.3 percent of the female population.⁹ However, women in fact actually outnumber men in all major psychiatric diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III),¹⁰ except one—antisocial personality disorder, according to two national epidemiological studies.^{9,11} These gender differences upset conventional notions that men have higher rates of anxiety disorders and non-affective psychoses, such as schizophrenia and schizoaffective disorder and that schizophrenia is primarily a disorder of young males. Despite the over-representation of women in most categories of mental illness diagnoses, it is men who are overrepresented in more intensive treatment programs: Women are more likely to receive outpatient treatment^{12,13} and men, inpatient care.³ Programs oriented toward schizophrenia report an overwhelming majority of males attending.¹⁴

There are also major gender differences in the demographics of persons with SMI. Several research studies have corroborated the fact that women in treatment with a mental illness diagnosis are significantly older than men¹⁵ and also that women have a later age of onset.¹⁶ The latter gender difference may be particularly marked in schizophrenia.¹⁷ That is, the age of onset for schizophrenia is 27 for females versus 21 for males.¹⁸ Similar though less dramatic differences are found for unipolar depression (25 for females vs. 23 for males) and for bipolar disorder (20 for females vs. 18 for males).¹⁹

Research also consistently indicates gender differentials in marital status among persons with mental illness: National weighted estimates show that while a minority of men with SMI marry (31 percent to 46 percent married), a majority of women do (55 percent to 75 percent married²⁰). In fact, in overall population studies, marriage has consistently been interpreted as serving a protective function in men, while in women its function is more questionable. Married men usually have the lowest rates of mental illness, especially depression, while single (never married) women are often *less* depressed than their married counterparts.^{3,21}

Differences in the racial composition of male versus female populations diagnosed with mental illness have been explored, but so far no significant differences have been supported. However, epidemiological data from one site of a major national study indicated a four-way interaction of age, ethnicity, sex, and diagnosis, that is, higher prevalence rates for older Mexican American women and younger non-Hispanic women, especially on alcoholism, drug abuse, phobias, and depression.²² Clearly, the meaning of gender is socially constructed and varies by culture; it is not surprising that these differential constructions would also affect manifestations of mental illness.

Explanations for gender differences in diagnosis have been posited, but none clearly established. They have included differential vulnerability due to socialization and social roles,³ environmental factors,¹⁷ hormonal differences,¹⁴ and other biological explanations.¹⁶ However, much of this research is flawed, using small samples that may not be representative, questionable measures of premorbid competence, and treatment outcomes that are confounded with gendered role expectations.

Thus, although often ignored in treatment considerations and research, gender appears to play a major role in the etiology and manifestation of mental illness. While more scientifically sound research is

needed as to etiology, at this time the evidence does seem consistent enough to mandate attention to gender differences in persons with SMI, and their implications for mental health services. We now turn our attention to reviewing the research findings that are available concerning women's role performance and problems in functioning.

GENDER DIFFERENCES IN INSTRUMENTAL ROLE PERFORMANCE

Test and Berlin's⁴ review of special concerns for women with SMI reported that women experienced significant vocational disadvantages. However, in the few subsequent descriptive studies of persons with SMI that investigated education and employment, no significant gender differences have been found.^{15,23,24} This might reflect social change; more likely, it reflects methodological problems (e.g., not controlling for women's older ages and thus greater opportunities for vocational experiences). Holstein and Harding²⁵ suggest there are measurement problems in assessment of work roles, in that multiple roles are often not considered in measures of social functioning. This was a particular problem for women in their sample in that nearly half of the working women, but none of the men, had additional responsibilities caring for others.

While gender differences in work status may be unclear, those involving vocational rehabilitation services provision are not. Across all types of disabilities, women represent less than one third of the caseloads of vocational rehabilitation programs, with reported earnings at closure only 56 percent of those achieved by men.²⁶ Similarly, in Fairweather Lodge programs (a psychosocial residential and employment program), fewer females than males are being served (37 percent vs. 63 percent).²⁷ Cook and Roussel²⁸ found that women in a large, urban psychiatric rehabilitation program were given fewer job placements than men before "graduating" and that they were retained in the agency longer before getting their first paid jobs. Once in these independent job placements, women received significantly lower salaries. The differential treatment and representation of women in vocationally oriented programs may reflect cultural expectations that vocational performance

is more important to men, higher staff expectancies for men's vocational activity,⁶ or the availability of primarily masculine jobs (e.g., janitorial, construction). Whatever the cause, this limited attention to their vocational needs would certainly appear to disadvantage women with psychiatric disabilities, especially given the traditional disparities between economic levels of women and men in our society.

The instrumental role of living independently has also received some limited study. In several reports, women with psychiatric disabilities were more likely to be in independent, stable housing than in dependent care or temporary housing.²⁹ In studying the residential status of clients in a large psychiatric rehabilitation center, Cook interpreted gender effects on housing status to be indirect, primarily due to women's better functioning and the fact that they were more likely to have children. While these results may reflect more positive outcomes vis-à-vis chances for more normative community living for women, they could as well reflect staff biases rating women as more functional because of their perceived compliance and greater experience in housekeeping roles, or they could reflect policies of dependent care facilities, which typically exclude residents with children. Thus, the meaning of gender differences in independent living outcomes for women may be unclear (similar to the vocational arena).

However, in terms of services, there are clear gender differences in obtaining adequate housing. For single women, neighborhoods that contain affordable housing are often unsafe and may contribute to high rates of assault.⁸ Women with psychiatric disabilities who are mothers also indicate unmet needs in terms of housing available to support them and their children.³⁰ Overall, it appears that gender differences in instrumental role performance have received insufficient research attention, and the unique needs women have for work and housing have not been considered in service provision.

INTERPERSONAL ROLES

Social and Sexual Roles

There is a relatively large body of literature linking socialization for female gender roles with depression, suggesting that women are social-

ized to be nurturing of others, supportive of their needs, and attentive to their desires. Unfortunately, this other-directedness can come at the expense of one's own sense of worth and efficacy.^{31,32} While social and sexual roles, friendships, and intimate relationships can be central supports, they can also be key stressors for women. However, we know very little about the interpersonal connectedness of women with SMI. What supports do they receive from friends, neighbors, and acquaintances; who can they turn to when they need help?

A recent study by Test, Burke, and Wallisch³³ suggests that the daily life circumstances of men and women with SMI differ in important ways. Women were more likely than men to be hospitalized for nonpsychiatric reasons. Women were also more likely to be married or divorced, involved in heterosexual relationships, parents, and actively involved in parenting when they were. Men were more likely to be jailed and to commit suicide. Males and females did not differ in the number of friends they were in contact with, but females were more likely to report kissing, dating, and sexual activity. From this and other reports, it appears that women with SMI are likely to be sexually active. Thus, Test et al.³³ report that in their sample of young adults, three quarters of women, but only 40 percent of males, were sexually active. Sexual activity has been documented in both hospital and community settings.^{29,34} Unfortunately, over time, stable sexual relationships may be replaced with casual sexual encounters.³⁵ Women with SMI may also be more at risk of experiencing unwanted sexual advances, harassment, and exploitation. Another recent study focusing on the social and sexual roles of women with SMI found that the vast majority of women self-reported a need for help in dealing with difficult relationships—both in getting their emotional needs met and in dealing with emotional and sexual abuse.³⁶

Marital and Family Roles

Marital and family roles are major social roles since marriage and parenting are normative signs of adult status and reflect important developmental tasks.³⁷⁻⁴⁰ Women are particularly likely to view social connectedness and relationships with others as important and self-defining.^{31,32} With regard to parenting and family roles, women are more

likely to value spending time and being involved with children and serving their emotional and physical needs.⁴¹ Given their normative, social, and developmental centrality, marital and family roles are particularly likely to be central to women's sense of who they are and what is possible for them. Success in this domain may therefore provide women more than men with a sense of worth and competence, while setbacks may be particularly stress-inducing and straining, providing the basis for a variety of negative self-images.⁴²⁻⁴⁴ In relationship to mental illness, developing and maintaining a sense of self as active and responsible may be critical to recovery.⁴⁵

Unfortunately, women with a mental illness appear likely to experience a variety of social stressors in their intimate and family relationships. These stresses may increase vulnerability; thus, for example, married women of low socioeconomic status with young children and no paid employment outside the home are at increased risk of developing a psychiatric disorder.⁴⁶ Mental illness in turn may increase stress in social relations. A recent review by Downey and Coyne⁴⁷ suggests that marital conflict is likely to be high up to four years after a depressive episode and that divorce is common among depressed women. In addition, women with a mental illness are more likely to marry a spouse with a psychiatric disorder—a situation that increases risk of exacerbation of their own symptoms and severity of marital and family disturbance.

As in other domains related to women and mental illness, information is scarce as to the marital and family roles women with a mental illness carry out and the successes and problems they may encounter. There does seem to be agreement that women with SMI have a greater number of children than average and are more often divorced or not married than the norm, thus raising their chances of raising children as single parents.³⁴ In their review of the literature, Hammen, Burge, and Adrian⁴⁸ suggest that adverse socioeconomic circumstances and lack of resources are part of the life circumstances of women with SMI. The stress of parenting under conditions of poverty, social isolation, and marital discord increases risk of childhood disorder.⁴⁹ And in fact a large literature exists suggesting that children of women with SMI are at risk for a variety of behavioral and emotional problems.^{47,50-62} In addition, these children make up a sizable minority of children removed from

home and placed in foster care or other out-of-home placements.^{30,63} Of course, these findings do not explicate the dynamic process through which illness and effectiveness of child rearing are interrelated.

While there is a relatively large literature examining the effects on the child of a mother's mental illness, the problematic behaviors of mothers have been studied less and are less clear. (See Oyserman, Mowbray, and Zemencuk⁶⁴ for a more complete review.) That research does suggest that mothers with a depressive diagnosis may be less responsive, rejecting, and/or critical of their children. A schizophrenia diagnosis appears to be related to higher probability of emotional unavailability, passivity, and lowered ability to provide a stimulating child-rearing environment.⁶⁵

The context of parenting with a mental illness clearly has risk implications for parents and children.⁶⁶ Available supports and resources and the difficulties and stressors women experience are bound to influence their ability to carry out the parenting role and also their perceived capacity to carry out other roles. Unfortunately, community mental health services available to women with SMI appear unlikely to focus on their needs as spouses, mothers, or family members. Several sources suggest that parenting appears to be a particularly unsupported role for women with SMI. First, the little empirical evidence that exists indicates that women are not even routinely asked if they are parents, let alone what help they may need to fulfill their parenting role.^{36,67} Second, our review of the literature³² suggests that few services exist to support mothers with SMI and their children. Third, even when available, women may be hesitant to request services since they run the risk of having their children become wards of the child welfare system, entering foster care or other out-of-home placement, sometimes only on the basis of a mental illness diagnosis.^{36,68}

Until recently,³ there has been little published work focusing on women's perspectives on their family, parenting, and intimate-spousal roles. Our work in the Detroit area⁶⁹ suggests that mothers with SMI view parenting as central to who they are and that they have concerns about their functioning as parents. Unfortunately, these mothers are also attempting to cope in difficult economic and social circumstances, trying to provide for themselves and their children without much support. From recent work in Vermont,³⁶ mothers with SMI are articulate about the services they need and the responses of the mental health

system to these needs. In-home services, though desired, are not readily available. Foster care and other out-of-home services do not strengthen the mother's ability to parent once her children are returned home. Mothers felt they needed help in concrete domains such as financial assistance, assistance in obtaining appropriate and nutritional food for their children, and help with child-rearing issues. Women who lost custody of their children felt they needed services to support them, to make visitation possible and to help them deal with the loss of their children on an ongoing basis.

Though very sparse, the literature clearly suggests that women who have SMI are not simply mentally ill, they are workers, mothers, wives, girlfriends, and even less discussed, also daughters, sisters, and members of family networks. However, the circumstances surrounding their role performance are often very stressful. Furthermore, mental health agencies are infrequently attending to these role-related needs and demands. Clearly, more work must be done to provide a better and more complete picture of these women and to support them in all of the social roles that they play and aspire to attain.

PHYSICAL HEALTH AND MEDICATION ISSUES

The comorbidity of physical and mental health problems is well-established. Psychiatric symptoms can be exacerbated by easily treatable physical illnesses,⁷⁰ and individuals with psychological symptoms and/or diagnosed mental disorders have higher rates of hospital use and poorer physical health.⁷¹ Among women compared with men with SMI, health problems may be greater,³³ although it is unclear whether reported differences may also reflect women's older ages. Thus, Mowbray and Chamberlain⁷² found that gender differences in nonpsychiatric medical treatments for a sample of state psychiatric hospital patients disappeared when age was controlled. However, in another study, dually diagnosed women from a state psychiatric hospital had higher self-reported medical problems but were also younger.⁸

A significant risk factor for the health of women with psychiatric disabilities may be psychotropic drug use. These agents have documented neurological side effects.⁶ Women compared with men are

given more prescriptions for psychotropic drugs,⁷²⁻⁷⁵ regardless of diagnosis.⁷⁶ Thus, their side effects should be of particular concern with women patients; for example, tardive dyskinesia has been repeatedly documented to be more frequent and more severe in females.¹⁴ Other research has also indicated health problems specific to or more prevalent in women, such as weight gain, amenorrhea, dysmenorrhea,^{4,6} skin and hair problems, problems with lactation,¹⁴ and breast cancer⁷⁷—all possibly side effects of long-term psychotropic medications.

Of perhaps even greater concern than these reports from small clinical studies vis-à-vis health problems is consistent documentation that women with SMI have problems accessing appropriate physical health care services. For a variety of reasons, psychiatric patients in general have been reported to often receive incomplete health care.⁷⁸ One study found that psychiatrists have difficulties detecting physical illnesses.⁷⁹ There are still reports published of undiagnosed medical problems being misdiagnosed as psychiatric.⁷⁹ For women, the fear is that because of preexisting beliefs concerning their tendencies toward hypochondria, health problems in women with SMI may be even more often mislabeled as part of a delusional system than they are in men.⁸⁰ In fact, Heyding⁷⁰ found that psychiatrists are more likely to miss physical illness problems in women.

Furthermore, in numerous areas, research has found that mental health providers give inadequate attention to gender-specific health problems of women, for example, services related to contraception, family planning, and avoiding sexually transmitted diseases;^{5,81} services delivered to pregnant mentally ill women,^{82,83} and pelvic examinations.⁷⁸ Despite the fact that substantial numbers of women are affected (30 percent according to Post⁸⁴), psychiatrists do not ask women with psychiatric disabilities about medication side effects of a sexual nature (e.g., vaginal dryness), while they frequently ask male patients about ejaculation and other sexual performance issues.⁸⁵ Women with a long-term mental illness have been found to be as sexually active as males (39 percent in one report from a large agency providing psychosocial rehabilitation services).⁸⁶ Among populations with a mental illness diagnosis, knowledge about AIDS appears woefully inadequate.⁸⁷ As might be suspected, mental health service providers are also inadequate in providing information about contraception, family planning, and so on. Given the fact that unwanted pregnancies have significantly

more impact on women than men, this lack of attention has vastly different gendered implications.

Thus, the overall physical health status of women with SMI definitely indicates the need for service providers to regularly include this topic in service planning for female clients. However, the literature also indicates that health education and health assessment services in mental health programs are not adequate, perhaps even less so for females. Attitudinal problems as well as competency and skills appear to be involved. Attention to the health of women psychiatric patients warrants more attention in service provision. While the literature on this topic has expanded since Test and Berlin's⁴ early review, larger-scale research studies providing more comprehensive information on health status and health care access, availability, and acceptability are definitely needed.

SUBSTANCE ABUSE

While several psychiatric diagnoses are more common in women, substance use diagnoses are not. However, while women use less drugs, a secular trend toward higher female drug abuse rates and earlier onset of drug use among women has been documented.^{88,89} Furthermore, the comorbidity of mental illness and substance abuse in women is high: At least 30 percent of mentally ill women also have a substance abuse diagnosis.⁹⁰ Additionally, women are more likely than men to become alcoholic after or during depression.⁹¹ Women in substance abuse treatment programs have been found to score higher on levels of depression and anxiety as well as on levels of general psychological distress than men.^{92,93} Overall, women's mental health problems may be compounded by feelings of guilt, shame, and anxiety about their addictions.⁸⁸

In terms of the type of substance use, women are more likely than men to abuse licit drugs, such as tranquilizers, stimulants, and sedatives.⁹⁴ These are often drugs prescribed to them or to other people they know.⁸⁸ In addition, women report having a high incidence of marijuana and cocaine use.⁹⁵ With regard to addiction type, women report substance abuse addiction more often than men^{88,95} and are more likely to

describe sudden, intense onset occurring after a major life event such as an accident, disruption of family life, or sudden physical illness.^{88,95} There is evidence to suggest that addicted women frequently come from families in which one or more family members are also addicted or in which drugs were used as a primary coping strategy by one or more family members.^{88,95} Therefore, family factors such as existence of drug abusers within the family, extent of the social network, and stress emanating from conflicts within the family should be considered in making sense of women's substance abuse.⁹⁶

Research with minority samples has found a number of subgroup differences. Street drugs and alcohol are the drugs most commonly used by low-income minority women, and prescription drugs are usually more prominently used by middle-class minority women.⁹⁶ Differences between minority and non-minority women have also been documented: Minority women overall are likely to start heavy drug use at a younger age than nonminority women.⁹⁶ Minority women are less likely than nonminority women to use drugs alone, tending to use drugs with groups or in the company of female friends.⁹⁷ These women's environmental exposure to drugs is compounded by relationships with drug-abusing partners and their dependence on family members or public assistance for survival.^{88,95,98}

The escalation of drug use, especially among women of childbearing age, is clearly a matter of concern.⁹⁹ Substance abuse history increases isolation from non-drug-related relationships that are more likely to provide support with parenting and everyday functioning.¹⁰⁰ The social networks of women with substance abuse problems may be where drug use started and/or is encouraged. In fact, research on family processes has documented that family maladaptive interactions are related to behavior problems especially when drug use is concerned.¹⁰¹

Women with both mental health and substance abuse problems present characteristics that are very different from men with the same mental health and drug-abusing histories. However, community-based interventions with women with mental illness do not address the unique characteristics and challenges that women must deal with, especially where parenting is concerned.¹⁰² A small survey of community mental health services in the city of Detroit revealed that less than 15 percent offered services to substances-abusing, mentally ill populations, and even these limited services focused on dually diagnosed individuals in

general. There are specialized programs aimed at children and young adults with a mental illness diagnosis, but none of them addresses the unique situation of women dually diagnosed.

It is important to develop programs that take into account gender and cultural-relevant characteristics to more completely help women with mental illness and substance abuse problems.⁹⁶ A careful consideration of women's multiple roles and social networks is crucial since these are issues likely to jeopardize women's use of prevention and treatment services. In addition, the characteristics of the services provided (e.g., individual vs. group services), the availability of service supports such as child care and transportation, and expectations about services should be taken into account since researchers have found that women are more likely than men to rely on these when deciding on whether to get help or continue service receipt.^{91,103} Finally, women who abuse substances are more likely to experience negative psychological consequences of drug use than are men due to less permissive and accepting cultural norms with regard to women's drug use.⁹¹ As a result, women are less likely to admit substance use and to seek out help.¹⁰⁴ Services aimed at reaching these women need to be developed.

SEXUAL AND PHYSICAL VICTIMIZATION

The victimization of women takes many forms, including physical and sexual abuse by strangers, acquaintances, co-workers, lovers, husbands, and ex-partners. General population surveys reveal that about a third of all married women can expect to experience some form of physical abuse during their marriages.¹⁰⁵ Violence in dating and cohabiting relationships may be even higher.¹⁰⁶ Sexual harassment affects a fourth to half of women employees and students.¹⁰⁷ About one fifth of adult women have been raped.¹⁰⁷ Many women also suffer from the effects of abuse experienced in childhood. Child sexual abuse, defined as any sexual contact from fondling to intercourse, affects 20 to 30 percent of all girls.¹⁰⁸ Physical abuse of girls, with injury or injury potential, affects approximately 10 to 20 percent.¹⁰⁸

Having a severe mental disorder does not provide immunity from abuse. In fact, the opposite seems to be true. Women outpatients and

inpatients have higher than normal rates of all forms of victimization. For example, in 11 studies, child sexual abuse histories were reported by 36-70 percent of the women, and averaged about 50 percent.¹⁰⁸⁻¹¹³ The rates of physical assault, usually by an intimate, are also higher in psychiatric populations, averaging 54 percent across four studies.^{109,111,112,114} Recently, we have learned of a very insidious form of abuse—the sexual abuse of women by their therapists, which occurs at alarmingly high rates.¹¹⁵

Victims differ from nonvictims on the rates and severity of many psychological problems. The core symptoms for most victims are chronic depression, anxiety, and phobias.^{107,113,116} The high rates of abuse in marriage may explain why married women are more depressed than single women.⁹⁶ However, physical and sexual assault survivors do not seem to have higher than normal rates of schizophrenia.^{116,117}

Rates of post-traumatic stress disorder (PTSD) are especially high in victim groups.^{117,118} Many victims alternate between “numbing” (dissociative states) and hyperarousal. There is increasing evidence of physiological changes in the brain from traumatic stress.¹¹⁹ When abuse occurs in a close relationship, a more complex form of PTSD may result, with the additional problems of difficulties with affect regulation, damaged self-image, idealization of the perpetrator, hopelessness, and somatization.¹²⁰ Victims usually experience a profound sense of betrayal, and their basic assumptions about living in a safe world may be shattered.¹²¹ Substance abuse is a common way to cope with anxiety, pain, and depression and may help victims achieve dissociative states.^{108,122} The effects of child sexual abuse deserve special attention because memories of the abuse may be partially or completely repressed,¹²³ personality development can be profoundly affected¹²⁴ (and include borderline personality traits or multiple personalities), and these survivors probably experience more isolation and shame than other victims.¹²⁵

Despite the association of victimization with certain types of psychological problems, conclusions about causation are difficult to make. Most studies can be easily misinterpreted because they fail to establish if the problems existed before or came after the abuse. One exception is a study showing that battered women differ little from other women prior to being battered.¹²⁶ After the abuse, their rates of suicide attempts, substance abuse, psychiatric emergency room visits, and mental hospitalizations rose dramatically. Fifteen percent entered state mental hos-

pitals and 26 percent attempted suicide. In addition to the likelihood that abuse usually precedes and contributes to depression, anxiety, and other problems, alternative scenarios are also possible. There is anecdotal evidence that offenders choose women who seem vulnerable; to create even greater dependence, some men who batter keep medication from their partners. Others may paternalistically use force to get their partners to take medication or to stop abusing drugs.

The association between victimization and severe mental disorders may also be a false one. Trauma symptoms can mimic mental disorders, especially dissociative symptoms and flashbacks. Psychiatric practitioners have a long history of not believing the reports of victims and seeing them as symptoms of “craziness.” Caution is needed, for example, because Minnesota Multiphasic Personality Inventory (MMPI) profiles of battered women can be easily misinterpreted to mean that they are schizophrenic, or have paranoid or borderline personalities.¹²⁷ Self-labeling may also occur. Many women seek help because their batterers convinced them that they are crazy after years of isolation and degradation.

Despite increased awareness of women’s victimization, detection rates by professionals remain quite low in both inpatient and outpatient settings.¹¹¹ Even if detected, the life-threatening nature of the abuse is often ignored.¹²⁸ A particularly tragic example is described by Ann Jennings,¹²⁹ whose daughter’s child sexual abuse was not detected despite many years of psychiatric hospitalization. Even when mental health workers were aware of the abuse, they did not help her to heal emotionally and she eventually killed herself.

Abuse goes undetected because practitioners may lack training or confidence in their ability to handle the issues involved.¹³⁰ Male practitioners are less likely to detect abuse, to see it as serious, and to take a thorough history.^{131,132} Victims may be reluctant to disclose out of shame or fear of retaliation. Most victims say they would tell if they were asked directly.¹³³ Emergency room workers and family therapists have learned to conduct assessment interviews away from male partners. Detection rates also increase when a large number of behaviorally specific questions are used. To be avoided are terms like “abuse,” “rape,” and “assault.” Instead, asking about specific behaviors like “hit you with an object” or “forced you to do something sexual” will bring better results. Questioning can also be normalized, for example, “We have learned that

many coming here are hurt by people they love, so we ask all our clients these questions."

Steps are increasingly being taken to provide more sensitive care and treatment. For example, private living quarters and alternatives to physical restraints may be especially important for sexual abuse survivors.^{134,135} Practitioners are increasingly aware that women may be stalked, harassed, and occasionally murdered after leaving an abusive partner.¹³⁶ Safety planning must be the first priority. Victim shelters and hot lines can help the victim or the practitioner with safety planning, including individual and legal strategies. Once safe, the woman can be helped with decision making, problem solving, and trauma recovery.¹²³ Most treatments help victims reframe their negative symptoms as coping behaviors—as their best attempts to respond to terrorizing events that anyone would experience as traumatic. Interventions may also be needed to help increase the support and sensitivity of the victim's significant others.¹³⁵ While retelling of the trauma is often essential for trauma recovery, women with SMI may need special support groups and carefully paced trauma work.¹³⁷ Psychotropic medication may actually interfere with accessing the emotions that are needed for recovery.⁹¹ Victims with severe mental disorders need special care. However, there is a "silver lining" to these women's bleak stories because in many cases, recovery from the psychic wounds of victimization can also lead to recovery from a mental disorder.

IMPLICATIONS FOR MENTAL HEALTH SERVICES DELIVERY

In a traditional model of mental health service provision, persons with mental illness periodically experience symptoms that, in turn, can produce impaired community functioning and role performance. The role of the mental health practitioner is to treat the symptoms (e.g., through medication or other therapies) or to minimize conditions that contribute to symptoms (such as stress). Client characteristics (such as lack of motivation) or environment (lack of resources) may present barriers to treatment effects. However, in this examination of gender differences in community functioning and in services receipt, we see re-

peatedly that gender itself is a barrier to effective mental health treatment. In numerous ways, the review identifies biased treatment based on gendered assumptions (e.g., that women have less need of vocational rehabilitation services) or discriminatory treatment (women are more often served in outpatient services; substance abuse treatment services are less accessible and acceptable to women). Furthermore, gender relates to factors that are more likely to keep women away from treatment: higher rates of health problems, medication side effects, parenting responsibilities, domestic violence, and victimization, which render women isolated and powerless. Related to the fact that women are more affected by the preceding factors, they are also likely to demonstrate increased mental and emotional problems. Their prior treatment and life events also put them at greater risk for psychiatric symptoms in adulthood, for example, due to higher rates of childhood sexual abuse, adult victimization, or greater comorbidity of substance abuse and psychiatric disorders.

Yet again and again in sections of this review, we have concluded that there is insufficient attention in treatment and rehabilitation services to women's special needs. Again and again, we have noted that there is insufficient research addressed to specific problems of women with SMI and to factors that increase or decrease the effects of these problems on community functioning, psychiatric status, and role performance. It is overwhelming how a factor like gender that has such extensive and significant effects on individuals' histories, their problems, their use of services, and service effectiveness could be so greatly ignored for so long a period of time. Since the review by Test and Berlin,⁴ now more than 15 years old, attention to gender and progress in treatment of women with SMI has been modest, at best.

The implications for mental health practice are far-reaching, yet simple. Gender and all its implications and ramifications have to be considered in every aspect of service to persons with SMI: diagnosis, assessment, planning, delivery of mental health treatment and rehabilitation, and evaluation of outcomes. This means that clinicians and administrators must be thoroughly familiar with, ever vigilant of, and committed to addressing differences associated with female gender. Initial and periodic training may be needed on many gender-related topics. This involves pre-service training from professional practice curriculums and inservice training in agency settings. Knowledgeable

supervisors will be particularly important to ensure that gender sensitivity is practiced through services. Administrators need to review procedures concerning referral, screening, and/or entry to programs to ensure that they are based on meeting women's actual needs, rather than gender stereotypes.

Many of the services gaps identified in our review can be filled by appropriate attention to women's issues within existing program structures. That is, women are more likely than men to use community mental health services, but less likely to view them as helpful. In fact, these women are quite likely to rate the services as being of no help at all. Perhaps this is because these services were not designed with the real-life needs and circumstances of women in mind.³⁶ Some new programs and service components may need to be added to increase access and effectiveness for women, for example, integrated treatment for women with dual diagnosis, group treatment for victims of sexual assault, respite care or baby-sitting access for children of female clients, and transportation to service locations. This is a question of investing now or paying later in terms of increased dysfunction of women as well as their children and/or other family members. Research is also needed on all the above topics. Journal editors should require authors to report on the gender composition of study samples and to routinely test for gender differences. Good research should regularly incorporate variables in study designs to help explain mechanisms through which gender differences occur. To address possible bias, researchers should use larger samples of clients, representative of those using psychiatric rehabilitation and mental health services, including minority populations, lesbians, and all age groups. Finally, the role of sociocultural context in framing the supports and stresses experienced by women with SMI must begin to be explored. For example, it has been argued that African American women are more likely to give and receive help within extended family networks than are Whites.¹³⁸ Yet the ability of family networks to provide support to women with a mental illness has not been explored. Similarly, we do not know the extent to which cultural beliefs about the meaning of mental illness or acceptance of formal support systems may change women's perceived supports and stresses, enable or hinder the uses of community mental health or community support services. Thus, many important topics remain unexplored, hindering our ability to provide effective, gender-relevant services.

Individuals with a mental illness have traditionally been understood primarily in terms of the course of their illness. This narrow focus has meant that their goals, motivations, and life tasks will have been seen as subsumed by their mental illness. After a generation of discourse involving the psychosocial rehabilitation and community mental health movements, the restrictiveness of the previous focus is clear. Individuals with a mental illness occupy sociocultural niches that inform the social and subjective nature of their everyday experiences and the nature of their normative goals as well as color the ways in which mental illness is experienced and expressed.¹³⁹⁻¹⁴¹ An awareness of the significance of gendered roles and needs and its interaction with cultural context has been lacking, with consequent effects being particularly deleterious for women. As did Test and Berlin⁴ nearly two decades ago, we once again issue a call to correct this situation.

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10

Parents With Severe Mental Illness and Their Children

The Need for Human Services Integration

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Parents with severe and persistent mental illness have generally been neglected by mental health policymakers and providers. A national survey conducted in 1990 found that fewer than one third of states routinely collected information about the parenting status of women in their care.¹ Existing policies focused primarily on the medical management of pregnancy, abortion, or labor and delivery. No states reported policies providing for visitation between state hospital patients and their children. Similarly, few states reported programs specifically addressing the needs of this population.

The needs of mothers with mental illness were highlighted in 1981 by Test and Berlin. They noted a general lack of attention to gender-related issues, and they recommended a range of services essential to assist mentally ill women who are mothers in managing daily parenting demands and in coping with the stresses of caring for children.² This issue was again documented by Bachrach and Nadelson in 1988.³

NOTE: This chapter appeared as an article in the *Journal of Mental Health Administration*, 1994, Vol. 21, No. 4, pp. 388-396.