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

Volume One of Two

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Submitted for the degree of Doctor of Philosophy

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Abstract

British psychiatry is dominated by a biological model of mental illness. To date, there has been considerable research which has focused on the validity of the biological of mental illness. There has been a dearth of research which has aimed to investigate the social impact of the biological model by reference to mental health service users' perspectives. Indeed, overall there has been little research that has aimed to evaluate mental health service provision by means of an analysis of service users' views. In the research that has been carried out previously, the specific issues affecting women service users have often been overlooked. This thesis contends that women service users' experiences must be taken into account in order to effectively analyse the operation of the mental health system. The research is based on interviews with women mental health service users and ex-users. These interviews suggest that many women are dissatisfied with mental health service provision. A recurrent criticism made by the interviewees was that they felt objectified by medical professionals who did not allow them to become involved in decisions relating to their treatment. In some cases the women described how oppressive experiences that were significant in causing their mental health problems were repeated within statutory service provision. The majority of participants criticised the policy of 'care in the community' for failing to address their needs; they opposed the programme of psychiatric hospital closure despite expressing reservations about hospital treatment. In this thesis it is argued that women's dissatisfaction with statutory mental health service provision often stems from the inherently conservative nature of psychiatry. The biological model serves to disempower service users, whilst providing a secure power base for psychiatrists. It also serves to divert attention from oppressive social processes and plays a role in maintaining the social status quo.

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Introduction

An investigation of community care provision for women mental health service users formed the initial focus of this research. The declared aim of the ‘care in the community’ policy was to redirect expenditure on mental health services to community based ‘needs-led’ services that would enable service users to remain within their own homes or in a ‘homely’ environment within the community (HMSO 1989). In line with this policy a programme of psychiatric hospital closure has been implemented. However, in the development of community care provision, the particular needs of women have often been ignored. The ‘All Wales Strategy for Mental Illness Services’ (Welsh Office 1989) and the ‘Welsh Office Agenda for Action in Housing’ (Welsh Office 1991a) for example, made no particular mention of women, despite the fact that government statistics at the time indicated a higher incidence of diagnosed mental health problems among women (Welsh Office 1991b). Some commentators have suggested that women service users’ may have a particular need for a residential place of safety in order for their mental health to improve (Williams, Watson, Smith, Copperman and Wood 1993, Ussher 1991). Consequently, I initially set out to examine women service users’ views on the type of mental health services that they found most effective, and I was particularly interested in whether women service users perceived a need for a residential mental health service.

As the study progressed, however, it became apparent that a fundamental issue underlying the organisation and provision of mental health services for women relates to the model of mental health and illness that is utilised within psychiatry. The biological model is the dominant approach within psychiatry, and has a considerable impact upon the organisation of statutory mental health services in Britain. The

biological model also has a significant effect upon the type of treatment that statutory services offer women who are perceived to have a mental health problem. In order to adequately investigate statutory mental health service provision for women, the biological model of mental illness must comprise a central consideration. To date, there has been a plethora of research concerning the validity of the biological model of mental illness. However, there has been very little research which has examined the effects of the biological model by reference to the perspectives of service users themselves. In this research I evaluate statutory mental health service provision for women, by means of an analysis of the effects of the biological model of mental illness on women service users' experiences.

The acknowledgement of issues relating to the experiences of fear, sadness and unintelligibility are common to most human societies (Rogers and Pilgrim 1996). Historically, however, there has been no universal cross-cultural agreement as to how these conditions should be analysed and understood. In contemporary Britain there are a variety of terms that are commonly used to describe these conditions, such as 'madness'; 'mental illness'; 'mental health problem'; 'mental distress'; 'mental disorder' and 'emotional distress'. The semantic variety in the discourse relating to issues of mental health and illness are often related to different approaches amongst stakeholder groups in the conceptualisation and treatment of mental health problems (Rogers and Pilgrim 1996). The term 'mental illness' forms part of the medical discourse found in the statutory mental health system in Britain. The term 'mental health problem' forms part of the discourse of many mental health service user groups (such as MIND for example) who question the dominant approach used within psychiatric practice.

In this research I generally use the term 'mental health problem' to discuss the range of psychological problems experienced by the mental health service users who participated in my research. However, I use the term 'mental illness' when I am discussing the biomedical approach utilised within mainstream psychiatry. I occasionally use the term 'madness' when discussing particular theorists who conceptualise psychological problems using this term (Foucault 1967 for example).

In this research I use the term 'statutory mental health system' to refer to the range of mental health services which are funded by central government. Statutory mental health services are predominantly provided by GPs; psychiatrists; psychologists; social workers; psychiatric nurses; and occupational therapists. Outside the statutory mental health system, services are also provided by voluntary sector organisations, such as mental health service user groups (for example the Manic Depression Fellowship; the National Schizophrenia Fellowship; and MIND); and housing organisations offering limited practical and emotional support. In this research I use the term 'mental health service user' to refer to a person who has received medical treatment and/or social care and support through a mental health agency, in either the statutory or voluntary sector. This service use may have been sought by them voluntarily, or may have been imposed upon them by an application of a section of the Mental Health Act 1983 (HMSO 1983).

Chapter One - Literature Review:

Psychiatry, Community Care and Women Mental Health

Service Users

Introduction

In this chapter I review the literature which provides the background to my research. I begin with a consideration of the biological model of mental illness, as this is the dominant approach utilised in British psychiatry (section 1.1). In the following section, I discuss the definition of mental illness and consider the process of defining and diagnosing mental illness that is used within psychiatry (section 1.2). In section 1.3 I discuss previous research which has indicated some of the effects of the biological model on service users. One outcome of the dominance of the biological model is that mental health service users are usually prescribed physical treatments (such as medication and electro-convulsive therapy) in an attempt to cure or control the illness with which they have been diagnosed (section 1.4). In this chapter I also consider the stigma surrounding mental health service use (section 1.5) and examine the development of the policy of care in the community (section 1.6). There is considerable evidence that this policy has not been informed by the perspectives of service users, and in particular, the specific needs of women service users have often been ignored. In the final sections of the chapter I consider research which suggests that mainstream psychiatry itself contributes to the disempowerment of women mental health service users (see sections 1.7, 1.8).

1.1 The biological model of mental illness

In the eighteenth and nineteenth centuries, a process began in which a list of deviant behaviour which had previously been described as heresy, sin, witchcraft and possession by demons, were renamed and reclassified as mental illnesses (Szasz 1971, Foucault 1967). This led to the creation of the medical specialism of psychiatry which aims to diagnose, treat and cure individuals thought to be suffering with a mental illness.

Within modern psychiatry there are a range of different approaches in understanding and treating people who are perceived to have a mental illness. These approaches can be divided broadly into three major schools of thought as to the aetiology and treatment of mental illness - the biological model, the psychodynamic model and the behavioural model. This is a simple differentiation as there are differences within these schools of thought and there are also other, less popular approaches which psychiatrists and other mental health professionals may utilise. In this section I discuss the biological model of mental illness, as this approach has a fundamental significance for the way that psychiatric services are organised and delivered within Britain.

Proponents of the biological model of mental illness argue that a whole range of emotional states and forms of behaviour (for example those that are often diagnosed as depression, anorexia, bulimia, alcoholism, schizophrenia and manic depression) are indicative of a biological abnormality or disease, usually (though not necessarily) located within the brain (Kramer 1993, Guze 1989, Trimble 1988, Andreasen 1984, Kety 1978). Many proponents of the biological model have asserted that social factors play a role in the aetiology of mental illness, to the extent that they provide a 'trigger' for mental illnesses to develop in individuals who

already have the biological prerequisites for the disease (see for example Kramer 1993, Kety 1978, Lader 1975, Mendels 1973, Rosenthal 1971). In particular it has been argued that there is a genetic 'predisposition' to mental illness. This 'predisposition', in the form of (as yet unidentified) genes, means that an individual does not develop the illness for many years, until stress factors in the environment provoke it to develop. It is contended that social factors will not lead an individual to develop mental illness unless they have in their genetic makeup a specific inherited gene which is key in producing the illness. For example Kety (1978) has asserted:

“None of these [biological] studies exclude the importance of environmental factors. In fact, we believe that what is genetically transmitted is simply a vulnerability to the disorder and that everyone who has the genetic vulnerability does not necessarily develop the illness unless certain crucial environmental factors operate. What these environmental factors are, we don't know.” (Kety 1978:9)

Despite referring to the importance of social factors in the genesis of mental illness, Kety (like other proponents of the biological model who refer to environmental 'trigger' factors, such as Kramer 1993, Lader 1975, Mendels 1973, Rosenthal 1971), devotes his attention to studying the hypothesised biological causes of mental illness. In all of these accounts social factors receive only cursory attention (if they receive any attention at all) and biological factors are presumed to have analytic primacy in the development of mental illness.

There is some evidence to suggest that the majority of British psychiatrists espouse a form of eclecticism, in which biological, social and psychological factors are acknowledged to play a role in the development of mental illnesses (see for example Griffiths 1996, Samson 1995). This has been termed the 'biopsychosocial

model'¹ (Rogers and Pilgrim 1996). It has been asserted, however, that this claim to eclecticism is misleading as psychiatrists working within British medicine² usually focus primarily upon the biological factors associated with mental illness. Samson (1995) studied the approaches of forty psychiatrists working within British medicine as well as examining the published writings of contemporary British psychiatrists. He concluded that social and psychological factors were not seen by psychiatrists as significant in the aetiology of mental illness, rather “social and psychological ‘factors’ simply gave the disease its individual stamp” (Samson 1995:250). Thus they could be seen to have some influence upon presenting symptoms (for example, in terms of the content of delusions) but were not themselves seen as primarily responsible for producing mental illnesses. Samson concludes that:

“...British psychiatry has not made any serious excursions into non-biomedical approaches...British psychiatry has been predominantly biological in its aetiological theories, medical in its professional organisation and political allegiances, and yet ‘eclectic’ in its self perception. That is, while biological medicine has provided its main source of knowledge for theory and practice, members of the profession have represented their enterprise as one engaging in wider domains within the social sciences. Although social theories of mental ill-health have been forwarded, these have been present only on the margins of the profession.” (Samson 1995:247-248)

One reason why psychiatrists may espouse an eclectic approach whilst retaining a primary focus on biology is that, currently, the scientific study of

¹ Because there is evidence to suggest that an eclectic approach has been used only on the margins, I have rejected the term ‘biopsychosocial’ in this research, in favour of the term ‘biological’ to describe the approach used in mainstream psychiatry. This is also the term used by Busfield (1996).

² The history of British psychiatry contrasts to some extent with that of psychiatry in the USA. Although biological explanations have become increasingly popular within the USA, historically American psychiatry has been significantly influenced by the development of psychodynamic ideas (Andreasen 1984).

genetics is a central preoccupation within medicine. Genes are hypothesised to play a role in the development of a myriad of biological, social and psychological phenomena (Sayce 2000). However, the hypothesis that genes have some effect on psychosocial phenomena can lead to an exclusive concern with identifying these genes, whilst neglecting the non-biological factors involved.

“Geneticist Gottesman admits that, in the current climate, a whisper of genetic influence tends to be turned into a shout of total genetic control.” (Sayce 2000:93)

A further reason may be that a claim to eclecticism serves to bolster the prestige associated with the practice of psychiatry (Griffiths 1996, Samson 1995). In his research, Samson found that many psychiatrists identified themselves as being intellectually superior to other mental health professionals (such as nurses, psychologist and social workers) because their medical training had enabled them to become experts in understanding and treating problems relating to the mind as well as the body.

“Psychiatrists claim they are absolutely vital to the mental health team because they have professional expertise over both body and mind. The psychiatrist is represented as a holistic healer, capable of transcending the philosophy of mind/body dualism which biomedicine is so often depicted as basing itself upon...However, this has been accomplished at the theoretical level primarily by materialising the mind as biological matter...Although the initial impetus may be thought to be socially derived - bereavement for example - this is held to trigger a physiological response which drives the illness. Therefore, lacking specialised training in neurology, physiology, pharmacology and anatomy, the psychologist, nurse, or social worker are considered less effective than the psychiatrist.” (Samson 1995:252)

There are various philosophical problems associated with a Cartesian position of mind/body dualism (Dilman 1988, Malcolm 1972). These are often solved within the theory and practice of mainstream psychiatry by conceptualising the mind (and its emotions, thoughts and behaviour) as determined by the organic

functioning of the material elements in the brain. This causal relationship is often conceived as operating in one direction only, so that psychosocial factors are often not acknowledged as causing physiological changes in the biochemical operations of the brain (Coleman 1998).

In a paper entitled 'Biological psychiatry: is there any other kind?' (1989), Guze (a professor of psychiatry), has argued that despite a lack of scientific knowledge about the organic structure of the brain and how it affects the development of mental illness, psychiatry should still concern itself exclusively with a biological approach to the study and treatment of mental health illness.

"...There is no such thing as a psychiatry that is too biological. I say this even though I believe that we still know all too little about the physiology of the brain in most psychiatric conditions." (Guze 1989:315 emphasis in original).

Guze argues that psychiatry is a science on a par with the natural sciences. In order to be properly scientific, he argues that psychiatry should utilise the same focus as that found in natural sciences such as biology.

"I believe that continuing debate about the biological basis of psychiatry is derived much more from philosophical, ideological and political concerns than from scientific ones. Modern biology...focuses appropriately on the fundamental elements of all forms of life: evolution, development, structure, and function. Modern psychiatry is inescapably biological because it shares this focus as applied to the psychopathology." (Guze 1989:322)

It could be argued, however, that all scientific research is inevitably affected by philosophical, ideological and political issues, psychiatry included (see section 2.1). Indeed, the debate about what causes mental illness is not simply a debate about which methods are most useful in the study of human behaviour and emotions. At the heart of the dispute lie radically different philosophies of human action and emotion, all of which have significant political implications. The nature of the

human mind, the effects of the mind upon behaviour, the interaction of the mind and body, and the relationship between the mind and the brain are all philosophical questions, the answers to which form the basic conceptual frameworks of the various schools in psychology (the study of 'normal' as well as 'abnormal' behaviour). These schools in psychology in turn inform the various schools of thought within psychiatry.

The biological model of mental illness derives its major support from diseases such as syphilis which can produce a disorder in thinking and behaviour. In 1952 tranquillising drugs were first introduced into psychiatry as method for treating psychiatric patients. A new discipline was created called psychopharmacology - the study of drugs useful in the treatment of mental illnesses and their application in clinical practice. The effects of these drugs in altering the emotion and behaviour of patients lent support to the idea that psychiatric disorders are medical diseases which are amenable to treatment and cure by specific drugs (Samson 1995, Szasz 1971).

Some proponents of the biological model have argued that the success of psychiatric medication in treating mental illness itself provides proof of the biological cause of mental illness (see for example Kramer 1993). This argument is somewhat inadequate however, as the fact that medication may improve an individual's condition does not mean that the condition itself was physiologically rather than psychosocially caused. For example a person might experience shock at the news of a bereavement, and a minor tranquilliser may help in ameliorating this shock, but nevertheless the shock has been caused by the bad news, not by a brain disorder (Pilgrim and Rogers 1994). That there is a biological dimension to conditions of psychological distress is clearly indicated by the fact that tranquillisers and antidepressants can work to ease painful feelings such as anxiety and depression (Busfield 1996, Breggin and Breggin 1994). Nevertheless it is unwarranted to infer

from this that biological factors take analytic primacy in the causality of all mental health problems, because, as in the example indicated above, the biological processes connected with feelings of distress can themselves be prompted by psychosocial experiences.

The primacy allocated physiology in the biological model tends to overlook the importance of social factors in the construction of diagnostic categories, and in the causation of many conditions perceived as evidence of mental illness (Busfield 1996). Of course there are behavioural and emotional states in which physiology is indisputably the most important factor, such as in the case of traumatic brain injury, or identifiable viral infections of the body which can have a deleterious effect upon brain functioning. It is also possible that further scientific research may uncover specific biological mechanisms that are significant in the aetiology of a range of mental health problems. However there is already considerable research evidence to suggest that social experiences may themselves be key in causing the psychological conditions which are diagnosed and treated as mental illnesses (see for example Nazroo, Edwards and Brown 1998, Ashurst and Hall 1994, Breggin and Breggin 1994, Herman 1992, Barnes and Maple 1992, Beliappa 1991, Corob 1987, Cochrane 1984, Brown and Harris 1978, Miller 1978 - see also section 1.7).

A further important issue is that discriminatory labelling within psychiatry can lead to individuals being diagnosed with a serious mental illness for engaging in behaviour which challenges the dominant political ideology³ (see for example

³ I use the term 'ideology' to denote an interlocking set of ideas - a cultural, communication and representational system that forms the distinctive perspective of a social group. I employ the Althusserian notion that the dominant ideology tends to operate in the interests of the dominant class and against the interests of oppressed groups. It presents a distorted picture of the relations of domination, misrepresenting the real relations of power (Althusser 1971 -see section 2.3 for a further discussion of this).

Burstow 1992, Torkington 1991, Littlewood and Lipsedge 1989, Burstow and Weitz 1988, Diamant 1987, Hill 1983). During the slavetrade a psychiatric category was utilised which was known as 'drapetomania' (Torkington 1991). This was meant to refer to the 'irrational' desire of slaves to escape from servitude to their masters. It disappeared as a diagnostic category on the abolition of the slave trade.

Homosexuality was defined as a mental illness until the 1970's when under pressure from gay rights activists it was removed from the official diagnostic frameworks (Diamant 1987). The pathologising of homosexuality has continued however, as there has remained an official category of psychiatric disorder which concerns homosexuals who are unhappy with their sexual orientation (American Psychiatric Association 1994). Treatment for them involves therapy to encourage them to become heterosexual rather than addressing the stigmatisation and oppression of homosexuals within society (Diamant 1987).

Because of the role of political factors in the construction and application of diagnostic categories, Szasz (1983) has argued for the abolition of psychiatry, maintaining that it is a 'pseudoscience' which cannot pretend to produce objective knowledge. Szasz has been rightly criticised, however, for ignoring the fact that questions of politics and ideology play a role on other branches of medical science (Bentall and Pilgrim 1993) and within the scientific enterprise as a whole (I discuss this issue in detail in section 2.1).

Because of the dominance of the biological model within psychiatry, the vast majority of research which aims to investigate the development of mental illness exclusively focuses on the search for the physiological factors which are presumed to be key in causing it. In addition, social science research which has indicated a link between social experience and mental illness is often overlooked within mainstream

psychiatry (such as that produced by Nazroo, Edwards and Brown 1998, Ashurst and Hall 1994, Breggin and Breggin 1994, Herman 1992, Barnes and Maple 1992, Beliappa 1991, Corob 1987, Cochrane 1984, Brown and Harris 1978). Critics of the biological model have argued that the reason why research in the biological model has been unsuccessful, is because the concept of mental illness used in the dominant model is fundamentally flawed, as it ignores issues relating to the social construction of mental illness (see for example Bentall, Jackson and Pilgrim 1988a, 1988b, Szasz 1976). It has been suggested that the study of the aetiology of mental illness should proceed using alternative hypotheses, which take into account the role of social, psychological and environmental factors (Ciompi 1984). However, despite the dearth of research evidence which supports its claims, the biological model remains the dominant approach taught to psychiatrists in medical school and is the most widely used model amongst practising psychiatrists. Indeed, many influential psychiatrists present their view that mental illnesses are primarily biologically induced, as an undisputed fact (Bentall, Jackson and Pilgrim 1988a, 1988b).

Despite its dominance within psychiatry, the biological model has come in for a considerable amount of criticism in the last thirty years (see for example Coleman 1998, Burstow 1992, Boyle 1990, Szasz 1987, 1971, Penfold and Walker 1984, Hill 1983, Chesler 1972, Laing and Esterson 1969, Laing 1967, 1960). During the 1960's it came under considerable attack from radical psychiatrists such as RD Laing (1967, 1960) and Thomas Szasz (1987, 1971) in a movement which became known as 'antipsychiatry'. Their fundamental objection to psychiatry was that it overlooked questions of politics and morality in relation to emotions and behaviour. In their analysis psychiatry forms another aspect of state social control, in that in many instances it labels nonconformity as an illness which then becomes liable to enforced psychiatric treatment. According to Laing, a condition like schizophrenia

should be renamed a 'problem in living' as it stems from social factors and has no proven organic basis (1967,1960).

Indeed, to date there has never been a proven physiological explanation for the development of mental illness⁴ and a gene which is supposed to cause it has not been identified (Sayce 2000, Pilgrim and Rogers 1994). It has not been possible therefore to examine whether people with or without the gene do or do not go on to produce the mental illness which the gene signifies or what factors including environmental ones are responsible for 'triggering' it. Of course, because there has been no substantive evidence produced for a biological cause for conditions diagnosed as mental illnesses, it does not follow logically that there cannot be a biological component involved (Bentall, Jackson and Pilgrim 1988a, 1988b). The success of psychotropic medication in ameliorating feelings of distress clearly indicates that there are biological mechanisms at work. Thus it would be unwise to assume a polar position and completely reject the role of biological factors in the aetiology and development of mental health problems. It could be argued that what is needed is a position in which the role of biological, psychological and social factors are acknowledged as interacting in a dynamic way to produce the conditions commonly diagnosed as mental illnesses (Sayce 2000, Busfield 1996). The role of issues of power and inequality in contributing to the experience of mental distress and in the construction of diagnostic categories are also factors which warrant examination (see section 1.2). This is the approach recommended by Sayce, when she says:

⁴ Whilst organic brain damage has been identified in post-mortem examinations of people diagnosed with schizophrenia, there is some dispute as to whether these changes were induced by the condition itself, or whether they were caused by long-term treatment with psychotropic medication amongst the sample groups (Pilgrim and Rogers 1994).

“Mental health problems...are biological, in the sense that every thought and feeling is a physiological event, but they need to be understood through a lens that scans a person’s interactions with his or her whole environment - and which is prepared to make ethical judgements, to spur action to tackle poverty, gender discrimination and other patterns of inequality that impact on people’s mental health. “ (Sayce 2000:91).

1.2 The definition of mental illness and the process of psychiatric diagnosis

Joan Busfield, in her book ‘Men, Women and Madness’ (1996), defines mental illness as “a shifting, changing category which classifies certain social problems as problems of mind, a process that involves attributes of irrationality and unreason” (1996:119). This definition means that a person comes to be defined as having a mental illness via a social process in which their feelings or behaviour are defined by themselves and/or others as being problematic, and this problem is located as being associated with the mind. Busfield’s definition is a useful one as it emphasises that the conception of mental illness is one which is itself socially constructed and therefore contingent.

When psychiatrists set about diagnosing people believed to be suffering with a mental illness they are concerned to isolate and identify the symptoms of the illness in to make an accurate diagnosis and prescribe medical treatment. The process of doing this is what enables psychiatrists to call themselves scientists, as within a positivistic methodology scientists are properly supposed to be ‘neutral disinterested observers’; classifying and cataloguing objective facts. Within psychiatry it is claimed that the diagnoses used are scientifically objective and thus independent of political bias. To acknowledge that political factors and value judgements may play a role in the development and application of categories of mental illness could tend to undermine psychiatry’s claim to scientific status and

thus involve a substantial loss of prestige to the discipline. The particular power relations which occur within the construction of diagnostic categories and within the application of these diagnoses to service users are therefore often not acknowledged, as to do so would mean acknowledging that a 'bias' had intruded into the consulting room which had rendered the process 'unscientific'.

However, psychiatric categories have not remained constant over time and sometimes reflect the dominant ideology concerning norms of behaviour. The diagnosis of slaves with 'drapetomania' in the era of the slavetrade, and the diagnosis of homosexuals as mentally ill, both reflect the dominant political ideology in wider society (see section 1.1). Freud's development of the diagnostic category of hysteria (see section 2.1 for a discussion of this) also indicates how social and political factors affect the construction of diagnostic categories.

The Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association 1994) presents a diagnostic framework which is widely used within British psychiatry (Prior 1999). It has undergone four revisions since 1952 when it was first introduced. Each revision has taken into account not only scientific developments, but also changes in social attitudes (hence the removal of homosexuality as an illness per se) (Prior 1999).

The DSM contains a wide variety of behaviours and emotional states which, it is contended, are indicative of particular mental illness. It is also contended that these disorders are 'objective' in character; having an identifiable existence independent of the political beliefs on the part of the psychiatrists who invent the categories or the psychiatrist who apply them to their patients. The DSM states that the aetiology of most mental health problems is unknown, although it does discuss some of the organic and biological factors which are presumed to cause them. The emotions and behaviours it contains are presented without reference to the social

context in which they originate, and are described as symptomatic of an identifiable disorder. In defining mental health problems, the DSM states that:

“...each of the mental disorders is conceptualised as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.” (American Psychiatric Association 1994:xxi-xxii)

The DSM provides some scope for individual psychiatrists to impose upon their patients their value system in terms of whether or not they think a particular response is one a rational person would have made, or whether it can rightly be seen to be indicative of a mental illness. The DSM warns in its introduction that if a particular emotional response is what it terms an “expectable” (1994:xxi) reaction to a given event (such as a bereavement) then it should not be interpreted as evidence of a mental illness. However the DSM does not discuss what it regards as “expectable” reactions to any particular life events. For example, although it specifically mentions bereavement it does not state how long the grieving process is supposed to last, or how it should be carried out, in order to classify as an “expectable” response. Of course this begs the question of who is doing the ‘expecting’. Psychiatrists are dominant in the structure of the mental health services in both Britain and the United States and have the most power to diagnose and treat service users. Thus their expectations are accorded the most power in how a particular persons feelings are understood. What psychiatrists believe is a rational response to any given event is inevitably informed by their social background, political perspective and of course their medical training. However psychiatrists are

drawn from an elite group within society - predominantly male and middle class (Samson 1995, Burstow 1992). Historically, as medicine has been professionalised women have been systematically removed from positions of power as healers and placed in a subordinate role in the medical hierarchy (Penfold and Walker 1984, Ehrenreich and English 1978). Many psychiatrists have argued that their training counters the bias presented by their personal backgrounds as it is a scientific training which is essentially apolitical and value neutral (Samson 1995). It could be argued, however, that science in general, and psychiatry in particular, is not and cannot be a politically neutral enterprise (see section 2.1 for a detailed discussion of this).

Torkington in her book 'Black Health: A Political Issue' (1991) describes a variety of cases in which psychiatrists have diagnosed black patients as mentally ill because of religious beliefs and/or cultural practices which did not conform to the dominant ideology in Britain. She cites one instance in which an Afro Caribbean man who refused to have his hair cut and who talked about going to Africa to fulfil his destiny with God was diagnosed as psychotic and held on section because his claims indicated that he was evidently 'out of touch with reality'. He was a Rastafarian, however, and his beliefs formed part of his religion. The DSM does state in its introduction that particular behaviour should not be regarded as symptomatic of a mental illness if it is a "culturally sanctioned response" (1994:xxii). However this comprises only one sentence in the introduction, and issues of politics or religion are not discussed any further. Indeed, the DSM persistently ignores political issues within inter-personal relationships and within broader society.

According to several commentators the labelling of oppressed groups by the elite characterises psychiatry as an institution of social control, in which behaviour which does not conform to the dominant ideology may be characterised as a mental

illness (Burstow 1992, Penfold and Walker 1984, Hill 1983). Burstow (1992), for example, says:

“The pathologization of deviance or of different life-styles is blatantly evident in DSM disorders...IT IS OUT OF THIS DIFFERENCE BETWEEN WHAT THE ELITE GROUP CALLED “PSYCHIATRISTS” EXPECT AND WHAT OTHERS DO THAT PSYCHOPATHOLOGY EMERGES”. (Burstow 1992:29 emphasis in original)

Women are caught in a particular double bind as they may be labelled as ill for not conforming to the dominant ideology of femininity; but they also may be labelled as ill precisely because they do conform. There is some evidence to suggest that the qualities associated with femininity are sometimes perceived as evidence of a disorder (I discuss this double bind in detail in section 1.7).

Discriminatory labelling has very serious implications for service users as the power relations inherent in service provision for those diagnosed with a mental illness differ considerably from that in services provided for individuals diagnosed as with physical illnesses. Because people labelled with a mental illness are regarded as inherently less capable of making rational decisions than those not similarly labelled, mechanisms exist to force them to accept the treatment which is deemed necessary by a psychiatrist. In general medicine if a doctor administers treatment to a patient against their will even if he believes it to be in the patients ‘best interests’ he will be liable to a charge of assault. This is still the case where a patient who refuses treatment is in danger of losing their life. However, a person who is classified as suffering from a mental illness can be detained in hospital under a section of the Mental Health Act 1983 (HMSO 1983) and kept there until they are deemed to be fit for release by a psychiatrist (Barnes, Bowl and Fisher 1990).

Compulsory admission to hospital (‘sectioning’) and enforced treatment is regarded as necessary in cases where someone is thought to be severely disturbed

and posing a danger to themselves or other people. Most patients in British psychiatric hospitals are voluntary patients who have the right to refuse treatment and can leave when they decide to. However many people become voluntary patients because they are told that unless they do so, they will be compulsorily detained under a section of the Mental Health Act 1983 (Community Care 1994). Furthermore under the provisions of the Mental Health Act 1983 a patient who has entered hospital on a voluntary basis may be compulsorily detained and forcibly treated under 'section', if this is deemed appropriate by medical personnel. For the 'sectioned' patient the power of medical personnel is almost absolute. The Mental Health Act Commission is the watchdog set up to safeguard the rights of patients detained under the Mental Health Act. However it is perceived by many to be inadequate in balancing the special powers of treatment and detention that apply to those who are regarded as suffering from 'mental disorder' under the Mental Health Act (Barnes, Bowl and Fisher 1990). Patients who are compulsorily committed must seek permission from hospital staff to leave hospital premises, they can be locked into their wards and can have medical treatment such as psychotropic medication and electro-convulsive therapy forced upon them (Pilgrim and Rogers 1994). This medical treatment can have serious irreversible side effects on the patient to whom they are administered. In some cases it proves fatal (see section 1.4). In addition the application of a psychiatric diagnosis, and a stay in a psychiatric hospital can in itself can have serious implications for a service user in terms of stigma, social isolation, and a lack of housing and employment opportunities (see section 1.5).

1.3 Previous research concerning the effects of the biological model on mental health service users

To date there has been a plethora of debate in the social sciences concerning the validity of the biological model of mental illness (for example Coleman 1998, Bentall and Pilgrim 1993, Bentall, Jackson and Pilgrim 1988a, 1988b, Burstow 1992, Boyle 1990, Szasz 1987, 1976, 1971, Hill 1983, Laing and Esterson 1969, Laing 1967, 1960). However, there has been a particular dearth of research which has aimed to examine the social impact of the biological model of mental illness by reference to the perspectives of mental health service users. Indeed, overall there has been very little research which has aimed to evaluate mental health service provision by means of an analysis of the experiences of service users.

“User/survivors’ views are seen as invalid by definition. In the media, this is conveyed by the chronic absence of users’ voices - everyone else, from clinician to relative, seeming more ‘listened to’ - and by articles commenting on the self-evident absurdity of the patients running the asylums.” (Sayce 2000:64)

It could be argued that the lack of research focusing on service users’ views is itself influenced by the dominant approach to understanding mental health problems, as serious mental illness is conceptualised as a condition which inevitably undermines service users’ rationality and thus reduces their capacity to communicate adequately⁵. For example, in research carried out by Barham and Hayward (1991) with twenty five women and men diagnosed with schizophrenia, they found that

⁵ Although the notion of a biologically based mental illness can tend to undermine service users’ views, this tendency may sometimes be seen in other approaches to conceptualising mental health problems. For example, psychodynamic theories could be used to undermine service users’ opinions by asserting that these views are motivated by unconscious factors of which the client is unaware (Sayce 2000).

because participants had received this diagnosis, their views were not taken seriously by mental health service providers. In fact when they expressed their opinions, these were perceived to be symptomatic of the illness with which they had been diagnosed. (see section 1.5). In his research with psychiatrists Samson (1995) made a similar observation.

“...in conventional psychiatric practice, patients are not always ‘believed’. Their conduct and speech is scrutinised for symptoms of mental illness and placed within a taxonomic scheme, rather than being seen, at least in part, as occurring in the context of particular, especially adverse, circumstances.” (Samson 1995:261)

In a guide to doing research with mental health service users, Dworkin (1992), warns that it is very difficult and sometimes impossible to interview people who have been diagnosed as mentally ill. She says that many service users deny that they have a mental illness at all, which, she claims, is symptomatic of the illness itself. Furthermore, she states that it is not appropriate to interview people who have received a diagnosis of psychosis⁶, as by virtue of having received this diagnosis, they will have a tendency to delusions of a grandiose or persecutory nature, and may often be incoherent and illogical. She asserts that it would be extremely difficult for an interviewer to establish rapport with people who have received a diagnosis of psychosis; and suggests that it thus would be preferable in many cases to interview

⁶ Within the mental health system, mental illnesses are often broadly divided into two categories - the neurotic disorders which are characterised by anxiety and depression, and the psychotic disorders (such as schizophrenia and manic depression) which are characterised by an inability to comprehend ‘reality’, because of delusional thoughts or hallucinations (Taylor and Taylor 1989). Where diagnosed neuroses are concerned there is sometimes more likelihood of medical practitioners acknowledging the effects of social factors in their cause, than there is in the case of the psychoses. This is because the neuroses are perceived as quantitatively rather than qualitatively different from ‘normality’ (Taylor and Taylor 1989).

the families of people with this diagnosis. Dworkin does acknowledge that the concerns of the families may differ significantly from those of service users but she also warns that information gained from other family members may be biased as they too may have a mental illness (implicitly holding the view that such conditions have a tendency to run in families).

In my fieldwork for this research I interviewed roughly even numbers of women who had been given a diagnosis of psychotic and neurotic mental illness (see section 2.12 table 8). I would not wish to deny that there are sometimes difficulties associated with carrying out research with mental health service users. Many of these are ones which are associated with doing research in an emotionally very sensitive area (see sections 2.6 and 2.7). In particular, the manner in which communication is carried out between interviewer and interviewee may be an issue which needs to be handled particularly carefully when interviewing on such a sensitive issue. For example, in interviewing one participant in this research, Joy (who had been diagnosed with a psychosis - see section 5.4.2), I found that there were initial difficulties between us, as she did not feel comfortable answering the questions I had outlined in my interview schedule. This problem was solved by allowing her to convey her concerns in the manner that was most comfortable to her. She did this by acting out a play she had developed, in which she described the experiences of an abuse survivor within the mental health system (a transcript of the play can be seen in appendix a). Although she adopted an unconventional manner of communicating her ideas, they were perfectly intelligible; as were the ideas of all of the other women I interviewed in this study. However, an uncritical acceptance of the medical approach (as evidenced by Dworkin above), means that service users' views, especially those of service users who may have received a diagnosis of psychotic disorders, are often regarded as inherently unreliable from the outset.

From this viewpoint it would seem that there is not a lot of point in taking the trouble to interview mental health service users, as their perspectives would, in many cases, yield unreliable information. Research carried out by Rogers, Pilgrim and Lacey (1993) and Barham and Hayward (1991) are among the few studies which have focused on service users perspectives. In both of these studies, the researchers indicated that social issues are not usually addressed by psychiatrists. Patients are not conceived of as people within a network of social relationships, both at the level of family and friends and at the level of the societal institutions which impact upon them. This research also indicated that psychotropic medication and ECT are the treatments most widely prescribed for service users. These findings can be seen as inevitable outcomes of the biological model of mental illness, as within this approach psychiatrists are supposed to concentrate on identifying the symptoms presented by a service user in order to make a diagnosis and prescribe what is thought to be the appropriate physical treatment. As many psychiatrists do not accord significance to social factors in the aetiology of mental illness; they would not see the relevance of discussing these issues with their patients.

In research which has been carried out with medical practitioners, it has been asserted that the training which is provided to doctors is inadequate in equipping them with the skills to communicate with emotionally distressed patients (Baker, Yoels and Clair 1996, Silverman 1987, Thompson 1984). Medical schools first select students who have pursued a narrow range of natural science subjects for admission to become trainee doctors (Baker, Yoels and Clair 1996). The training which they then undergo is dominated by a biological model of physical and mental illness causation (Johnstone 1991). Psychiatrists in particular, are trained through completing the standard five or six year medical training course and then following a further three year course of basic specialist training in psychiatry (Royal College of

Psychiatrists 2000). Although there is an option to specialise in psychotherapy, this is one of the least popular and less accessible study options. It has been suggested that a lack of training in the personal and social issues affecting service users means that, when they eventually qualify, doctors are fundamentally ill-equipped to communicate with service users about emotional issues (Baker, Yoels and Clair 1996, Silverman 1987, Thompson 1984).

The biological approach used by most psychiatrists has been criticised by mental health professionals working lower down in the hierarchy of the statutory mental health services. For example, research carried out by Johnstone (who herself worked for eleven years as an NHS psychologist) indicated major dissatisfaction amongst nurses and occupational therapists because of the dominance of physical treatments within the system and the lack of attention paid to the social and personal issues affecting service users. However, they feel powerless to challenge the dominance of psychiatrists in treating patients. Johnstone says that in her research she:

“...uncovered widespread demoralization and elicited comments such as ‘Real issues are avoided when patients are admitted. We concentrate on symptoms rather than the family or home situation. We take away people’s responsibility and put them in the sick role. We are doing nothing and getting nowhere.’ This was coupled with hopelessness about the possibility of change. Much blame was pinned on the doctors, who are the most powerful professional group and have most invested in maintaining the status quo...their official powers (to admit, discharge, diagnose, medicate, section and have the final say on treatment plans) are considerable.” (1993:30).

Johnstone points out that nurses feel particularly disillusioned by dominant psychiatric practice.

“Nurses...have the kind of close day to day contact with patients that exposes the meaningless of psychiatric diagnoses and highlights the real social and emotional dilemmas behind the labels. Even if they stop short of querying the whole theoretical basis of

psychiatry, they are often deeply disillusioned with its practice.” (Johnstone 1993:30)

Johnstone argues that psychiatry is actively involved in suppressing dissent. She says that this is carried out by individual psychiatrists working in hospitals and clinics who will not allow any other models to be considered in the treatment of patients and by psychiatric journals which will not allow papers to appear that criticise the dominant viewpoint. She says that alternative viewpoints are suppressed in order to maintain the dominance of the biological model and the vested power interests of psychiatrists and the pharmaceutical industry. Indeed, a significant outcome of the dominance of the biological model is that as psychological distress is conceived of as a medical illness, then medically trained doctors must be regarded as the experts in the diagnosis and treatment of the condition.

Among the few pieces of research which have attempted to systematically investigate the perspectives of women mental health service users is that carried out by Miles (1988), with sixty five women who had all received a diagnosis of neurosis. Despite providing valuable information relating to the women’s experiences (in relation to the women’s experience of consulting GPs for example - see section 4.2), Miles’s study is limited in certain respects. For example, she does not consider the impact of the biological model of mental illness upon women service users’ experiences within the statutory mental health system. Miles contacted her interviewees through one or more psychiatrists (the number of psychiatrists who participated is unclear) who wished to co-operate in her study and who were treating the women as their patients. Because of the power relations inherent in psychiatric service provision, such an arrangement can have a significant effect on whether interviewees feel able to speak freely (see section 2.10 for a further discussion of this issue as it affected my research). Although Miles does not indicate the theoretical outlook of the psychiatrists who participated with her fieldwork, there

may be some reason to believe that psychiatrists who would be willing to participate in qualitative social science research (like that carried out by Miles) may not operate within a strictly biological model of mental health. Research carried out by Britten (1991) is somewhat suggestive of this conclusion (see section 3.3 and 3.5).

Whatever the case in this respect, the lack of a thorough analysis of the power relations (and the dominant model used) within the statutory mental health services, is an important limitation in Miles' research.

Other research which has aimed to explore the social implications of psychiatry has been done by practitioners who work (or have worked) within the mental health system; who have provided illustrative evidence for their arguments drawn from a small number of their clients' case histories (see for example Barnes and Maple 1992, Johnstone 1989, Penfold and Walker 1984). All of these studies have yielded important information and have been key in drawing attention to some of the damaging effects of statutory mental health services. In particular, it has been argued by Johnstone (1989) that the medical approach to the treatment of mental illness underlies all of the problems which service users may experience within the statutory mental health system - such as discriminatory labelling (see section 1.7) and an over reliance on physical treatments (see section 1.4). However, to date there has not been a systematic attempt to investigate the social impact of the biological model of mental illness on women, by reference to women mental health service users' perspectives. In my research I aim to make a contribution to the debate on the social effects of the biological model of mental illness, by presenting a study which is based on the perspectives of women mental health service users (see also sections 2.3 and 2.4).

1.4 The medical treatment of mental health problems

1.4.1 Psychotropic medication

Due to the dominance of the biological model of mental illness, physical treatments are the favoured treatment options for service users in the statutory sector. From his research with psychiatrists (see section 1.1), Samson has asserted that alternatives to medication and electro-convulsive therapy may be used by some practitioners “if they happened to be available, but [they] would not be the dominant treatment modalities on any NHS ward” (Samson 1995:251).

In this country up to twenty five percent of the total NHS budget for medicines is spent on psychiatric drugs (Gorman 1992). This amounts to a cost of around twenty five million pounds a year (Williams et al 1993). In 1987 there were forty-six million prescriptions for psychotropic drugs for a population of fifty-five million people in Britain (Ashton 1991). Previous research has indicated that women are twice as likely as men to be taking tranquillisers (Darton et al 1994). Up to two thirds of people taking antidepressants in Britain are women (Association of Metropolitan Authorities 1993).

Major tranquillisers can have serious irreversible side effects such as tardive dyskinesia and in some cases even cause death (Burstow 1992, Scheff 1984). Tardive dyskinesia is a neurological disorder, indicating brain damage. It is an incurable condition and is caused by the use of major tranquillisers - neuroleptic (which literally means ‘nerve seizing’ (Burstow and Weitz 1988)) drugs such as chlorpromazine. It has the same effects on the nervous system as Parkinson’s Disease. The disorder is permanent and it has been estimated that world-wide at least twenty-five million people suffer from the disease, and that roughly twenty-five to fifty percent of those receiving medication with major tranquillisers will

develop it (Burstow and Weitz 1988). Tardive dyskinesia typically occurs within the first two months of a patient beginning treatment (Brown and Funk 1986). Its symptoms include involuntary muscle spasms, especially as regards the tongue, lips and jaw, a shuffling walk, tremors, restlessness and immobility (Brown and Funk 1986). These symptoms are mistaken by many people as symptomatic of mental illness even though they are in fact produced by the medication prescribed to control the symptoms of diagnosed mental illness (Burstow 1992). The standard treatment for tardive dyskinesia is increased dosage of major tranquillisers which will serve to mask the symptoms of the disease whilst at the same time furthering its development (Burstow 1992). The medication which can induce tardive dyskinesia (neuroleptics such as chlorpromazine) are usually prescribed to people who have been diagnosed with a psychotic mental illness. These drugs do not cure the disease which has been diagnosed however, they merely serve to control its 'symptoms' (Scheff 1984). Because of the severity of the side effects which may be incurred, including the possibility of death, treatment with neuroleptics may incur worse effects for the patient than the disease which they are supposed to cure (Scheff 1984).

The history of tardive dyskinesia has been marked by widespread resistance to acknowledging its seriousness and even its existence, by psychiatrists. Part of the reason for this resistance has been that drug companies have themselves failed to publicise the condition, even obstructing research which provided evidence of the disease being linked to major tranquilliser use, and psychiatrists often rely exclusively on the information provided by the drug industry (Brown and Funk 1986).

At present, there is scientific consensus that tardive dyskinesia is currently the most pervasive side effect of medication with major tranquillisers other than sedation (Brown and Funk 1986). Nevertheless there is continuing resistance

amongst psychiatrists in both Britain and North America to properly publicise the risks of the disease and to inform patients and their families of the possibility of their contracting it (Burstow 1992, Brown and Funk 1986). In explaining this tendency, Brown and Funk suggest that:

“Perhaps the reluctance to make the TD [tardive dyskinesia] case into a larger public health issue stems from the fact that to take such a tack might suggest that the profession was not in control of its own practice. Were that so, one implication might then be that external regulation might be necessary, and physicians have always resisted such control.” (1986:127)

Although the minor tranquillisers such as Valium (diazepam) do not have such dangerous or dramatically visible side effects as the major tranquillisers, they are very addictive. It has been estimated that only three weeks of regular use causes a physical addiction. In the long term, minor tranquilliser use can actually cause the symptoms which the drugs are supposed to cure, such as acute anxiety (Burstow 1992). Because of an increasing acknowledgement of the addictiveness of minor tranquillisers, GPs and psychiatrists are now far less likely to prescribe them for long term regular use. Antidepressants are believed to be physically non addictive and are now routinely prescribed in place of tranquillisers for people suffering anxiety and depression. Many types of antidepressants are highly toxic in large doses however. The side effects which they may incur include lethargy, dry mouth, loss of libido and an increase in, or loss of, appetite.

The pharmaceutical industry is worth billions of pounds world-wide. It has often been ranked the first or second most profitable industry in the world since 1955 when psychotropic drugs began to be marketed on a widespread basis (Johnstone 1989). It has been claimed that one reason for this, is because medication does not provide a ‘cure’ and only alleviates the symptoms of a perceived disorder,

psychiatrists may be tempted to resort to continuous drugging of their patients in order to control 'symptoms' which otherwise they could do nothing about (Scheff 1984). Indeed the drug industry has a vested interest in the biological model, and is in fact a powerful and influential force in maintaining the dominance of the biological model in conceptualising mental illness (Johnstone 1989).

Drug companies sponsor a considerable amount of research into finding a cure for conditions diagnosed variously as anxiety, depression, schizophrenia and manic depression (Pilgrim and Rogers 1994). Usually this comprises of the testing of pharmaceutical drugs which the company manufactures (Johnstone 1989). It has been claimed (by Johnstone 1989 for example) that research which indicates favourable effects of the drug is promoted, whilst more negative findings are suppressed. Such research has several important effects. It preserves the notion that conditions diagnosed, for example, as schizophrenia and manic depression, are categories of biological disease which manifest psychological symptoms, and which are amenable to cure (at least in theory) through drug intervention (Johnstone 1989). This is despite the fact that a cure has never been found, and there is, in fact, substantial controversy as to whether many of these conditions have any basis in a physical disease (Bentall, Jackson and Pilgrim 1988a, 1988b). Furthermore, the drug industry spends vast sums of money on advertising and promoting psychotropic drugs to medical practitioners (Johnstone 1989). This is done in various ways, for example, through full page advertisements in medical journals, reports of research carried out which has supported the use of the drug and free gifts offered to doctors who agree to prescribe the drug (such as stationery, watches, clocks, microwaves, televisions, free lunches and all expenses paid visits abroad for doctors and their partners to attend conferences set up to promote the drug - see Johnstone 1989). In addition the industry sponsors the training of trainee psychiatrists through the

provision of books, reports, films and other learning materials. It also funds postgraduate training and the making of television programmes which support its interests. There is evidence of corruption by the pharmaceutical industry, in particular the bribery of politicians who could affect the interests of the pharmaceutical industry and the fraudulent reporting of research on drug testing (see Braithwaite 1986). Many medical journals are so reliant on advertising revenue from the drug companies that they routinely reject articles which criticise the pharmaceutical industry, or which question the biological model of mental illness, for fear of offending their sponsors (Johnstone 1993, 1989).

1.4.2 Electro-convulsive therapy

Despite widespread public unease over the use of electro-convulsive therapy (ECT) it has not become a marginalised procedure within psychiatry (Samson 1995). Much of the controversy concerning the use of ECT centres on the extent of the side effects which the treatment produces. ECT involves passing an electric current of approximately 120 volts of electricity through the skull and into the brain of a patient in order to induce a grand mal seizure (Hill 1983). This inevitably produces brain damage in the patient. Its immediate effects are confusion, headache, disorientation, muscle ache, weakness and dizziness. Some patients who have received the treatment as well as doctors who support its use report therapeutic benefits from ECT despite the side effects which are incurred (Ussher 1991). Psychiatric professionals who support the use of ECT, claim that mild memory loss lasts two weeks to three months, while critics of the procedure insist that memory loss is more profound and should be taken more seriously as a side effect of the treatment. There is no doubt that ECT does induce amnesia although the extent of this is argued over. It has been suggested, however, that the very reason why ECT is

experienced as effective at all, is that it causes amnesia in patients. Like leucotomy (the surgical removal of sections of the brain) it literally removes from consciousness memories which are experienced as distressing (Ussher 1991).

Furthermore, ECT has proved to be fatal in some cases. There are no reliable statistics relating to ECT induced deaths available in Britain. However, according to one study there have been four hundred deaths due to ECT reported in English language medical literature since 1941 (Burstow and Weitz 1988). According to a study carried out by the American Food and Drug Administration in the 1970s (quoted in Hill 1988), between one in three thousand and one in twenty eight thousand ECT treatments prove fatal to patients. This is certainly a worrying figure, especially as ECT is never administered as a single dose. Those who have been prescribed it often receive between six to thirty five treatments (Burstow and Weitz 1988).

Because of the dominance of the biological model of mental illness in psychiatry, government policy aims to concentrate resources on the provision of medical treatment (such as medication and ECT) for those diagnosed with mental illness, rather than providing social support (Goodwin 1993). The development of the biological model and the increasing medicalisation of mental health problems has not had the hoped for result of curing people who are affected by mental health problems however. This is reflected in the increasing numbers of readmissions to psychiatric hospitals and the failure to reduce the long stay hospital population as quickly as successive Governments have intended by developing the policy of care in the community (Goodwin 1993). (I consider issues relating to care in community in detail in section 1.6).

1.5 Stigma

Stigmatised individuals are widely regarded as inherently less valuable than others not similarly labelled (Goffman 1963). An excerpt from the definition of 'stigma' provided in the Shorter Oxford English Dictionary states that 'stigma' is:

“2. A mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing, a 'brand'...b. A distinguishing mark or characteristic (of a bad or objectionable kind); in *Path.* [Pathology] a sign of some specific disorder, as hysteria 1859.” (1983:2127)

Several studies have indicated that there is a stigma associated with mental illness (see for example Rogers, Pilgrim and Lacey 1993, Barham and Hayward 1991, Teasdale 1987). This stigma means that a history of psychiatric service use can be used to cast doubt on the reliability of a person's behaviour or feelings at any time (Rogers, Pilgrim and Lacey 1993, Miles 1988, 1987, D'Arcy and Brockman 1977). People identified as mental health service users are often discriminated against in terms of housing, employment and a range of other social activities (Rogers, Pilgrim and Lacey 1993, Barham and Hayward 1991).

Research carried out by Barham and Hayward (1991) indicates some of the difficulties encountered by people diagnosed with a serious mental illness such as schizophrenia, in trying to re establish a life for themselves outside of the psychiatric services. A major problem for many service users, especially ex-psychiatric patients, is that they are not treated as 'normal' people. Instead they are regarded with fear, suspicion and mistrust. Even when no longer using mental health services the fact that a person has been a psychiatric service user means that their credibility can be called into question at any moment. They are often excluded from wider social life. Ex-psychiatric patients in particular face enormous challenges when they leave

hospital. Not only are they faced with trying to obtain employment and secure housing, they have to cope with the realisation that a disclosure of their psychiatric history may invoke enormous repercussions across all aspects of their life. In addition, they are faced with the challenge of having to 'reorientate' themselves, that is to make sense of their experiences, to understand and come to terms with themselves and their mental health issues and to assimilate their experiences into their understanding of themselves. The researchers found that this vital part of the recovery process is not helped by official psychiatric frameworks, such as the psychiatric interview and the diagnostic procedures. These do not address the central concerns of service users and centre solely on the delivery of medication. Furthermore, Barham and Hayward (1991) found that even community based services within the mental health system did not provide a 'stepping stone' to more fulfilling forms of social life, but instead marginalised and disempowered users, exacerbating feelings of isolation and worthlessness. Participants often felt that they were confined within a stigmatised identity as a community psychiatric patient .

Barham and Hayward reported that the participants in their study were largely defined by others in terms of their psychiatric labels. Although they rejected this identification of themselves with the psychiatric diagnosis they had received in the mental health system, they did not want to have to hide this aspect of their lives. In order to cope with the inevitability of unemployment, the lack of suitable affordable housing, the poverty, and social isolation, participants felt pressure to conceal their psychiatric history. This contributed to their distress and if they decided not to disclose their psychiatric history to a prospective employer, they were left with the problem of how to obtain suitable references and fill large gaps in their work history.

Miles (1988), in her research with women diagnosed as suffering with

neurosis and receiving psychiatric treatment on an outpatient basis, reported that her participants also experienced considerable stigma connected with their service use. She argues that one of the most significant reasons for the attachment of this stigma is that:

“Disturbed persons may fail to comply with social norms, may even violate them, and thus they appear unpredictable and inexplicable to their fellows. The consequence of a breakdown in social expectations is the attachment of stigma.” (Miles 1988:68)

However the women in Miles’ study (1988) described how it was not their feelings or behaviour which was the source of the stigma they experienced. Rather, if it became known that they had seen a psychiatrist, stigma inevitably followed (1988:84-85). Because of the stigma associated with specialist psychiatric services Miles argues that alternatives to specialist psychiatric treatment should be provided so that psychiatric labelling can be avoided.

“...if problems can be handled by non-psychiatric services, for example, family practitioners, health visitors or even, where appropriate self help lay groups, then in some cases stigma may not arise, or at least, may be minimised. Those whose behaviour does not of itself invite lay labels of ‘mental’ and such-like would benefit most from the absence of professional psychiatric labelling.” (Miles 1988:86)

Avoiding labelling in this way would no doubt reduce the stigma experienced by many service users. Nevertheless there are further issues associated with conceptualisation of mental illness which are a considerable source of stigma for service users, and which are not investigated by Miles. In particular, she does not consider the power relations in mental health service provision which render it inevitable that service users believed to be suffering with a severe mental illness are referred (involuntarily in some cases) to psychiatrists for diagnosis and treatment. All of Miles’s participants were diagnosed as suffering with a neurotic disorder and none had been hospitalised. There is reason to believe that for people believed to be

psychotic, there is even more stigma, especially when they have had inpatient treatment. Much of the furore surrounding care in the community (see section 1.6) has concerned ex-hospital inpatients diagnosed with psychosis posing a threat of violence in the community.

Several commentators have argued that the power relations inherent within the medical approach result in dependence, stigma and a basic mistrust of those labelled as mentally ill (see for example Pilgrim 1993, Barham and Hayward 1991, Burstow and Weitz 1988, Chamberlain 1988). They have argued that this is not merely a by-product of the system which can be removed by altering the geographical sites of treatment. Within the debate surrounding community care (see section 1.6), the psychiatric hospital has been condemned for stigmatising service users and there has been a clear assumption that relocating services within the community would solve these problems. However, there is limited evidence to suggest that since community based services have retained a medical analysis of mental health issues they have replicated some of the problems evident in large scale institutions (see for example Pilgrim 1993, Davis 1988).

In a study carried out by mental health service providers (Teasdale 1987) it was reported that clients attending a psychiatric day unit experienced considerable stigma in association with the use of the service. This report recommends that service users should be more open about their fears about stigma and that service providers should encourage their openness in order to help them manage this problem. However, the role of service providers themselves in contributing to the stigma that the service users experienced was largely ignored in the study. By contrast, in the Barham and Hayward study (1991), the researchers reported that their participants were stigmatised as irrational and unreliable by hospital staff. Because their participants had been diagnosed with a severe mental illness, they

were not taken seriously by mental health professionals. When they tried to communicate their point of view, what they verbalised was frequently disregarded as a symptom of the illness with which they were diagnosed. Thus the service users' attempts to talk to the clinical staff involved in treating them was not regarded as meaningful discourse in itself, and was often used only to study the progress of their illness. The process of diagnosing mental illness is carried out by medical practitioners by means of identifying the symptoms of the illness, as evidenced by the speech and behaviour of service users. Thus the views expressed by service users are often reconceptualised to represent symptoms which are presumed to indicate the presence of a biologically based illness (see also sections 3.4 and 3.5 on the particular issues relating to women and the stigma of a psychiatric diagnosis).

1.6 The policy of care in the community

1.6.1 The development of the policy

The organisation of mental health services within the statutory sector in Britain has been influenced significantly over the last twenty years by the introduction of the policy of community care. The term 'community care' is infamously ill defined, both in government policy documents, and in other literature on the subject (Goodwin 1993, McCourt Perring 1993). This reflects the lack of clarity in the formulation of the policy (Pilgrim and Rogers 1994). In practice, the term refers to the policy of administering treatment and care in non-institutional settings to people who have learning disabilities, are physically disabled, diagnosed with mental illness or elderly people in need of care (Pilling 1991). Among the main initiatives in community care for those diagnosed as mentally ill, are the development of acute psychiatric units in district general hospitals, the introduction of multi-disciplinary community mental health teams, the development of day

centres, and community mental health centres. There is also an emphasis on caring done by volunteers, unpaid relatives and friends (Pilgrim and Rogers 1994). Women may find themselves particularly affected by the policy as they often assume a caring role for other family members affected by health problems (Annandale 1998). In addition, as members of the working class of both genders often cannot afford to pay for caring services, they may also be disproportionately affected by the move towards community care and the rundown of formal caring services (Arber and Ginn 1992).

A major justification for the introduction of the programme of psychiatric hospital closure has been the negative effect upon patients of institutionalisation. Studies suggest that those who remain in psychiatric hospitals for a prolonged period of time experience a severe decrease in social functioning and have an increased risk of rehospitalisation when they are released (Pilling 1991, Wales 1975, Goffman 1961). The hospital environment where even the smallest details of everyday life are regulated - when to get up, when to go to sleep, when and what to eat and drink for example, is inherently disempowering and fosters passivity and dependency in patients (Wales 1975, Goffman 1961).

Another significant reason for the closure of psychiatric hospitals has been a desire by the medical establishment to create a more secure and prestigious basis for psychiatry. The latter had long been regarded as the 'poor cousin' of general medicine (Pilgrim and Rogers 1994). There has been a clear desire on behalf of the medical profession to locate psychiatry alongside other medical specialisms in the general hospital (Pilgrim and Rogers 1994, Busfield 1993, McCourt Perring 1993, Baruch and Treacher 1978). In addition there have been problems for service providers in maintaining large psychiatric hospitals, for example the high level of financial expenditure needed to run them, chronic understaffing and difficulties in

recruiting and retaining staff (Pilling 1991).

However, the policy of care in the community has been developed and implemented quickly over the last twenty years, largely due to financial constraints on the welfare state. Scull (1977) has pointed out that the critique of the asylum system of psychiatry was nothing new, in fact it was a hundred years old, but was being implemented in Britain as a matter of urgency largely for financial reasons. This led to what has been called an 'unholy alliance' between those whose main concern is the cost saving potential for community care and those who have a genuine interest in the provision of a comprehensive therapeutic community based service (Pilling 1991).

The original intention in much of the rhetoric around the policy was that the money from the closure of the hospitals would be used to fund community based services. However, there is little evidence that this money is being redirected into community based alternatives and there have been no explanations offered for this by the relevant government departments (Prior 1999, Community Care 1994).

Despite a steady decline in the number of people occupying hospital beds in Britain since the 1960s, short stay admissions have actually increased dramatically. This increase is indicative of a 'revolving door syndrome' of hospitalisation rather than of care in the community (Francis 1994, Pilgrim and Rogers 1994). This is a common situation where psychiatric patients are released from hospital, but because they receive inadequate services in the community must be readmitted to hospital. Clearly this syndrome is perpetuated by providing services which are not responsive to the needs of service users.

The care in the community policy has been roundly condemned by user groups (see section 1.6.2) and campaigning bodies such as the Zito trust and SANE (Schizophrenia A National Emergency). There is no doubt that community based

services are seriously underfunded and as a result significant numbers of people are not accessing mental health services (Prior 1999, Community Care 1994). However, the failure of the policy has been emphasised by some groups by means of highlighting the acts of violence which have been carried out by some psychiatric patients in the community. This has been criticised by many users for further stigmatising and demonising psychiatric service users (see section 3.4). Indeed, in the public perception violence has become increasingly linked with mental illness (Sayce 2000, Pearson 1999, Prior 1999, Samson 1995), despite the fact that over 95% of violent crime is committed by people who have never received a diagnosis of mental illness (Sayce 2000).

It has been asserted that the criticisms of the community care policy, in particular, the perceived link between violence and mental illness may lead to a reversal of the policy and moves towards reinstitutionalisation of service users (Prior 1999, Samson 1995). In 1999 the Department of Health issued a report on the community care policy entitled 'Modernising Mental Health Services: Safe, Sound and Supportive' (Department of Health 1999). In discussing proposed changes to the system it emphasises the failure of the community care policy, particularly in terms of public safety.

"Care in the community has failed because, while it improved the treatment of many people who were mentally ill, it left far too many walking the streets, often at risk to themselves and a nuisance to others. A small but significant minority have been a threat to others and themselves." (Department of Health 1999:6)

It asserts that the first priority of mental health services is safety for the public. One of the problems it identifies is an "outdated legal framework which failed to support effective treatment outside hospital" (Department of Health 1999:3). It also suggests the introduction of more hospital beds. As a result of this

report the Mental Health Act 1983 is currently being reviewed. One of the suggested changes is that individuals can be legally compelled to accept psychiatric medication (if they are deemed to be a danger to themselves or other people) whilst they are residing in the community (Scoping Study Committee 1999). The government has announced that “non compliance with agreed treatment will not be an option” (Quoted in Sayce 2000:120). Under the provisions of the 1983 Act, enforced treatment can only take place within a hospital environment.

A major justification for the move towards community care was that the changes in the system would benefit the people who actually use the services in question. However, the development of successive governmental policies in this area has not been informed in any significant way by the perspectives of service users (Prior 1999, Davis 1988). As successive governments have assumed that dominant psychiatric practice is effective, they have tended to rely upon the views of psychiatrists when reorganising psychiatric service provision (Goodwin 1993, Pilgrim 1993).

“Politicians of all hues still defer to doctors to identify the clinical needs of ‘their’ patients. This reinforces the tradition of paternalism in welfare provision in which professionals ‘know best’ and patients are not expected to speak for themselves.” (Pilgrim 1993:254)

It could be argued that in order to effectively reform mental health service provision the views of users themselves should, at a fundamental level, inform the development of alternative service provision (see also sections 2.3-2.4). This is especially relevant as the rise of the mental health users movement and the large scale survey ‘People First’ carried out with the user group MIND (Rogers, Pilgrim and Lacey 1993), indicates widespread dissatisfaction with psychiatric practice among service users (see section 1.6.2). To continue to fund services which are not

regarded as beneficial by users is a serious waste of resources and one that can have a long term damaging effect upon the users involved. For this reason service users' groups have consistently campaigned for more input into the policy-making processes that take place at both a national and local level. Despite some successes, however, they are still not perceived as the equal partners of psychiatrists and other professional bodies in the consultative process.

“...although they are expanding in number, many user organisations are disappointed by the lack of progress that the movements have made in terms of making an impact on changes in policy directions. In the UK, for example, user organisations are increasingly being asked to sit on committees of service users to give feedback to the NHS trusts responsible for mental health services. However, there is very little power attached to such committees, and any changes made are usually fairly minor.” (Prior 1999:74)

1.6.2 The mental health users movement and community care

The proliferation of mental health service users' groups in the last two decades has been noted by a number of commentators (Rogers and Pilgrim 1991, Burstow and Weitz 1988, Chamberlain 1988). This development is a result of a groundswell of dissatisfaction among service users which health and social services have overall failed to contain (Pilgrim and Rogers 1994).

The dominant groups in the mental health users movement are MIND, The National Schizophrenia Fellowship (NSF), The Manic Depression Fellowship (MDF), Survivors Speak Out and the Campaign Against Psychiatric Oppression⁷. There are important differences in theoretical approach among user groups. The NSF and MDF propound the biological model of mental illness. They accept the

⁷ These are the dominant groups within the movement but there are other smaller groups, such as women's advocacy groups, groups for survivors of abuse (in which members are also mental health service users) and inter-group service users' forums.

labels 'schizophrenia' and 'manic depression' uncritically; believing that 'sufferers' have a biological disease and supporting the medical profession in its attempt to find a medical cure for the conditions. By contrast, other groups such as MIND, Survivors Speak Out and the Campaign Against Psychiatric Oppression reject the term 'mental illness' and the notion that there is a biological illness which requires a cure. The term 'mental illness' is therefore replaced by terms such as 'emotional distress', 'mental distress' or 'mental health problem'. There is some hostility towards the NSF by other user groups. One of the reasons for this is that the organisation is perceived as giving priority to the interests of relatives and carers over those of the users themselves (Rogers and Pilgrim 1991) and their uncritical acceptance of professional authority. However, the majority of groups within the mental health users movement overall, have a critical attitude towards mental health professionals. The oppressive power relationship inherent in dealing with mental health professionals, is constantly emphasised (Rogers and Pilgrim 1991).

Rogers and Pilgrim (1991) carried out a study of the British Mental Health Users' movement based on interviews with ten activists in the movement. The researchers discussed with interviewees their views on the care in the community policy which has been pursued by successive governments. They concluded that:

"A consensual principle... is that alternatives to the status quo are required in relation to mental health policy and practice. In particular, the need for non-hospital based 'asylum' during crises and material resources such as housing to enrich everyday life are emphasised as current deficiencies, as were the negative effects of psychotropic drugs. Generally, deinstitutionalisation was deemed to be a positive aspect of policy and there appeared to be few reservations about its consequences... All shades of opinion emphasised the importance of being listened to and treated with respect."(Rogers and Pilgrim 1991)

The 'People First' study carried out in conjunction with the user group MIND (Rogers, Pilgrim and Lacey 1993) also indicates a high level of

dissatisfaction among mental health service users with the current organisation of psychiatric services. Of a sample of 516 service users who had all been hospitalised on at least one occasion, 73% thought that their admission to hospital had been necessary because of a need for asylum and a failure to cope with their everyday lives. However, half of the sample thought that they should have been offered an alternative form of crisis care. Only 14% of the sample were actually offered an alternative to hospitalisation, but this was perceived as inadequate as it was usually only the offer of an outpatient appointment.

The 'People First' (1993) study indicates that psychiatric intervention is still based primarily on the hospital and is dominated by drugs and ECT. Despite the removal of the old Victorian psychiatric hospitals, the hospital still remains the key focus for the care of clients regardless of whether they are treated on an in or outpatient basis. This is often an acute unit in a district general hospital (Pilgrim 1993). The 'People First' study also indicated problems in relation to the coercion of patients, even those who are resident in hospital on a voluntary basis. Frequently participants had felt forced into becoming a hospital patient and receiving physical treatments because of a lack of any other alternatives (Pilgrim 1993). In addition there was a general lack of informed consent. According to Pilgrim

"The data make it clear that the further recipients are away from hospital, the more they like their lives. Hospital interventions are not user-friendly. They are associated generally with an oppressive or distressing experience. If patients and prospective patients are to live as normally as possible in the community, the implications are that service options should be available in that setting. These would include crisis houses, outreach work and 24-hour, seven-days-a-week crisis intervention teams, counselling, drop-in centres and day centres housing a variety of activities."(Pilgrim 1993:252).

The 'People First' survey provides a valuable source of information on a wide range of topics relating to the concerns of service users, but the findings of the

study are not rigorously analysed according to the gender of the participants in the research. For example, the specific views of women participants on the policy of care in the community were not analysed and presented in their research report. In addition, the 'People First' study was carried out by means of a questionnaire in which the researchers did not set out to gather information on issues which specifically relate to women. Thus issues such as the mixed ward system in hospital, sexist attitudes amongst service providers, and the lack of childcare provision for users with young children were not addressed. This does represent a significant omission in the 'People First' study.

The 'People First' study (1993) clearly indicates that service users are dissatisfied with the emphasis on the medical, rather than the social, assistance of service users within the statutory mental health system. The medicalisation of mental health issues is, at least in part, responsible for the lack of mental health services that are available outside of the hospital setting as within psychiatry, medical treatment, rather than social support, is regarded as the most appropriate way of assisting mental health service users.

1.7 The incidence of diagnosed mental illness among women

Over the last twenty years numerous studies have been published which indicate that women have a higher overall rate of diagnosed mental illness than do men (for example Darton et al 1994, Community Care 1994, Association of Metropolitan Authorities 1993, Cobb 1993, Gorman 1992, Welsh Office 1991b, HMSO 1987). One of the explanations which has been offered for the higher rate of recorded mental illness amongst women, is that reproductive processes affecting women, such as childbirth, menstruation and menopause, make them particularly susceptible to developing mental health problems (Busfield 1996, Cochrane 1983).

A significant number of women (10-30%) experience depression after childbirth and there is some debate as to whether this is the result of psychosocial stresses, changes in physiology, or a combination of the two (Busfield 1996, Ussher 1991, Nicolson 1989). Research relating to this issue (such as that carried out by Nazroo, Edwards and Brown 1998, Weissman and Klerman 1977) has asserted that the social factors associated with women's reproductive processes - such as the social isolation of new mothers for example - significantly mediate women's experiences of these biological processes. They conclude that the biological factors in themselves could not account for the rate of diagnosed mental illness, as sex differences in the incidence of diagnosed mental illness are not universal across time and place. As women's biological processes are the same, this tends to rule out biology as being the simple cause of women's diagnoses of mental illness

Feminist theorists have offered two basic reasons for the higher incidence among women of recorded mental illness - the social causation hypothesis and the labelling theory (Darton et al 1994, Gorman 1992). The former asserts that experiences of violence, harassment and discrimination on the grounds of gender produce a high level of actual mental distress among women (Darton et al 1994, Gorman 1992, Barnes and Maple 1992, Beckert 1987). The latter indicates that cultural notions of what constitutes 'proper' femininity influence the definition and treatment of mental health problems among women, so that more women are labelled as 'mentally ill' (Darton et al 1994, Gorman 1992, Barnes and Maple 1992). In making both of these arguments feminist theorists have sometimes been accused of making an essentially contradictory statement; asserting that more women are mentally ill because of their position in society, and also saying that they are not mentally ill but merely labelled as such because of the application of sexist diagnostic criteria (Sedgwick 1982). Busfield (1996) has correctly pointed out that

this criticism stems from a misreading of the feminist argument. The actual experience of mental distress and the process of diagnosing mental illness by psychiatrists are two quite distinct social processes. Large numbers of women approach mental health professionals for help with psychological distress which is caused by oppressive social experiences. The diagnostic labels which are then applied to women in a clinical setting may be chosen with reference to sexist criteria. Thus there is no inherent contradiction in the feminist position, a position which I will now explore in more depth.

It has been asserted that women are often perceived to have a mental illness simply by virtue of their gender (Gorman 1992, Barnes and Maple 1992, Penfold and Walker 1984, Broverman, Broverman, Clarkson, Rosenkrantz and Vogel 1970). In a study carried out by Broverman et al in 1970, seventy nine medical practitioners were asked to describe a healthy, mature adult, sex unspecified, a healthy mature man and a healthy mature woman. It was found that definitions of healthy men and women differed according to traditional sex role stereotypes. In addition the characteristics of the healthy adult sex unspecified were the same as the characteristics listed for the healthy adult man. Thus the characteristics clinicians believed to be mentally healthy in general, were the same characteristics which they ascribed to healthy men. Particular characteristics were thought to be evidence of pathology in one sex, but not pathological in the opposite sex. The researchers conclude

“...we see the judgements of our sample of clinicians as merely reflecting the sex-role stereotypes, and the differing valuations of these stereotypes prevalent in our society. It is the attitudes of our society that create the difficulty. However the present study does provide evidence that clinicians do accept these sex role stereotypes, at least implicitly, and by so doing, help to perpetuate the stereotypes. Therapists should be concerned about whether the influence of the sex-role stereotypes on their professional activities acts to

reinforce social and intrapsychic conflict.” (Broverman et al 1970:7)

Although this study is now thirty years old, it has been claimed that this tendency to sex role stereotype men and women remains (Busfield 1996, Barnes and Maple 1992, Gorman 1992, Penfold and Walker 1984). Women who show signs of aggression, anger, independence and are concerned with self advancement are often perceived by clinicians to be less emotionally stable than men with the same personality characteristics (Gorman 1992, Penfold and Walker 1984).

“Clinical judgements of women tend to reflect the traditional stereotype of femininity centred on passivity, dependency and putting others before oneself - characteristics which are at odds with healthy adult behaviour centred on activity, independence and assertiveness. Femininity and positive mental health seem to be mutually exclusive - to be considered mentally healthy, women are required not to respond in a natural manner to events but in a predetermined ‘feminine’ manner...”(Gorman 1992:19)

However, even if women act in a ‘feminine’ manner, the characteristics which they display may be perceived by many clinicians to be inherently unhealthy (Hill 1983 - see also section 1.2). The dominant ideology which asserts that men are more rational than women may have some impact upon psychiatry. Women are sometimes thought to be particularly susceptible to mental illness as mental illnesses themselves are characterised by a loss of rationality (Busfield 1996). In reviewing the literature which indicates this tendency Hill concludes

“...women entering ‘mental health’ agencies are victims of the same vicious double-bind which so effectively oppresses them in the broader society. Women are devalued for acting the way their socialization trained them to act and are punished for trying to escape the roles traditionally imposed on them.” (Hill 1983:270).

It has been claimed that because they are often expected to be less healthy anyway, women are often not diagnosed with the most severe mental illness unless

they are breaking out of traditional gender behaviour (Hill 1983). Behaviour which violates traditional gender norms for women and men may incur a severe reaction both in society generally and in the mental health services in particular (Busfield 1996, Barnes and Maple 1992, Gallagher 1987, Penfold and Walker 1984).

It has been argued that a further reason for the higher rate of recorded mental illness among women is that women are socialised into expressing emotion and talking about their problems, so that they are more likely to be labelled and to label themselves as having a mental health problem (Busfield 1996, Gorman 1992, Chesler 1972). Men who are socialised to be less expressive concerning their emotions may be less likely to consult a GP concerning a mental health problem (Gorman 1992). Men generally have a higher incidence of alcoholism and death by suicide than do women (Busfield 1996, Department of Health 1993, HMSO 1987). If the prevalence of diagnosed mental illness amongst women was only due to an increased tendency amongst women to admit to problems, however, it would not explain why some studies have suggested that married women have higher rates of diagnosed mental illness than married men or single women (Gallagher 1987). This research appears to suggest that marriage can have a positive effect on men's mental health whilst sometimes having a detrimental effect on the mental health of women (Faludi 1992, McRae and Brody 1989, Gallagher 1987).

There have been various reasons suggested why marital status should affect the distribution of mental illness. One reason is that marriage may be more stressful for women than it is for men. Bearing responsibility for the running of a household is particularly frustrating and unrewarding (Oakley 1990). The role of the housewife is simply to do 'everything', all the domestic tasks within the home (Oakley 1990, Gove 1972). The work is isolated, unstructured, and highly demanding (Oakley 1990). There is no wage to be earned in return for work done, there are no set hours

to be worked and no holidays. Married women who have jobs outside the home are often under greater strain than their husbands since they often still bear responsibility for housework while also in paid employment (Gove 1972).

Historically, the development of the modern nuclear family has seen the separation of work and home, and the increasing privatisation of family life. The ideology of the family, including psychological theories about the role of the mother in the healthy development of children, has led to increasing pressure upon women to perform the emotional and practical tasks of creating a 'haven in a heartless world' for other family members to enjoy (Penfold and Walker 1984, Barrett and McIntosh 1982).

“The emotional management of strains created outside the family but experienced within the family, along with the management of those strains in the family, is all seen as the woman's job. Further, with the recognition that the workplace is insecure, alienating and, for most middle - as well as working-class men, organised in ways which are outside of their control and location, women are expected to provide the intimacy lacking outside and to take up the emotional and economic slack in times of hardship”. (Penfold and Walker 1984:68-69).

In addition, women have a lower socio-economic status than men overall (Ussher 1991). They often earn less income, have less status and participate less in leisure activities. This is significant, as there is an established link between poverty and psychological distress (Bruce et al 1991). The responsibility of caring for children can contribute to emotional distress (Barnes and Maple 1992, Brooke and Davis 1985, Brown and Harris 1978). Sexual and physical violence against women is also a significant cause of emotional distress (Dobash and Dobash 1992, Herman 1992). In fact, there is a considerable amount of research evidence which suggests that a history of physical and sexual abuse is the cause of many conditions which receive a diagnosis of severe mental illness (Darton et al 1994, Williams et al 1993,

Herman 1992, Barnes and Maple 1992 - see also chapter five).

It is only through the women's movement that attention has been focused on the problems of domestic violence and incest (Dobash and Dobash 1992, Herman 1992, Armstrong 1991). It has been estimated that domestic violence occurs in 1 in 4 households (Smith 1989). This violence is usually carried out by men and is directed towards the women and children within their families (Hague and Malos 1993, Dobash and Dobash 1992). The violence ranges from repeated assaults to rape and murder. Research has indicated that men's possessiveness and jealousy, their expectations concerning women's domestic work, the importance to men of exercising their authority along with a sense of their 'right' to punish 'their' women for perceived wrongdoing are all significant sources of conflict leading to men's violent attacks on women (Dobash and Dobash 1992). Domestic violence is not confined to any particular socio-economic group (Hall and Lynch 1998, Dobash and Dobash 1992).

The prevalence of child sexual abuse has been estimated at between 6% and 62% for girls, and 3% to 27% for boys (Ghate and Spencer 1995). The discrepancies in these estimates relate to the definitions of sexual abuse; sample size; and the methodologies used in the studies. Previous research has indicated that more children are sexually abused within their families of origin than by strangers (Ciba Foundation 1984, Finkelhor 1979). The sexual abuse of children within the family is not confined to any particular socio-economic group (Hall and Lynch 1998, Finkelhor 1979). The effects of child sexual abuse can be far reaching and continue into adulthood. Anxiety, depression, problems forming relationships, phobias, panic attacks self mutilation, attempted suicide, substance abuse and eating disorders are some of the effects of this abuse (Hall and Lynch 1998, Mullen, Martin, Anderson, Romans and Herbison 1996, Herman 1992, John 1991, Browne and Finkelhor

1986). A woman having a history of abuse is often linked to high levels of mental health service use (Williams et al 1993, Barnes and Maple 1992, Herman 1992). In planning and providing mental health services it is vital, therefore, that abuse issues are tackled in order to create a responsive service (Williams et al 1993). However there is some evidence that services are not providing women help in dealing with their abuse history (see for example Neate 1995, Williams et al 1993, - see also chapter five which concerns the particular experiences of women survivors of child sexual abuse in the mental health system). In particular, Herman (1992) has indicated that dissociative feelings are often perceived by medical practitioners to be symptomatic of a psychosis. She asserts that:

“Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Because of their characteristic difficulties in close relationships, they are particularly vulnerable to revictimisation by caregivers. They may become engaged in ongoing, destructive interactions, in which the medical or mental health system replicates the behaviour of the abusive family.” (Herman 1992:123)

In this manner, many feminist theorists have argued that the incidence of recorded mental illness amongst women is produced, at least in part, by the high level of actual distress amongst women caused by social factors such as poverty; the stress of motherhood and the responsibilities for housework; and sexual and physical abuse. It has also been argued that the development and application of sexist diagnostic criteria may create the appearance that women suffer more from mental health problems than do men. In addition to sexism, it has been claimed that clinicians sometimes use racist; classist; ageist, and homophobic criteria in diagnosing mental illness (Darton et al 1994, Barnes and Maple 1992, Torkington 1991, Diamant 1987, Penfold and Walker 1984). The problem of discriminatory

labelling is not one that can simply be removed by encouraging psychiatric professionals to change their attitudes to women and other oppressed groups, by means of equal opportunities training for example. The problem is a much more fundamental one than this, as historically theories of psychological development and psychological disorder have developed in a social context which is imbued at every level with the ideology of women's inferiority to men, black people's inferiority to white people, homosexual inferiority to heterosexual.

There are further issues relating to the gender distribution of mental illness, and these relate to the relationship between gender differences in expressing emotions and the construction of diagnostic categories within psychiatry. Busfield (1996) argues caution in generalising from statistical data on the epidemiology of mental illness the theory that women as a group suffer from more mental health problems than do men. She points out that such studies do not take account of gender differences in the way that men and women experience and express psychological distress. Busfield argues that men and women are socialised to express their feelings in different ways. Women are encouraged to turn distressing feelings inwards so that they are experienced as anxiety and depression, states which commonly come within the remit of psychiatry. Men, on the other hand turn these feelings outwards, being more inclined to alcoholism and acts of violence (Busfield 1996, Barrett and McIntosh 1982).

Anti-social behaviour is often diagnosed by psychiatrists as evidence of a personality disorder. Personality disorders are often regarded as untreatable within psychiatry and whilst they are perceived as indicative of a mental disorder, they are not defined as mental illnesses. Therefore they are often disregarded in epidemiological studies which aim to collect data on the prevalence of mental illness. Similarly, substance abuse is not defined as a mental illness and so is not

included in many studies which focus on mental illness. However, men have much higher prevalence rates for both personality disorders and substance abuse than do women (Prior 1999). Prior (1999) has asserted that the exclusion of these conditions from statistical studies on the prevalence of mental illness has led to the mistaken view that women suffer more mental health problems than do men. When these other conditions are taken into account, the incidence of recorded mental health problems amongst women and men tends to balance out (Prior 1999).

In Wales in 1998, women made up the majority of psychiatric inpatients (10,061 women compared with 8,446 men - Welsh Office 1999). However research has indicated that in urban areas particularly, young men are quickly becoming the group most likely to be admitted to psychiatric hospitals (Prior 1999, Payne 1996, 1995). This is in part explained by the implementation of the community care policy and the closure of many psychiatric hospitals. A perceived link between mental health problems and violence, coupled with a scarcity of hospital beds means that priority is often given to admitting young men, particularly young men from ethnic minorities, who are often seen as more prone to violence (Prior 1999, Payne 1996, 1995).

Outside of inpatient treatment however, women still largely predominate as mental health service users (Prior 1999). Prior has argued that because of the way men express emotions they are often perceived to be 'bad' rather than 'mad' and so are more likely to be relegated to the prison system rather than to outpatient medical care (Prior 1999).

1.8 Psychiatry as a mechanism of social control

In 'Madness and Civilization' (1967) Foucault argues that madness is a socio-historical construction that is defined and treated according to the particular preoccupations of the age. In mediaeval England madness was defined in religious terms. From the mid-seventeenth century a 'great confinement' took place in Europe when deviant groups who posed a threat to bourgeois values - such as the mad, the destitute, the lazy and the criminal - were segregated from the rest of society⁸. Economic inactivity was seen as a particular threat at the time and madness was condemned as a morally reprehensible form of idleness. Foucault also argues that in line with enlightenment values (which placed a great emphasis on rationality), those who were seen as irrational were stigmatised and excluded from the rest of society. The emergence of psychology and psychiatry was thus based on the exclusion and containment of madness by reason.

Foucault has described how the emergence of a dominant medical discourse defined notions of normality (health) and deviance (illness) in relation to the population. He asserted that this medical discourse plays a significant role in the management both of the bodies of individual people and of collectivities of bodies. The power of the medical profession stems from their monopoly over the construction of this medical discourse (Foucault 1973). Thus the practice of medicine concerns wider structures of power and control both in relation to individuals and the population at large. Foucault (1967) argues that medicine plays a moral role in articulating the norms of behaviour (such as 'appropriate' forms of sexuality). In Foucault the notion of discipline is also important, as medicine plays a

⁸ This picture is somewhat inaccurate, however, as it was not until after 1780, that the number of psychiatric institutions grew rapidly in Britain (Pilgrim and Rogers 1996).

role in disciplining both public and private bodies in terms of what is appropriate behaviour for any given space (Foucault 1979, 1973).

One of the important aspects of Foucault's analysis is that he drew attention to the fact that issues such as madness, asylums, hospitals and institutions had largely been forgotten by many Marxist theorists in their analyses of power. These detailed operations of power had been ignored through an exclusive focus on global forms of power. Foucault asserted that power does not take on a monolithic form and cannot be reduced to centralised macropolitical power. According to Foucault (1979), power is not centralised but is reproduced in discursive⁹ networks at every point where someone who possesses knowledge is in a position of instructing those who do not know. Thus power relations are reproduced whenever there is an exchange of knowledge. Discourses promote specific kinds of power relations, usually favouring the 'neutral' person or professional who is using the discourse (the psychiatrist, lawyer, professor etc.). Knowledge is therefore not a neutral phenomenon but entails participation in complex webs of power.

The work of Foucault has been influential in the development of postmodernist theories (for example Weedon 1987). However, many feminists utilise a Foucault-derived concept relating to the role of discourse in maintaining and reproducing power relations without subscribing to a postmodernist position of the radical deconstruction of the subject (Andermahr, Lovell and Wolkowitz 1997, Charles and Hughes-Freeland 1996). It is also possible to make use of the concept whilst at the same time indicating the importance of state and legal power in

⁹ Foucault defines discourse as "the group of statements that belong to a single system of formation" (1972:107-8). Discourse is also used to denote an authoritative way of describing. Discourses are propagated by specific institutions and divide up the world in specific ways. For example, economic, medical, legal and psychological discourses.

regulating women. The notion of discourse has been seen as a useful tool in analysing power relations, for even where power is conceptualised as being invested in the global forms of capitalism and/or patriarchy, there are a nexus of micropolitical channels in which power relations are exercised and reproduced on an interpersonal level (Grosz 1990). Indeed, the feminist notion that ‘the personal is political’ indicates that power relations are sustained in the interpersonal as well as the public domain. Although not adopting a postmodernist approach in my research I utilise the Foucauldian notion of discourse as embodying forms of power in order to analyse some of the specific relations between service users and providers in the statutory mental health system.

In addition, throughout my research I make use of the approach adopted by Penfold and Walker in their analysis of psychiatry entitled “Women and The Psychiatric Paradox” (1984). In this work they utilise both Marxist and feminist ideas to explain what appears to be a fundamental paradox within psychiatry; namely that the discipline claims to be assisting mental health service users, whilst at the same time often engaging in practices which oppress many users.

According to Penfold and Walker psychiatry serves both as a mechanism of social control within contemporary Western capitalist society whilst at the same time seeking to cure individuals of the psychological distress which the oppressive mechanisms of this society (psychiatry included) can actually produce.

“Psychiatry is both part of the ideological and coercive mechanisms of industrial society and at the same time is committed to the resolution of the very tensions and strains which that society and its institutions produce. It is from this central contradiction that many other difficulties stem and this makes it possible for psychiatry to take a part in the oppression of some of the very people it purports to help.” (Penfold and Walker 1984:v)

Penfold and Walker argue that psychiatry is an agent of social control for

two reasons. Psychiatry often seeks to promote conformity to the ideological norms of behaviour in society. Thus for example people who act against the stereotypical norms of gender behaviour sometimes incur severe diagnoses of mental illness and treatment often aims to make them adjust their behaviour to these ideological norms (see also Busfield 1996, Barnes and Maple 1992, Gallagher 1987). Secondly, it is an inherently conservative institution due to its emphasis on individual pathology.

Social forces within society are either ignored altogether or receive very cursory attention. The fact that there are oppressed groups within society, and that ideological and material discrimination against these groups can lead to psychological distress in individual members of the group is often ignored. Instead psychological distress is perceived as personal pathology, and the societal mechanisms which have contributed to this distress are left unaddressed. Penfold and Walker note that:

“Many decisions that directly affect people’s lives are made at state and corporate levels...Those who, like psychiatrists intervene at the level of individual experience, must restrict their interventions to the immediate environment...Hence, the focus on adaptation or adjustment of the individual to the circumstances, for which psychiatry has often been criticized, can be seen as both a reflection of, and a justification for, the ideology of individualism - which obscures the actual structuring of society. The work of psychiatry is to make individual experience comprehensible in individual terms, and not in any other way in which we might understand it.” (Penfold and Walker 1984:50)

Penfold and Walker argue that the dominant psychiatric approach embodies the liberal ideology of individualism which came to the fore during the development of Western capitalism. As psychiatry both mirrors and sustains this ideology of individualism it can be seen as part of the ideological structure of advanced Western capitalist systems, and tends to obstruct social change in those systems.

Penfold and Walker assert that the experience of psychological distress in

Western society forms part of what they describe as the 'social cost of living' of being a member of an advanced industrial capitalist society which is vastly out of step with human needs. Thus they argue that strategies for social intervention in an individual's experience of mental ill health need to be grounded firmly in an acknowledgement and analysis of the social processes which play a role in the genesis of mental health problems, including issues of women's oppression.

Conclusion

Within modern psychiatry there are a range of different approaches in understanding and treating people who are perceived to have a mental illness. Many lay people believe that psychiatrists predominantly concern themselves with providing 'talking therapy' for their patients, to the extent that within public perception, psychiatry and psychoanalysis are often regarded as synonymous (Trimble 1988, Andreasen 1984). This view is a mistaken one however, as despite some eclecticism within the discipline as a whole, British psychiatry is dominated by a biological approach to the study and treatment of mental health problems (Busfield 1996, Samson 1995, Pilgrim and Rogers 1994, Bentall and Pilgrim 1993, Dworkin 1992, Johnstone 1989, Andreasen 1984). Psychiatrists are placed at the top of the hierarchy within statutory mental health service provision and the training they receive in psychiatry is dominated by the biological model (Johnstone 1993, 1989). This model is also the approach most widely used amongst practising psychiatrists (Busfield 1996, Johnstone 1993, 1989). The biological model thus comprises the single most important influence in the conceptualisation and treatment of mental health problems within statutory mental health services.

Philosophical questions relating to the interaction of the mind and body are significant in the conceptualisation of mental health and illness. The notion that

'mind' and 'brain' are actually two different terms for talking about the same phenomenon is a widely held view in biological psychology. In this theory emotions are conceptualised as being caused by chemical processes in the brain. Thus in this view the study of the material structure of the brain and the biochemical processes which occur within it form the proper basis of the discipline of psychology and of psychiatry (Kalat 1992, Guze 1989, Carlson 1986,1984, Beloff 1975, Blundell 1975). Although many proponents of the biological model assert that environmental factors 'trigger' mental illnesses to develop in people who already have a genetic vulnerability to the diseases; social, psychological and environmental factors are not accorded much attention in their studies. Because of the dominance of the biological model, the majority of research which is carried out into the causes of mental illness focuses on identifying the precise genetic or biochemical processes which are thought to produce mental illness. To date, the findings of this research remain inconclusive. However, social science research which has identified links between social experiences and the causation of mental health problems has often been overlooked within psychiatry (section 1.1).

Associated with the biological approach in psychology and psychiatry is the widespread belief that in order to produce accurate knowledge, scientific disciplines should employ a positivist methodology (see section 2.1). A crude positivist methodology entails that issues relating to the researcher's politics, emotions, and values represent a bias when conducting scientific research and are thus an obstacle to the attaining of factual knowledge (see section 2.1). In this perspective, psychologists and psychiatrists, in order to count as scientists, must concern themselves with studying 'hard' data related to objectively measurable (at least in theory) changes in the organic structures of the brain and body. They should not set out to consider issues of politics and emotions in the aetiology of mental distress as

this would represent subjective and therefore essentially unscientific data.

There is considerable evidence to suggest that scientific research is inevitably affected by political issues; and so a refusal to acknowledge them tends to make the political ideas in the research enterprise covert. I discuss the role of politics and emotions in the research process in detail in chapter two. In terms of psychiatry however, diagnostic categories are invented by theorists within the discipline; and are then applied to individual service users by medical practitioners. Therefore psychiatry inevitably has an important social component and one that is also crucially affected by political issues (Scull 1989) (section 1.2).

To date there has been considerable debate (mostly occurring outside psychiatry) concerning the validity of the biological model of mental illness. However, there has been very little research done which has aimed to examine the social impact of the biological model by reference to the users of services themselves. Within the biological model of mental illness service users are perceived be suffering with a disease which can tend to undermine their ability to think, behave and communicate rationally. From this perspective there would not always be a lot of point interviewing service users, as the information which would be gained would tend to be unreliable.

The growth of mental health user groups in the last fifteen years provides evidence of widespread dissatisfaction amongst service users with the organisation and provision of mental health services under the community care policy. Research carried out with the user group MIND (Rogers, Pilgrim and Lacey 1993) indicates that a serious cause for concern among users is the lack of any alternative to psychiatric hospitalisation for those experiencing a mental health crisis. Many service users feel coerced into becoming a psychiatric hospital inpatient and/or receiving physical treatments because of a lack of any alternative service. Barham

and Hayward (1991) indicate that service users then have to deal with the stigma of a psychiatric label and a problematic identity as an ex-mental patient. Often their experiences leave them feeling isolated and alone, with difficulties in finding employment and suitable housing.

Research which has focused on service users perspectives (such as that carried out by Barham and Hayward 1991 and Rogers, Pilgrim and Lacey 1993), whilst providing valuable information relating to service users' views, do not investigate the specific issues affecting the women mental health users who participated in their research. This is a significant omission as gender is an inevitable factor in the construction and treatment of diagnosed mental illness. Although mental health issues can be seen as relevant to all members of society there are very distinctive political issues which need to be considered when investigating mental health service provision for women. The concept of mental health itself, and the way it is operationalised in the mental health system is an historical and social construct. Feminist researchers have drawn attention to the ways in which fundamental concepts of mental health and illness cannot be operated independently of gender (see section 1.7). Women comprise an oppressed group in society (see section 2.3) and this inevitably will have an impact upon their experiences of service use. Family life may be a significant factor in the causation and exacerbation of women's mental health problems. The pressures of motherhood, sexual abuse, incest and domestic violence are all factors that can have an impact upon women's mental health.

Although useful, research carried out with women service users by Miles (1988), does not explore key issues relating to the power relations within mental health service provision and the social construction of the concept of mental illness. In this research I argue that the social experience of women service users, including

issues relating to the oppression of women both within and outside psychiatry, must be fully taken into account in order to effectively analyse the operation of the mental health system (see also section 2.3). The conceptualisation of mental illness within the biological model of mental illness has a significant impact upon the organisation and provision of mental health services. In this research I have set out to interview women service users with a variety of social characteristics in order to analyse the women's perspectives on mental health service provision in the era of community care, and I use this information as the basis of an analysis of the social impact of the biological model of mental illness.

Chapter Two -

Methods and Methodology

Introduction

In the last chapter I reviewed the research which forms the background to my study. In this chapter I consider issues related to the research process. I discuss the epistemology which informs my research (sections 2.1-2.4), and go on to describe the methodology that I have used (sections 2.5- 2.9). I conclude by describing the methods I used in my fieldwork (sections 2.10-2.12). I use the term ‘method’ to refer to the actual techniques used for gathering information and the term ‘methodology’ to refer to the theory which informs the research process. I use the term ‘epistemology’ to refer to the theories of knowledge which constitute the philosophical basis for deciding what kinds of knowledge are possible and how knowledge claims may be validated. In line with my methodological commitments to reflexivity in the process of research I include an account of my background and political beliefs (section 2.5).

Epistemology

2.1. Objectivity in social scientific research

The dominant model of science in the Western world is based upon the empiricist approach and can be referred to as ‘positivism’ (Bryman 1988, Phillips 1977). Positivist epistemology has exerted a tremendous influence upon the development of science and has, in fact, become a defining factor in what counts as knowledge in many scientific disciplines (Steedman 1991).

According to the positivist model, scientific knowledge is a collection of individual facts about the world, collected and ordered by science by means of systematic observation of empirical data (Phillips 1977, Kolakowski 1972, Ayer 1966). In the positivist approach, the adequacy of any knowledge claim is based on its objectivity. The two criteria of objectivity are that, first, claims are capable of being verified by others by reference to observable facts, and that second, claims are not affected by the researcher's personal emotions, values and political interests. In order to ensure objectivity in hypothesis testing there is a common method which is meant to be followed systematically in order to exclude bias and ensure the neutrality of the process of observation. Observation of empirical data provides the evidence against which hypotheses can be tested and so is the basis for settling conflicting claims between competing theories. In the positivist approach it is often contended that empirical observation is unaffected by theory, and therefore neutral between competing theories and hypotheses.

The notion of empiricist objectivity which accompanied the development of Western capitalism was historically very progressive as it freed scientific research from the constraints of the church. All scientific and social scientific research is built upon a foundation of ideas which were developed during the enlightenment period, in which reason (rather than religion) was championed as a source of knowledge (Annandale 1998, Gurnah and Scott 1992)

However, there are several criticisms which can be made of the positivist conception of objectivity. Feminist researchers have revealed the white male bias in many of the dominant scientific explanations of social life (Campbell 1994, Harding 1993, Longino 1993). This bias indicates that political ideology has influenced the findings of the research in question.

Indeed, there is some evidence to suggest that the hypothesis testing method is not and cannot be 'value free', and so it cannot be 'objective' in the strict empiricist sense. Numerous philosophers of science (such as Winch 1990, Wittgenstein 1988, Kuhn 1962) have argued that observation is always mediated by a prior understanding of how the world interrelates. The formulation of any research question and the process of research itself, including the method of empirical observation, takes place within an overall theoretical framework. It is not possible for it to do otherwise for this is what renders the whole process meaningful.

“We do not deploy seeing in the activities of observation with a mind purged of all its contents; just the opposite is true, we need to know what sort of thing we are looking for before we can find anything to which we could give a name. We come, in fact, to the activities of observation with minds crammed full of ideas.” (Steedman 1991:54).

Which particular models for understanding and interpreting data are dominant at any given time is determined by what theories are available and, crucially, which of these theories is preferred above others. In this way the process of empirical observation cannot be strictly neutral, as it is inevitably affected by the theoretical commitments of the individual researcher, which in turn are influenced by the commitments of the wider scientific community.

Furthermore, political ideas may be an important factor in determining which theories are preferred in the scientific community and therefore may play a role in shaping the research process (Ramazanoglu 1992, Herman 1992). For example, on the basis of his clinical work with women at the end of the last century, Sigmund Freud developed an understanding of the origin of a psychological condition prevalent among women which was labelled 'hysteria', as being based in the sexual abuse of children (Freud 1962). However the radical political implications of his

theory were unacceptable in the wider scientific community, and consequently became unacceptable to Freud himself (Herman 1992, Masson 1985). Freud went on to develop an alternative explanation based upon the same clinical evidence. In his new theory he argued that child sexual abuse did not actually occur and that complaints of childhood sexual abuse by patients were really only produced by their sexual fantasies. Significantly his theory then served a politically reactionary purpose, the implications of which were held to be acceptable in the wider community (Herman 1992, Masson 1985). This reformulation of theory inevitably affected the observations which he made from his clinical work with women. Previously, women's complaints of sexual abuse in childhood were seen by him as revealing that children were actually sexually abused by adults. Armed with his reformulated theory however, he perceived the women's complaints as evidence of their childhood fantasy of engaging in sexual activity with adults. Although the women in his practice were saying similar things in both of these stages of his intellectual work, his observations were mediated by a radically different theory in each stage. Which of these theories was held to be acceptable by both Freud himself and by the scientific community was significantly influenced by the political climate of the time.

This example serves to illustrate a major problem with the conventional notion of objectivity. Not that it is too rigorous or objectifying - but that it is often not rigorous enough (Harding 1993, Jaggar 1983). This is because it has rested on the notion that it is possible for research projects to transcend political interests and values. In writing up accounts of research projects language is often used which masks individual emotion, perception and political belief. A third person account of research is still the required form of presentation in many disciplines within the natural and social sciences. This is because it makes a stronger claim to the objectivist

stance, appearing to remove the ‘fingerprints’ of the individual researcher. In fact many researchers have no choice but to write up their research reports using the ‘voice of god’ technique or they would have their work rejected by their peers.

“...fieldwork analyses reflect our identities, ideologies, and political views. Yet we often omit them from our published accounts because we want to present ourselves as social *scientists*: objective and neutral observers”. (Kleinman and Copp 1993:13 emphasis in original)

Certain Marxist theorists have argued that a political and ideological bias is working especially strongly in a crude positivist conception of objectivity; as the notion suggests that there is a category of knowledge which is totally independent of the social context in which it originates (Lukacs 1971).

It is by means of a thorough critique of the dualisms which were key in the development of Western capitalism that feminist theorists have identified the androcentrism in some scientific knowledge production (Maynard 1994, Ramazanoglu 1992). The dualisms which have been criticised are those which assume that objectivity is separable from and superior to subjectivity, just as mind is to body, reason is to emotion, male is to female. Hartmann (1979) has argued, for example, that the denigration of women as ‘emotional’ is an historically locatable phenomenon which is inextricably linked with the development of Western capitalism. Within Western capitalist society men are identified with reason, while women are identified with emotionality. From an early age therefore, girls are socialised to be dependent, empathic, receptive and responsive to emotions in others, while boys are socialised to be independent, instrumental, controlling and unemotional in their interactions. Males are encouraged from childhood therefore to concern themselves with issues of ‘fact’ untinged by emotion or value, the very norm which is so valued within scientific

research. Females on the other hand are encouraged to concern themselves with emotions and ‘values’, skills which are seen to be inferior to the masculine traits, and often thought inappropriate to scientific research.

“...sexist ideology serves the dual purpose of glorifying male characteristics/capitalist values, and denigrating female characteristics/social need. If women were degraded or powerless in other societies, the reasons (rationalizations) men had for this were different. Only in a capitalist society does it make sense to look down on women as emotional or irrational. As epithets, they would not have made sense in the renaissance. Only in a capitalist society does it make sense to look down on women as ‘dependent’. ‘Dependent’ as an epithet would not make sense in feudal societies.” (Hartmann 1979:21).

It is somewhat misleading however to posit a simple male/female dichotomy within the dominant ideology of Western capitalism, as within this ideology it is white men (particularly of the middle class) who benefit from being identified with reason. For example, by contrast, men of Afro Caribbean descent are identified with emotionality - excessive aggression and violence (Littlewood and Lipsedge 1989). This has significant impact upon the way they are treated within society generally and within mental health services in particular. Similarly, women of Afro Caribbean descent and white working class women may not be encouraged, within their own cultures, to be dependent and passive in the same way that white middle class women are.

However, it is important to note that emotions can provide a valuable source of knowledge. The analysis of emotional response, as this affects the researcher in the course of his/her work can yield important insight into the dynamics of the subject which is being investigated (Kleinman and Copp 1993, Kirkwood 1993, Kelly 1988) (for a discussion of the methodological implications of this see section 2.6). Whether emotions in the research process are acknowledged and analysed or not, however, all

researchers are affected by emotions at some time in the course of their studies. As Stanley and Wise have observed:

“Whether we like it or not, researchers remain human beings complete with all the usual assembly of feelings, failings and moods. And all of these things influence how we feel and understand what is going on. Our consciousness is always the medium through which the research occurs; there is no method or technique of doing research other than through the medium of the researcher.” (1983:157)

Historically, the notion of empiricist objectivity embodied in the positivist approach has been crucially important in the development of social scientific ideas. However there has been a tendency within this approach to overlook important questions relating to the role of values, emotions and politics as they affect researchers within the course of their work.

“There is no alternative to political commitment in feminist or any other ways of knowing. Since knowing is a political process, so knowledge is intrinsically political. The problem for sociologists of any persuasion is then how to validate the knowledge they produce.” (Ramazanoglu 1992:210-211)

The issue of validation will be discussed in the next section.

2.2 The role of ontology in questions of epistemology

Any discussion of epistemology inevitably entails ontological issues, that is, questions concerning the theory of being. Discussing what kinds of knowledge are possible and how these knowledge claims can be validated implies a view of what there is that can be known - the ‘it’ of which we are trying to gain knowledge. The issues of epistemology and ontology are currently a complex and contested ground within the social sciences. Positivist epistemology entails an ontology whereby reality

is comprised of a set of objective facts - truths which exist independently of theoretical or political belief. Therefore the role of the scientist is to find, analyse and present these objective truths in a neutral, objective and impartial way. Consequently many epistemologists working within the empiricist mode assert that the proper standpoint for research is that of the neutral disinterested observer. In the previous section I discussed arguments which suggest that no such standpoint is possible, as all research is politically and socially situated. Numerous researchers have asserted that all social science knowledge is unavoidably political in character and is therefore neither neutral nor disinterested (Ramazanoglu 1992, Finch 1984, Bell and Newby 1977).

It would be wrong however, to assume that this argument leads inevitably into a position of relativism where knowledge comprises a set of competing beliefs, each as valid as the other. Postmodernism, for example, in its strong form, responds to the problems associated with positivism by asserting that it is mistaken to attempt to research material reality at all, as there is no way of accessing an objective set of truths which comprise reality. Many postmodernists assert therefore that science is a 'doomed enterprise' and the task of research is to criticise and deconstruct existing examples of cultural production.

My position in this research is that although there is no standpoint outside of material and social life, there is a material and social reality which can be analysed and made accessible in the research process. As individuals we engage in material and social activities; our identities are created and recreated in these socially structured interactions. Social and material interactions influence the way we identify ourselves, and understand the world around us. As researchers we are affected by material and social processes at the same time as we attempt to analyse and understand these

processes. Thus for example in considering gender issues or questions of race, class, ethnicity and age it can be seen that we are all gendered, of an age, of a race, ethnicity and social class. There is no way to climb out of these material experiences to achieve the status of a neutral observer. Therefore research which makes a commitment to strong reflexivity in the research process and thus explicitly addresses its own social situation, including the political interests, power relationships, and imbalances which impact upon the researcher and the researched, yields a form of knowledge which is more valid and more rigorous. As the personal identity and political commitments of the researcher inevitably impact upon the research process, these factors should be clearly acknowledged and situated within the research focus. This approach has been developed (though not exclusively) by feminist researchers in the social sciences (see for example Maynard 1994, Kelly 1988, Harding 1987).

Furthermore, just as the social science researcher cannot become a neutral observer for the purposes of research, the social issues which are the focus of investigation are not themselves politically neutral. We can gain knowledge of social and material reality in studying material practices in society, but this knowledge is inevitably political in character. The operation of the medical establishment, or the family, for example, are not politically neutral phenomena. Such institutions structure social activity, their history and operation in society is crucially expressive of, and affected by, questions of political ideology. Conceived in this way, material reality is itself a political and social phenomenon and so it is not actually possible to obtain apolitical knowledge of it. This means that as regards research there are not simply competing opinions each as valid as the other. Instead there are competing political standpoints concerning material reality. In this way the particular analysis which is

adopted will reflect the political interests and motivations of the individual researcher, and the wider community of which the researcher is a part.

2.3 Standpoint Theory

Within the social sciences there are a variety of social locations which may be used as the central focus in researching any particular issue, but some of these locations will provide a more effective epistemological source of investigation than others. The importance of studying the experience of oppressed groups in order to understand the operation of the social system, has historically been acknowledged by a number of philosophers including Marx and Hegel. This idea has been picked up and developed by feminist (for example Hartsock 1987, Smith 1987) and Marxist epistemologists (for example Lukacs 1971). Inevitably however, asserting the standpoint of the oppressed as a significant epistemological source of investigation, entails an ontological position in which it is acknowledged that there are groups which experience oppression within society. It also implies a political commitment to understanding this oppression in order to challenge it. It is not surprising therefore that this idea has been developed by both Marxist and feminist theorists. Both of these social movements are concerned with praxis - theory as a guide to action.

In this research I use a Marxist definition of an oppressed group as a group of people who are systematically disadvantaged in relation to economic and social factors within the social structure, and in relation to whom there is a dominant ideology which asserts that this group is inferior to the rest of society who are not identified as belonging to the group. Women; the working class; people of colour; disabled people; and lesbians and gays, are examples of oppressed groups within British society.

I also utilise the Marxist view that the dominant ideology in any historical period is the ideology of the dominant class, a class in society which has a vested interest in maintaining its own position (Marx 1977). Because they wish to maintain their position at the upper echelons of the social hierarchy, the dominant class has an interest in ignoring, distorting and concealing the condition of oppressed groups within that society. As the ruling class within Western capitalism tends to dominate access to the means of knowledge production, prevailing scientific knowledge often reflects and perpetuates their interests (Lukacs 1971). Furthermore the ruling class tends to accept an interpretation of reality which perpetuates a hierarchical system of organisation which satisfies their needs. They are largely insulated from reality as it is experienced by oppressed groups within society. On the other hand oppressed groups have an awareness of the dominant ideology within society which justifies this status quo, coupled with an awareness of their own experience at the lower layers of the social hierarchy.

Marx has sometimes been accused of subscribing to a position of economic determinism in relation to ideology. This is a somewhat inaccurate criticism however, as within a position of Marxist dialectical materialism¹ social institutions like the state and the family (and the ideology which is embedded within them) are seen as operating relatively independently of the economy and are perceived as key variables in the organisation of economic relations of domination and subordination.

It has been claimed that because of their unique material position in society, studying social organisation from the standpoint of oppressed groups provides

¹ Dialectical materialism holds that human labour is the basis of social activity, and that all social phenomena have a material character. Development in the social, historical, ideological and intellectual spheres occurs from the conflict of emerging contradictions and the creation of a new more advanced synthesis from this conflict (Marx 1964, 1960, Engels 1960).

important insight into the material and ideological operations of the social order. Thus the standpoint of oppressed groups within society has been described as an epistemologically advantageous one (Smith 1987, Jaggar 1983).

Feminist standpoint theory (for example as advocated by Hartsock 1987, Smith 1987, Jaggar 1983) argues that the experience and worldview of women provides one of the best sources of knowledge in our society. Against this it has been argued that since women are divided in crucial ways by a variety of other characteristics including their social class, race, ethnicity, and sexuality, the standpoint of 'women' cannot be conceptualised as providing the best vantage point from which to carry out research projects. It cannot account for the variety of lived experience of the oppressed of different genders, classes, sexualities and so on. This is a criticism which has been levelled at standpoint theory by postmodernist theorists in particular (for example Smart 1995).

The acknowledgement and exploration of issues of difference, identity and power has been centrally important in the response of many feminists to the criticisms posed by postmodernist theorists, especially over the last twenty years (Charles 1996). Black feminists within the women's movement have recognised that their own experience has been excluded in some analyses of women's oppression (Lorde 1992, hooks 1989, 1984, 1981, Collins 1986, Bhavnani and Coulson 1986, Davis 1982). Lesbian feminists have indicated too that the particular experiences of lesbians have been ignored in some feminist writing (Frye 1983, Wittig 1980). As a consequence many feminists working within the women's movement have striven to develop a more inclusive politics which explores the tensions and contradictions, as well as the similarities, in women's lived experience.

In addressing strong postmodernist criticisms of standpoint theory, feminist

theorists have argued that all knowledge is inevitably socially situated and so there are a multiplicity of diverse standpoints (Haraway 1991, Stanley and Wise 1990). Different standpoints can represent different positions among women in terms of the type of oppression they experience and the power they may possess. A multiplicity of standpoints among women actually reflects the relations of ruling in society - a society where women may not be completely powerless by virtue of the fact that they are women, but may be in a privileged social and material position as regards other women and men in terms of factors such as for example, class, race, and sexuality (Ramazanoglu 1986). Thus there are a range of possible vantage points which can be consciously chosen according to their political and social location, and which may be available to men as well as women (see for example Cain 1990).

It has also been claimed that standpoint theory has strongly essentialist underpinnings² (Andermahr, Lovell and Wolkowitz 1997). However feminist standpoint theory attempts to avoid essentialism by asserting that experience only produces knowledge when it is analysed according to theoretical concepts relating to the operation of social processes (Harding 1991, Smith 1988). In providing a theoretical basis upon which knowledge claims can be validated, it is argued that knowledge must be able to account for experience but it is not itself directly given by that experience³. To say that oppressed groups are epistemologically privileged therefore, does not mean that the more oppressed a person is the more complete their

² Essentialism is often contrasted with social constructionism. The term 'essentialism' means certain essential, unchanging qualities from which differences spring (often cited as biological ones) (Andermahr et al 1997).

³ In this way standpoint theory attempts to avert a kind of identity politics in which knowledge is conceptualised as arising directly from experience so that one would need to share the same experience in order to properly understand it.

knowledge will be. A political understanding of the social relations which produce oppression and a personal experience of that oppression are two distinct entities. Experience of oppression does not in itself produce a critical awareness and understanding of the social relationships which have engendered this oppression (Maynard 1994, Jaggar 1983). For example, an individual member of an oppressed group within society may relate an experience which indicates that they been disadvantaged in a socially significant way and they may indicate that this caused them practical and emotional suffering. This does not mean however that they will necessarily perceive the political and social mechanisms which have produced this disadvantage. Significantly also they may not perceive themselves to be oppressed at all. As the ruling class tends to dominate access to knowledge production, the fact that the dominant class benefits directly from exploitative practices in society is often obscured. Within this ideology oppressed groups are often described as being disadvantaged because of a supposed flawed group characteristic. For example, there is some evidence to suggest that women are sometimes regarded in psychiatry as being inevitably more prone to mental illness than men, simply by virtue of the fact that they are women and so are by definition less psychologically healthy (see section 1.7). Because of this ideology, in many circumstances the distress suffered by oppressed groups does not push them towards a criticism of the social order but instead instils in them a belief that there is something wrong with them for feeling this distress. Thus feminist standpoint theorists are not taking up an essentialist position in the sense that they do not interview members of an oppressed group and simply repeat uncritically the views which they have on particular issues. They locate these views within a theoretical and political framework wherein the social processes which give rise to these experiences can be explored.

Of course it must be noted that research which sheds important light on the systems of oppression within society is often carried out with the dominant group in the relationship rather than the oppressed (see for example Samson 1995 section 1.1, Britten 1991 section 3.5, Broverman et al 1970 section 1.7). Researchers who aim to challenge oppression do not necessarily have to work with oppressed groups therefore. Nevertheless, interviewing members of oppressed groups can yield important information concerning the operation of institutionalised power relationships, which would not necessarily be accessible by focusing on the perspectives of the dominant group within such relationships. In my research, I utilise the perspectives of women mental health service users in order to examine the operation of the mental health system in general and the specific social effects of the biological model of mental illness. I will discuss this in further detail in the next section.

2.4 Women who use mental health services

The statutory mental health services are characterised by an extreme power imbalance between service providers and service users (see section 1.2). There is some evidence to suggest that psychiatry itself plays a role in the oppression of women service users (see sections 1.7 and 1.8). In my research I interview women service users in order to investigate women's experiences within the mental health system. I use this information to analyse the social implications of the biological model of mental health problems in psychiatry. I do not rely on the women's service users' experiences alone however, as their subordinated position in the psychiatric system often means that they gain a fragmented knowledge of the power relations at work in the system as a whole. It is necessary therefore to bring in knowledge of

social relations and the wider social structure which do not necessarily come from the women themselves (see also Glucksman 1994, Smith 1988).

I set out to interview women service users and ex-users from a variety of different social backgrounds including black women, lesbians, working class women, older women and women with disabilities in order to explore their experiences of mental health service use and consider the impact of wider societal oppression in the provision and use of mental health services. Despite my efforts to attract volunteers however, I did not interview any women who were over the age of sixty years old and I only interviewed one black woman and two lesbians. In view of these limitations it could be argued that it would be a mistaken enterprise for me to make any generalisations regarding the discrimination experienced by women belonging to these groups. The problem of extrapolating generalisations, however, is one that faces all qualitative research which focuses on the experience of a small number of participants. I can make no claims about the statistical representativeness of the women who participated in the research (see sections 2.11 and 2.12), nevertheless I do make generalised assertions throughout this thesis which I believe to be justified on the grounds of 'logical inference'. By this I mean that they are based on informed political and theoretical positions. Whether or not these generalisations are accepted as valid will hinge to some extent upon whether the theoretical and political positions I have adopted are accepted (see Gabe and Thorogood 1986 for a similar argument). This is also the approach recommended by Maynard (1994) when she says:

"If feminism is to fully confront racism and heterosexism, if it is to be able to analyze the interrelationships between class, race, gender and other forms of oppression, then it cannot let its focus remain with experience alone. One way of going beyond this is to use our theoretical knowledge to address some of the silences in our empirical work." (Maynard 1994:24)

Methodology

2.5 Situating the research self

I have argued that in order to promote validity and improve rigour within social science research, strong reflexivity should be included as an integral part of research methodology (see section 2.1). An investment of the researcher's identity within the research process is also an integral part of feminist research practice. It entails the researcher placing herself squarely within the focus of investigation, so that she owns the fact that she is as much a part of the data comprising the research as are the people who are being studied (Maynard 1994, Harding 1987).

By introducing reflexivity into the research process, knowledge will be gained which is more valid than competing claims which attempt to ignore this social context (see section 2.1). The background, assumptions and beliefs of a researcher provide important data in any research project. In this section therefore I will briefly outline my own biographical details and political commitments and discuss the ways that these impact upon the research.

I am thirty three years old, white and from a Welsh working class background. I have been committed to political activity from a young age, becoming chairperson and then secretary of my local Labour Party Young Socialist branch at the age of fourteen. At fifteen I was elected youth representative on the Wales Labour Party Regional Executive Committee. In the mid 1980's the Labour Party leadership decided to close down the youth wing of the party nationally, because they perceived its membership to be predominantly Marxist in ideology. Following this move I did not renew my membership of the Labour Party. At about this time I became aware of feminism through reading a book on the oppression of women

called 'Hidden From History: 300 years of Women's Oppression and the Fight Against It' by Sheila Rowbotham (1973). I became interested then in feminist politics as I perceived that an important dimension of my own experience as a woman in a male dominated society had not been addressed satisfactorily in the political activity which I had already been involved in. Subsequently I became engaged in feminist political activity - attending a consciousness raising group, joining 'reclaim the night' marches and becoming involved in women's groups for survivors of domestic violence and child sexual abuse.

My interest in issues relating to mental health have been stimulated by both personal and professional experiences. In my mid twenties I became a mental health service user primarily because of the distress I was experiencing related to experiences of childhood abuse. I was given a course of psychotropic medication to deal with the emotional distress I was experiencing, and I found this to be quite useful. In addition, as I was not offered any counselling on the NHS I enlisted the services of a private counsellor on a friend's recommendation. I found the experience of counselling to be a very rewarding one in terms of increasing my self awareness.

In terms of professional experience, I worked for eighteen months as a housing rights adviser at a homelessness charity. From this work I became aware of the lack of adequate services for many women experiencing severe emotional distress. When advising women who were experiencing domestic violence for example, it was usual to refer the woman to a Women's Aid refuge. However I found that the refuges could not accept women with very serious emotional disturbance, such as suicidal tendencies. These women then faced a choice of either returning to a violent partner or trying to become a voluntary patient in the local psychiatric hospital. Being in a position of advising women in such a situation was very difficult

as many did not want to take either of these two options, and there was very little else that I could refer them to. In one particular case a client told me that she wanted to go into a psychiatric hospital because she felt extremely distressed as a result of her partner's violence, and was afraid that she was going to kill herself. When I took her to see the admitting doctor at the hospital however, she was turned away because he said her mental health problems were not serious enough to require inpatient treatment. He told her she was 'attention seeking', gave her a course of medication and told her to 'go home and sort things out with her husband'. Understandably she did not want to do this, so I tried to place her in a women's refuge. As she was openly threatening to kill herself however, they said they could not accept her. She had no choice then but to return to the violent and dangerous situation in her home. Experiences like this provided me with some insight into the provision of mental health services for women.

The personal experiences that I have related in this section can be seen as key in motivating my interest in women's mental health issues. They can also be seen as influential in determining the methodology which I have chosen to investigate these particular issues. These experiences and the political conclusions that I have drawn from them are important in my sense of identity and as I am the researcher they inevitably exert some influence upon my work. This does not represent a bias which could be seen to discredit my research however. As I have already argued personal values, interests and political commitments are common to all researchers and will inevitably impact to some extent upon the research process (see section 2.1). To attempt to maintain a stance as a 'neutral disinterested observer' within the social scientific research process merely means that these factors are hidden from public view and exert covert influence upon the research. My contention is that personal and

political information relating to the researcher has relevance to the research investigation. It is an important part of the data as it clearly identifies the ideological and personal stance of the researcher, and so can be taken into account when considering the findings of the research. In this way it contributes to the rigour and validity of the research process.

2.6 The role of emotions in research

The sociological study of the role of emotions in fieldwork is a significantly under-researched field. This can be seen as an inevitable outcome of the demand for the social sciences to adopt the positivist approach which has been so influential in the natural sciences (see section 2.1). This has enormous costs for research in general however, and for the fieldworker in particular. Emotions are often seen as unprofessional and unscientific, and if acknowledged may be perceived as a weakness in the research process (Kirkwood 1993, Kleinman and Copp 1993). This is especially true for women researchers, whose emotional responses may be used as evidence for a misogynistic ideology in which women are seen as hysterical, overemotional and unable to reason properly (Kleinman and Copp 1993, Kirkwood 1993). This is not surprising as disregarding emotions as a source of knowledge is one way in which women can be devalued, in relation to white middle class men in particular (see section 2.1). As Kirkwood has observed:

“The challenge of recognising the utility of emotions and emotional receptivity is not simply the challenge of adding tools for the understanding human behaviour that have not previously been seen as valuable skills. It is also the challenge of contesting the fabric of patriarchal culture, in which ‘rational men’ are valued more highly than ‘emotional women’.” (Kirkwood 1993: 23).

Textbooks on interviewing all assert the need for interviewers to establish and maintain rapport with interviewees. Here rapport means being friendly but not 'too' friendly so that distance is always maintained. In order to be properly 'scientific' researchers are not supposed to address emotions in their work any more than this. Emotions which then do not fit this frame are often filtered out of the written version of research, lest its inclusion bring a charge of unprofessionalism (Kleinman and Copp 1993). However, emotions can provide a valuable source of knowledge within the research process (see for example Williams and Bendelow 1996, Kleinman and Copp 1993.) The emotions that are experienced in any given situation depend upon the individual's understanding and perception of that situation. In addition what is perceived as an appropriate emotional response is socially determined, and therefore influenced by factors of gender, class, political belief and so on (Jaggar 1983). Because of this, both the positive and the negative emotions which a researcher experiences can be analysed sociologically in order to provide a more in depth analysis of the subject in hand.

Emotional responses can also be used reflexively as a means of providing extra insight and refinement in the analysis of research findings (see also Kirkwood 1993, Kelly 1988). A simple example from my research indicates that the acceptance and analysis of an emotional response can provide additional insight for the researcher into the issues which are being researched. I found that on one occasion I was very anxious about visiting an interviewee in her home. On analysing the source of this anxiety however, I found that this was not a simple case of nervousness because I was travelling to another town to interview a woman I had never met before, regarding personal matters, in unfamiliar surroundings. Rather the source of my anxiety was that she had told me over the phone that she was a paranoid

schizophrenic. I was somewhat ashamed to find that my anxiety was a direct result of the stigmatising of mental health service users, especially those labelled as schizophrenic, as violent murderers who are out of control. In our society there is enormous stigma attached to anyone who is perceived to be suffering with a mental health problem. In a very immediate way my own emotional response made me realise the all - pervading impact of this stigmatisation, especially as I had always thought myself to be well aware of the demonisation of mental health service users which occurs in the media (for a discussion of this stigmatisation see section 3.4). The feeling of shame which I experienced here was triggered by a realisation that I had been 'taken in' by the prevailing ideology of inferiority of mental health service users. That I experienced this emotion provides an important clue as to my political beliefs, which include a commitment to studying and challenging the oppression which women mental health service users encounter.

2.7 Emotions and research on sensitive issues

The role of emotions in fieldwork is particularly important when sensitive issues are being researched. I became aware early on in the fieldwork of the strong emotional impact that the interviews would have upon me and that they often had upon the women I interviewed. The women interviewees usually talked openly and emotionally about their life experiences, revealing episodes of child abuse; domestic violence; rape; relationship breakdown; substance abuse; self harm; suicide attempts, and the traumatic experience of acute mental distress and emotional breakdown. In turn I experienced a whole range of strong emotional responses - often I felt nervous before an interview was to take place, anticipating the response I might get by the interviewee. I was often worried that the women might think my research too

intrusive into their private lives. As the fieldwork progressed I felt privileged that many of the women trusted me enough to be open about their feelings and experiences in the course of the interviews. I felt admiration for many because of the work they were doing in rebuilding their lives after experiencing a great deal of trauma. In many cases I felt angry and upset about what the women had experienced. In one interview I was moved to tears by a woman who told me about her experiences of child sexual abuse, the role that this played in causing her mental health problems and the lack of help she had received to help her deal with it.

I used a field journal in order to write down my immediate perceptions of the interviews I carried out. It proved valuable as it gave me an immediate outlet for the strong emotions I experienced during the course of the fieldwork. This also became an important tool for purposes of reflexivity. However, I found that the emotional effects upon me of the interviews I carried out in my research was not something I had been prepared for. In my previous work as a housing rights adviser I had been used to interviewing clients who were experiencing considerable distress. The interviews I carried out for my research however, proved to be a very different experience for me both practically and emotionally. The process of doing this type of research is a very isolating experience. In my previous role as a housing rights adviser I worked in a team and although I had sole responsibility for interviewing and advising a caseload of clients, there practical and/or emotional support available from colleagues immediately after the interviews, should this be necessary. Once it became apparent that my PhD fieldwork would become an emotionally distressing experience for me, my supervisors and myself made an arrangement that one of them would provide emotional support and a space to offload stressful emotions in supervision sessions during the course of the fieldwork, and the other would take responsibility

for the more traditionally academic aspects of research supervision. As Holland and Ramazanoglu state “the impact of interviews on sensitive topics should not be underestimated, and a support structure is advisable” (1994:137). Making a division of duties between supervisors in this way proved very useful to me, providing a clear definition of our roles as regards each other during this particular stressful stage of the research. Despite this support however, I did experience a substantial level of emotional distress. I believe that this is probably not unusual for anyone engaged in PhD research however given the subject that I was investigating I think that this did make it a particularly stressful experience.

I found that during the course of the fieldwork I began to re experience vivid memories and dreams of traumas that I had experienced in my own past which were no doubt prompted by the stories that the women were telling me. This accords with the experience of other researchers who have been involved in researching emotionally charged issues (for example Kelly 1988). Emotional responses in this type of research cannot be ignored as they will inevitably affect both the research and the researcher, whether they are acknowledged, analysed and used as an integral part of the research findings or not (see also Kirkwood 1993, Dunn 1991).

After the first four interviews I made the decision that in future I would not try to interview more than one woman in a day because of the emotionally demanding nature of the work. I developed a routine whereby immediately after the interview I would return home, write down all my responses to the interview in my field journal and then go to sleep for an hour or two because I was so emotionally exhausted. In addition as the fieldwork progressed I made the decision to see a private counsellor on a weekly basis in order to discuss the personal issues which were coming up for

me. This was extremely useful in view of the fact that the interviews were prompting the recollection of emotionally distressing experiences in my own past.

2.8 Interviewing as a reciprocal arrangement

As Ann Oakley has indicated in her influential paper “Interviewing Women: A Contradiction in Terms” (1981) what many methods textbooks have to say about interviewing in the field is often unworkable in practice. This was my experience in interviewing as I found that it was neither possible nor politically desirable for me to side-step interviewees requests for information (see section 2.9), or to maintain a stance of neutrality and disinterest in response to their concerns (see section 2.7). As the interviewees were recounting some of the most traumatic experiences in their lives, it was important that I engaged with them in a responsive and reciprocal way and did not attempt to establish rapport with them only in order to exploit them more effectively as a source of data. I was also concerned not to add to the distress of the women I was interviewing. However a familiar emotion when I began my fieldwork was guilt that some of the women were becoming upset in the course of the interviews. These feelings of guilt persisted often some time after the initial interviews were over and relate to my concern that I did not exploit the women in the study.

It has been argued that in order to avoid the dangers of exploitation, fieldwork should be reciprocal, that in return for participation in the research, the researcher should offer the participants something, such as a service or material reward (Skeggs 1994). One aspect of establishing reciprocity within the interview situation entailed my answering interviewees requests for information directly rather than side-stepping them (see also section 2.9). There were many requests for

information from the women I interviewed about the mental health services which were available to them; the side effects of their medication; the meaning of certain diagnostic labels, and so on. Where I could I provided this information, I also referred them to mental health agencies where appropriate, offering the telephone numbers of user groups, telephone advice lines, counselling services, and self help groups. It became quite obvious that many of the interviewees felt starved of information about such matters, and in fact more information being made available was probably the single most repeated suggestion for improving the mental health system made by participants in the course of the research. In addition, as the interviews progressed, I realised that I was offering interviewees a space to offload emotionally about their experiences. It became apparent to me that many of the women simply wanted to be heard and validated, although in the course of this some women would become upset.

Several of the women commented during the interview that I was not what they had been expecting when they first heard about the research, because I was not like the mental health professionals that had been involved in their treatment and care (see also section 2.9 on power dynamics and the issue of the researcher's perceived identity). The difference they indicated here was that they often felt disregarded and patronised by service providers. They were clearly relieved that I adopted a different approach, as many women indicated that a lack of interest, warmth and empathy on the part of professionals working in the mental health system was a significant obstacle to them when they were attempting to explain their experiences of emotional distress (see sections 3.2, 3.3, 4.2). What seemed to be the common thread in this feedback was that the interviews were experienced as beneficial because the women had been given attention and the space to talk to someone who wanted to listen to

them without imposing any pat answers or condescending pieces of advice. Although this is a very simple requirement, it is something which most of the women had not had much experience of. Other feminist researchers have found that the women they have interviewed have reported beneficial effects from their interview experience, for similar reasons (see Skeggs 1994, Phoenix 1994, Finch 1984, Oakley 1981). Some women commented on the therapeutic value of the interview. One woman (Heather) told me that the interview was part of her “healing process” and as I walked down her garden path on leaving her home after the interview, she shouted after me “thanks for what you’re doing for us!”. Another (Judy) said that the interview was a way of “clearing away more cobwebs”. On one occasion however I became concerned that one interviewee, Isabel, actually thought that I was a therapist and the interview was meant to be a therapy session rather than research. I was concerned to clarify the position and when I did so I found that what she was saying was that she knew that it was a piece of research but she thought that what I was doing ought to be provided as therapy. She said she found my use of a tape recorder to record the interview therapeutic in itself, as she thought it was proof that her views mattered because they were being kept and would be noted down in detail.

Negative feedback that the interview had been experienced as damaging or pointless was not given by any of the women I interviewed, but of course this is not to say that no one felt this way, just that they did not convey this message to me. All of the women that were interviewed at their homes were very warm and hospitable towards me and I was often moved by their acts of kindness, as I was after all, carrying out a one-off interview and was a complete stranger to them. I was always offered tea or coffee and sometimes I was invited to stay for meals. One woman who lived some distance away told me I was free to stay overnight in her spare room if I

did not want to take the long journey home after the interview was over. Another offered me the services of her husband in taking my car to the garage because I told her I was having some trouble with it. At Christmas time I received several Christmas cards from interviewees, a present of a book of poetry, and an invitation to a party at a mental health daycentre. Although I interviewed each woman only once I felt that in some cases an emotional bond had been established. This meant that occasionally I felt quite an emotional wrench when I left the interviewee, knowing that I would probably never see her again.

2.9 Power relationships within the interviewing process

Feminist researchers have drawn attention to the hierarchical power relationships which have characterised much social scientific research (Phoenix 1994, Skeggs 1994, Maynard 1994, Finch 1984, Oakley 1981). The social context in which research is carried out renders it almost inevitable that some kind of hierarchical relationship takes place. However much the feminist researcher may want to democratise the process of research, she will usually have more control over the research process than her interviewees, and where her interviewees do not share what can often be a privileged background, she will hold a place further up in the social hierarchy than them. It is important to note too, that the women interviewees in a study are usually not all equally powerless in terms of class and race, and can hold views which are oppressive in relation to other women and men. Interviewees may express views which the interviewer finds oppressive, for example if she is a black interviewer interviewing white women who express racist views to her (see for example Phoenix 1994). Phoenix (1994) mentions the case of the Jewish woman interviewer who carried out an interview with a woman whose flat was decorated

with swastikas. In this way many feminist researchers have asserted that it is necessary to become aware of, and explicitly address the complex power relations between the researcher and the researched (Skeggs 1994, Maynard 1994). An analysis of these power relations can prove difficult however as factors such as class, sexuality, age and race in both interviewer and interviewee, as well as the dynamics inherent in the issue which is being researched, all impact simultaneously upon the power dynamics of the interview (Phoenix 1994).

Despite my efforts to minimise the imbalance in the power relationship between myself as researcher and the women I interviewed, I was aware of a hierarchical relationship between myself and many of the interviewees. I come from a working class background, but in indicating to the interviewees that I was carrying out research for a PhD, I was immediately established within the social hierarchy as someone with a privileged educational background. It has been observed that the inevitable power relations in the interview situation can be mediated to some degree by the interviewer by allowing interviewees to ask questions which are addressed honestly by the interviewer rather than being side-stepped (Phoenix 1994, Skeggs 1994, Oakley 1981 - see also section 2.8).

Many of the women asked me questions about my own personal background, in particular asking me whether I had shared certain distressing experiences that they had experienced and were discussing with me. It is important to note that these requests for information were of an entirely different category to those that were purely fact based (see also section 2.8). To answer openly in this situation often meant that I was disclosing sensitive information about experiences in my own past and of course, unlike my interviewees I did not have a promise of confidentiality with regard to this information. When this happened I made the decision to answer such

questions honestly however, as I thought that since I was asking women interviewees to reveal sensitive details about their own lives, I should be prepared to mediate the power dynamic by being similarly open and honest within the interview situation. Clearly this decision was influenced by my political commitments which entail a rejection of the role of the interviewer as a 'neutral disinterested observer'. This political commitment also entails an understanding that women's oppression is a significant factor in women's experience of mental health problems, so that many of the experiences which contribute to mental distress are commonly experienced by women in our society (see section 1.7). I was therefore prepared for the fact that I would have at least some degree of shared experience with the women in my study. As the interviews progressed I became aware of the tendency of many of the women to want to look after and support others emotionally. Therefore I was careful when I answered such questions that I did not displace the emphasis onto my own personal experience so that the interviewees would have put themselves in the role of emotional outlet or support for me.

Answering questions in this way was an important aspect of my research and in most cases led to the adoption of a conversational style of interviewing. It has been suggested that such a conversational style is more likely with middle class interviewees who feel an equivalent status with the women who are interviewing them (Brannen 1993). This was not what I found in my research however, as working class women did not seem to differ from middle class women noticeably in this respect. This could stem from the fact that although I am involved in a middle class occupation I come from a working class background and this I think can be detected (as it often is in Britain) by accent. More importantly perhaps, the importance of my identity in relation to social class appeared to be superseded on many occasions by

the issue of my identity in relation to the mental health system, particularly as regards the service user/ service provider dichotomy.

The five interviews that were held on statutory service premises were the least successful in enabling the interviewees and myself to feel at ease in the interview situation. I did not feel at ease whilst interviewing within statutory services because on several occasions I was drawn into the power relationships that were being played out in these environments. The staff at the centres treated me with much greater respect and accorded me the privileges of a fellow mental health professional which they denied to the women users at the centre whom I had come to interview. Ann Phoenix (1994) has observed that when the rapport between interviewer and interviewee is disrupted it can be analysed to provide an important insight into the power dynamic of the issue which is being researched. Two interviews where rapport was extremely difficult to establish provides an illustration of the importance of the power dynamics which occur between mental health service user and service provider.

The fact that the professional staff at the daycentres where I carried out interviews treated me like a fellow mental health professional, meant that often I was perceived as such by the centre's users. One woman, Justine, seemed very anxious at the beginning of the interview and although she appeared keen to talk at length about her experiences in the mental health system she proceeded to do so in a manner in which a lot of anger was directed at me personally. In the course of the interview with Justine, she revealed that she had a lot of anger towards mental health professionals because of their inability to address her needs. That she perceived me to be another 'one of them' could very possibly have been one reason for her anger towards me. Although I assured the interviewees that I was not a medical

professional, by using the premises belonging to a statutory mental health service I was blurring the boundaries between myself and the mental health professionals involved in treating them. This blurring of roles was revealed when another of the women I interviewed at a statutory service daycentre, despite my indications to the contrary, told me that initially she thought that I was a medical student who was carrying out the research in order to qualify as a psychiatrist. Another said that she was surprised to find that I wasn't "cold and patronising like most medical professionals", suggesting, of course, that despite my manner I was in fact a medical professional. This was damaging in terms of establishing rapport with interviewees as the providers of mental health services are in an extremely powerful relationship with regard to the people that use mental health services. A consideration of this dynamic was influential in my deciding that I would not interview any more women on statutory service premises.

Issues relating to the researcher's perceived identity in the research situation have a significant impact upon the power dynamics of the interview. As my fieldwork progressed I became increasingly aware that clarifying my identity in relation to the mental health system both personally and professionally, was a key factor in mediating the power relationships between myself and the interviewees and in establishing trust within the interview situation.

In describing a study with Clergymen's wives, Finch (1984) asserts that she agonised about whether to reveal her identity as a clergyman's wife in case this would be perceived as a bias in the research. However, she found that some interviewees deduced that she was a clergyman's wife, and when she confirmed this fact, they became much more relaxed and willing to talk to her. Therefore Finch rejected the role of interviewer as a 'neutral disinterested observer' and took the

decision to invest her own personal identity within the interview situation in order to allay the fears and suspicions of her interviewees. As I have already mentioned (see section 2.5) my interest in the research topic has been inspired partly by my own personal experience as a service user. Initially however I was unsure as to whether to indicate this to the interviewees at the beginning of the interviews or merely whether to let it arise in response to any questions they asked. I was also wary of declaring any kind of shared identity merely in order to facilitate a more effective means of data collection by encouraging the women's disclosures.

My sense of confusion in relation to these issues was clarified in the course of the interviewing process. Like Finch, I found that I was 'unmasked' by some interviewees as the interviews progressed. Comments were made such as "you know you're very understanding about this, has anything like it happened to you?" This indicated to me that, at least to some extent, I did have an insider identity, and this was something which was being picked up on by some of the interviewees. After the first few interviews therefore I decided that I would indicate to the interviewees at the outset that my own personal experience was one of the reasons for my interest in the topic. Inevitably the women asked me questions about this and so I was able to clarify the situation. I believe this was important in establishing trust within the interview situation, especially considering the stigmatised identity of women mental health service users. This stigma meant that many women were particularly wary of being interviewed and exposing the details of their experiences of mental distress to someone who did not have at least some personal experience of this themselves. Many interviewees appeared to relax visibly when I mentioned that my interest in the subject was partly inspired by my own experiences. One interviewee told me that she

would not have been prepared to offer an interview at all if I had not revealed some shared personal experience in our initial discussion about the research.

As Finch's study has indicated, matching interviewer and interviewee in terms of social identity can promote rapport and encourage disclosure. Which particular aspect of a researcher's identity will encourage this rapport will depend to a large extent upon the particular dynamics of the issues that are the focus of inquiry. Of course this does not mean that a shared identity with participants is necessary in order to effectively carry out research. Political and theoretical understanding mediates experience in crucial ways so that it is perfectly possible for someone who does not identify with their participants to analyse and gain an understanding of their experiences and the social factors that give rise to them (see section 2.3). It is also possible that aspects of similarity could limit disclosure within the interview, because an interviewee might not want to discuss certain issues with another 'insider'.

Although investing my personal experience in the research was for the most part conducive in encouraging disclosure, on a couple of occasions it did appear to limit it. Because shared experience can sometimes appear to imply a shared understanding of the situation, I was aware that occasionally women were not clarifying what they thought because they assumed I would already know. I was alerted to this by being told things like "well I don't have to tell you, you know what I mean." I became careful therefore to ask interviewees to spell out things for me as it was important that I clarify what their thoughts on the matter were, rather than making assumptions from my own opinions.

Methods

2.10 The Pilot Study

Before I carried out the pilot study I submitted a research proposal to the directors of social services and the relevant health authority ethics committees in the South Wales area requesting permission to seek volunteers for the research in their areas. Of the three health authority ethics committees that I approached the first gave me ethical permission to proceed by letter after consideration of my proposal.

Another requested me to attend the meeting of the ethics committee where they would discuss my research proposal. This meeting itself comprises relevant data in research as it illustrates some of the power dynamics which are important when considering mental health service provision. I will outline the proceedings by quoting from my field journal.

“They were all medical doctors sitting in the board room of the hospital. I was shocked that in a meeting open to the public they were sitting around the table laughing, showing off, trying to compete with each other in ‘humorous’ tales about the severity of the eating disorders of their patients. “Well one of mine ate chips meant for 20 people!” “Well one of mine ate the plaster cast off her arm!”... Sitting there waiting for the meeting to start one of the two woman doctors on the committee said very loudly “this first proposal, I’ve never seen such a lot of confused nonsense...talking to them indeed, it’s no different to what we all do anyway. If she wants to know something she should ask us.” The others nodded and smiled in agreement. Of course mine was the first one and that was the one she was talking about...Needless to say they made it clear they did not understand the point of the research, and they did not like it. The research came under considerable attack... I felt small, short, young and very female.”

At this meeting most of the medical professionals (women included) seemed to be of the opinion that my research was pointless because I was intending to interview women service users about their experiences. Their opinion seemed to be

that they were the real experts, rather than the service users, and so the study would probably not provide any worthwhile knowledge. The hostile manner in which they received my research proposal contrasted with the enthusiasm with which they received the other proposals, all of which concerned the double blind testing of newly developed pharmacological medication upon patients. This attitude actually reflects one of the major criticisms made of the medical profession by many of the women who took part in my study. This was that the women felt disempowered by their doctors who they felt did not listen to them and did not respect what they had to say. Despite this ethics committee's opposition to my research, I received a letter from them telling me that they could not object to the study on ethical grounds and I was given permission to proceed. The third health authority ethics committee turned down my application for ethics permission, because, in the opinion of their scientific officer, the research did not fulfil adequate scientific criteria. They requested by letter that I amend the study in order to fulfil the scientific standards which they required, asserting that they would not even allow the study to be considered by the ethics committee unless I adopted a positivist approach in the research. I declined to do this.

Of the social services directorates, only one replied. This was done through a mental health officer who called me in for a meeting. By contrast, at this meeting I found him to be very interested in and enthusiastic about the research. He asked for a copy of the findings when they were available and told me that I could quote his name when approaching social services staff in a bid to find volunteers to take part. In addition he gave me a list of all the mental health daycentres in his area, and offered to write to them individually to ask them to participate in my research. He

told me that he thought that it was an important piece of work and so would like to offer help in whatever ways he could.

Following this, the pilot study was carried out with four women who were users of a mental health daycentre and were ex-psychiatric inpatients. I contacted these women via a feminist facilitator of a women service user's group at a mental health daycentre. I told about her the research and she asked the women in the group whether any of them would be willing to take part. Four women volunteered. The group facilitator, with their permission, gave me their phone numbers and I rang them to describe the research in more detail and arrange a time for the interview to take place.

I selected semi-structured interviews as the method of investigation for the research. Semi-structured interviews provide direction while still allowing a significant degree of open-endedness (Barham and Hayward 1991, Kirk and Miller 1990, Hakim 1987). I thought that this was appropriate, because my aim was to encourage the women to reflect upon their experience of mental health service use, and also to consider specific questions regarding the provision of mental health services. In this thesis I have used the information the women provided in the interviews as the basis for examining the social effects of the biological model of mental health problems upon service users. However, most of the women were not aware of the particular model of mental health that their practitioners were using. In the majority of instances, the content of the consultations the women described (including the explanations some of the women had been given for their mental health problems) indicated that their medical practitioners were using a biological approach to mental health issues. Indeed, as I described in section 1.1, the biological model is the dominant approach used in British psychiatry and it is a fundamental organising

principle for mental health services throughout the statutory sector. I did not attempt to check the conceptual approach used by the women's medical practitioners by contacting the practitioners themselves, for two main reasons. Some of the women could not remember the names of the practitioners they had seen, and second, I did not wish to do anything which would, or might appear to, compromise the confidentiality of the women who took part in the study. I thought that this was particularly important in view of the extreme power relations that exist within statutory mental health service provision. Consequently, I relied on the women's descriptions of the content of their consultations with medical practitioners as the main indicator of the approach their practitioners took to conceptualising mental health issues.

Because of the power relations in psychiatric service provision, I attempted to make it clear to interviewees at the outset that I had no connection with any health or social services body in order to distance myself from the mental health professionals that they were used to dealing with (but see also section 2.7 on the effect on power relations of the researcher's perceived identity). I dressed informally and explained that I was carrying out the research as part of my PhD project. I explained exactly how much information from the interviews would be kept completely confidential and how much might be used in publication. I reassured them that their names and addresses, and the names and addresses of any family, friends, services and staff they mentioned would be kept completely confidential. I also pointed out that short passages from the interviews might be quoted verbatim in the research but only if they did not hold information which could be used to identify the participant. Each participant was given a written letter which provided this information again and included my name, work address and telephone number for her to contact if she

wanted to discuss the research at a later date (see appendix d). Each interviewee was asked to sign a written consent form (see appendix e) and asked for permission to tape record the interview. All participants were asked if they would like a copy of the summary of the research findings when they are available. I made it clear to each participant that if she did not feel comfortable with any question she could 'pass' and move on to something else, and that she could end the interview at any time if she didn't feel like carrying on with it.

At the end of the pilots I discussed with the women what they had thought of the questions I had asked and the interview process generally. I interviewed each woman once, as I thought that I had collected adequate information from a single interview. I was also somewhat wary of making too many demands on the women's time and energy. Although establishing trust is certainly an issue (see section 2.7 for example) it could be the case that there are certain benefits associated with a one off interview in terms of the fact that interviewees do not have to commit themselves to continued participation.

In the course of the research I found it quite difficult to find women who were willing to volunteer to participate. The search for volunteers became quite a time consuming process, no doubt being seriously affected by the issue of the stigmatisation of mental health service users. Even when no longer using mental health services the fact that a person has been a psychiatric service user means that their credibility can be called into question at any moment. Many service users declined to be interviewed expressing concern over the stigma attached to mental health problems. Those who did volunteer to participate in the research often told me that they "didn't care what anyone thought about them anymore".

I included the pilot interviews in the research findings as they yielded extremely valuable information for the research, and also because the women I interviewed wished to contribute to the main body of the research as well as involve themselves in the pilot study. Following this pilot I amended the interview schedule only slightly. Of the four pilot interviews, three women spontaneously told me that they had experienced sexual abuse as children. This obviously has important implications in the provision of services and so I decided to add a question relating to abuse in the schedule. I was initially somewhat unsure about this as I felt concerned about asking the women to talk to me about such a distressing subject. On reflection however, I decided that the issue was of the utmost relevance and therefore I would ask directly about it. I took steps to make this as safe as possible - I made sure that although I had told the women at the beginning of the interview that they should feel free to pass on any question, I reminded them again at the beginning of questions 16 and 19 that they were free to pass. I located the questions relating to abuse carefully in the interview schedule, siting them in the middle of the interview so that I would have time to establish rapport with the women, ensuring also that I was not ending the interview on a potentially distressing topic.

The final draft of the interview schedule can be seen in appendix f. Thirty five women mental health service users were interviewed. Five interviews were carried out in mental health daycentres, two in the offices of user groups and the rest were carried out in the homes of participants. The shortest interview lasted only twenty minutes, the longest four hours. These were exceptions however and on average the interviews lasted around two hours. All thirty five women participants agreed to the interview being taped. I assured them that the tapes would remain securely locked in a filing cabinet and no one but myself would have access to them.

2.11 Finding volunteers to participate in the research

The criterion of selection used by Rogers, Pilgrim and Lacey in the 'People First' Study (1993) (see section 1.5.2) was that each participant should have had experience of being a psychiatric hospital inpatient. However, as a programme of psychiatric hospital closure has been implemented the number of psychiatric hospital inpatient beds has been drastically reduced. This criterion would therefore impose severe limitations on the number of women eligible for participation in this research. In addition there is evidence to suggest that women are more likely than men to be diagnosed by their GP and are less likely to be referred for specialist psychiatric treatment (see section 3.2). My criteria in selecting volunteers was that they should be women and should have had experience of using a mental health service from the range available in the statutory and voluntary sectors. Resource limitations dictated that volunteers were sought only in the South Wales area. I sent out a poster and leaflets to GPs surgeries, mental health daycentres, outpatient clinics, self help groups, user groups, supported housing schemes, women's refuges and so on in South Wales. In addition I attended various meetings of service users and mental health professionals in the voluntary sector. In these meetings I introduced the research, made a request for volunteers and distributed more leaflets. I explained to potential volunteers the purpose of the research and what would happen in the interview. If they wanted to go ahead we then arranged a place and time for the interview to take place. A full breakdown of the participants characteristics in terms of service use, race, social class, age, and diagnostic label, can be seen in section 2.12 below. I did not seek volunteers who were actually hospital inpatients at the time the interview was to take place. This decision was based on problems associated with

researching hospital inpatients which has been revealed in previous research, in particular that carried out by Batcup with inpatients of the Royal Maudsley psychiatric hospital (1995). She found that although her participants were assured of the confidentiality of the interview, some still did not feel able to speak freely, perceiving that a criticism of the hospital establishment could have repercussions for them in terms of their treatment. As many inpatients are held in hospital involuntarily and can have physical treatments like medication and ECT imposed upon them, this factor is important in limiting the effectiveness of interviewing inpatients.

I have adopted a qualitative approach in my study in order to explore in depth the experiences and perceptions of a small number of women mental health service users in regard to service provision. The representativeness of the women participants in this research in relation to the whole population of women mental health service users is an issue however. As there is no central bank of statistics which presents a comprehensive profile of women who use the mental health system, the participants cannot be compared with appropriate data relating to the female mental health service user population of either Wales or Britain. Because of this, it is not possible to ensure that the women are representative of the whole population of women mental health service users. However I attempted to ensure that the women came from a variety of social backgrounds and have used a diverse range of mental health services (see section 2.12). In addition, although all of the women lived in the South Wales area, they were drawn from five different Health Authority areas in South Wales.

2.12 Breakdown of services used by interviewees

In this section I include a breakdown of the mental health services which women in the study have used in both the voluntary and statutory sectors, in order to indicate the particular range of service use which has informed their experiences, and consequently informs this research (see table 1). In addition I include a breakdown of the point of first contact with women in order to indicate the range of social locations in which service users were enlisted to participate in the study (see table 2). In the literature review (sections 1.2, 1.7 and 1.8) I discussed how the practice and theory of psychiatry can perpetuate the oppression which some service users experience in the rest of society. This is a theme which I explore throughout this research and I therefore include a breakdown of the participants characteristics in terms of race (table 3); social class (table 4); age (table 5); sexuality (table 6); and disability (table 7). The experience of mental health service use is affected significantly according to the medical diagnosis which women have been given as users of services within the statutory sector. Therefore I include a breakdown of the diagnosis which participants have received within the statutory mental health system (table 8).

Table 1: Services Used by Interviewees

Service:	No. of women who have used this service (out of a total 35):
GP	33
Psychiatrist	25
Psychologist	21
Psychiatric hospital (inpatient)	19
Mental Health Daycentre (statutory)	16
Community Psychiatric Nurse	11
NHS counsellor	3
Social Worker	11
Women's Refuge	2
User Group	12
Supported Housing	3
Self Help group	17
Private Counsellor/psychotherapist	6
Residential Rehabilitation Unit (drugs and alcohol)	1
Complementary therapies:	
Aromatherapy	10
Homeopathy	6
Hypnotherapy	7

It can be seen that thirty three women have consulted their GP regarding a mental health problem. For most of the women their family GP was the first point of contact when they sought medical help with a psychological or emotional problem. Three women were referred to counsellors working within the NHS. Six women have paid for counselling/ psychotherapy in the private sector. Three women said that they had received counselling from community psychiatric nurses and three said they had been counselled by psychologists. A third of women have used some form of

complementary therapy, usually aromatherapy, homeopathy, or hypnotherapy which was offered in the private sector and which they paid for themselves.

Table 2: Where Interviewees Were Initially Contacted

Via - Mental Health daycentres (statutory sector)	6
Mental Health network (voluntary sector)	5
Sexual Abuse Survivors groups (" ")	5
Manic Depression Fellowship groups	5
MIND groups	4
National Schizophrenia Fellowship groups	2
Psychiatrist Outpatient Clinic	1
Women's Resource Centre	2
Other (being told by a friend etc.)	5
<hr/>	
Total	35

I attempted to attract participants in the research from a wide range of services. It can be seen that five women were recruited by 'word of mouth'. This refers to women who were not recruited directly via a mental health service, but who came forward to be interviewed after hearing about the research from friends and family who were themselves mental health service users.

Table 3: Race of Interviewees

Black - GB	1
White - GB	32
White - Other	2
<hr style="border-top: 1px dashed black;"/>	
Total	35

Previous research has indicated that people of Afro Caribbean descent are over represented in the psychiatric inpatient population (MIND 1992b, Torkington 1991) but seriously under represented in service user groups such as MIND. In order to address this I printed and distributed leaflets to statutory and voluntary services which specifically appealed for black women to come forward to participate in the research (see appendix c). In addition I contacted the only two groups in the voluntary sector in South Wales who provide services for people of colour specifically. Unfortunately no volunteers were forthcoming from these groups and I was only able to interview one black woman. As I asserted in section 2.2 questions of race, class, gender, sexuality and other oppressions have relevance in the discussion of the provision of mental health services. In order to address these factors fully it is necessary to focus on theory as well as experience. As there is only one interviewee who is black in this research, this represents an important limitation in the research. Nevertheless I will address issues which relate to racism in the provision of services using theory; and secondary sources where these are available; in order to compensate for the gaps in experience which are present in the research (see section 2.4).

Table 4: Social class by present or last occupation held

Registrar general's classification by occupation:	No. of women participants:
Social class I /II (professional/managerial)	13
Social class IIIN (non manual)	15
Social class IIIM (skilled manual)	1
Social class IV/V (semi-skilled/unskilled manual)	3
Never held a full time paid occupation	1
Still in Full time education	2
<hr/>	
Total	35

As an indicator of social class position in my study I use the Registrar General's classification of class according to occupation, which is used in population studies in Britain. The women are classified according to their last full time paid occupation however, as some of the women are full time carers, others are unemployed, or have withdrawn from full time paid employment due to physical and/or mental ill health. It must be borne in mind however that occupation is only one indicator of social class position. A wide range of factors have a bearing on social class position - such as occupation, educational qualifications, income, housing and family background (Charles 1990, Pollert 1981).

Nineteen women who participated in my research belong to categories III - V and therefore could be described as working class (category IIIN indicates shop work and low grade clerical work - Charles 1990). Thirteen women belong to categories I/II. This category predominantly represents a number of teachers and qualified nurses who took part in the study. A link between poverty and mental

distress has been suggested in previous research (see for example Bruce et al 1991, Hollingshead and Redlich 1958). Therefore it would seem that women from a professional and/or managerial background are proportionately over represented in the research. In the course of my fieldwork it did become apparent that women who had been educated beyond secondary school level were proportionally more likely to volunteer to take part in the research, as compared with women who hadn't had the same level of educational opportunity. I interviewed five trained nurses and four teachers. A further six women have been university educated, although not all of them were able to complete their studies at university because of their experience of mental health problems. It would certainly be true to say that their education meant that these women were more familiar with the purpose of PhD research. For example many of the nurses that I interviewed had already encountered this kind of research in the course of their professional training.

Table 5: Age of Interviewees

Years Old:	No. of women participants of this age range:
16 - 19	1
20-29	9
30-39	7
40-49	11
50-60	5
Did not choose to disclose age	2
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Total	35

Significantly there are no participants in my research who are over sixty years of age. The available literature indicates that older women are prescribed more

psychiatric medication than any other age group and they are least likely to be offered counselling despite the fact that they are more at risk from the side effects of medication (Williams et al 1993). In an attempt to attract older women I printed and distributed leaflets appealing directly to women over sixty. In addition I contacted voluntary organisations and social workers who work with older people in order to appeal to older women service users to participate in the research. However no one over sixty came forward to take part in the study. Mental health statistics compiled by the Welsh Office (1999) indicate that the largest single age group of psychiatric hospital inpatients is people over the age of sixty five years old. There were 7,865 people in this age group who were inpatients in 1998 (compared to 3,335 in the thirty five to sixty four age group - these figures were not broken down according to gender - Welsh Office 1999). It is therefore a significant limitation in the research that there are no women over sixty.

Table 6: Sexuality of Interviewees

Lesbian	2
Bisexual	2
Heterosexual	30
Not Sure	1
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Total	35

I printed and distributed leaflets appealing specifically for lesbians to come forward to take part in the research (see appendix c). I also contacted groups for lesbian and bisexual women in a bid to find volunteers. However, only two women came forward who defined themselves as lesbians and two who defined themselves as bisexual.

Table 7: Disability of Interviewees

Disability (physical)	7
Disability (mental)	2
No disability	26
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Total	35

Problems of definition came to the fore as regards disability. Several of the women inquired as to whether they should describe themselves as disabled because of their mental health problems. In these circumstances I left it up to them to define their identity themselves. Two women defined themselves as suffering with a disability because of their mental health problems. Seven women said that they were disabled because of a physical condition.

Table 8: Most Recent Diagnosis of Interviewees

Acute Psychosis	1
Manic Depression	7
Schizophrenia	2
Depression	10
Anxiety	2
Personality Disorder	1
Not informed of their diagnosis	10
Respondent did not wish to disclose diagnosis	1
Not consulted a medical doctor	1
<hr/>	
Total	35

Within the statutory services, the first stage in the treatment of any psychological or emotional problem is the diagnosis of the problem by a medical professional (Foster 1995). GPs usually diagnose what are regarded as the ‘minor’ mental health problems (anxiety, non severe depression) while a psychiatrist usually diagnoses the ‘major’ illnesses (e.g. schizophrenia, manic depression). There is considerable disagreement in the medical profession as to the specific diagnostic categories used in psychiatry (Foster 1995). In my study many women had accumulated several diagnoses from different doctors and psychiatrists throughout the history of their service use. Therefore this table represents only the diagnosis they had received most recently. Ten women have not been informed of a diagnosis although they use statutory mental health services on a regular basis. Of those women who had been told a diagnosis and who wished to disclose it to me, depression and manic depression were the most common categories applied.

2.13 Data analysis

In 'Analysing Qualitative Data' Bryman and Burgess state:

“[First] there is no standard approach to the analysis of qualitative data; secondly data analysis relates not only to technical procedures but also to the social relations aspects of fieldwork; finally...much of the work in which investigators engage in this stage of the research process is as much implicit as explicit.” (Bryman and Burgess 1994:12)

I discuss the 'social relations' aspects of fieldwork in sections 2.5 - 2.9. In this section I describe the technical procedures used to analyse the data collected.

Stage one of the analysis process was to familiarise myself with the data I had collected (Ritchie and Spencer 1994). Interviews were replayed, transcribed and re-read soon after completion to ensure a successive development of ideas during the interview process (Porter 1993). I immersed myself in the data - reading through my fieldnotes several times, listening to the tape recordings of the interviews twice through and then transcribing them verbatim. In the course of doing this I examined the issues that were highlighted by the original research question and explored the answers to the questions that were posed to the interviewees (Miles and Huberman 1994). In the initial stage of the research process I had formulated general hypotheses and these hypotheses were empirically tested in the interview and analysis process (Porter 1993). This led to a degree of hypothetical reformulation. For example it had been my intention to analyse the need for residential service provision for women, but as the interviews progressed it became apparent that in exploring this question, the use of the biological model of mental illness has considerable salience (as it does for the provision of mental health services across the board - see also

introduction to the thesis). I thus readjusted my focus to explore the impact of the biological model of mental illness upon mental health service provision.

In analysing the interview data I made a list of the recurrent themes and issues which were important to the interviewees. I looked for recurring phrases and common threads of ideas and examined themes arising from the recurrence or patterning of particular views or experiences. For each of the main themes I drew up a flowchart in which I explored the causal connections, contradictions and similarities in the conceptual data. From these charts I developed a thematic framework. I systematically applied the thematic framework to the textual data, making notes of the headings on the margins of each transcript (Ritchie and Spencer 1994). I adopted a 'cut and paste' approach whereby sections of verbatim text were regrouped and compared/contrasted according to their thematic references. I then went back to the flowcharts and fed back into them new information gleaned from the analysis of the verbatim texts. As the final stage I interpreted the data set as a whole.

In the thesis I numerically count personal characteristics and viewpoints in order to provide further information about the salience of particular issues and I indicate percentages accordingly. However, the use of percentages is not meant to indicate that the study makes any claims to being of a statistical nature (Mason 1994). Rather this is used to provide information relating to the proportions of the sample group who had particular views, characteristics or experiences.

Conclusion

In this chapter I have provided an in depth review of the methodology I have used in my research and considered the epistemological issues which inform the theoretical basis of my methodology. I have argued that in order to improve the

validity of research, the background and political views of the researcher must be placed squarely within the research frame, as issues of values, politics and emotions can have an important effect upon the research process.

In this chapter I have detailed the methods I used to contact and interview the participants in my research. I have also provided a breakdown of the characteristics of the women interviewees in terms of service use; point of contact; medical diagnosis; race; class; sexuality; disability; and age. In order to investigate issues relating to women's oppression within the mental health services I attempted to attract women participants from a diverse variety of social backgrounds. However I was not altogether successful in this aim as only one black woman volunteered to take part in the research, only two lesbians and no women over the age of sixty years old. This does represent a significant limitation in my research. In order to make up for the gaps in my empirical material, I use theoretical and secondary sources wherever possible. However, this does not always compensate for the lack of participation of women who come from the aforementioned groups, as there is a dearth of research available concerning women service users perspectives on the operation of the mental health system. Consequently, my research findings are limited in these key areas of women's experience.

In the following four chapters I present the findings of my research in relation to the women's experience of diagnosis, stigma and medical treatment (chapter three); issues of discrimination within mental health service provision (chapter four); the particular experiences of abuse survivors in the mental health system (chapter five); and the women's views of community care and psychiatric hospitalisation (chapter six). At the beginning of the next chapter I introduce the findings of my

research by providing a brief overview of the main issues which came up in the interviews.

Chapter Three -

The Impact of the Biological Model on Stigma, Diagnosis and Treatment

Introduction

I begin this chapter by providing a brief overview of the main findings of my research and I indicate the sections in my thesis where these findings are analysed in depth (section 3.1). I then go on to discuss the women's experiences of consulting GPs and psychiatrists (sections 3.2 and 3.3). I consider the women's experiences of stigma, examining in particular the ways in which the biological model of mental health problems contributes to the stigmatising of service users (section 3.4). I also consider in detail the women's experience of diagnosis (3.5) and medical treatment (3.6). In considering these findings however, it must be borne in mind that these issues do not operate in isolation. For example, issues of discrimination (the subject of chapter four) are connected with the medical approach used by GPs and psychiatrists. Therefore throughout this thesis I make references to other relevant sections in the research, where appropriate. Instead of describing the detailed social characteristics of each of the participants every time I refer to them, I have provided biographical data relating to each of the women at the end of the research (appendix a). Of course the names of the women have been changed in order to preserve their confidentiality.

3.1 An overview of the main research findings

I asked all of the women who took part in the study whether the mental health services they had used had been helpful to them. I then went on to identify what, for them, characterised a helpful experience in relation to the specific attitudes of service providers and the treatments that were made available.

The majority of women in the study (sixteen, or 46%¹) reported that overall they had had mixed experiences within statutory mental health services. They cited numerous problems but had on occasion received assistance from mental health professionals which they had found to be helpful to them. Thirteen of the thirty five women (37%) whom I interviewed for this research reported that their experiences within statutory mental health services had been totally unhelpful, and had even been damaging to them. The women in this group said that overall their experiences with mental health professionals had exacerbated their mental health problems, rather than helping them. Six of the thirty five women (17%) who took part in this study said that overall, the statutory mental health services they had used had been helpful to them.

The problems which the women described covered a broad range of issues including an over reliance on drug treatment and ECT (see section 3.6), widespread discrimination against women service users (chapter four) and an inability amongst many statutory service providers to deal with mental health problems which are social rather than biological in origin (chapter three, four, five). Many women in the study

¹ As I mentioned earlier, the use of percentages is intended to give the reader an indication of the prevalence of certain viewpoints, characteristics, or experiences amongst the interviewees. It is not meant to imply that the research is statistically representative.

reported being treated like 'objects on a conveyor belt' rather than people by medical practitioners (see section 3.3).

Some women said they would like to see women psychiatrists and community psychiatric nurses and were unhappy that they were prevented from doing this despite repeated requests (see section 4.3). Several women said that they would like to see psychiatrists with key social characteristics in common with them other than gender, such as race (see section 4.9), class (see section 4.8), and sexuality (see section 4.5). Opportunities to see psychiatrists who shared these characteristics with them were not made available however.

The majority of women criticised the policy of care in the community for failing to address their needs; they opposed the programme of psychiatric hospital closure despite expressing reservations about hospital treatment (see chapter six). One reason why many women opposed hospital closure was because they identified a need for a residential mental health service when they could no longer cope within their home environment (see section 6.5).

Several women said that they had originally approached mental health services for help with distress caused by the oppression they had experienced in wider society. Significantly many of these women indicated that the services did not help them and, in some cases, this oppression was actually repeated within the services themselves. This issue is explored in depth in chapter four on women's experiences of discrimination within the mental health system, and in chapter five concerning the particular experiences of women abuse survivors.

One of the most disturbing issues which came up within the interviews referred to the sexual abuse of women patients by male professionals and male service users. Several women in the study referred to incidents of sexual harassment

and physical and sexual abuse within statutory mental health services. This ranged from reports of male professional's apparently salacious interest in the sex lives of female patients to repeated rape by male professionals and male patients in psychiatric hospitals. All of the women who reported that they had been abused when they were using the services were survivors of child sexual abuse and had also experienced abuse from male partners. I describe the experiences of the women abuse survivors who participated in my research in detail in chapter five.

3.2 The women's experiences of consulting GPs

The first point of contact for people seeking help with a mental health problem in Britain is usually their GP. In most cases it is via an initial GP referral that access to specialist psychiatric services is gained; whether this is a consultation with a psychiatrist, a visit from a community psychiatric nurse, psychiatric social worker or sessions with an NHS counsellor (where these are available). Mental health problems which are regarded as mild by GPs are treated by them without specialist intervention, while conditions which are regarded as indicative of a serious mental illness are referred on to psychiatrists.

Of the thirty five women who participated in this study, thirty three (94%) had approached their GP with a mental health problem. Of these, fourteen (42%) said that their GPs had been consistently unhelpful to them. Thirteen women (39%) said that they had had mixed experiences overall, and six women (18%) said that their GPs had always been helpful in assisting them with a mental health problem.

Amongst the women who had unhelpful or mixed experiences there were five main sources of dissatisfaction. These included their GPs displaying a dismissive attitude towards them and refusing to take their concerns seriously; sexist attitudes amongst

GPs; the very brief time their GPs spent in consultation with them; a reliance on prescribing medication; and an inability to discuss psychosocial issues relating to their mental health problems.

Many women complained that they found it difficult to access specialist services because their GP would not take their mental health problems seriously. For example, Pauline described how her GP had been dismissive towards her when she approached him for help because of the distress she felt at having been sexually abused in childhood:

“I told my doctor 15 years ago about it and he just told me to forget it...he said ‘well these things bother us when we get older’. So I actually got into the services via the doctor in the family planning clinic...I said look, I can’t cope anymore and I couldn’t go back to my own GP. So she wrote a letter for me and she sent it to my own GP as well and that’s how I got into the [specialist] services.”

Previous research has indicated that women are more likely to be treated for a mental health problem by their GP but less likely to be referred for specialist help than men. For every hundred women diagnosed by GPs as having a mental illness, only three were known to specialist psychiatric services (Community Care 1994). This compared to ten in a hundred for men.

In this study, several women complained that their GPs had expressed sexist attitudes towards them, and in particular had disregarded their concerns by making patronising references to ‘women’s troubles’ (sexist attitudes amongst GPs are discussed in detail in section 4.2). The ideology that women are inevitably more prone to minor mental illnesses by virtue of their gender - in particular their reproductive processes (see section 1.7) - can be seen as influential in the attitude of many GPs who refuse to take their women patients concerns seriously and refuse to refer them on to specialist service providers. In order to overcome the obstructive

attitudes of some GPs, many women argued that there should be a process of self referral to specialist services, so that they could directly access community psychiatric nurses, counsellors, psychologists and psychiatrists.

Another central criticism was that GPs spent only a very brief amount of time in consultation and usually prescribed medication to ameliorate the women's feelings of distress, without discussing with them the possible reasons why they felt this distress. Many of the women felt dissatisfied because their GPs did not provide them with any sort of explanation for their mental health problems. For example Jade said:

“Over the years doctors have just dished them out [tranquillisers and antidepressants] willy nilly. You go to see some doctors and you go in and they've got the pen ready on the prescription pad 'right what do you want?' 'Well I would like to know what's wrong with me first'. 'Oh!' .”

Foster (1995) has asserted that many GPs may prefer to prescribe their patients medication to ease their feelings of distress without making a formal diagnosis of mental health problems, particularly as many are aware that the reasons for their patients distress reside in social problems such as poverty, bad housing, and unemployment. Foster asserts that as they feel powerless to do anything to resolve these issues, GPs prescribe medication in order to assist their patients to cope with their life situation. She notes that:

“Doctors may be fully aware that what their patients really need is better housing or a job or a divorce but they cannot provide these stress relieving solutions for their patients, nor in many cases can their patients avoid the social conditions which may be creating their anxiety...Whilst GPs may be able to do little or nothing to prevent or alter very poor housing conditions or bad marriages, the prescribing of tranquillisers to women facing such problems must at the very least be regarded as palliative for social inequalities, rather than a cure for medical illnesses.” (Foster 1995:91)

However, many of the women who participated in my research indicated that their GPs had neither the time nor the inclination to find out about the social issues which may have contributed to their mental health problems. Two women (Mandy and Sheila) were referred to counsellors attached to their GPs' surgeries, because their GPs believed that the women's distress was linked to stressful life events. However this was exceptional overall, as the majority of women indicated that they were prescribed medication without being offered the opportunity to discuss the social and personal issues which may have been significant in causing or contributing to their mental health difficulties. Pressures of time in a busy GP's surgery obviously encourages the tendency of many doctors to prescribe medication without inquiring into the possible causes of a patient's distress. Funding shortages in the NHS mean that many GPs may find that they have only a few minutes to spend in consultation with each patient. Some GPs do, as Foster has asserted, believe that their patients' distress has been caused by psychosocial issues. Nevertheless, medication is often the only treatment which is available to service users. Furthermore, the medical training of GPs is dominated by a biological model of illness causation in which they are primarily trained to diagnose and treat physical illnesses on the basis of their patients presenting symptoms. GPs receive only a relatively small amount of training relating to mental health (within the biological model of mental health problems), and thus they may often feel ill equipped to discuss issues relating to mental health problems with their patients; especially where they perceive these problems to be caused by psychosocial issues (Foster 1995 - see also section 1.3).

Of the women who had had good experiences with GPs, a recurrent source of praise was that their GP respected them, took the time to talk to them about their personal concerns and was willing to refer them on to specialist service providers

when they were requested to do so. In addition a helpful GP was one who listened to them and took into account what they wanted to achieve rather than simply imposing a treatment plan upon them regardless of their wishes in the matter. Such attitudes made the women feel that their GPs were attempting to work with them rather than against them. For example Diane said:

“I felt like she trusted my own judgement of what the situation was. She didn't want to rush me off to the nut house, but on the other hand she didn't want to play it down and oh say this is nothing serious. She accepted my judgement that this is probably a temporary problem that might be helped by a drug of some sort just to give me a foothold out of it and yeah she wasn't judgmental about it or putting me down or anything.”

Similarly Heather observed that her GP had been very helpful. She said:

“He doesn't seem to be in such a rush as some people are - you know writing the prescription before you get through the door sort of thing. He treats me on a level of intelligence with himself, which I probably am. I really think he tries to help me on the way to where I want to go rather than pushing me to somewhere where he wants me to go.”

GP's often act as gatekeepers for other services, and as GPs are the first point of contact for many women service users, they should, at the very least, provide women with up to date information concerning outside agencies which provide support, free advice and assistance. A lack of information being provided was one of the central concerns expressed by the women who participated in my study; and many said they would like to be informed about the existence of other mental health services, such as self help groups; women's refuges; free counselling services; and housing and welfare benefits advice centres.

Many of the women clearly had a low expectation of the amount of assistance they could expect from GPs in relation to mental health problems. GPs were perceived by some women to represent a gateway to further service provision rather

than as experts themselves in the treatment of mental health problems. By contrast psychiatrists were regarded as the ultimate experts and so there was a far higher expectation of their potential to assist service users (even though in practice many said that they did not provide adequate assistance - see section 3.3). I explore issues relating to the women's experience of consulting psychiatrists in the following section.

3.3 The women's experience of consulting Psychiatrists

Twenty five (71%) of the thirty five women I interviewed had been treated by psychiatrists. Of these, seventeen (68%) had found their psychiatrists to be totally unhelpful to them, four (16%) had found them to be helpful, and four (16%) had had mixed experiences with their psychiatrists.

Amongst the women who had had unhelpful experiences with psychiatrists there were six main sources of dissatisfaction, some of which were closely linked together - that of being objectified; of not being listened to; a predominance of physical treatments; an unwillingness to discuss psychosocial issues; a lack of information being provided; and discriminatory attitudes (see also chapter four).

Several women reported feeling objectified because little attention was paid to their own unique life histories. Their feelings, concerns, knowledge and experiences were largely disregarded in favour of isolating the medical symptoms that were perceived to be indicative of an illness and prescribing physical treatments (see also Coyle 1999). Their views were not sought and they were often not listened to when they attempted to talk about concerns relating to their mental health. All of the women who found their psychiatrist to be unhelpful mentioned this as a central

criticism, as did most of the women who had had mixed experiences with them. For example Charlotte said:

“He has never seemed interested in me...He’s just delivered you with these drugs and he just wants to see if they’re working rather than looking at all the other problems which are connected with it.”

Veronica said:

“He saw my problem as a chemical imbalance. So he felt that if he gave me Prozac then it would alleviate my problems. He wasn’t really interested in how I felt, he was more interested in treating me from a physiological point of view, rather than a psychological point of view...I terminated the sessions I had with him because I didn’t feel that I was benefiting in any way from it. He spent more time talking about his holiday home in Barbados and his family than he did in talking to me”.

In Miles’s (1988) study with women mental health service users, all of her sixty five women participants had seen a GP initially, and had then been referred to a psychiatrist. Twenty five women (38%) in her study found the psychiatrist to be helpful to them, twenty five (38%) found them to be unhelpful and fifteen (23%) had had mixed experiences with psychiatrists. This compared favourably to their experiences with GPs - only five women (8%) described their GP as helpful, fifty (77%) described them as unhelpful and ten (15%) described them as being mixed in their efficacy at helping them with mental health issues. Many of the women in Miles’s study observed that their psychiatrist spent a longer time than their GP talking to them and appeared to be genuinely interested in talking over their problems. In fact the women in Miles’s study perceived that talking was the main treatment which psychiatrists provided, to which the prescription of medication was secondary. Miles said:

“Most of those who found the psychiatrists helpful, and even most of those whose feelings about them were mixed, commented favourably on the length of time that these specialists spent with them, compared with the few minutes accorded them by their family doctor, and on the much greater interest shown in their personal problems. Secondly, although the psychiatrist prescribed drugs, patients gained the impression that these were ancillary to the main treatment which centred upon talks.” (Miles 1988:124)

By contrast, the majority of women I interviewed who had been treated by psychiatrists did not believe that the psychiatrists were interested in talking over their problems as a means of treating them. A central criticism made of psychiatrists was that they did not appear to be interested in talking over the women’s concerns about the problems they had in their lives and the impact these had upon their mental health. Gail’s comments were typical of this complaint, which was made by twenty one (84%) of the twenty five women who had been treated by psychiatrists:

“I really believe that he [the psychiatrist] didn’t care how I was feeling. I was just number such and such on that little card. Because I’d come away from there when I’d go for my appointment, and I’d feel what was the point of going because I didn’t achieve anything. I was just walking out with yet another prescription.”

As in the case of GPs, this criticism was made of psychiatrists regardless of whether they were male or female. For example, Jade, who was diagnosed with an anxiety disorder said:

“I never got any help from her [the psychiatrist]. We’d sit throughout the whole session saying nothing...she’d say ‘what medication are you on at the moment?’, and I’d tell her and that would be about it. I’ve seen a couple of others over the years, and they were just the same.”

A study carried out by Barham and Hayward (1991) with a group of twenty five men and women diagnosed with schizophrenia found similarly that psychiatrists were only concerned with prescribing medication and did not discuss with them

social and/or personal issues (see section 1.3). This was also found in the 'People First' study carried out by Rogers, Pilgrim and Lacey (1993) with 516 men and women service users with a variety of diagnoses (see also section 1.6.2).

At first sight it could be argued that the explanation for the discrepancy in findings between my study and that carried out by Miles, is that by contrast with my research (see section 2.14 table 8), and the studies mentioned in the preceding paragraph, all of the women in Miles's study had been diagnosed as suffering with a neurotic condition. If psychosocial factors are considered at all by psychiatrists, they are often only considered in connection with diagnoses of neurotic disorders (see section 1.2). On closer examination however, this argument is inadequate as in this study the women who knew they had been diagnosed with a neurotic disorder all made similar criticisms of psychiatrists to the women who knew they'd been diagnosed with psychoses; namely that their psychiatrists appeared to have neither the time nor the inclination to talk to them about their lives, and were interested in prescribing them medication only.

Similarly with the Barham and Hayward study and the 'People First' study there was no apparent connection between the willingness of psychiatrists to talk over service users personal problems and the diagnosis they had been given.

Another reason worth considering for the difference in findings between my study and that carried out by Miles, is that in her research she contacted all of her women interviewees through one or more psychiatrists who wished to co-operate with the aims of her research (although how many psychiatrists were involved in helping her seek volunteers for her research is not clear). The content of the consultations which Miles described suggests that the psychiatrist(s) who treated her participants did not employ a strictly biological model to understanding mental health

issues. Indeed, although the biological model is the dominant approach used in British psychiatry, it is not employed by each and every practitioner working within the discipline (see section 1.1). Furthermore, it could be the case that psychiatrists who are willing to co-operate with qualitative social science research with their patients (as in Miles' study), are less likely to employ a strictly biological approach in treating mental health problems. Whether or not this is the case is a matter of conjecture however, as the issue is not dealt with in Miles's research report. Research which is suggestive of this conclusion was carried out by Britten (1991). Britten asserted that doctors who employed a biological approach were largely opposed to information sharing with patients as they wished to retain complete control over the doctor - patient relationship, believing in the infallibility of modern medicine and the need to preserve their role as the experts in treating health problems through medical treatments.

Britten interviewed twenty four consultants drawn from a variety of specialisms which included psychiatry, gynaecology, oncology/radiotherapy, paediatrics, medicine, surgery, dermatology, ophthalmology, and genito-urinary medicine. She found that hospital consultants who used the biological approach were opposed to patients having access to their medical records (sometimes because they were opposed to letting patients know what their diagnosis was). Whilst those who adopted a more psychosocial approach were in favour of giving patients access to their files, discussing with them their diagnosis, the details of their medical history and their personal concerns about their health problems. The main reasons she discusses for this difference in attitude, include the fact that doctors working from a biological model wish to retain complete control of the process of diagnosing and treating patients. By withholding information from patients this high level of control

is maintained. She says that practitioners in this model may be afraid of upsetting patients by being open with them about their diagnosis and prognosis. They also subscribe to the belief that modern scientific medicine is largely infallible and that patients, by virtue of being ill, are not capable of participating adequately in decision making processes regarding their health problems. Thus in the biological model, the patient is perceived to be suffering with an illness over which they have no control, and the very fact they have been diagnosed with the illness tends to count against their being able to participate adequately in consultation processes relating to their treatment (see also section 3.5 on diagnosis).

Consequently, it may be the case that psychiatrists who subscribe strictly to a biological model of mental health problems would have less of a tendency to see the relevance of a qualitative study which aimed at consulting service users about their experience within the mental health system. Britten's (1991) study does suggest that such practitioners are inclined to objectify their patients more than those who use a psychosocial model, simply because of the way they have of conceptualising mental health issues.

A sense of objectification was exacerbated for many of the women in my study by a lack of listening skills amongst their psychiatrists. They perceived many psychiatrists as lacking in warmth, interest and empathy. Previous research with medical practitioners has indicated that the training provided in medical school, which is predominantly within a biological approach to treating issues of physical and mental illness, means that practitioners are poorly equipped to discuss personal and emotional issues with their patients (Baker, Yoels and Clair 1996, Silverman 1987, - see section 1.3). The stance of some medical practitioners as scientists (in a crude positivistic model) and therefore 'neutral disinterested observers', may be one reason

why the interviewees experienced them to be cold and dispassionate². Foucault described how the power relations within doctor-patient interactions may be intensified by the ‘medical gaze’: the adoption of an ‘objective’, distant, critical stance towards patients (Foucault 1973). The structure of discourse within the medical encounter itself may also tend to contribute towards feelings of objectification. The doctor dominates the interaction by employing a question and answer technique and the patient’s narrative is often interrupted so that the doctor, acting as a scientist, can isolate the symptoms which may suggest a particular disease process (Coyle 1999, Mishler 1984). In so doing the information tends to be decontextualised from its personal biographical context and dismantled to fit into the diagnostic frameworks of psychiatry.

Several women also complained that they felt objectified by being provided with standardised medical treatment for which they were not properly consulted. Thus they were often not asked which treatments they would prefer and were not given information about any possible side effects (see section 3.6 for a further discussion of this).

In addition to feeling objectified many women indicated that they felt disempowered because they were not provided with adequate information relating to their diagnosis, prognosis, and treatment (see sections 3.5-3.6). Indeed a lack of information being provided was the most common criticism made by the women who participated in the study (see section 3.5-3.6). It has been argued that maintaining a strict control upon the amount of information that is provided tends to sustain a

² In chapter two I described how many of the women said they had found the process of being interviewed to be a rewarding one, specifically because I did not attempt to adopt a stance of neutrality in response to their concerns.

hierarchical power relationship between doctor and patient, as mystification increases the authority of the doctor as the expert within the consultation (Waitzkin 1979).

A further source of complaint relates to widespread discrimination within the statutory mental health services. I discuss this in detail in chapter four.

The women who had had some positive experiences with psychiatrists indicated that the psychiatrists they had found to be helpful were those that respected their individuality and were willing to take the time to listen to and discuss their personal concerns in relation to mental health issues. In addition, as in the case of GPs, a helpful psychiatrist was one who did not want to dominate them completely in a consultation, shared information with them, and was willing to allow the woman some level of input and control in matters relating to her treatment. For example Evelyn said:

“Some of the doctors have been marvellous, they’ve got time for you and they’re great... There’ve been doctors though that I didn’t want to know...one doctor treated me like I didn’t know anything about the illness, which I didn’t like. I had to show him that I was serious and I did know about it. If it was possible I wish that they could listen to the patient because in this illness [manic depression] the patient knows more than the doctor, unless they happen to be a manic depressive doctor or psychiatrist.”

Similarly Mary (who had been diagnosed with manic depression), found that psychiatrists who were unwilling to allow her control over her treatment were completely unhelpful to her.

“Various treatments were tried, depot injections, ECT, and it was only when I decided I wanted nothing more to do with any form of psychiatric help at all, that I made contact with a second psychiatrist who handed the illness back to me. Now I manage the illness myself through self medication and a recognition of what my stress factors are.”

In talking to interviewees it became apparent that doctor-patient interactions can have a significant effect upon a woman's self esteem. Not being consulted on questions of diagnosis and treatment; not being properly listened to (see also section 4.3); being patronised, and not being respected as an individual could all conspire to make a woman feel disregarded and devalued. However the women conceptualised their mental health status (see section 3.5), they wanted to be perceived as whole people with feelings and a life outside the consulting room. Thus they wanted to be respected as people rather than simply the 'carriers' of an illness.

3.4 The women's perspectives on the stigmatisation of mental health problems

Several studies have indicated that there is a stigma associated with mental health problems (see section 1.5). There is some evidence to suggest that mental health problems have been particularly stigmatised in recent years, as a link has increasingly been made between a diagnosis of mental illness and a propensity to violence. This has been described as a 'moral panic' (Pearson 1999) fuelled by the fact that within the media, any violence carried out by a service user or ex user has been highlighted and sensationalised. The present government has responded to widespread public concern by reviewing mental health policy and proposing stricter legal controls upon service users within the community in order to protect the public (see section 1.6)

In this study, thirty four (97%) of the thirty five women I interviewed identified the stigmatisation of mental health problems as a significant problem for them. Some of the women expressed surprise that I was asking them about this issue as they thought that the stigmatisation of them as psychiatric service users is clearly obvious in their everyday lives. In describing the impact of this stigma, several

women reported a significant change in their friends' and colleagues' attitudes to them when they found out about their use of psychiatric services. For example, Evelyn described how she had lost her job when it was discovered that she had been diagnosed with manic depression. Many of the women in the study thought it was important to hide the fact that they had used mental health services and/or had been diagnosed with a mental health problem from friends, employers, and sometimes from members of their own families. This subterfuge was thought to be undesirable, but fear of the repercussions which would ensue if their experiences became common knowledge, was the motivating factor in leading them to attempt concealment. This has also been found in other studies with mental health service users (for example Barham and Hayward 1991, Miles 1988).

Some women who took part in my study described how they had encountered stigmatising attitudes amongst medical staff as well as members of the general public. For example Gillian observed that general hospital staff treat patients less favourably when they discover they have been diagnosed with mental health problems. When I interviewed Gillian, she was a nurse in a general hospital. She said:

“If someone comes with an appendicitis, they'll write on the notes 'has a history of psychiatric admissions' and then they're marked. If someone else comes in with appendicitis that hasn't had that, then it's totally different. But what has that got to do with it? We've had some right up and downers there about it. It's subtle mind, they don't do it openly, the patients perhaps wouldn't notice - but I can see they don't build up such good rapport with them or get close to them. They don't get that closeness. Fear is at the root of it. There's a stereotype that all mental patients are violent...sometimes I think mental illness has got a bigger stigma than AIDS. Once you've been unbalanced then you're always unbalanced - they're waiting for you to turn or erupt or something.”

Elaine said that she had encountered stigma in the attitudes of the staff at her health centre. She said:

“When I first went to register up there and I was talking to the receptionist and I said ‘schizophrenic and manic depressive’ - they said ‘oh she’s schizophrenic - oh I’ll get the doctor to see you now’! It was as if I’d got two heads!”

Jane said that she had encountered stigma even in the attitudes of her Community Psychiatric Nurse (CPN). She explained that her CPN stopped visiting her, when Jane, who is a survivor of child sexual abuse, disclosed the degree of anger she sometimes felt about her experiences. Jane clearly felt angry, hurt and let down by the behaviour of her CPN. I asked her why she thought that her CPN had this attitude towards her, and she answered:

“One of the first things we were talking about, she said well ‘how does it make you feel?’ And I said... ‘well sometimes I get so mad I want to smash the house up’. From this now she suddenly got this idea that I was a violent person and I went out and committed violent acts, whereas I already explained to her although I feel violent a lot of the time, what makes it worse is that I *don’t* go out and commit violent acts...But this girl really did think that I was violent, and I really was paranoid that she was frightened to come round in case I hit her...One thing she said, she said something about ‘oh I hope you don’t hit me’. I said ‘don’t say that!’...She’s my fucking psychiatric nurse for fuck’s sake, she’s bound to say sensitive things to me and hit things on the head, but I’m not going to hit her! But she really did think that one day I would lose it in here talking about something upsetting and give her a good kicking. I had to curb my feelings on certain things then, because I knew she’d be frightened. I’m not a loony...And she kept saying things that made me think she really does think I’m a loony.”

Eventually Jane’s CPN stopped visiting her altogether and no explanation was offered. Jane said that she had blamed herself for this, and consequently, her CPN’s behaviour had actually worsened her feelings of distress.

In accounting for the stigma they had experienced, many of the women in my study referred to a general lack of understanding about mental health problems in society, which is a source of a great deal of fear for many people. Most interviewees

blamed the media for fuelling this fear by highlighting acts of violence which are committed by ex-psychiatric inpatients living in the community, thereby implying that all service users pose a danger to the general public. The women were broadly of the opinion that the majority of violent acts are committed by people who have never used mental health services, but anyone who has had a history of psychiatric service use is singled out by the press for special attention. Whilst the majority of interviewees opposed the policy of closing psychiatric hospitals as part of the policy of care in the community (see chapter six), they all (with one notable exception) vehemently opposed the argument that hospitals need to be kept open to accommodate patients who would otherwise murder innocent members of the public. Thirty four women (97%) thought that media stories served to substantially reinforce the stigma they experienced. For example Gail said:

“I personally think myself that they [the general public] hear the words ‘mentally ill’ and they actually think you’re off your head, you’re not capable of making a rational decision or having a proper conversation...What should be done really, there shouldn’t be all these wild stories that you read in the newspapers about a person whose just come out of hospital and whose been mentally ill and it just goes out of all proportion. And that’s what I think - they [the media] play a big part in causing it.”

One participant in the research, Debbie, was notable because she did not criticise the media for this point of view and in fact emphasised the violence committed by ex-psychiatric patients in the community. She said:

“It does frighten you that one person a week is killed by a mental patient. Which means there’s a lot of sorting out to be done in mental hospitals into who is dangerous and who is bloody not. I mean we’re talking about perhaps women or men who have stress or nervous conditions, but then you take these other people and you’re talking about a different kettle of fish, you know. I mean because they’re a threat to themselves and they’re a threat to society - they *are*. Because I mean, an eleven year old girl was stabbed, wasn’t there, by a

schizophrenic - well they always stab people - they have shown in reports, one a week has been killed by one of them. If it was my daughter then I'd want them all locked up too."

Debbie's viewpoint was an exceptional one in the context of the other women I interviewed, as all of the other women criticised this viewpoint in the media for contributing significantly to the stigma which they experience. Debbie clearly differentiated herself from other psychiatric service users, such as those diagnosed with schizophrenia, as she thought that her mental health problems (which she described as anxiety) were of a different, less severe category in which she was not prone to violence. Although the other women in the study did not share Debbie's views on the danger posed by ex-psychiatric patients in the community, several also wished to distinguish between the sort of mental health problem they had experienced, which they often described as caused by 'nerves' or stress and which they thought was relatively minor, compared to the conditions experienced by people diagnosed with serious psychotic illnesses such as manic depression and schizophrenia. Some of these women wanted to distance themselves from people diagnosed with psychoses because they appeared to them to be so disturbed as to be truly 'mad'. Seven women (20%) said that they did not want to share service provision (such as being on the same inpatient ward) with women (and men) who had more severe mental health problems like schizophrenia, as they felt frightened being around them (see also chapter six).

In this sense, the women who took part in this research were not a homogenous group, and there were important divisions between them in terms of their self identity as a psychiatric service user or ex-user. The women who had been diagnosed with neuroses were more likely to express a fear of 'madness', either the madness of fellow service users, or a fear that they might become 'mad' too. This finding accords with that of Miles in her study (1988) of women diagnosed as

neurotic. It would certainly be true to say that the stigma which is encountered by people diagnosed with psychotic illnesses such as schizophrenia and manic depression is far greater than that which is entailed in diagnoses of neurotic illness like anxiety and non-psychotic depression. A diagnosis of psychosis represents true 'madness' as people who have received this diagnosis are perceived to be completely out of touch with reality (see section 1.2). People diagnosed with psychotic mental health problems are also widely believed to be more prone to acts of violence. However there is no clear dividing line in public perception between different categories of diagnosed mental health problems so that those diagnosed with neurotic conditions may also experience considerable stigma (see also Miles 1988).

In discussing with the women their ideas for removing or reducing the stigma associated with psychiatric service use, the most popular suggestion for improving the situation was that there should be more education and information available relating to mental health issues. In particular it was argued that media coverage should be improved.

"It's just educating the public, it is literally just educating and informing the public so that people are no longer frightened." (Mary)

Stephanie said:

"People need to know that for a start people that have used mental health services are not criminals - you've probably got less likelihood to be attacked by someone whose got mental health problems than from anyone else...you know I picked up all these stereotypes myself that somebody whose been in a psychiatric hospital is a danger to society, that they're violent, that they're not intelligent, that there's something wrong and they should be avoided. And they're an object of derision...Mental health problems need to be seen as just part of the normal human experience. We're not talking mental health problems we're talking people who experience emotional distress and trauma, people who are logically expressing reactions,

normal human reactions to trauma and distress. And that's how all our symptoms need to be treated. They're not to be scared of and they're not to be derided."

Some interviewees suggested that people should be more open about their experiences of mental ill health and this would in turn serve to lessen the stigma attached to mental health problems. However it was recognised that this would involve a 'Catch 22' situation, as people are reluctant to identify themselves as having a mental health problem precisely because of the degree of this stigmatisation. In view of this problem several women said that there was probably no way of removing this stigma altogether. Jane said:

"You'll never be able to do it. It's like the prejudice against blacks... You can't explain to a whole nation that mental health is a part of life, you can't. If you haven't been through it, then the attitude is - 'for god's sake sort it out'."

Kate thought that psychiatric services themselves played a key role in stigmatising their users. She asserted that psychiatric hospitals themselves stigmatise inpatients through the process of sectioning some patients, diagnosing them with mental illnesses and then relying exclusively on drug treatment. Her suggestion for reducing the stigma attached to mental health problems was to reorganise psychiatric service provision (see also section 6.4 on the stigma associated with psychiatric hospitals and community based services respectively).

"You could remove the stigma if mental hospitals were run in a different kind of way, made into you know clinics or something. I mean if they were just going to be like for women they could just be called women's centres or something, you know where people could go when they needed a rest, not somewhere people go when they're supposed to be nuts or something. But I think it's going to be really difficult to take that stigma away anyway. I don't know if you could actually do it. But I'm sure there are things you could do to try."

Kim, an ex-psychiatric nurse herself, argued that the stigma attached to mental health problems could not be removed without a complete change in the way that society is structured. She asserted that society is based on an inequality in the distribution of power in which men have the power to discriminate against women, and in which heterosexuals have the power to discriminate against homosexuals. She argued that the stigma against mental health service users in society was another way of discriminating against a section of society in order that the dominant group (which she described as male heterosexuals) remain in control.

“It’s because society always needs something to stigmatise. We’re back to control again. The government is a form of control and all the services within that government are designed to control people. It’s as simple as that.”

As I outlined in section 1.5, it is my contention that psychiatry itself plays a role in stigmatising psychiatric service users. The notion of stigma encapsulates both disgrace and the evidence of disorder. A psychiatric diagnosis can be seen to demarcate its recipient as a person whose identity is itself fundamentally flawed, as it indicates that they are suffering with an illness which renders their communication, behaviour and thought processes illogical and unintelligible. A diagnosis of a mental health problem thus permanently focuses doubt on the conduct and thought processes of the person diagnosed. Within the biological model of mental health problems, the social factors which may have caused an individual’s mental health difficulties are ignored (see section 1.1 and 1.2). This has some impact on the stigmatising of service users, as drawing a link between social factors and the experience of mental health problems, could serve to indicate that many emotional and behavioural problems which are perceived to be indicative of a mental health problem, are actually explicable responses to psychosocial pressures. For example, in research with people

diagnosed with schizophrenia and their families, Laing has consistently indicated that when placed in a familial context, the content of the speech of diagnosed schizophrenics is rendered intelligible, and even logical, in relation to their particular family dynamics (Laing 1960, Laing and Esterson 1969). However, in the traditional psychiatric consultation, diagnoses of mental health problems are made by studying the behaviour and speech of service users, without reference to the social context in which service users' live. Ignoring this social context means that the behaviour and/or speech of service users may be regarded by medical practitioners as meaningless in itself, and explicable only in so far as it represents a symptom of mental illness.

In their study of stigma, Barham and Hayward (1991) assert that "people with mental illness" should be referred to in the "vocabulary of membership, as 'one of us'" (1991:1). They add however, that there should not be "an opposing form of normalising discourse in which difference comes to be glossed over or denied, as though a benign regard or the force of good intentions could prise away the stubborn reality of chronic mental illness" (1991:5). Thus they argue that the notion of mental illness itself ought not to be abolished. One of the inevitable problems with the dominant biological model of mental illness however, is that the individual is sometimes regarded as merely an extension or carrier of their illness (Pilgrim and Rogers 1993). Since this illness is regarded as a disease of the mind, the implications are enormously damaging for the lives of those so labelled. The biological model of mental health problems itself establishes difference, attaches stigma and labels 'sufferers' as an essentially disempowered pathological 'other'. It serves to obscure the common psychosocial issues which can be key in an individual's experience of psychological disturbance.

Although a psychiatric diagnosis inevitably entails stigma, in my research I found that there are further issues relating to stigmatisation which are specific to women service users. For example, some women who participated in my study indicated that receiving a psychiatric diagnosis, even where this denoted a psychotic illness, actually made them feel less stigmatised than if they had not received the diagnosis. These women said that receiving a medical diagnosis meant that they were suffering with a disease over which they had no control, and thus it meant that their distressing feelings were 'not their fault'. They had been given a label which, although it entailed stigma, was preferable to the stigma they would have experienced if their feelings had been perceived as indicative of them being women who were troublesome or badly behaved through their own choice. I will consider issues relating to women and psychiatric diagnosis in detail in the next section.

3.5 The effect of the biological model on the diagnosis of mental health problems

In this study twenty four women (68%) had been presented with at least one psychiatric diagnosis by the GPs and/or psychiatrists involved in treating them (see table 8, 2.14). One woman had not been treated by medical practitioners in the statutory services and so no diagnosis would have been made. Ten women (28%) had not been given a diagnosis, although they may have had one applied to them as they were regular users of statutory psychiatric services. Some of these women were curious as to whether they had been diagnosed, and if so what that diagnosis was. Whether or not they had actually been diagnosed is unclear. It has been claimed that many GPs avoid formally diagnosing their women patients if they feel their conditions

are not serious and instead provide them with minor tranquillisers and/or antidepressants (Foster 1995, Miles 1988 - see also sections 3.2, 4.2).

A study carried out by Miedema and Stoppard in Canada (1994) (see also section 6.3) with women who had been psychiatric hospital inpatients found that very few women were actually informed of the diagnosis which had been made of them, a situation which they were dissatisfied with. However they found that the women in their study who had been informed of their diagnosis did not find the diagnosis itself to be helpful to them (although the researchers did not describe why). As I discussed in the preceding in section 3.3, there may be tendency for some practitioners (especially those working within a biological model) to withhold information from patients. Several studies have indicated that a lack of information being provided by doctors is one of the most frequently cited sources of dissatisfaction amongst patients (see Rogers, Pilgrim and Lacey 1993, Miles 1988, Cartwright and Anderson 1981, Miles 1979). I also found this in my research as many women complained that they had been 'kept in the dark' by doctors who would not discuss with them matters relating to their diagnosis and/or treatment.

One of the reasons that Britten (1991) cites for this tendency is that practitioners working within the biological model have a commitment to the infallibility of modern medicine and believe that patients do not need to know details about their own case and should trust their doctors to know what is best for them (see section 3.3). This belief in the efficacy of mainstream psychiatric practice is not shared by a substantial number of commentators on mental health service provision (see section 1.1). Indeed the process of diagnosing mental health problems by psychiatrists and GPs has been described as an 'uncertain science' as there is

controversy regarding the diagnostic categories which are used within the discipline (Foster 1995, Pilgrim and Rogers 1994, Miles 1988). It has been asserted that

“...a careful study of psychiatric textbooks and psychiatric journals soon reveals, even to the relatively untrained eye, that many psychiatric diagnoses are based more on educated guesswork or current fashion than on proven uncontested medical science.” (Foster 1995:88).

Clinicians making diagnoses on the same patients have achieved a substantial degree of discrepancy in the diagnoses applied (Wing 1988). Indeed, many of the women who participated in this study had accumulated a range of different diagnoses from different doctors over the course of their service use.

Of the twenty four women who had been given one or more psychiatric diagnoses, eleven (46%) had found it be completely unhelpful; seven (29%) had found that receiving a diagnosis had been helpful to them and two (8%) had found that receiving a diagnosis had entailed both helpful and unhelpful aspects. Four women (17%) said they had no particular views on the helpfulness or otherwise of receiving a psychiatric diagnosis.

There was no overall correlation between the nature of a diagnosis and whether it was perceived as helpful or not in the sample group. Thus of the eleven women who found a diagnosis to be unhelpful, six (55%) had been diagnosed with a psychosis and five (45%) had been diagnosed with a neurosis. Of the seven women who found a diagnosis helpful, four (57%) had been diagnosed with a psychosis and three (43%) had been diagnosed with a neurosis. In view of the increased stigma attached to psychotic mental illnesses, it might have been expected that more women would have found a diagnosis of psychosis to be unhelpful precisely because of this stigma. However, this did not come across in the interviews and what emerged were other issues relating to stigma which were not related to the nature of a particular

psychiatric diagnosis (I discuss this later on in the section regarding women who found a diagnosis to be helpful).

In terms of how they conceptualised their mental health status themselves, twenty six women (74%) overall identified social and personal problems in their lives as causing their mental health problems, regardless of the type of diagnosis which they may have received (and any alternative explanations which may have been provided them by medical practitioners). Five women (14%) identified their mental health problems as being caused by a biological illness. Four women (11%) were unsure about what had caused their mental health problems and were dissatisfied that they did not have, and had not been offered within the statutory services, an adequate explanation of why they had experienced these problems. In talking with the interviewees about their thoughts concerning the issue of diagnosis, a number of issues became apparent. First and most obvious was that all of the women had originally felt that they had needed assistance with feelings and/or behaviour which they felt was distressing and was impinging negatively upon their lives. The emotional and behavioural problems which the women described covered a very broad area - there were several reports of self harm; attempted suicide; hearing voices when there was no one there speaking; an inability to communicate with other people; feeling compelled to indulge in frenetic activity; not being able to do anything or to face anybody; fear of going out of the house; a complete inability to function in their day to day lives; seemingly inexplicable feelings of fear and anxiety; lack of energy; feeling depressed and hopeless; nightmares; flashbacks to previously traumatic events, and acute panic attacks. Though not all of them believed that they were mentally ill or suffering with a biological disease, all of them thought that they were seriously distressed and in need of some kind of assistance.

Issues relating to the predominance of biological explanations; medical jargon; and lack of participation, were significant for the eleven women(46%) who found a diagnosis to be completely unhelpful to them. A central criticism was that the diagnosis did not appear to take into account, or signify in any meaningful way, the fact that social and personal issues had caused their mental health problems. Many of these women experienced the process of diagnosis as a disempowering one where they were being labelled with an illness, so that their distress was seen as pathological rather than a logical outcome to a distressing social situation. For example Joy was variously diagnosed as manic depressive and as schizophrenic. She said that problems in her relationship with her husband were responsible for her distress, but she was diagnosed by a psychiatrist as suffering with a biologically induced psychosis. Her need for practical and emotional support in dealing with the problems she had in her marriage have been ignored by the psychiatrists responsible for treating her. She said:

“I am not psychiatrically ill but my heart was sore and aching and I did not need treatment, I needed comforting and tenderness. I find it impossible to convince my psychiatrists that any of these needs are relevant. He believed that I was a manic depressive and still am and therefore I need the drugs to cure it....I think there is no such condition as manic depressive psychosis, schizophrenia, etcetera, etcetera. I think they are convenient labels to describe a set of symptoms which people produce when they are misunderstood. And become so misunderstood that they have to resort to a place of safety, an asylum, which technically translated means a quiet place in the wood, but is rarely so.”

Some psychiatrists and GPs utilise a diagnostic category called exogenous, or reactive, depression, which is meant to signify depression which has been caused by personal experiences (Corob 1987). Endogenous depression on the other hand is meant to signify depression which is purely biologically induced. However previous research (Corob 1987) has indicated that many doctors diagnose endogenous depression because they do not ask their patients about the events in their lives which

may have caused the depression. This was a major criticism made by many of the women who took part in the study, and was made in relation to a broad range of diagnostic categories, not just depression. Many women thought that doctors were content only to diagnose and prescribe medication for their symptoms of distress and were not willing to talk over with them possible social causes. For example, Gillian was diagnosed with endogenous depression when she was admitted to hospital after a suicide attempt, because her doctors did not identify any external causes of her feelings. Her distress was therefore accorded to a chemical imbalance in her brain and she was given psychotropic medication and several courses of electro-convulsive therapy. Gillian points out, however, that the reason why she felt so depressed was that she was trapped in a violent marriage with three small children, no money and nowhere else to go. No one ever asked her about her personal circumstances however. Thereafter her husband used the fact that she had been diagnosed as mentally ill as a way of further humiliating and abusing her. Gillian's feelings of depression were perfectly understandable without recourse to expert medical knowledge given the position that she was in at home. Her feelings of distress, which included feeling trapped and suicidal in order to escape from her life, were nonetheless transformed in the medical process of diagnosis into medical symptoms which signified faulty brain functioning. In this way the cause of Gillian's distress was explained back to her by the medical experts as residing in her own brain malfunction. This was also explained to her husband, who was exonerated from any role in causing Gillian's distress. When Gillian was discharged from hospital the power relations between her and her husband were further weighted in his favour, the stigma associated with mental health problems being used by him as a means of further disempowering her. Gillian attempted to commit suicide soon after her discharge and

was admitted to hospital once again. On her return her medical notes were produced and her continuing suicidal impulses were seen as further evidence of her endogenous depression, which required stronger medication and further courses of ECT. Her increased feelings of distress were perceived to be medical symptoms which further justified the diagnosis she had been given. This diagnosis also served to divert attention from the abusive situation which she was experiencing at home (see also chapter five on the experiences of abuse survivors within the system).

Several women commented that their diagnosis was an inaccessible piece of medical jargon and their doctor did not explain in layman's terms what it meant. I asked Jade whether she had experienced the psychiatric diagnosis she had been given as helpful. She said:

“Not at all. Because they never went on to explain what exactly they mean. You just come away thinking- ‘oh my god, I’m mad!’ Not helpful at all, in fact the opposite. They come out with some fancy jargon, some name, you know and I’d think bloody hell, you know! And I didn’t have the courage, the confidence to say ‘can you explain what you mean?’ They just say blah blah blah and you think ‘oh right’ and leave sheepishly.”

I asked her whether receiving these diagnoses had affected the way she felt about herself subsequently. She answered:

“Yes, yes. I thought I must *really* be mental, you know?”

Foster (1995) describes how receiving a diagnosis of a mental health problem is often unhelpful and can be completely devastating for the women diagnosed. One negative outcome is that women may think that they are labelled as mentally ill for life. Another is that they may simply not understand the diagnosis which is applied to them because their doctor does not explain it. This was certainly the case with Jade, as she described above. Like the withholding of information generally, it has been

argued that the use of medical jargon helps to maintain a power relationship where the doctor is perceived as the possessor of expert knowledge which cannot be accessed by the layperson. Thus the layperson becomes wholly dependent upon the doctor to interpret symptoms and make diagnoses (Britten 1991, Banton, Clifford, Frosh, Lousada and Rosenthal 1985, Waitz 1979).

A significant source of dissatisfaction amongst the women was that they were not allowed any degree of participation in the diagnostic process. They found it disempowering that they were not asked for their views on what had caused their mental health problems and their diagnosis was imposed upon them without any consultation (beyond asking them about their symptoms). For example, Charlotte said that an abusive relationship with a partner was significant in triggering her mental ill-health, culminating in her hospitalisation and diagnosis as a manic depressive. This diagnosis was imposed upon her however; her psychiatrist did not ask her for her views about what had caused her condition. She has wanted to discuss with her psychiatrist the possibility that the domestic violence played a role in causing her mental health problems (and the possibility of other causative factors which are social in origin), but because she has been diagnosed with manic depression her psychiatrist will not entertain the possibility of any psychosocial factors being significant in the aetiology of her mental health problems. She said that she cannot make too much of a fuss about this and argue the point, because, crucially, being argumentative with the psychiatrist can be used as evidence that she does suffer with a biological illness over which she has no control. Thus in this situation she is offered only one way to make sense of her problems - the official version - and she is constrained to accept it.

Issues of validation; the easing of guilt; a lessening of stigma; and self-education, were significant factors for the seven women (29%) who reported their diagnosis to be helpful to them. Six women (86% of those who had found a diagnosis helpful) said that being given a diagnosis represented a validation that they had a mental health problem. It provided a welcome acknowledgement that there was something significantly wrong. They commented that without the acknowledgement represented by a diagnosis they had felt guilty because of their inability to cope adequately in their everyday lives. Gail described the relief she felt when, after many years of service use, she was finally told of her diagnosis:

“I really did feel better for it you know...When you're down you blame yourself for absolutely everything that happens, you know, bad mother, bad wife, you know you really do. You know and you can think this is why I'm feeling like this. You know - it's some sort of answer.”

When I asked her about her feelings on being diagnosed as depressed, Wendy said

“I think it does help. Because if you're quite depressed and you're not communicating, you're not socialising, you feel guilty, you don't know what is going on. But if someone says to you, 'you're depressed, you're ill' you can accept that I think, it's easier to accept. You don't feel guilty because it's an illness. And sometimes you've got to convince yourself of that mind you because you do still feel a bit guilty. But, um, I think it's quite useful mind, you say 'yes you've got depression, or you've got anxiety' or whatever you know.”

A diagnosis may be particularly welcomed by some women because it can in some circumstances help to relieve them of stressful responsibilities (for example paid employment). It also provides an explanation which does not blame the women for being unable to properly shoulder these responsibilities. Conceptualising mental health problems as a malfunction of the physical body (the brain) means that they are

not located as a problem within the 'mind' and so cannot be removed by an effort of will.

Three women (Charlotte, Mary and Wendy) all specifically said that having a medical diagnosis did not make them more stigmatised, but actually reduced the stigma they experienced because their mental health problems were being accorded to an illness rather than their own actions. From this it would seem that for some women to be perceived as suffering with a severe mental illness is preferable to being perceived as being troublesome and badly behaved, because to have an illness means that your problem is not your fault. For these women it did seem that the only way to explain and understand their mental health problems was either to accord it an illness (being mad) or to accord it to a voluntarily chosen attitude (being bad). Both labels involve stigma, but the latter for women especially, can be very negative indeed, incurring as it does strong feelings of guilt exacerbated by the challenge to gender stereotypes which bad behaviour by women entails.

Foster (1995) explains this situation in the following terms:

“Naturally some women who are suffering extreme distress, for which they can find no logical explanation, may actually welcome a medical diagnosis which both explains the pain and relieves them of any responsibility for it. Our society may still attach a stigma to mental illness but an even greater stigma may be attached to bad behaviour, especially bad mothering, for which there is no medical explanation.” (1995:89)

Although it may serve to validate a woman's experience of mental distress and play a role in easing guilt, there are some drawbacks associated with a diagnosis of mental illness which I have not yet addressed. A diagnosis can tend to foster dependence as it places the woman squarely within the sick role. Because she is perceived as ill a woman service user may not be thought capable of looking after her

own children (see section 4.4 for a discussion of the particular problems facing women with childcare responsibilities). It can also foster dependence in the sense that it makes the service user reliant on medical intervention to treat her condition.

Medical consultations are essentially asymmetric in character and involve a microsocial play of power (Atkinson 1995). The medical doctor is by definition the 'expert' in any consultation; service users are not accorded the power of the medical professional to define and treat health problems. There is a social distance between doctor and patient and an unequal distribution of medical knowledge and resources. Psychiatric knowledge lays claim to the status of objectivity and so tends to disqualify other discourses which cannot make the same claim (such as service users' own views on the causation of their mental health problems). The power relationships within the medical encounter can thus subjugate service users' own discourse to that of the doctor (Coyle 1999).

Another significant factor in whether a diagnosis was welcomed by the women relates to the issue of education and information. Seven women (29% of the women who had received a diagnosis) commented that a medical diagnosis was useful because it enabled them to educate themselves about the nature of their condition. Receiving the diagnosis presented a welcome opportunity for them to go out and gather information on issues relating to the distressing psychological disturbances which they had experienced. They thought that a medical diagnosis provided the first stepping stone in developing a means of understanding why they felt and behaved in ways which they thought were abnormal and distressing, but for which previously they had no explanation (thus contradicting the finding made by Miedema and Stoppard 1994). With two exceptions, these women had all been diagnosed with manic depression and were members of the Manic Depression

Fellowship (MDF). They had contacted branches of this user group once they had been diagnosed and the group had provided them with information relating to the condition. These women agreed with the diagnosis they had been given and attributed their mental health problems to a biologically based illness, thus concurring with analysis provided by the MDF³. The MDF appeared to be influential in the women's understanding of their mental health problems and in their acceptance of psychiatric discourse. These women found that the knowledge they had been provided with by the MDF had enabled them to actively and assertively engage with the medical discourse when discussing their mental health problems with doctors.

From this data it can be seen that women are not passive participants in the medical discourse relating to mental illness. They may engage, resist, struggle, and develop alternative discourses (see also chapter five). Feminist researchers have indicated that women actively construct as well as interpret the social processes constituting their everyday realities (Stanley and Wise 1990, Smith 1988). In terms of diagnosis it can be seen that women adopt one discourse over another according to its potential to make sense of their experience and also because of the advantages that accrue in choosing one discourse over another. However, this is a complex process as what is advantageous in one context (for example, because it eases guilt), may bring with it distinct disadvantages in others (for example increased dependence on medical intervention).

³ The discourse of the MDF resembles very closely that of the dominant medical discourse. Thus manic depression is perceived to be a biologically based mental illness which is triggered' by stress factors in the environment.

3.6 Drug Treatment and ECT

Samson (1995) has demonstrated that there is a clear linkage between the hypothesis of the biological aetiology of mental illness and the perceived efficacy of physical treatments. The existence of physical treatments which alter biochemistry is used by many psychiatrists to validate the hypothesis of the biological causation of mental illness (this is a somewhat misleading argument however - see section 1.1).

In this study thirty three (94%) of the thirty five women I interviewed had been prescribed psychiatric medication. One interviewee had not been prescribed medication by her GP (the only doctor she had seen) and one had not sought any assistance from doctors in dealing with her mental health issues. The medication which doctors and psychiatrists have prescribed for the women in the study range from antidepressants such as Prozac to major tranquillisers such as chlorpromazine. Of the women prescribed medication, eighteen (55%) reported serious side effects with the drugs they had been prescribed, but most of these women had not been warned of the potential side effects when they were first prescribed the medication. The side effects the women reported, ranged from the addictive effects of minor tranquillisers like Valium (diazepam), intense drowsiness associated with high doses of some antidepressants, to severe interference with the functioning of the nervous system, which is associated with major tranquillisers (see also section 1.4). The most serious side effect which is induced by psychiatric medication is the disease called tardive dyskinesia which is caused by even short courses of treatment with major tranquillisers (see also section 1.4). The disease is a chemically induced form of brain damage which is similar to Parkinson's disease, and is irreversible and sometimes

fatal. Joy said that her friend, who was also a service user, died of the condition. She said:

“If they give a person too much largactil [chlorpromazine] then it kills them, they call it tardive dyskinesia. I have witnessed it and I found it one of the most painful things in my life. I’m talking about a person whom I loved very much and I begged her not to take the tablets but she wanted to because she was ready to die. She was on largactil for about 25 years. I suspect they put something innocuous on the death certificate such as heart failure or something.”

Joy described the effects of the medication which she was forced to take whilst detained in hospital for several years under a section of the Mental Health Act. She said:

“I’ve taken everything. And I had every side effect possible - sickness, diarrhoea, headaches, depression. I only agreed to go on it because my husband made me. I was told by a doctor when I was first admitted [to hospital] that if I took haloperidol for six weeks I would be right as rain. I tried and tried not to take it and then I was persuaded against my best judgement to take it and six weeks turned into six months and they kept on trying to shove it down my throat or inject my backside with it and I got more and more sick.”

There was a significant degree of polypharmacy among the women in the research (prescribing more than one drug at a time) despite the fact that multiple prescribing and the consequent interaction of drugs is commonly understood to be dangerous by psychiatrists. A high rate of polypharmacy was also found in the ‘People First’ study carried out by Rogers et al 1993. Multiple prescribing and overprescribing was a source of concern for some women in the study, especially amongst ex-psychiatric inpatients who described the prevalence of overprescribing on hospital wards (see section 6.3).

“I’ve seen people on half a dozen drugs at the same time, which is a completely illogical way of doing anything because you have no idea which is doing what. And very

dangerous. I saw them, other patients, falling down - staggering along because they were under such a weight of medication...The health service creates addicts. If you're not very canny and very careful it can induce new diseases." (Kim)

The women in the study were broadly divided in how helpful they found the medication they had been prescribed. Some thought that it had actually worsened their feelings because of the side effects they had experienced. For example several women said that minor tranquillisers had initially been useful, but because of their addictiveness they had actually added to their problems over the long term. Several women thought that psychotropic medication (particularly antidepressants) had been useful in improving the way they felt, despite any side effects which might have been incurred by taking them. Other women who had been prescribed antidepressants said that the medication had not made any difference at all in the way they felt. Most of the women who had been prescribed neuroleptic medication (major tranquillisers) had been prescribed them whilst hospital inpatients. I discuss the particular issues relating to the over prescribing of medication within the hospital environment in section 6.3.

Six women (17%) in my study (Gail, Gillian, Heather, Mary, Joy and Margaret) had been given ECT. All of those who had had ECT reported serious side effects with the treatment, the most worrying of these being long term permanent memory loss (see also section 1.3.2). None of them had been informed of the side effects of the treatment prior to receiving it. The women reported that even though they had all received the treatment many years ago, they had never recovered their memories fully, and have permanently incomplete memories of parts of their past. Gillian said that she had found a course of ECT to be useful in lifting her feelings of depression, despite the fact that she had encountered severe side effects in terms of memory loss. The other women who had received ECT said that it was ineffective in

reducing the severity of their symptoms of mental distress, and because of the side effects incurred had actually increased feelings of depression. Heather said:

“They didn’t explain about the side effects of the ECT or anything...for about a year after that I had a terrible pain in the back of my neck and I think of course that was because of the spasm that you go into when they give you the shock. And the other thing of course is that my memory was very patchy for a long time. The thing I particularly remember about that was that a postcard came to the house addressed to me written in a very friendly way and I just could not remember who this person was and that really upset me. To think that someone could be writing to me who knew me and I didn’t know them, that I had completely lost my memory...I will never have it [ECT] again. The thing is if something’s not brought to your attention then you won’t realise that you’ve forgotten it. My memory isn’t very good now.”

Many women in the study complained that drugs and ECT were the only treatments they had been offered. They thought that counselling would be effective in helping them to deal with their experience of mental ill health. For most of the women it was not thought to be straight choice between drug treatment and counselling, however. The majority of women in the study thought that drug treatment can be useful in controlling their symptoms but they also want assistance to address the social issues in their lives which they perceive as either causing or having impact upon their mental health problems. They were clearly dissatisfied with the ‘doctor knows best’ attitude and would like more information sharing, control over the treatment options available to them including the type and strength of the medication they are prescribed and access to complementary therapies. This finding is echoed by that in the ‘People First’ study (Rogers et al 1993, Pilgrim 1993) which clearly indicates that service users are dissatisfied with the predominance of physical treatments in the mental health system, due to the unwanted side effects of such

treatment and the fact that it does not address the social difficulties which many service users perceive as significant in their experience of mental ill health.

Too often service users are reduced to the level of symptom carriers rather than being perceived as people who exist and find meaning for their lives within a complex network of social relationships. In protesting against this tendency Charlotte argued that professionals should:

“Treat people with a lot more respect as people, take a holistic view of the person rather than just symptoms, treating symptoms. Actually take the time to examine what’s going on in this person’s life and what other solutions might be possible.”

Many of the women who took part in this research reported that they were prescribed drugs (and even given ECT) to cope with distress which they identified as being caused by social and personal problems, rather than by medical illnesses. This tendency to prescribe physical treatments to suppress feelings of distress caused by social problems has been indicated in other studies (for example Darton, Gorman and Sayce 1994, Barnes and Maple 1992, Curran and Golombok 1985, Ettore 1992, Brown and Harris 1978, Brooke and Davis 1985, Chamberlain 1988). The pressures of motherhood; domestic violence; sexual abuse; racism; homophobia; and poverty; were some of the social problems which the women in this study described as being key in causing their experiences of mental distress (see also sections 4.2 - 4.9). Physical treatments such as medication and ECT are therefore being prescribed to many women to suppress painful feelings caused by the social situations they have encountered. Clearly there is a biological aspect to many conditions of emotional distress (Busfield 1996, Breggin and Breggin 1994, - see section 1.1) - this is why medication such as antidepressants and tranquillisers can actually work to ease painful feelings. However, to concentrate on altering these biological responses to the

neglect of the social, personal and political factors which have an impact upon women's mental health, leads to some women becoming psychologically and/or physically addicted to medication, possibly endangering their health with side effects (and even their lives as in the case of major tranquillisers which induce tardive dyskinesia).

Certainly psychotropic medication can be very useful for many women because it can provide a temporary respite from what can be the crippling symptoms of emotional distress. However in order that it does not become an additional problem, at the very least prescription of psychotropic medication should be an adjunct to other forms of non-chemical assistance. This assistance may come in the form of counselling and psychotherapy for those who request it. Just as important however is practical assistance in terms of childcare provision; and information about outside agencies which provide free information and advice relating to issues such as domestic violence (see chapter five); claiming welfare benefits, and obtaining housing allocations. I discuss this in further detail in chapter four concerning issues of discrimination within the mental health services, and chapter five concerning the specific experiences of women abuse survivors in the system.

Conclusion

A diagnosis is made by talking to and observing the behaviour of the patient. The patient may complain about thoughts, feelings and/or behaviour which they find distressing, or other people may indicate that their behaviour seems odd. In many other branches of medicine a hypothesis is developed on the basis of presenting symptoms and this is verified by physiological testing. In diagnosing mental illness, however, there are no laboratory tests which can be carried out which can verify the

presence or absence of a particular mental illness. The diagnosis is made purely on the basis of verbal reports and observations of behaviour. Thus communicational processes lay at the very heart of the diagnostic procedure.

Issues relating to objectification, disempowerment and discrimination (see chapter four on issues relating to discrimination) were key in the women's criticisms of medical practitioners, particularly psychiatrists. Several women reported that they found psychiatrists cold, lacking in empathy and patronising. A particular source of concern for the majority of women who had been treated by psychiatrists, was that they adopted a 'doctor knows best' attitude and would not allow them involvement in decisions relating to their treatment. Psychiatrists were particularly criticised for their unwillingness to discuss social and personal issues with their patients.

The process of diagnosis usually take place within the medical consulting room. Thus it is often divorced from the social surroundings which may provide alternative meanings for the phenomenon being studied. This lack of social context may be one reason why the focus often tends to remains with personal pathology. Furthermore, the diagnostic framework used is based on symptom patterns which assume an underlying pathology. The process of diagnosis itself is generally perceived as a non-social event which aims at uncovering this pathology. Thus mental illness is presented as a neutral scientific 'fact' which is investigated by scientific methods of observation. However the process of diagnosis is crucially affect by the social interaction between the doctor, the patient, and the physical environment in which any consultation takes place.

The exclusive focus upon identifying symptoms in order to make a diagnosis and prescribe medication, can tend to have the effect of objectifying service users. One outcome of focusing exclusively on personal pathology is that service users'

views can tend to be invalidated as meaningful in themselves, and regarded only as the symptoms of a mental illness. If a service user disputes their diagnosis, this too can be seen as symptomatic of the mental illness with which they have been diagnosed. Ignoring the social context of women's everyday lives means that women's feelings of distress are often seen as symptomatic of a biologically induced illness, rather than as intelligible responses to stressful experiences. Furthermore, because practitioners working within the biological model often tend to attribute the distress caused by social problems (such as domestic violence and child sexual abuse), to the symptoms of a biologically induced illness, it inevitably diverts attention from social and political issues within society. I discuss this tendency in further detail in chapter five.

Although the biological model is the dominant approach utilised within psychiatry; not all medical practitioners working within the discipline subscribe to a strictly biological model of understanding mental health problems (although many do - see section 1.1-1.3). However, many psychiatrists believe that a patient is suffering with a biological illness simply because their training has led them to conceptualise mental distress in this manner. Medical practitioners and other mental health professionals are not trained to consider the effects of social problems and interpersonal issues on service users' feelings of emotional distress (Johnstone 1993, 1989, -see section 1.1-1.3). A frequent failure by medical practitioners to carry out adequate 'detective work', so that appropriate questions are not put to patients to ascertain the distressing social experiences which may have caused their mental health problems, is one outcome of the dominance of the biological model of mental health problems within the statutory mental health services. Thus many doctors may diagnose a biological illness in ignorance of the common social experiences which

have caused a woman's mental health problems (see also section 5.2 on this issue as it relates to women abuse survivors).

Overall, the women who took part in this study were broadly divided over whether they chose to accept or reject the diagnosis they had been given (if indeed they had been told one). There is considerable stigma attached to diagnoses of mental health problems, especially where these denote psychotic disorders (see section 3.4). However, there is also considerable stigma associated with women who break dominant gender norms concerning women's behaviour. Thus for many women a psychiatric diagnosis provides an explanation for their distress which does not entail that they are bad wives, bad mothers or simply troublesome women. What did seem to be key in some women's decision to reject the diagnosis which was applied to them, was whether they believed that they had an adequate alternative means of explaining to themselves and other people why they were suffering with mental health problems which again did not mean that they were 'doing it on purpose' or 'attention seeking'. Significantly, the women in the study who had experienced sexual abuse as children were more likely as a group to reject the medical diagnoses which had been applied to them because broadly they thought that they had an explanation which made more sense to them than the one they were being provided with in the psychiatric establishment. A growing awareness in society of the prevalence of child sexual abuse coupled with a proliferation of self help books, self help groups and helplines for survivors of child sexual abuse have provided them with an alternative way of conceptualising their mental health status. Amongst the women who did not acknowledge child sexual abuse as an issue for them, there were several (including some survivors of domestic violence) who speculated as to what degree social factors would have influenced their mental health problems. They were clearly ambivalent

about their own mental health status, a situation which many were not happy with as they thought that they would like an adequate explanation of why they felt the distress they did (see chapter five on further issues relating to women survivors of abuse).

Whether or not the women perceived themselves to be suffering with a biological illness; reacting to oppressive social and/or personal circumstances; or were confused about the causation of their mental health problems; all of them indicated that mental health service delivery should focus on more than the prescription of medication. They thought that service providers should take account of other factors in their lives, beyond the symptoms of their mental health problems. In particular they felt that medical practitioners should pay attention to the whole person rather than focusing exclusively on the symptoms of illness.

In addition, what all of the women said they wanted from service providers was assistance in dealing with their mental health problems, as well as some answers as to why they were suffering with them in the first place. A lack of information being provided by mental health professionals was one of the most frequently mentioned criticisms made by the women, however. They thought that they were being 'kept in the dark' by many practitioners, either as a result of a conscious decision on the part of the professional, or because professionals did not have the time or the inclination to provide accessible information concerning their mental health problems. Thus, for example, some women complained that they were not told what their diagnosis was while others complained that they were told, but that their doctors did not discuss with them what the diagnosis actually meant, what had caused it, what were the treatment alternatives and what the likely outcome of their condition would be. In

addition the majority of women had not been advised of the potential side effects of the physical treatments they were prescribed.

In this study I found that in some cases, experiences of oppression that women identified as being key in causing their mental health problems were actually repeated within the mental health services themselves. I will discuss this in the following chapter in relation to issues of discrimination in the statutory mental health services. In chapter five I go on to explore this tendency specifically in relation to the experience of women abuse survivors.