1997

Women: The Ignored Majority

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Introduction

The major thrust of psychiatric rehabilitation is to provide skill development and supports enabling individuals to function in their roles of choice. The model thus contains an underlying assumption that meaningful life roles are "chosen" roles. It therefore may tend to overlook the impact on persons' lives of the roles that they are given. These given or ascribed roles include those based on gender, ethnicity, and socioeconomic class. Self-definitions, behaviors, beliefs, attitudes, and values are all likely to be structured within such social roles, which can also serve as important social identities (Oyserman & Markus, 1993). In spite of increased awareness of gender as an issue, in current Western culture, gendered roles are those for which there are, perhaps, the least latitude. Yet, as we shall show, the field of psychiatric rehabilitation has paid little attention to the subject of gender differences. We reviewed the 1992–93 volumes of the *Psychosocial Rehabilitation Journal* and found that only 15 out of a total of 21 studies, which reported information on individuals who were recipients of psychiatric rehabilitation services, presented the gender composition of the study sample at all. Furthermore, of these articles, less than half ($N = 6$) tested for gender differences (40%). Thus, only 28% of the articles could inform their readers about whether men and women differed on the study results. It seems likely that when differences between women and men are not even examined, the result is likely to be a service model that is theoretically androgenous, but in actuality male-biased. Again, the psychiatric rehabilitation literature on service approaches bears this out. The primary domain considered in services is vocational. There has been some consideration of the generic topic of rehabilitation in housing choices. However, those domains where women are considered to occupy primary roles, e.g., the family, parenting, and interpersonal relationships (Miller & Stiver, 1993), have received scant attention (Oyserman, Mowbray & Zemencuk, 1996).

This lack of concern for possible gender differences in psychiatric rehabilitation overall and especially to those issues of primary concern to women, is not unique to this field, but may be seen to reflect the perspective of the entire psychiatric/mental health establishment. For decades, feminists scholars and advocates have decried sex bias in the treatment system. Early research by Broverman et al. (1970) established the negative perceptions of women held by clinicians and the double bind in which women were placed, in that the expected characteristics of a "healthy" adult varied markedly from those for an adult female. Similarly, Chesler (1972) contended that because gendered roles were so proscriptive of mental health, women were in double jeopardy; those who overconformed to female sex roles were likely to be viewed as mentally ill as well as those who violated "appropriate" gendered role expectations. Additionally, clinical and practice research has found gender biases in diagnosis (Loring & Powell, 1988) and

in treatment, which serve to demean women (as dependent, passive, seductive, hysterical, etc.), foster traditional and limited sex roles, and respond to women patients as sex objects (Hankin, 1990).

An awareness of how such biases might affect services to women with long-term psychiatric disabilities is of more recent origin. Test and Berlin (1981) were apparently the first to point out that the "chronically mentally ill are regarded as almost genderless..." (p. 136). Although the research literature was limited, their review was able to identify the existence of significant gender differences in numerous domains of life functioning: instrumental roles, social and sexual roles, marital and family roles, and physical health. Several authors have elaborated on the problems raised in Test and Berlin's pivotal article (e.g., Bachrach, 1984; Bachrach, 1985, Bachrach & Nadelson, 1988). However, systematic attention to gender differences is still clearly lacking. For example, a 20-year metaevaluation of published treatment effectiveness studies involving aftercare services (Feis, cited in Mowbray & Benedek, 1988) found that 22% of studies did not indicate the gender composition of their sample and another 15% contained all male subjects. Over all the studies which did report gender ratios, there was a predominance of male participants (54.8%). A more recent review of 1992 issues of the *American Journal of Psychiatry* found that while a large proportion (84%) reported on the gender composition of their samples, less than half (46/99) tested for gender differences. Considering the significance of the topic of gender differences and the state of our practice ignoring women's special needs, more writing, discussion, and training are clearly mandated concerning psychiatric rehabilitation for women.

In this article, we will review the most recent literature concerning women with long-term, severe mental illness. The review has been organized to cover the same major topics earlier identified by Test and Berlin (1981) regarding role functioning. We will begin with a summary of gender differences in the target population on demographics and clinical characteristics. We end our review with a discussion of ways to improve both the treatment and knowledge bases.

Gender Differences in Demographics and Clinical Characteristics

Gender Differences in Diagnoses

It comes as no surprise to most rehabilitation and mental health providers that women far outnumber men in diagnoses of major affective disorders, especially depression. In fact, the lifetime prevalence for major depressive episodes in women is 1.67 times that of men—affecting a staggering 21.3% of the female population (Kessler et al., 1994)! What is much less commonly known, however, is that women actually outnumber men in all major *DSM-III* psychiatric diagnoses except one—antisocial personality disorder. This epidemiological finding was first established in the 1980 Epidemiological Catchment Area (ECA) studies from 5 sites (Robins, Locke & Regier, 1991) and more recently replicated in the National Comorbidity Study, using a national probability sample (Kessler et al., 1994). These gender differences upset conventional notions that men have higher rates of anxiety disorders and non-affective psychoses, such as schizophrenia and schizoaffective disorder, and that schizophrenia is primarily a disorder of young males. Comorbidity is another area in which conventional wisdom held that men outnumbered women. In fact, the National Comorbidity Study revealed that women, compared to men, have a higher prevalence of comorbidity of three or more disorders (Kessler et al., 1994). Women with either

alcoholism or cocaine use diagnoses appear more likely to exhibit a concurrent depressive disorder than do males (Gomberg, 1993; Denier, Thevos, Latham & Randall; 1991, respectively).

Despite the overrepresentation of women in most categories of mental illness diagnoses, it is men who are overrepresented in more intensive treatment programs: women are more likely to receive outpatient treatment (Wilcox & Yates, 1993) and men inpatient care (Hankin, 1990). In a recent statewide study, females as compared with males with severe mental illness were served predominantly in the less intensive services of crisis/emergency and outpatient care; while males outnumbered females in use of case management and residential services (Mowbray & Benedek, 1988).

Gender Differences in Demographics

There are also major gender differences in the demographics of persons with severe mental illness. Several research studies have corroborated the fact that women in treatment with a mental illness diagnosis are significantly older than men (Test, Knoedler, Allness & Burke, 1985) and also that women have a later age of onset (Goldstein, Tsuang & Faraone, 1989). The latter gender difference may be particularly marked in schizophrenia (Greenwald, 1992). That is, the age of onset for schizophrenia is 27 for females versus 21 for males (Gottesman, 1991). Similar though less dramatic differences are found for unipolar depression (25 for females vs. 23 for males) and for bipolar disorder (20 for females vs. 18 for males) (Burke, Burke, Regier & Rae, 1990).

Research also consistently indicates gender differentials in marital status among persons with mental illness: National weighted estimates show that while a *minority* of men with serious mental illness marry (31% to 46% married), a *majority* of women do (55% to 75% married; National Institute of Mental Health, 1986). In fact, in overall population studies, marriage has consistently been interpreted as serving a protective function in men, while in women its function is more questionable. Married men usually have the lowest rates of mental illness, especially depression; while single (never married) women are often *less* depressed than their married counterparts (Gove, 1979; Hankin, 1990).

Differences in the racial composition of male versus female populations diagnosed with mental illness have been explored, but so far no significant differences have been supported. However, the ECA data for one site indicated a four-way interaction of age, ethnicity, sex, and diagnosis; that is, higher prevalence rates for older Mexican-American women and younger non-Hispanic women, especially on alcoholism, drug abuse, phobias, and depression (Burnam et al., 1987).

Possible Reasons for Gender Differences

Explanations for gender differences in diagnosis have been posited, but none clearly established. For major affective disorders, a social roles explanation appears to be the best heuristic at present (Hankin, 1990). According to this explanation, women's socialization emphasizes relationships with others and de-emphasizes the importance of independence and personal autonomy. Women's social roles place multiple demands on them, but offer little status and few opportunities for personal gratification, and encourage minimization of their own needs. Combined, these factors make women more vulnerable to depression as they seek to meet role obligations and view problems in goal attainment as due to personal shortcomings.

Explanations for gender differences in schizophrenia are more diverse. A hormonal basis has been raised as a parsimonious way to account for the age differential. That is, female hormones may serve as pro-

tective factors for women disposed genetically or constitutionally to schizophrenia. Postmenopause, this protection disappears, thus explaining the two or three to one ratio of female to male schizophrenics in midlife and older age groups (Greenwald, 1992; Seeman, 1982). Hormonal differences have also been used to explain the supposedly better treatment outcomes observed for women schizophrenics; i.e., female hormones enhance the effectiveness of antipsychotic medication—an enhancement that ends postmenopause, when the sex differential in treatment outcomes is also thought to end.

Other nonhormonal explanations for these gender differentials have also been advanced: For one, that women's later age of onset produces better premorbid functioning and hence better outcomes. Secondly, women and men have been found to exhibit different types of schizophrenia. That is, men exhibit more negative symptomatology (such as withdrawal, amotivation, etc.), while women show more florid and affective symptoms, more acting out, and more overt hostility (Shtasel et al., 1992; Goldstein & Link, 1988). Women compared to men also appear to have more negative early life experiences, suggesting that schizophrenia for women may be more environmentally influenced (Greenwald, 1992). These differences in symptomatology and past history may reflect an actual difference in the underlying psychiatric illness (e.g., left hemisphere dysfunction and the deficit syndrome; Goldstein, Tsuang & Faraone, 1989); or they may reflect socialization and cultural proscriptions which affect how the illness is manifested.

It should be noted, however, that many of these studies about supposedly better outcomes for females versus males who are diagnosed with schizophrenia are flawed. That is, many of the studies use small samples which may not be representative; for example, including only first admission patients (so older women with greater disturbance are not studied) or recruiting solely from private psychiatric hospitals (in which middle to upper income women with insurance are overrepresented). Also, the measures of treatment outcomes or premorbid competence may not be valid; for example, common outcomes such as compliance with the treatment plan, attendance at day programs (Mowbray & Benedek, 1988), and adjustment ratings which include marital status as a major indicator (Angermeyer, Goldstein & Kuehn, 1989) may stack the deck in favor of women who follow their gender roles, are submissive to authority, and marry.

Thus, although usually ignored in treatment considerations, gender appears to play a major role in the etiology and manifestation of mental illness. At this point, more scientifically sound research is definitely needed to explain the gender differences which have been observed. However, the evidence does seem clear enough to mandate attention to gender differences on the basis of findings from clinical studies. We now turn our attention to research which has explored gender differences in role functioning.

Gender Differences in Instrumental Role Performance

Few studies have been conducted which focus explicitly on gender differences in functioning in or support needed for instrumental roles; such as employment, educational activities, home maintenance, etc. Some large-scale descriptive studies of populations with serious mental illness were located which happened to test for some of these gender differences. For the most part, no significant differences appear between men and women on education and employment, for North American groups studied (Herman et al., 1988; Shtasel et al., 1992; Test et al., 1985). This contrasts to dramat-

ic vocational disadvantages for women reported by Test and Berlin in 1981. The lack of current differences may reflect methodological problems (e.g., not controlling for women's older ages and thus greater opportunities for vocational experiences). Or, it may reflect more subtle influences now operating. Even if real, a lack of gender differences in employment status may not necessarily be to women's advantage, given the competing family obligations faced by most working women, including those with severe mental illness. For example, Holstein and Harding (1992), in a small sample follow-up of individuals discharged from an inpatient psychiatric facility, found that 13 out of 14 women were working and of those, 6 reported having homemaking responsibilities for others. For the men, 7 of 10 were working and none of the 7 had responsibilities caring for others. The investigators suggest that women's multiple work roles may significantly increase their stress and consequent symptomatology.

Whether or not past or present labor force and educational status for persons with severe mental illness are affected by gender may thus be questionable. However, there are clear differences in services to males and females in rehabilitation agencies. Nationally, across all types of disabilities, women represent less than one third of the caseloads of vocational rehabilitation programs, with reported earnings at closure only 56% of those achieved by men (Menz et al., 1989). Cook and Roussel (1987) found that women in a psychiatric rehabilitation program were given fewer job placements before "graduating" and that they were retained in the agency longer before getting their first paid jobs. Once in these independent job placements, women received significantly lower salaries (Cook & Roussel, 1987). Examination of data from Fairweather Lodge programs (a psychosocial residential and employment program) indicates fewer female than males being served (37% vs. 63%) (Fergus, 1987). This may not be surprising, given the typical jobs available to Lodge members (e.g., janitorial, landscaping, construction, etc.). Perkins and Rowland (1991) report that for a psychiatric rehabilitation center in London, a minority of day program patients are women (41%). These women are underrepresented at the higher intensity service levels and show significantly less movement out of the program than men. Thus, despite an apparent lack of gender differences in education and work histories, or even an alleged "better premorbid functioning" for women versus men, women seem to be under-represented in vocationally-oriented programs. This may reflect cultural expectations that vocational performance is more important to men or higher staff expectancies for men's vocational activity (Bachrach, 1985). Such attitudes, implicitly tied to the social construction of gender, violate the rehabilitation principle of individualized treatment. It should also be pointed out that for many women, the full-time homemaker role does not offer the safety and comfort assumed, but rather presents many stressors which may increase symptomatology and decrease adaptive functioning.

The instrumental role of living independently has also been studied, albeit in a limited manner. Contrary to expectations, women appear to more often live in independent settings—alone, in houses or apartments (Mowbray & Chamberlain, 1986; Test, Burke, & Wallisch, 1990). For example, Cook and Jonikas (1993) found 41% of females but 29% of males living in normal housing 6 months after closing services from a psychiatric rehabilitation agency. While these differences may be reflective of women's experience and socialization in household maintenance and domestic chores, they may also reflect differences in age and maturity. Cook and

Jonikas also reported that when length of program participation was controlled for, gender differences in living arrangements disappeared. Gender differences in living arrangements may also reflect males' greater involvement in the criminal justice system (higher arrest records and days spent in penal settings) and in using substances (Mowbray et al., 1996; Test et al., 1990). Both of these factors would promote more assignment of males to dependent/supervised living situations.

Social, Sexual, Marital, and Family Roles

Social and Sexual Roles

There is a relatively large body of literature linking females' socialization into gendered roles with depression: that is, while women are socialized to be nurturing of others, supportive of their needs and attentive to their desires; this other-directedness can come at the expense of their own sense of worth and efficacy (e.g., Oyserman & Markus, 1993). In fact, when women do focus on dissatisfactions with their family and social relationships, their treatment rarely addresses these issues (Zemenchuk, Rogosch, & Mowbray, 1995). Socialization practices through which women become centered on social connections and men on autonomy are not routinely explored, leaving women with a sense that their needs are not being met and that they are somehow to blame Thus, while the mental health of the family is oftentimes considered to be the responsibility of the mother, no one has responsibility for seeing that her needs are being met (Bernardez, 1984).

In overall population studies, marriage has consistently been interpreted as serving a protective function in men, while in women its function is more questionable.

Cogan (1993) has reported that while women are more likely to utilize community mental health services, they are less likely to view them as helpful than men. In fact, these women are quite likely to rate these services as being of no help at all. Perhaps, as Cogan suggests, this is because these services were not designed with the real life needs and circumstances of women in mind. In fact, relatively little is known about the everyday life circumstances of women with a severe mental illness. Social and sexual roles, friendships, and intimate relationships are likely to be central supports and could also be stressors for anyone. However, information is rarely reported about the interpersonal connectedness of women with psychiatric disabilities. What supports do they receive from friends, neighbors, and acquaintances; who can they turn to when they need help?

A recent study by Test and associates (1990) suggests that the daily life circumstances of men and women with a severe mental illness differ in important ways. Women were more likely than men to be hospitalized for nonpsychiatric reasons. Women were also more likely to be: married or divorced, involved in heterosexual relationships, parents, and, when parents, actively involved in parenting. Men were more likely to be jailed and to commit suicide. Males and females did not differ in the number of friends they were in contact with, but females were more likely to report kissing, dating, and sexual activity. From this and

other reports, it appears that women with a severe mental illness are likely to be sexually active. Thus, Test et al. (1990) report that in their sample of young adults, three quarters of women but only 40% of males were sexually active. In a survey of members of a large psychosocial rehabilitation agency (Cook et al., 1994), 39% reported that they were sexually active; on average, members reported having more than four sexual partners in the past 5 years. Less than half of the members reported more than occasional use of condoms. There were no differences between reports of men and women in this sample. Katz, Watts, and Santmann (1994), surveying a sample of persons with serious mental illness, also found no gender differences in high risk sexual behaviors. Sexual activity has also been documented for women in hospital settings (Mowbray, Oyserman & Zemencuk, 1995).

It does not appear that women with a severe mental illness can assume that the community mental health and psychosocial rehabilitation services they are offered or receive will focus on their needs as spouses, mothers, or family members.

Verhuist and Schneidman (1981) report that, unfortunately, over time, stable sexual relationships may be replaced with casual sexual encounters. A recent study, focusing on the social and sexual roles of women with severe mental illness, found that the vast majority self-reported a need for help in dealing with difficult relationships—both in getting their emotional needs met and in dealing with emotional and sexual abuse (Cogan, 1993). Women with severe mental illness may be more at risk of experiencing unwanted sexual advances, harassment, and exploitation as will be discussed later in this chapter. However, sexuality also involves desired intimacy and attainment of adult roles.

Marital and Family Roles

Marital and family roles are major social roles since marriage and parenting are normative signs of adult status and reflect important developmental tasks (Belle, 1982; Cohler & Musick, 1983; Gizynski, 1985). In addition, it is often argued that women are particularly likely to view social connectedness and relationships with others as important and self-defining (Oyserman & Markus, 1993). Given their normative, social, and developmental centrality, these marital and family roles are particularly likely to be central to women's sense of who they are and what is possible for them. Success in this domain will therefore likely provide the self with a sense of worth and competence, while setbacks may be particularly stress inducing and straining, providing the basis for a variety of negative self images (Markus & Cross, 1990; Stott, et al., 1983).

Unfortunately, women with a mental illness appear likely to experience a variety of social stressors in their intimate and family relationships. These stresses may increase vulnerability; thus, for example, married women of low socioeconomic status with young children and no paid employment outside the home are at increased risk of developing a psychiatric disorder (Romans-

Clarkson, Walton, Herbison & Mullen, 1989). Mental illness in turn may increase stress in social relations. A recent review by Downey and Coyne (1990) suggests that marital conflict is likely to be high up to 4 years after a depressive episode and that divorce is common among depressed women. In addition, women with a mental illness are more likely to marry a spouse with a psychiatric disorder—a situation that increases risk of exacerbation of their own symptoms and severity of marital and family disturbance (Downe & Coyne, 1990).

As in other domains related to women and mental illness, information is scarce as to the marital and family roles women with a mental illness carry out and the successes and problems they may encounter in these roles. However, it appears that women with a severe mental illness have a greater number of children than average and are more often divorced or not married than the norm, thus increasing their chances of raising children as single parents (Mowbray, Oyserman, & Zemencuk, 1995). In their review of the literature, Hammen, Burge, and Adrian (1991) suggest that adverse socioeconomic conditions and lack of resources are part of the life circumstances of women with a severe mental illness. The stress of parenting under conditions of poverty, social isolation, and marital discord increases risks for disorders in children (e.g., Hammen et al., 1987). In fact a large literature exists suggesting that children of women with mental illness are at risk for a variety of behavioral and emotional problems (e.g., Downey & Coyne, 1990; Persson-Blennow, Binet & McNeil, 1988; Phillipps & O'Hara, 1991; Richters, 1992; Tronick & Gianino, 1986). In addition, these children make up a sizeable minority of children removed from home and placed in foster care or other out-of-home placements (Blanche, Nicholson & Purcell, 1944; Oyserman, Benbishty & Ben-Rabi, 1992). Of course, these findings do not explicate the dynamic process through which illness and the perceived effectiveness of child rearing may be interrelated.

Parenting

A number of recent studies have examined aspects of mother-child relationships as these related to child outcomes and to mental illness status. These studies have documented risk in the quality of early dyadic relationships between mother and infant and the security of the infant's attachment to the mother (see Oyserman, Mowbray & Zemencuk, 1994, for a more complete review). In particular, mothers with affective disorders appear to be less able to synchronize their emotional and communicative efforts with the child's. However, while mothers with an affective disorder were found to be less responsive and less able to sustain social interactions with their children than comparison mothers, they were no less affectionate and tended to express this in physical play and touching. While some studies have suggested that mothers with affective disorders may be more rejecting and critical than comparison mothers, Conrad and Hammen (1989) suggest that depressed mothers are more accurate in their assessment of their children and more negative in their responses to their children's difficulties and shortcomings, perhaps because they find them to be more overwhelming. In general, mother's depressive episodes appear to have a negative effect on their children such that a temporal association between mother and child episodes of major depression has been documented (e.g., Hammen et al., 1991).

Many studies have compared depressed with nondepressed mothers but relatively few compare nonmentally ill mothers to both mothers with schizophrenia and mothers with an affective disorder. When such comparisons are made, a schizophrenia

diagnosis appears to be related to higher probability of emotional unavailability and passive lack of responsibility in interactions with children (e.g., Goodman & Brumley, 1990). Women with schizophrenia were also found to be less likely to provide a stimulating and enriched child-rearing environment for their young children than comparison or depressed mothers.

Available supports and resources and the difficulties and stressors women experience are clearly likely to influence their ability to carry out the parenting role and also their perceived capacity to carry out other roles. Unfortunately, it does not appear that women with a severe mental illness can assume that the community mental health and psychosocial rehabilitation services they are offered or receive will focus on their needs as spouses, mothers, or family members. Parenting appears to be a particularly unsupported role for women with severe mental illness. First, the little empirical evidence that exists suggests that women are not even routinely asked if they are parents, let alone what help they may need to fulfill their parenting role (e.g., Cogan, 1993; DeChillo, Matorin & Hallahan, 1987; Zemencuk, Rogosch & Mowbray, 1995; Wallace, 1992). Our review of the literature (Oyserman, Mowbray & Zemencuk, 1994) suggests that few services exist to support mothers with severe mental illness and their children. Second, women may be hesitant to request services since they run the risk of having their children become wards of the child welfare system, entering foster care or other out of home placement (Cogan, 1993; Perkins, 1992; Wallace, 1992). The extent to which mothers with SMI lose custody of their children is unclear, although a few reports suggest that it may be high, especially for older children (Bazar, 1990; Coverdale & Aruffo, 1989; Miller, 1990 Spielvogel & Wile, 1986; Test et al., 1990). Analyses of state appeals court decisions of termination of parental rights hearings for seriously mentally ill mothers suggest that these women may experience discrimination (*Mental and Physical Disability Law Reporter,* 1985; 1986a,b).

Until recently, there has been little published work focusing on women's perspectives on their family, parenting, and intimate/spousal roles. Our pilot work in the Detroit area (Mowbray, Oyserman & Ross, 1995) suggests that mothers with severe mental illness view parenting as central to who they are and that they have concerns about their functioning as parents. Unfortunately, these mothers are also attempting to cope in difficult economic and social circumstances, trying to provide for themselves and their children without much support. Recent work in Vermont (Cogan, 1993; Wallace, 1992) also focuses more directly on the concerns and issues of mothers with a severe mental illness, presenting difficulties experienced by those who need help in their parenting role. The centrality of family, intimate relationships, and motherhood issues to the lives of the women in these studies is clear. Women were articulate about the services they needed and the responses of the mental health system to these needs. A listing of their needs and the service options open to them is illuminating. In-home services, though desired, are not readily available. Foster care and other out-of-home services do not strengthen the mother's ability to parent once her children are returned home. Mothers felt they need help in concrete domains such as financial assistance, obtaining appropriate and nutritional food for their children and with child-rearing issues. Women who lost custody of their children felt they needed services to support them, to make visitation possible, and to help them deal with the loss of their children on an on-going basis.

In summary, the literature clearly indicates that women who are severely mentally ill are not their condition: they are mothers, wives, girlfriends, and even less

discussed, also daughters, sisters, and members of family networks. Clearly more work must be done to provide us with a better and more complete picture of these women and the social roles they play and aspire to attain. This information will better allow us to plan for and carry out rehabilitative efforts. In so doing, we need to also examine the role of sociocultural context in framing the supports and stresses experienced by women with a severe mental illness. For example, it has been argued that African American women are more likely to give and receive help within extended family networks than are whites (Hogan, Eggebeen & Clogg, 1993). Yet the ability of family networks to provide support to subgroups of women with mental illness has not been investigated. Similarly, we do not know the extent to which cultural beliefs about the meaning of mental illness or acceptance of formal support systems may change women's perceived supports and stresses, or enable or disenable the uses of mental health of psychosocial rehabilitation services (Sue & Sue, 1987). Thus, many important topics related to social roles remain unexplored, hindering our ability to provide effective gender-relevant services.

The studies all support the conclusion that women with psychiatric disabilities have more health problems than their male counterparts.

Physical Health and Medication Use

Health Issues for Women With Serious Mental Illness

The inattention to women's problems by the health care delivery system has been documented, as has the inadequate treatment women in the general population receive from health providers (Dan, 1994). Since the comorbidity of physical and mental health problems is high, it might be expected that women with severe mental illness should experience health problems and differences in health care provision. Although this area of gender differences is not well-researched, enough information is available to indicate that such a conclusion is warranted.

Only a handful of research studies could be located which investigated indicators relevant to the physical health of women with severe mental illness. While few in number, the existence of these studies contrasts positively with coverage reviewed by Test and Berlin—who cited only one article in 1981. The studies all support the conclusion that women with psychiatric disabilities have more health problems than their male counterparts. Thus, Test and associates (1990), in their long-term study of Assertive Community Treatment clients, found that women spent significantly more time in general medical inpatient settings (for nonpsychiatric reasons). Similarly, in a hospitalized sample, Mowbray and Chamberlain (1986) reported that women received significantly more nonpsychiatric medical treatment, particularly related to cardiology, diabetes, dermatology, and X-rays. (Men received more treatment for broken bones and minor wounds.) In a hospitalized dually diagnosed sample, gender differences were found in medical problems and their rated severity (Mowbray et al., 1996). To some extent, increased medical problems may reflect the older ages of female versus male groups studied. In fact, the health difference reported by Mowbray and Chamberlain (1986) was no longer significant when age was controlled. However,

age may not be a singular explanation since, in Mowbray et al. (1996), the female patients were younger than the males. The general literature on women's health problems suggests that oftentimes a woman's problems go unnoticed or unattended until a late treatment stage (Dan, 1994). Particularly with a psychiatric patient, health problems may be erroneously viewed as part of her delusional system (Mowbray & Benedek; 1988). Advocates concerning women's health needs have interpreted gender differences to reflect morbidity concerns for women and mortality concerns for men. This distinction seems to be maintained for persons with psychiatric disabilities wherein women have more health problems and complaints, but men have a higher suicide rate (Seeman, 1982; Test et al., 1990). Unfortunately, the medical establishment is less focused on morbidity issues, especially those requiring long-term care (Dan, 1994).

Women and Psychotropic Medications

Other studies (summarized by Bachrach, 1985) have described women with schizophrenia as having frequent complaints of weight gain, skin problems, constipation, pseudopregnancy, and menstrual irregularities. Many of these difficulties can be related to use of psychotropic medications, particularly neuroleptic drugs. Tardive dyskinesia, which is purportedly directly related to such drug use, is more frequent and more severe in females than in males. Cook and Jonikas (1993) suggest that medication side effects are often not considered by psychosocial rehabilitation programs, especially for women members. In focus groups, female members of a psychiatric rehabilitation program reported that their doctors never asked about problems of a sexual nature, e.g., vaginal dryness. In contrast, doctors appeared comfortable querying male members about ejaculation and other sexual performance issues. Thus, physical health issues, including those related to medication use, appear to be significant but largely ignored for women.

Besides their effects on sexuality and menstrual problems for women, use of psychotropic medications poses unique problems for women who are pregnant, postpartum, or planning to have children. In general, the vast majority of research on drug use has been conducted on males. However, since nearly all drugs cross the placenta (and are present in lactation), doctors oftentimes feel that female psychiatric patients should discontinue psychotropic medications during pregnancy (and in the postpartum if they are nursing mothers) (Allen, 1994; Mowbray et al., 1995). In actuality, lithium carbonate is the only psychotropic whose teratogenicity on fetal development is well established (Schou, 1990). However, a chance of birth defects has been reported for antidepressants and minor tranquilizers in some studies, but contradictory findings are common. (See Allen, 1994; and Mowbray et al., 1995; for more information.) In general, this area has not been well-researched, similar to other topics concerning medications for women. Understandably, physicians often disagree as to the alternative risks to the fetus from maintaining psychotropic drug use versus untreated, severe maternal psychiatric symptoms, which could lead the woman to harm herself or her child directly or through neglect (Allen, 1994; Cohen, 1989). Obviously, psychiatric patients may have many concerns about these issues. However, it appears that most physicians assume it is their role to *make* medication decisions for their patients (Krener, Simmons, Hansen & Treat, 1989). In fact, Allen (1994) describes one study which found that few programs even required written informed consent from females receiving lithium during their childbearing years. Thus, women are denied involvement in a major topic concerning not only their own life course but that of their off-

spring. Such practices are, of course, contrary to psychiatric rehabilitation principles and should be addressed by psychiatric rehabilitation programs. However, it appears that few are doing so for their female members. Women who are pregnant or contemplating conception should be given information that is complete and understandable concerning the risks of use and non-use of psychotropics as well as treatment alternatives, and be given help in making their own decisions.

A major problematic factor concerning physical health is the fact that women, compared to men, are prescribed psychotropic medications more frequently and in greater quantities (Allen, 1994; Mowbray & Chamberlain, 1986; Seeman, 1982). The literature has been quite consistent in such findings both for women with psychological/emotional problems and for those with more severe disorders, and across many classes of psychotropic medications from minor tranquilizers to antipsychotics. These gender differences may reflect the general societal trend to take women's complaints of any sort less seriously, write them off as of psychosomatic origin, and inappropriately use medications to silence them (Dan, 1994).

Substance Abuse

Comorbid Substance Abuse and Mental Illness—Prevalence and Characteristics by Gender

Alcohol and illicit drug use and misuse is far more common in men than in women (National Institute of Drug Abuse, 1990). In a national study, Kessler and associates (1994) found that 35.4% of male respondents reported a lifetime history of substance dependence or abuse versus 17.9% of female respondents. Although the co-occurrence of alcohol and drug dependence and mental illness was not reported, women have been found to be more likely to have a comorbidity of three or more disorders (Kessler et al., 1994). Consistent with gender differences in overall psychiatric epidemiology, among the most common comorbid mental disorders for those with a lifetime history of alcohol dependence or abuse are affective and anxiety disorders (although antisocial personality disorder is also prevalent; Regier et al., 1990). Among individuals seeking substance abuse treatment for a cocaine disorder, Ziedonis, Rayford, Bryant, and Rounsaville (1994) found that women had higher rates of current phobia and childhood attention deficit disorder. Another epidemiological study of a similar population (Halikas et al., 1994) reported that women exhibited significantly higher lifetime rates of all psychiatric diagnoses except antisocial personality disorder (ASPD). Finally, an examination of gender differences in psychiatric diagnoses at three substance abuse treatment programs found women, compared to men, were more likely to have a psychiatric problem other than a personality disorder (e.g., agoraphobia, dysthymia, anorexia, suicide attempts, and bulimia; Wilcox & Yates, 1993). Thus, several research studies concur that women are more likely to have a psychiatric disorder concurrent with substance abuse (although there is less agreement on the specifics of the psychiatric diagnosis). Explanations for these gender differences are usually consistent with social psychological theories on sex roles, in that "...female deviance tends to be inwardly directed whereas male deviance is more outwardly directed and antisocial...[suggesting] that substance abuse exerts a greater psychological impact on females but a greater impact on the social functioning of males" (Robbins, 1989, p. 126). In addition, childhood sexual abuse has also been correlated with adult females' addictive behaviors and could be hypothesized

as a common cause for co-occurring psychological problems (Briere & Runtz, 1987; Briere, 1988). That is, substance abuse can be viewed as self-medication against depression or as chemically induced dissociation (Hamilton, 1990).

Few studies have examined differences other than diagnoses between males and females with a psychiatric disability and substance use disorder. Mowbray et al. (1996) found that among psychiatric inpatients with substance abuse problems, women were more likely to be younger, report a family history of drug use, be unemployed, have medical problems, and utilize self-help services than their male counterparts. Women were also more likely to have children and to have their children living with them. On the other hand, men had more legal problems, a greater number of residences in the past three years, higher alcohol severity ratings, and more employment problems within the last 30 days than female respondents. These gender differences among those with a dual diagnosis appear to be consistent with the social role theory of gender differences, explicated by Robbins (1989). However, another study of comorbidity at three substance abuse treatment programs found that most gender differences were age related. For example, alcohol was the drug of choice for older men and women, poly-substance use was more common among younger subjects, and ASPD traits were more often found among males under 40. Women also reported more depressive symptomatology, were more likely to abuse benzodiazepines (minor tranquilizers), and to have their drug of choice be something other than alcohol (Wilcox & Yates, 1993).

Treatment Issues

Although the number of women misusing alcohol or drugs is not greater than the number of men, chemically dependent women face many obstacles when seeking treatment. These obstacles are likely to be exacerbated when we consider that these women are also more likely to have a serious psychiatric problem. Mondanaro (1989) notes that for women, chemical dependency involves a unique set of issues. First, women may experience a greater number of psychological problems, such as lower levels of self-esteem, and more anxiety and depression. In addition, they may face more stigma associated with their chemical dependency than do men. Historically, legal drugs such as alcohol and tobacco were reserved for men. Although times have changed somewhat, women who use substances still suffer the residual effects of these attitudes. For African American women, the stigma may also be reinforced by racial stereotypes, suggesting that they are more likely to use street drugs than other women. In addition, the media has done little to address damaging and unsubstantiated stereotypes about African Americans using and selling drugs more than any other group of Americans.

Compounding the above problems, many women who abuse substances have lower educational levels and, therefore, decent employment may be hard to find (Mondanaro, 1989). In fact, combined with the traditionally lower wage scale for women, a poor job history may make earning a viable wage even more difficult. Due to lack of money, many women cannot afford substance abuse services or ancillary expenses which would facilitate their treatment, such as transportation and childcare. Third, issues of sexuality and intimacy are likely to be more significant for women. Sexual abuse, incest, rape and violence have been reported by many chemically

[1] A common definition of abuse used in the literature is: The involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend to which thy are unable to give informed consent, or that violate the social taboos of family roles.

dependent women (Mondanaro, 1989). Their addiction may represent their attempts to cope with past abuse (Root, 1989). In an analysis of the life histories of female substance abusers, Woodhouse (1990) found that violence and abuse were common themes. Fifth, due to feelings of powerlessness, some women may not be motivated or may feel unable to change (Mondanaro, 1989), as if they had done too many bad things to ever remedy them. Traditional 12-step programs, like Alcoholics Anonymous, may be less helpful to women because of their focus on giving up control—which many of these women have too little of anyway.

Mondanaro (1989) has also noted that women may not seek direct help for their substance abuse since they often view it as a secondary problem. Instead of chemical dependency treatment, they may seek help for problems of a physical or psychiatric nature. Men, on the other hand, are more likely to see substance abuse as a primary problem and to thus seek help directly for drug or alcohol use. Mondanaro's seventh point is sobering. Women may actually experience more physical problems due to their drug use than men who use drugs. Such problems include cirrhosis of the liver, digestive disorders, and circulatory disorders. Eighth, for pregnant substance abusing women, very few services exist. The scarcity of programs for these women is unfortunate due to the fact that many women are especially motivated to stop using drugs when they find out they are pregnant, but just cannot get the help they need. As a result, their babies may be exposed to the deleterious effects of drugs for longer periods of time, simply because their mothers were unable to receive needed substance abuse counseling in an inpatient or residential setting. In this light, current legislative efforts to take punitive action against drug-addicted women found to be pregnant is unfortunate in that it may keep more women away from treatment rather than seeking what little treatment is currently available.

The incidence of childhood sexual assault among female psychiatric patients has reportedly ranged from 20–51% in inpatient settings and 22–54% in outpatient settings—as compared to 6–15% for the general population.

On a more positive note, according to a recent treatment review article, out of 80 studies, women and men appeared to have similar treatment outcomes (Toneatto, Sobell, & Sobell, 1992). Although, similar to the psychiatric literature, few (only 28%) studies actually examined gender differences.

Limitations

As in other literature cited, research and evaluation of the chemical dependency problems of women with serious mental illness has some significant limitations. Although more research is being conducted to explore dual diagnosis among women, studies vary greatly in the demographic characteristics of subjects, the substance use studied, comorbid mental disorders examined, the use of inpatient versus outpatient samples, examination of onset differences between mental illness and substance use comorbid disorders, and whether individuals studied were seeking mental health or substance abuse treatment. Without com-

prehensive studies exploring all aspects of the etiology of comorbid alcohol, licit and illicit drug use, and various types of mental illness among representative study populations, the development of effective treatment programs for dually diagnosed women will continue to be difficult. Again, the message to service providers is to improve their assessment techniques to better identify women with this concomitant problem. This may only be a partial solution, however, since substance abuse treatment resources for women are likely to be difficult to find or to access. Thus, psychiatric rehabilitation services may have to engage in more of their own program development activities.

Sexual Victimization

Another pressing, and yet often unaddressed issue affecting women with a serious mental illness is that of sexual abuse,[1] including childhood incest as well as current adult abuse. Research investigating the incidence rates of childhood abuse among mentally ill women suggests a higher occurrence than among the general female, adult population (Finkelhor, 1979; Russell, 1983; Siegel et al., 1987). Studies have also documented the relationship between childhood sexual assault histories and severity of symptomatology (Beck et al., 1987; Bifulco, Brown & Adler, 1991; Brownes & Finkelhor, 1987; Craine, Henson, Colliver & MacLean, 1988). Unfortunately, histories of current or past sexual abuse among severely mentally ill women are seldom explored by mental health professionals (Jacobson & Richardson, 1987) . This contributes to a poor knowledge base on this topic, as well as to ignoring important issues in treatment and rehabilitation programming.

Histories of Childhood Sexual Assault

The incidence of childhood sexual assault among female psychiatric patients has reportedly ranged from 20–51% in inpatient settings and 22–54% in outpatient settings—as compared to 6–15% for the general population (Bifulco et al., 1991). Estimates vary for a number of reasons. First, definitions of sexual abuse vary, e.g., the amount of contact necessary to constitute abuse, the age of the victim, the use of force or coercion, and the relationship with the perpetrator (Bifulco, et al., 1991). Secondly, methods of obtaining the information also vary (Finkelhor, 1986). Common methods include interviews, surveys, and chart reviews. Although surveys and chart reviews pose the advantage of being less invasive and preserving confidentiality, an interview is more likely to yield complete information, depending on what questions are asked (Jacobson & Richardson, 1987). Questions phrased with innocuous wording such as, "sometimes when children are still young, someone does something sexual with them. Did anything like that happen to you?" are more likely to yield affirmative responses than those containing words such as "incest" or "abuse." Similarly, questions regarding specific abuse instances are more likely to yield information than more general questions (Finkelhor, 1986).

In the general population, a history of sexual assault has been linked to such problems as excessive aggression, sexual dysfunction, histories of adult victimization, hyperactivity, substance abuse, dissociative states, and chronic feelings of depression and helplessness (Beck & van der Kolk, 1987; Hamilton, 1990). The results of one study of 286 working class mothers in England revealed a strong relationship between childhood sexual abuse and clinically relevant levels of depression (Bifulco et al., 1991). Furthermore, over half of the participants who reported childhood sexual abuse experiences also reported other negative childhood experiences

including lack of parental care, parental violence, and institutional stays prior to the age of 17. Although histories of child abuse were associated with depression in women who had not experienced other negative early experiences, it was fairly rare and constituted only 5% of the cases of depression in the sample as a whole. This suggests an important link between sexual abuse and parental neglect among severely mentally ill women.

Studies examining psychiatric populations have found even more severe symptoms among sexually abused patients than among other adult, female patients (e.g., Beck & van der Kolk, 1987; Craine et al., 1988). In one study of 26 female patients in a state hospital, those with sexual assault histories (N = 12) were more likely to experience sexual delusions, affective symptoms, substance abuse, suspected organicity, and major mental problems; and they spent more time in seclusion than other patients (Beck & van der Kolk, 1987). Similarly, in a study by Craine et al. (1988), 51% of an inpatient sample reported sexual abuse as children or adolescents. Of these women, 66% met criteria for posttraumatic stress disorder. In addition, every woman who was positive for all of the following six symptoms had been sexually abused: compulsive sexual behavior, chemical dependency, sadomasochistic sexual fantasy, sexual identity issues, chronic fatigue, and loss of interest in sex.

Although research on childhood sexual assault suggests high rates among women with severe mental illness, as well as more severe symptoms when compared with their non-abused counterparts, mental health professionals often remain unaware of assault histories among their female clients. Ann Jennings (1994) recounts the story of her daughter, who was not identified as a victim of early childhood sexual trauma until nearly 12 years of "treatment" in psychiatric hospitals, mainly with psychotropic drugs. Furthermore, even after the trauma was revealed, the reaction of mental health professionals was to ignore the information. In a study by Craine et al. (1988), 56% of abuse patients had never been identified as such during the course of their hospital treatment. Many of these patients remarked that they had never told any of the staff in the hospital because they had never been asked. This lack of awareness is likely to produce ineffective or inappropriate treatment for these women. In traditional therapy situations, unidentified abuse histories may lead to transference and countertransference issues with male therapists which are detrimental to the therapeutic process. Indeed, there is some concern that most adult women who are survivors of abuse be given female therapists because of their tendency to distrust men, perform for men, and/or give power away to them (Hamilton, 1990). In rehabilitation programs, lack of awareness of a prior abuse history may mean that programs do not develop effective strategies to enable women to fully function in roles of choice, e.g., because staff do not understand the barriers which the woman's past experiences are presenting. Gelinas (1983) contends that many adult survivors of incest are wrongly diagnosed as psychotic or borderline personality disorders (due to the dissociative states they display, their impulsivity and/or perceptual disturbances). Thus, failure to discover past abuse histories can be a very serious problem. Ten years and 15 mental hospitals after her disclosure, Ann Jennings' daughter committed suicide. Possible reasons for mental health and rehabilitation providers' failure to inquire about or deal with sexual assault histories include discomfort with the topic, the belief that such information is irrelevant, disbelief of women's reports, and the difficulty in obtaining reliable information.

Jacobson and Richardson (1987) argue

that in order to avoid inappropriate treatment for severely mentally ill women, routine inquiry into sexual assault histories is essential. She recommends that therapists develop standard times and ways of asking about different types of abuse. She emphasizes the importance of investigating the circumstances surrounding the abuse as well as the perceived effects of the abuse. Based on research findings, mental health workers should also inquire about specific levels of assault, since relatively less severe forms of abuse may have different effects on the client than do more severe forms (although this cannot always be assumed). Obviously, obtaining reliable abuse histories is dependent on the establishment of a trusting and safe relationship between the client and the mental health professional.

Although routine inquiry into the presence of early childhood sexual assault histories is an important first step in responsible treatment planning for women with severe mental illness, more basic questions in this area remain unanswered. The relationship between childhood abuse and adult psychiatric status is well documented. However, little is known regarding the nature of this relationship. Researchers in this area have relied primarily upon retrospective correlational studies. Inherent in such methods are memory biases. Furthermore, such studies are subject to multiple interpretations. For example, as mentioned above, some researchers have suggested that the important variable in psychiatric symptoms is not sexual abuse per se, but rather a generally unstable or neglectful environment in which parents fail to keep the child safe from harm (Bifulco et al., 1991; Muenzenmaier, Meyer, Struening & Ferber 1993). The high co-occurrence of neglect and child abuse is consistent with this interpretation.

Another ambiguity is whether varying levels of abuse may translate into varying levels of psychiatric symptoms. In other words, it is unclear at this point whether all forms of sexual abuse are equal in their deleterious effects. Finally, the existence of psychosocial risk factors which mediate the relationship between childhood sexual abuse and later onset of mental illness are yet unknown. Such risk factors might include family history of mental illness, socioeconomic status, or coping style.

Clearly, more in-depth research is needed in order to design effective prevention programs, and to coordinate services tailored to the special needs of victims of childhood or adolescent sexual assault. Unfortunately, few reports of intervention models for women with serious mental illness could be found in the literature. The most accepted model for adult survivors of incest is one patterned after treatment for posttraumatic stress disorder, in which the trauma memory and associated affects are slowly brought to the fore during outpatient therapy sessions. However, for clients who are likely to decompensate during this process (which could be the case for many women with existing psychiatric disability), this approach is not recommended (Gil, 1988). Herder and Redner (1991) describe an intervention designed for women with serious mental illness who have sexual assault histories, which incorporates case management, as well as a specific group therapy. They contend that this approach has shown initial favorable results. Group therapy is thought to be advantageous in that it enables these women to reestablish trusting relationships with others. The primary focus of their model is on psychosocial education and cognitive reframing of the abuse incident. Victims of childhood sexual assault are taught to view their symptoms as early attempts to cope with the abuse incident. This reframing of what are often viewed as dysfunctional reactions to the abuse is intended to increase feelings of self esteem and control over women's lives. Therapy then shifts to exploring

alternative, more productive coping skills for the present. Although outcomes of this form of group therapy are based on subjective, anecdotal reports, they suggest that addressing the abuse incidence directly results in positive therapeutic change.

Adult Sexual Victimization

While we have thus far focused primarily on childhood sexual abuse, sexual and physical assault of women with severe mental illness in adulthood is also a topic of serious concern. Research indicates that more than a quarter of all women in North America have been beaten by a male partner—or 3 to 4 million American women annually. Battered women constitute 22-35% of women seeking care in emergency departments (Dan, 1994). In psychiatric settings, the prevalence of battering appears to be much higher (e.g., 50% of female psychiatric outpatients and 64% of psychiatric inpatients; cited in Dan, 1994). In fact, it has been alleged that for some women, a psychiatric condition may be directly produced by repeated current experiences of physical or sexual abuse. That is, women's health advocates have long contended that women's responses to coping with their battering situation are often misinterpreted and mislabeled with psychiatric diagnoses and treated with tranquilizers rather than addressing the abuse, per se. Women who are battering victims have been labeled as masochistic personality types and blamed for their abuse—contributing, of course, to an even greater feeling of lack of control and consequent depression on their part (Schechter, 1987). Once a woman is given a psychiatric label, she is less likely to be believed concerning specific abuse allegations, and she risks losing custody of her children (Dan, 1994).

As is the case with child assault, possible reasons for this scarcity of information concerning adult victimization are failure to inquire about these events, or failure on the part of mental health workers to believe reports from severely mentally ill women. Unfortunately, these failures can lead to physical as well as psychological harm. Research suggests that severely mentally ill women are at greater risk for adult sexual assault (Dan, 1994). Presumably this reflects an interaction between a greater tendency to exploit disenfranchised groups and a lack of security in the houses and neighborhoods where these women live. Interventions, therefore, might include the provision of safer low income housing or education for mentally ill women on strategies for protecting themselves against sexual victimization.

Past and present sexual assault is a serious problem facing severely mentally ill women. Intervention strategies need to target a wide area including appropriate assessment of survivors of childhood sexual assault and early intervention for child and adolescent sexual assault victims. Mental health providers and advocates also need to ensure the provision of safe, low income housing, sex education, and assault prevention training in order to reduce the occurrence of adult sexual assault. Finally, more in-depth research is needed to determine which intervention strategies are best suited to the special needs of severely mentally ill women who have suffered past or present abuse.

Conclusions

Research and practice in psychiatric rehabilitation have paid insufficient attention to the specific needs of women with psychiatric disabilities. However, gendered roles have a significant impact on individuals' social identities and their self-conceptions in our society—thus, they cannot be ignored. An expanding (but still less than adequate) clinical and empirical knowledge base documents that there are significant issues which must be addressed to achieve rehabilitation goals for female clients. The issue areas which require attention concern

women's instrumental roles (vocational, household maintenance), social roles (friendships, sexuality, intimate relationships, marriage, family planning, parenting, and childcare), physical health problems, side effects of medications, substance use, childhood sexual abuse histories, and vulnerability to adult sexual victimization.

This literature review is but a beginning to helping psychiatric rehabilitation and mental health professionals improve services to female clients. Further steps will be needed, as follows:

1. Service providers need to expand their knowledge concerning issues of particular importance to women with severe mental illness. These involve:

a. Gender differences in age, diagnoses, and functioning and their possible etiologies.

b. Vocational and educational needs and the barriers of bias and discrimination which women may differentially encounter.

c. Women's relational needs and the potentially important roles in recovery played by social networks, friendships, personal relationships, etc.

d. Sexuality, including sexual safety, sexual education, family planning, etc.

e. Pregnancy and the postpartum period—the need for economic and social resources, as well as decision-making concerning medication risks, alternative treatments, etc.

f. Needs associated with parenting, such as economic and emotional support, training in household management and parenting skills, knowledge of child development, advocacy concerning custody, assistance with child-care arrangements, etc.

g. The physical health problems women experience, including unwanted side effects of psychotropic medications, especially on menstruation and sexual functioning.

h. Substance use disorders in women and how they relate to psychological and emotional problems.

i. The aftereffects often experienced by adult survivors of childhood sexual abuse, as well as likely indicators of having experienced this trauma.

j. The dynamics of adult sexual victimization, including correlates of sexual assault and domestic violence experiences.

2. Service providers need to expand upon their initial and periodic assessment methods to ensure that issues significant to female clients are adequately considered, such as childhood and/or adult sexual and physical assault histories, substance use disorders, battering and other domestic violence victimization, and parenting needs. Since these are sensitive topics, staff should be given training and adequate supervision when they begin to do these assessments.

3. Service providers need to review their practices concerning referral, screening, and/or entry to programs and services to ensure that they do not discriminate by gender; e.g., are equal numbers of women and men referred to vocational rehabilitation? enrolled in training programs? provided access to independent living opportunities with enough support? Are the same prescribing policies followed for men and women? Are men and women equally able to gain access to appropriate substance abuse treatment?

4. Needs assessments should be periodically conducted to ensure that the needs of special subgroups of women are being met within regular programming. If not, new program components should be initiated, e.g., integrated treatment for women with dual diagnosis, educational programs to promote sexual safety, group treatment for victims of childhood sexual assault, parenting education, etc. Support services may

also need to be added to meet women's special needs, e.g., respite care or babysitting access for children of female clients who are mothers, transportation to service locations, etc.

5. Research is needed on all the above topics. To address bias, researchers should utilize larger samples of clients, representative of those utilizing psychiatric rehabilitation and mental health services, including minority populations, lesbian women, and all age groups.

Our review indicates that women are an ignored population in psychiatric rehabilitation and mental health services. This situation has gone on for too long: many of the unmet needs identified in this review were also cited by Test and Berlin more than 10 years ago. It is clear that research and service provision should prioritize female clients to improve this situation before another review is completed 10 years from now! Since many of the changes needed involve awareness and assessment issues, this is also a significant area for educators and trainers in psychiatric rehabilitation.

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