Women's Mental Health: Implications for Occupational Therapy

Rochelle Nahmias, Jeanette Froehlich

Key Word: mental health

This article describes issues of sexism in the mental health profession. Theoretical bias in psychiatry and the sociopolitical status of women are both linked to the inappropriate mental health treatment of women. A relational model of women's psychological development is offered as an alternative theoretical perspective for understanding the mental health needs of women. Ways to integrate this perspective in occupational therapy practice are included.

Rochelle Nahmias, MA, OTR/L, is Director of Psychiatric Rehabilitation, Baystate Medical Center, 759 Chestnut Street, Springfield, Massachusetts 01199.

Jeanette Froehlich, MS, OTR/L, is Assistant Professor, Department of Occupational Therapy, University of New England, Biddeford, Maine.

This article was accepted for publication July 13, 1992

A basic principle of occupational therapy is understanding the patient in the context of family, work, and community. This context can be broadened to include patients' cultural histories and the recognition that patients' lives enact a political and social role within a larger system. The circumstances, privileges, and consequences of this role affect the apparent presentation of illness. Because it is difficult to discuss diversity without considering gender, in this article we consider issues of gender in the mental health field and their implications for occupational therapy.

Occupational therapy literature describes the patient in many ways, including age, diagnosed condition, developmental level, and severity of illness. An effort to understand the cultural background of patients—Native Americans, Hispanics, blacks, lesbians and gay males, and regional ethnic populations—will provide the therapist with knowledge of the psychological challenges in their lives. Similarly, a knowledge of the patient's social, political, and economic position will offer the clinician an understanding of the community in which the patient interacts. Ultimately, this knowledge will be the foundation for the provision of occupational therapy mental health services.

Awareness of the patient's social and cultural contexts has been receiving increased attention in the field. Grady (1990) in her presidential address at the 1990 Conference of the American Occupational Therapy Association (AOTA), recommended that therapists consider sociocultural issues. Gibbs's (AOTA, 1990) description of his function as AOTA's Program Manager for Minority Affairs was "to promote a greater sensitivity and awareness of cultural diversity ... for both minority clients and therapists" (p. 10). Both the September 1990 Physical Disabilities Special Interest Section Newsletter (Post, 1990) and the August 1992 issue of the American Journal of Occupational Therapy (Evans, 1992) were devoted to the topic of cultural diversity.

Although increased interest in the cultural and social diversity of patients indicates that occupational therapists have made progress, gender differences are also important to examine. Social role within the family and community is affected by a person's gender. In this paper, we examine the psychological development of women who, like the minority patients Gibbs referred to, occupy a particular social position in society that affects their ability to function. Understanding the social roles and psychological development of women can inform the treatment considerations of the occupational therapist who practices in psychiatry.

Sexism

In 1970, a landmark study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (republished 1981) found pervasive gender-role stereotyping in psychiatric
treatment: Therapists had different diagnostic concepts of mental health for men and women. As they stated, “a double standard of health exists wherein ideal concepts of health for a mature adult, sex unspecified, are meant primarily for men, less so for women” (p. 87). Furthermore, these stereotypes in mental health paralleled the prevalent gender-role stereotypes in our society. For example, passivity was and may still be considered a normal characteristic in women, but not in men. The therapists in Broverman et al.’s study were more likely to suggest “that healthy women differ from healthy men by being more submissive; less independent; less adventurous; more easily influenced; less aggressive; less competitive; being more emotional, more conceited about their appearance; less objective; and disliking math and science” (p. 92).

It is clear from this study that therapists adjusted the norms of mental health when they diagnosed and treated women. They expected female patients to adapt to their social situation and did not see that a woman's social position might not have been conducive to her mental health (Miller, 1976). Bias in providing services was also revealed in other studies conducted in the 1970s and early 1980s. Russo and Sobel (1981) found that psychiatric hospital stays were much longer for women than for men. Brodsky and Holroyd (1981) found that depressed women were likely to remain in the hospital up to twice as long as depressed men. In regard to specific treatment, when men and women presented with the same symptoms, women were more likely to be treated with tranquilizers (Cooperstock, 1981). Fabrikant (1974) found that “females in therapy are victimized by a social structure and therapeutic philosophy that keeps them dependent for as long as possible” (p. 96).

Suggesting some improvement in therapists’ attitudes toward women, a replication of the Broverman et al. study 15 years later did not find the same gender bias (Phillips & Gilroy, 1985). However, as Walsh (1987) suggested, the type of instrument used in these studies might not have been able to detect subtle gender biases.

The developers of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association, 1980) attempted to eliminate bias based on both gender and race (Muller, 1990). However, Kaplan (1983) argued that male-based assumptions about healthy and crazy behavior are codified in DSM-III. She explored these assumptions specifically in relation to two diagnoses frequently given to women, Histrionic and Dependent Personality Disorder. Kaplan noted that behaviors exhibited by women with these diagnoses, such as being overemotional or subordinating one’s own needs to others, could be considered normal reactions to women’s socialization, yet are labeled personality disorders. As she pointed out, DSM-III scrutinizes the ways that women express dependency but does not scrutinize men in a similar way. Additionally, the behaviors that warrant these diagnoses are similar to behaviors that clinicians in the Broverman et al. study (1981) identified as normal female behavior. As Silver (1991a) stated, “women have to walk a thin line between being too feminine, that is histrionic, dependent—or not being feminine enough” (p. 254).

In 1987, despite the protests of feminists in the field of psychology and psychiatry, DSM-III-R was revised to include Self-defeating Personality Disorder and Late Luteal Phase Dysphoric Disorder (the psychiatric name for premenstrual syndrome) in its appendix. Feminist critics argue that both these diagnoses do more to blame women for their position in society and their hormonal makeup than to assist them (Walsh, 1987).

The preceding data suggest that discrepancies continue to exist in mental health treatment between men and women. Twenty years after the publication of her book Women and Madness, Chesler (1990) contended that

a “normal” woman is still supposed to be passive, dependent, emotional and not good at math or science; as such she commands little respect. However, a woman who is aggressive, independent, emotionless and good at physics commands as little respect and is also without a clean bill of mental health. (p. 315)

Some of this discrepancy in psychiatric treatment may be rooted in the inadequate understanding or interest in the psychological lives of women.

Sociocultural Perspective

As early as the 1930s, psychoanalysts like Horney and Thompson were exploring connections between women’s disadvantaged social, economic, and political status and their psychological difficulties. Their work opposed Freud’s theory that women’s biological and innate deficiencies contributed to their psychological difficulties (Howell, 1981). Later, Miller (1976) elaborated on the connection between women’s oppressed social status and their psychological difficulties. For example, a woman’s decreased ability to support her family financially is likely to negatively affect her self-esteem. Carmen, Russo, and Miller (1981) stated that acknowledgment of this connection obligates mental health professionals “to understand how the social context contributes to the origin and persistence of the problems of their patients” (p. 1319).

Self-in-Relation Theory

Theories of psychological development have been predominantly based on studies of male subjects (Gilligan, 1982). These were then generalized to include women but in many cases they do not accurately reflect women’s development. As was noted, understanding and diagnosing a woman with a male theoretical construct has often led mental health professionals to the conclusion that a particular woman is defective and deviant from the norm.
Theories specific to women’s psychological development cast the characteristics that are stereotypically linked with being female, like passivity and dependence, in a different light (Gilligan, 1982). Logically, they describe women’s psychological development more accurately than do theories based on male development.

One such theory, the self-in-relation theory, states that core elements of a women’s sense of self are organized around the centrality and continuity of relationships (Surrey, 1985). It suggests that a woman’s self-structure is organized around her sense of connection in relationships. The developmental task of separation from the mother in early childhood, as espoused by developmental theory, is not valued in self-in-relation theory. The primary experience of the self is relational. When evaluating her life, a woman looks at the quality of her important relationships rather than the degree of her independence (Surrey, 1985). Separation is differentially valued and encouraged in males and females. When disconnection is the presumed outcome of development, the male-identified characteristics of autonomy, independence, and self-reliance become an integral part of development. Our society places a high value on these characteristics, but they are not the inevitable outcome of female psychological development (Gilligan, 1982).

Central to most women’s self-esteem and identity is the quality of their relationships (Surrey, 1985). If the psychological development of males focuses on separation and autonomy, and the psychological development of females focuses on connection and emotional attachment, relationships between men and women can be fraught with tension and conflict. This often leads to the lament voiced by many women patients, “What is wrong with me?” If this gender difference in psychological development is not understood by the clinician, the female patient is likely to be negatively viewed as needy and dependent, a dynamic that is often repeated throughout her hospitalization. This patient is not likely to understand her behavior as a developmental position that can grow within the context of healthy and empowering relationships. Instead, she will absorb the notion that she is structurally deficient; the best she can do is adjust to her so-called pathology. The following case demonstrates this point.

A 40-year-old black woman, hospitalized after a suicide attempt, has had several hospitalizations for the physical sequelae of her abusive common-law husband. She is blind in one eye and has several disfiguring scars on her body. In the past she has left her husband, but has returned to him in the hope that she can help him change and because she is financially dependent on him. In therapy groups, she described her caring feelings for him but recognized that he abused his physical and financial power over her. She felt stuck in an unhealthy relationship. While fearing for her life, she simultaneously felt empathic toward her husband and felt a responsibility to help him reform.

In the traditional psychiatric paradigm, the staff would see this patient as being classically masochistic and hopeless. A victim of severe abuse, she would be blamed for having difficulty in choosing to leave her husband. If the staff used a relational model and acknowledged the socioeconomic stresses in this patient’s life, they could obtain a better understanding of this patient’s conflict about leaving her husband. Swift (1987) commented on this common situation of women living in violence:

If they act to save their physical selves by leaving to avoid being battered, they risk destroying their primary relationship and their economic security. If they act to preserve the primary relationship and their economic security, they put themselves at risk of physical destruction. Women in battering situations are forced to choose which parts of themselves they will save— their physical safety and well-being, or their economic safety and well-being. Is this surprising that many women find this a difficult choice to make? (p. 15)

If we accept the relational model of psychiatric development, we understand that to deviate from this developmental characteristic of placing a high value on connection is to threaten a sense of self. A contextual and developmental knowledge of women can guide appropriate clinical formulations and treatment interventions.

Implications for Occupational Therapy

How can occupational therapists integrate concepts from the self-in-relation theory to understand the difficulties some women have in the areas of vocation, self-maintenance, and leisure pursuits? What implications does this theory have for therapeutic use of self? Although the following suggestions focus on clinical practice in mental health, the theory’s concepts are appropriate for other occupational therapy areas of practice as well.

Therapeutic Use of Self

A number of occupational therapists have emphasized that the patient–therapist relationship is integral to practice (Gilfoyle, 1980; King, 1980; Peloquin, 1990; Yerxa, 1983). Caring is a central concept in these writings. As Stiver (1991a) suggested, using a relational context promotes caring, empathy, emotional expressiveness, and connection. As the therapists offer sensitivity to the particular mental health needs of women, communication can be enhanced.

The establishment of a therapeutic relationship can facilitate exploration of many life events, both hardships and successes. In his 1921 paper presented to the National Society for the Promotion of Occupational Therapy, Adolf Meyer suggested that occupational therapy provides opportunity for exploration and discussion; that it gives opportunities rather than prescriptions. Consistent with this idea, Gilligan (1982) suggested that women describe our lives to one another.

As patients describe themselves to occupational therapists, they may share traumatic events. The prevalence of physical and sexual abuse compels all therapists...
to learn about treatment strategies that respect the needs of the abuse victim and survivor while offering an opportunity to heal. Some occupational therapy literature is available on incest survivors and their treatment, including an issue of the American Journal of Occupational Therapy (Fike, 1990) devoted to multiple personality disorder, a disorder strongly linked to pervasive sexual abuse (see also Froehlich, in press). To be therapeutically effective, therapists may need to explore their own feelings about women and abuse issues.

In a therapeutic relationship, one interacts to introduce healthful options, choices, and alternatives rather than encourage dependence on the professional (Gilfoyle, 1980; Yerxa, 1980). To empower is far more useful than to imply by our actions that we have cures and remedies. Understanding the subordinate position most patients feel in relation to the staff is an important aspect of empowerment. Acknowledging this position is the first step in minimizing the effects of the inequality in the patient–staff relationship. We must keep a vigilant guard on the power inherent in the role of therapist.

Respect is essential in any therapeutic relationship. The terms we use when describing a patient's occupational history or behavior to colleagues can bias the listener. Critical, subjective, stereotypical characterizations of women such as manipulative, needy, hysterical, and masochistic are value laden. If colleagues use them, we can ask for clarification to get a more clinically accurate picture. We can actively guide staff and patients to make the necessary links between the realities of their lives and the feelings, behaviors, and symptoms exhibited. Taking such a stance promotes the patient–therapist relationship.

As Baum (1980) stated, "we are nothing more than a bystander in the life of [the patient] until a relationship is formed" (p. 514). Therapeutic use of self will affect all areas of intervention. Sensitivity to the particular health needs of women is interwoven in the following discussion of vocation, leisure, and self-maintenance.

Vocation

The work of women is complex and contributes to their psychological health. Occupational therapy theorists stated that "work is important to the individual as an arena for expressing interests and values and for developing self-esteem. Because work is valued by the culture, those who work experience a sense of personal worth through their contribution to the social group" (Barris, Kielskofner, & Watts, 1988, p. 19). If one assumes that women occupy a devalued and disadvantaged status in society, one can also assume that this "sense of personal worth" experienced through work is differentially available to women.

In 1990, women in the United States made up 45.3% of the labor force (Johnson & Daily, 1992). This figure does not account for the unpaid work that women pro- vide in the home as mothers, cooks, and housekeepers. Primeau (1992) addressed the psychological effect of this unpaid work on women and suggested implications for occupational therapy. We will instead briefly address women as wage workers and salaried employees.

Although the pay gap between men and women showed some improvement in the early 1980s, by 1988 women were once again earning 59 cents for every dollar men earn (Faludi, 1991). Despite a 5% increase in the number of women with professional jobs between 1972 and 1988, the vast majority of women entered low-paying service occupations during this time period (Faludi, 1991).

Although people derive a sense of value from many different aspects of work, it is important to acknowledge the effect of engaging in low-paying, low-status work on women. Issues of power, subordination, and stereotyping are deeply rooted in the workplace (Bergmann, 1985). In general, women are not encouraged to advance to more independent and powerful positions. As Stiver (1991b) indicated, work inhibitions in women include the risk of feeling unfeminine, self-serv­ing, and possibly destructive to their families. Women's characteristic strengths of relatedness and empathy are generally not valued outside of female-identified jobs.

In vocational groups for inpatients, we have seen many women struggle with the choice to remain on public assistance or to get a job that would provide limited financial gains or status. These women acknowledge that the social aspects or relationships at a job would be welcomed and helpful. They seem to have an innate awareness that working would be good for them. At the very least it would reverse their isolation. Financially they are likely to remain in poverty if they work, but something compels them to the workplace.

The data substantiate this drive to work. Gove and Geerken stated "that married men who work are in the best mental health, that married women who are unemployed are in the worst mental health, and that the mental health of employed housewives falls in between" (1977, p. 71). Work contributes to the mental health of women but often for different reasons than for men. A nationwide poll tracking social attitudes for 20 years indicated that the leading definition of masculinity for men, by a huge margin, is being a good provider for the family (Faludi, 1991). Although work may not be an avenue toward upward mobility or financial security for women, work can decrease personal isolation and foster an active position in the world.

Because work has unequal status and financial rewards for men and women, occupational therapists must acknowledge most women's difficulty in obtaining high status, high paying work. This is extremely validating for the female patient. A woman's decision to obtain work may have to be based solely on the desire to decrease isolation and therefore improve mental health. The finan-
cial stability and well-being of her family is unlikely to improve. When their thoughts are discussed and understood in this framework, women in our groups have been left with the decision to act on their own behalf while acknowledging the limited returns for the others with whom they are connected. Occupational therapists can support and clarify this decision-making process.

Teaching vocational skills has an important place in occupational therapy. But we must recognize that access to certain therapeutic aspects of vocation in our society is not equally distributed across gender, race, age, and socioeconomic status. In our experience, once an empathic position toward those in a disadvantaged position is conveyed, a psychoeducational discussion group that focuses on work issues becomes more meaningful and vocational skill building becomes more effective. Overt expression of cultural realities sheds a barrier that otherwise might limit communication and collaboration between patient and therapist in achieving treatment goals. Patients stop blaming themselves for lacking skills and become more energized to change their current situation.

Leisure

To evaluate the quality and effectiveness of patients' leisure skills, therapists often ask them to describe avocational interests. The links between physical fitness, relaxation, and improved mental health are widely known. As health professionals, occupational therapists can provide health education and offer healthy life-style alternatives. The manner in which this education is approached is critical to its therapeutic value. Empowering women to choose a healthy life-style that includes leisure pursuits is far different from dictating that one must have hobbies to be mentally healthy.

Most women who require psychiatric hospitalization are concerned with survival, their own and their family's. Therefore, the importance of a discharge plan that includes leisure activities may not be immediately acknowledged by the patient. For example, a single parent experiencing a sense of isolation may feel that a suggestion to attend a group at the community center is merely a superficial response to her loneliness. Offering leisure alternatives while maintaining an empathic connection to the patient's current emotional state may be a more helpful approach. In this way the therapist does not minimize the patient's sense of isolation in the service of providing long-term treatment options.

Women have a finely tuned awareness for the needs of others (Surrey, 1985). Many women feel that they can only relax after everyone else's needs are taken care of. Therefore, leisure activities are unlikely to be a priority unless the activities serve the needs of others as well. Helping women to understand how their psychological and social development contributes to their disregard for their own need for relaxation can be helpful.

An important aspect of inpatient hospitalization is the exploration and practice of social and leisure activities. Clearing a psychological space and giving permission for this type of experience can powerfully demonstrate the importance of leisure and relaxation. At this juncture, naming available community resources takes on more meaning. To prepare the patient for discharge, occupational therapists must make a conscious effort to become familiar with culturally diverse leisure options as well as agencies that offer activities on a sliding fee scale for those with limited financial resources.

Self-Maintenance

Self-maintenance refers to "those activities or tasks which are done routinely to maintain the person's health and well-being in the environment" (Reed & Sanderson, 1983, p. 252). In mental health practice, self-maintenance goes beyond the more concrete activities of daily living to encompass the ability to maintain emotional well-being through various coping skills such as stress-management techniques, assertiveness, and time management. Because women have been socialized to care for others, the self-maintenance role may cause internal conflict. In many cultures, women's ability for connectedness, to be in relation with others, becomes socialized in the role of caretaker. Most women find it easier to act on someone else's behalf (as with their children) than on their own behalf. A woman's self-identity or even the self-esteem derived from caring for others may feel threatened when coping strategies are introduced. She may feel conflicted over any action to care for herself.

Occupational therapists can offer coping mechanisms while simultaneously acknowledging the inherent conflict or obstacles to effective self-maintenance. When psychiatric rehabilitation is based on the women's psychological developmental framework, the patient is understood contextually. When the therapist communicates this understanding, patients are likely to engage in meaningful discussions around the psychological consequences they fear, such as feeling guilty or selfish when they begin to care for themselves. Again, a knowledgeable and empathic view of the internal conflicts women face may increase the therapist's effectiveness when empowering women to integrate the self into the network of care receivers.

Frequently when a woman's life appears out of control, the well-intentioned remedy offered is assertiveness training. However, sometimes it is an unassertive style that keeps women alive in unhealthy relationships with abusive husbands. Without an awareness of this dynamic, the therapist may offer an assertiveness group that is a superficial solution to a woman's subordinate position in her community. Women must be made aware of the bigger picture and be given permission to move out of a
constricted and often silent role. If assertiveness training is not approached with a thorough understanding of women’s psychological development and sociopolitical realities, it is as effective as giving a dollar to a homeless person.

An assertive posture, although important, is a small piece of what needs to be remedied for most women. A woman must first find her own voice and be able to describe her experience before she can assert herself with others. Some women may need to discover and then discuss their intrapsychic conflicts before they can adopt a more assertive style. Another consideration in recommending assertiveness training is not to trivialize women’s history with passivity and dependency. Linking passive and dependent behavior with being female is rooted in the theoretical biases of psychiatry and not an inherent deficiency in women.

Summary

In the past two decades, mental health professionals have been active in reversing issues of sexism in clinical practice. Occupational therapy, however, has been slow to integrate the psychological development theories for women. Gender-related issues are virtually absent in the occupational therapy literature. Therapeutic programs for women, both alternative and within traditional health institutions, are now visible in the community, as are mental health institutions. Mental health professionals in particular have an obligation to understand the developmental and social context of the women they treat. Occupational therapy’s domain of concern – work, leisure, and self-maintenance skills – is compatible with the needs of women, as is our emphasis on collaboration and caring in the patient-therapist relationship. However, our knowledge base requires integration of theories on women’s development. An increase in our awareness of women’s psychological development and gender bias in psychiatry will contribute to our being more effective providers of treatment and advocates for women patients.

References


Coming in February:

- Contingent interaction for mothers with multiple sclerosis and their daughters
- A board game as a treatment activity
- OT in psychiatric rehabilitation
- Enhancing the research image of OT

Turn to AJOT for the latest information on occupational therapy treatment modalities, aids and equipment, legal and social issues, education, and research.