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A Reinterpretation of Historical Gender Bias and Women's Mental Health

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University of Nebraska, 2003

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This epistemological review suggests that gender stereotypes and oppression have occurred throughout history and reflects past and present portrayals of women. Particularly, the reflection of stereotypes and oppression cause women to suffer mental health consequences in two ways. First, societal oppression reduces and enforces women to an inferior status, which promotes mental health suffering and consequences. Second, women suffer from biased assessments, diagnoses, and treatment via hierarchical relationships and gender stereotypes from professionals. Presently, women are maintained at this subordinate position due to a lack of people and policies enforcing health standards specifically for women.

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Chapter I

A Reinterpretation of Historical Gender Bias

and Women's Mental Health

By reinterpreting history and questioning preexisting knowledge, the framework

for sexism and mental health significantly suggests women's mental health to be

questioned. Do social oppression and gender stereotypes prescribe women's mental

health? Two trends are analyzed when reinterpreting historical data as evidence. First,

according to Mirowsky and Ross's study (as cited in Rieker and Jankowski, 1995), a

fundamental link exists across time between the experience of powerlessness and

women's emotional distress. Second, gender stereotypes measure women as inferior

compared to maleness (Rieker & Jankowski, 1995). This thesis suggests that a

combination of these trends along with the abuse of hierarchical power by the current

clinical profession lead towards inappropriate treatment, misdiagnosis, and mis-

medication of women.

Suggested gender-bias and mental health consequences have been documented in

writings throughout history. It is argued that, "cultural assumptions about essential

gender differences, which can be found in most psychodynamic theories and research, not

only mask inequality and conflict between men and women but, in a complex dialectic,

may even preserve the status quo" (Rieker & Jankowski, 1995, p.32). To advance change

for the future, feminist work has promoted an epistemological and contextual

interrogation of traditional historical sources (Shapiro, 1992). Strong arguments proclaim

that a sexist society makes women prone to emotional distress (Tomes, 1990). "Sex-role

stereotyping has depressed and confined the vocational aspirations of females, caused

psychic conflict regarding achievement and mental illness, and contributed to devaluation

of their own sex by females" (Maslin & Davis, 1975, p.87). The stereotypes and

oppressive factors, which cause distress, are construed as symptoms of mental illness by

clinicians. "Gender bias ingredients ... in diagnosis must be recognized, and the

diagnoses, descriptions, and etiological explanations ... should reflect such recognition"

(Philipson, 1985, p.213).

Social and clinical bias suggests each gender has expectations and limitations

along with views and punishments for embarking on the opposite's trademarks. Studies

reveal that women are pathologically labeled for both acting too female and acting too

male. According to a study cited in Russell (1986):

Healthy women differ from healthy men by being more submissive, less

independent, less adventurous, more easily influenced, less aggressive, less

competitive, more excitable in minor crises, having their feelings more easily

hurt, being more emotional, more conceited about their appearance, and less

objective. Overall, these are traits that are devalued ... (and) the judgements

involve a powerful, negative assessment of women (p.86).

Gender bias stereotypes about women's socially expected passivity and

dependence might lead to a depression diagnosis, or agoraphobia may be the label for a

woman's position as a housewife (Franks & Rothblum, 1983). The Diagnostic Statistical

Manual (DSM-IV-TR), suggests depression, defined partly as depressed mood most of

the day, markedly diminished interests, feelings of worthlessness and indecisiveness, is

diagnosed twice as often in women compared to men (2000). Agoraphobia, also diagnosed more prevalently in women, is defined by the DSM-IV-TR as anxiety related to places or situations from which escape might be difficult (2000). The DSM gives special attention to distinguishing the diagnosis of agoraphobia from some ethnic and cultural groups, which restrict women from participation in public life (American Psychiatric Association, 2000).

Two studies documented in Russell (1986), show women who are successfully following the female role by revealing emotional responsivity, naivete, dependency and childishness may be subjected to the diagnosis of hysteria. Although hysteria is no longer published in the DSM, it originated as meaning "wondering uterus," or womb related disturbances diagnosed in women (LaBruzza, Mendez-Villarrubia, 1997). Compared to adult standards, these traits indicate impairment in functioning. Overall, the passive emotionality could lead to major ego weaknesses for further pathological scrutiny (Tomes, 1990).

Disapproval of assertive behaviors or expressions of anger in women are also seen as negative mental health characteristics. According to Whiffen, Thompson, and Aube (2000), it is practically unanimous that men are socially allowed aggressive outbursts, however, women's angry and aggressive feelings are heavily suppressed from childhood onward with few socially approved outlets. Gender bias suggests that women are caught in an impossible situation. "If a women breaks out of the female role she may be regarded as mentally unhealthy, as she is not fulfilling her role, but if she stays within her role she may be regarded as mentally unhealthy on an adult standard" (Russell, 1986, p.87).

The clinical profession historically displays beliefs and actions exhibiting bias, according to documented theories. For example, "psychoanalytic ideas about women serve up scientific evidence for reinstating women in their 'proper' domestic place. These ideas include interpreting women's ambition as penis envy, blaming mothers for an extensive array of difficulties and disorders of kids and adult life, and equating heterosexuality, marriage, and motherhood with psychological maturity" (Marecek & Hare-Mustin, 1991, p.523). "Psychological and behavioral dysfunction conceals this underlying problem that 'dysfunction' embodies a moral evaluation and thus works strongly against women" (Russell, 1986, p.87). "The devaluing, restricting, and pathologizing of women, created the very unhappiness that it purported to cure" (Marecek & Hare-Mustin, 1991, p.523).

> Gender inequality is based solely on the essentialist assumption, that the physical differences between females and males are so significant that they should determine virtually all social and economic roles of men and women .... Gender-restricted social roles... rests on the philosophical and 'scientific' belief that women are essentially different from men. Measured against male experience and maleness as the implicit standard, women as the 'other sex' are different and thus assumed to be substandard or inferior (Rieker & Jankowski, 1995, p.30).

With the belief that each gender is different, why are males and females judged, labeled and diagnosed comparatively against each other? This question will be carefully analyzed through a reinterpreted historical review of initiated knowledge by male dominance. In order to maintain this suggested mono-gender supremacy, carefully

constructed rhetoric and interpretation maintain a plethora of one-sided existing theories. These interpreted historical and current theories lead toward the existing bias in assessment and diagnostic methods, which have perpetuated over time.

Terms such as epistemology and hermeneutics are important to understand when reinterpreting suggested historical knowledge. As defined The American Heritage Dictionary of the English Language (2000), epistemology is "the branch of philosophy that studies the nature of knowledge, its presuppositions and foundations, and its extent and validity". Hermeneutics is defined as "the theory and methodology of interpreting" (The American Heritage Dictionary of the English Language, 2000). Feminist theory uses both terms as resistance against presumed historical knowledge. "In its broadest outline, feminist work seeks to produce a set of destabilizing questions that generate a reexamination of the context, methods, and epistemologies of existing academic paradigms as it theorizes the meaning of sexual difference" (Shapiro, 1992, ¶2).

Guided by feminist theory, this thesis will explore and reinterpret the historical perspective towards oppressing women and the mental health consequences which gender bias has on women's health. This thesis will also reexamine the differences represented in men and women, question the single-accepted norm, and challenge the resulting gender bias. Furthermore, this thesis will combine the interpreted gender bias and clinical consequences, such as etiology, diagnoses, and medication. A study documented in Marecek and Hare-Mustin (1991), demonstrated that clinicians do not draw their knowledge of gender differences from scientific sources, but instead from bias and stereotypes similar to those of the majority public. Similarly, Russell (1986), states that,

"...[*the*] standard way of behaving or experiencing is not one which emerges from medical theory; rather it is based upon certain value judgements, which perhaps enjoy the agreement of many..." (p.89) [Italics added by author].

While gender is the only key subject in this work, it is not the only affected group that is shaped by the abuse of power. Caplan considers racism, ageism, classism, and homophobia as other prejudices that are reflected in the creation and assignment of diagnostic labels (1992). In general, power is the tool, which molds minority groups into coerced sub-systems; thus, other written works can provide knowledge in these similar related fields.

This thesis does not purport to solve the gender bias problem by unifying one norm to congregate the sexes, but rather too reeducate and prevent further consequences towards women's mental health. Feminist innovations toward change suggest sex-role resocializing, understanding gender and power, and using this knowledge to challenge the established theories and practices of clinical psychology (Marecek & Hare-Mustin, 1991). "All these developments call for renewed feminist activism against the medicalization of social problems" (Marecek & Hare-Mustin, 1991, p.530). This thesis will: 1) discuss historical ramifications, 2) explain new interpretations, 3) consider employable theories, and 4) suggest implications for improving clinical gender bias. As follows, the first chapter will explore the chronological gender biases that have existed over time.

Chapter II

An Historical Outlook Constructing Women's

Psychological Disposition

"The focus of male-female differences has pushed the question of male

dominance and female subordination to the periphery. ...The center of inquiry is gender

and power" (Marecek & Hare-Mustin, 1991, p.531). Correspondingly, gender refers to

that of maleness and femaleness, rather than man verses women. Feminist theory

believes that many of the resulting pathological behaviors in women are caused by

presumed, gender hierarchy (Collins, 1998). Historical reinterpretation displays gender

and power as themes throughout the fields of philosophy, religion, and medicine; among

these are social and cultural biases, which prescribe human norms. In this chapter, history

will be discussed and reinterpreted in order to explore the mental health effects of biased

gender roles.

Mental health care has been documented since 10,000 BC with the initiation of

medicine, magic, and religion. Prehistoric practices were administered by "witch

doctors," "medicine men," and "priest-physicians," all predominately men (Darton, 1999,

p.1). An historical reinterpretation suggests that men ruled psychological theories and

philosophies until the twentieth century. More importantly, "the study of women in

ancient literature is the study of men's views of women and cannot become anything

else" (Katz, 1992, p.8). The following historical areas reveal misogynistic trends, which

are thoroughly documented in cultural and social facets over time. This chapter will begin

with philosophical trends in which root medical and psychological theories.

Philosophical Trends

The presupposition that history is man's interpretation of the past, for his own

benefit, denounces women in many regards. However, the notion that historic life really

demanded such bias trends suggests harsh realities to the actual hierarchical standards

that existed.

Since virtually all scholars had been male, their attitudes no doubt

reflected the age-old fact of male dominance in Western society. However, the

assumption that it is right for males to rule, carried into philosophic thought, also

helped to sustain and even shape the anti-female biases of scholars, educators, and

politicians across the generations.... Philosophers, whose task it is to question the

dominant assumptions, instead reinforced the tendency of the educated gentleman

to ignore the matter of sexual equality as an important element of justice

(Bluestone, 1988, p.41).

Examples of such philosophers, Aristotle and Plato, are documented as being "the

most influential" (Bluestone, 1988, p.41), "foundational architects of the Western world"

(Green, 1992, p.71). However, feminist reinterpretation deems their philosophies as,

"...unconventional and disturbing" (Bluestone, 1988, p.41), "...insufficient warrants of

theoretical insightfulness" and "...bias-driven arbitrariness" (Green, 1992, p.70).

Aristotle, 384BC, regards differences between men and women, husband and

wife, like that between master and slave (Green, 1992). Furthermore, if both men and

women are to experience "the good life" (Green, 1992, p.80), each must assume their

proper place. Sex, body heat, and development are responsible for determining relative,

proper places within the household. Proper places for women are in the home, "giving their efforts to care of the family under the direction of their husbands and masters" (Green, 1992, p.80). It is suggested that, "all women...regardless of social position or age, are relegated to a second plane" (Feminias, 1994, p.164).

Contrarily, Aristotle suggests that men's role assumes a superior status. "The male is by nature superior, and the female inferior, one rules and the other is ruled; this principle of necessity extends to all mankind" (Femenias, 1994, p.166).

> While the head of the household rules over both wife and children, and rules over both as free members of the household, he exercises a different sort of rule in either case. His rule of his wife is like that of a statesman over fellow citizens; his rule over his children is like that of a monarch over subjects. The male is naturally fitter to command than the female... (Green, 1992, p.85).

These Aristotelian hierarchical gender differences are developed from numerous, suggested theories. First, men are attributed to being hot, active, form-making, and dominant; whereas, women are considered cold, passive, form-receiving and submissive (Green, 1992). It is men's greater amount of body heat which allows him to develop deliberative reason to a higher degree, whereas, women's deliberative reason never achieves full activation (Green, 1992). Second, each gender is equipped with immaterial called nous, which is suggested to be "the divine mental substance of which humans share a small part of" (Green, 1992, p.79). Women have slower nous, which is responsible for their inferior status (Green, 1992). Feminists rebut such beliefs by suggesting that Aristotle is not entitled to conclude such accusations, furthermore, "his

views about the natures and places of women…are blatant and historically harmful examples of distortion" (Green, 1992, p.70). These "anti-women, stereotyped, prejudiced things that Aristotle says about women" (Green, 1992, p.70), are similar to that of other antiquated philosophers.

Plato's theories and attitudes towards women were considered ambivalent. "In some of his writings he advocates a fairer deal for women….On the other hand, he ascribed the inferior status of women clearly to a degeneration from perfect human nature" (Greek philosophy on the inferiority of women, 2003, ¶1).

According to Plato, women came about through a physical degeneration of the human being. It is only males who are created directly by the gods and are given souls. Those who live rightly return to the stars, but those who are "cowards" or lead unrighteous lives may with reason be supposed to have changed into the nature of women in the second generation (Women were considered inferior creatures, 3¶).

When historically reflecting on Plato's theories, the inconsistency is apparent when uncovering the less gender bias trends. For example, Plato and his teacher, Socrates, proposed "an ideal society in which superior men and women would rule together equally" (Bluestone, 1988, p.41). This startling proposal suggested egalitarian styles not previously regarded. Plato furthermore assessed that "identical leadership roles required identical education for the most capable members of both sexes" (Bluestone, 1988, p. 41). Upon translation of these theories, interpreters considered Plato's original

comments as "mistakes" (Bluestone, 1988, p.46). Further commentary according to translated theories of Plato suggest the following:

> ...that the proposals are undesirable, that women have better things to do. A third group insists that Plato himself didn't really mean what he wrote. *[Some translators found]* the suggestions for gender equality unintentional..., unwelcome, *[and]* ...amusing, Plato's attempt to write comedy (Bluestone, 1988, p. 47). [Italics added by author].

Other commentary on Plato's theory claim, "Hitler has already incorporated Plato's plans for women into the state he envisions in Mein Kampf" (Bluestone, 1988, p. 48).

In regards to these gender biased philosophies, "are these comments symptomatic of a deeper disease that pervades the entire Aristotelian corpus? Might they be clues to the mysterious basis of the Western world's assignment of unequally valued hierarchical places" (Green, 1992, p.71)? It is suggested that ancient philosophical views initiated similar trends elsewhere in history, such as religion and spirituality.

Religious Trends

Historiography, reinterpreted, depicts negative beliefs and practices towards women among different religious denominations. For example,

> Greek philosophy which was adopted by Christians, held women to be inferior to men by nature. Roman law, which became the basis for the Church's laws, gave women a low status in society. Women did not enjoy equal rights in their homes and in civic society. Some Fathers of the Church linked women's

presumed inferior status to scriptural texts: only the man, they said, was created in God's image. ..."Church Orders" of the first millennium also show traces of belief in women's inferiority; Theology too copied this line of thinking, integrating the anti-women views of Greeks and Romans into their theological reasoning" (Women were considered inferior creatures, 2003, ¶1).

Furthermore, ancient Hebrews labeled menstruating women as unclean; "She should be put apart seven days, and whoever touches her shall be unclean" (Gies, 1978, p.8). Childbirth was considered to be similarly polluted; "She shall touch nothing that is holy, and shall not enter the sanctuary till her days of purification are completed" (Gies, 1978, p.9). The Christian church adopted similar tactics towards pregnancy, menstruation, and post-childbirth. These types of women were not allowed to make bread, prepare food, or touch holy water (Gies, 1978). These religious biases interlaced with spirituality and other non-religious sorts to presume women to be inferior.

Overall, the three general vices, which had control over wicked women, were infidelity, ambition, and lust. These led to parallel premises of witchcraft labels. "All witchcraft comes from carnal lust which is in women insatiability" (Alexander & Selesnick, 1966, p.68). Furthermore, women of ambition were more deeply affected to fulfill their filthy lusts (Alexander & Selesnick, 1966).

The only cure for the many women condemned to witchcraft was to hunt and exterminate them. The product of these witch-hunts was hundreds of thousands of women and children, healthy and ill, being burned at the stake for sex differences (Alexander & Selesnick, 1966).

As witchcraft faded, women fought religious injustice for equality as members of congregation, as ministers and officials in church hierarchy (Gies, 1978). Centuries passed before women were acknowledged as writers in Church literature. Women accounted for only three percent of the biographical entries in the Encyclopedia of Religion (Wiesner-Hanks, 2002). A woman's name finally appeared in the title of *Church History*, forty-two years after the initial journal publication (Wiesner-Hanks, 2002).

Medical Trends

Religion's gender bias entered the medical field by relating disease with the devil. Furthermore, as mental disorders were equated with sins, the sinful devil was preoccupied by negative sexual connotation (Mathews, n.d.). Through examination of a woman, if a doctor could not find a reason for the disease, or if drugs could not relieve the symptoms, then it was considered to be related to the devil or witchcraft (Alexander & Selesnick, 1966). Women were quickly labeled "witches" and "devils," as well as proclaimed "Woman, a temple built over a sewer" (Alexander & Selesnick, 1966, p.67). Women could also inherent these labels through sexual interactions with men. In the thirteenth to sixteenth centuries, women were believed to "stir up men's emotions, thus they may contain the devil" (Mathews, n.d., p.4). "Psychotic women with little control over voicing their sexual fantasies and sacrilegious feelings were the clearest examples of demonical possessions" (Alexander & Selesnick, 1966, p.67).

Aside from devil equated diagnoses, the medical field arranged further verdicts around gender. "Men and women were placed on vertical, hierarchical axis, in which their bodies were seen as two comparable variants of one kind" (Harvey, 2002, p.901),

often called the one-sex model. From antiquity to the eighteenth century, the one-sex model dominated sexual theories and constricted women to less powerful bondage roles (Harvey, 2002). However, scientific advances shifted the one-sex model to the two-sex model. Reproduction and orgasms were central themes when debating the new physiological dichotomy. "Male semen was visible and tangible, and its relationship to reproduction readily deducible, but the discovery of the female ovum awaited the invention of the microscope" (Gies, 1978, p.48) before it gained necessary importance. As previously interpreted by Aristotle, medical theorists concluded that man "produced the 'active principle' in conception; the woman contributed 'matter' (Gies, 1978, p.49). Similarly, related to orgasms, "men's sexual desire was central…women were often punished for taking sexual initiative, and it was prostitutes who were thought to display 'exceptional sexual initiative' (Harvey, 2002, p.907). Medical debates lasted centuries before women's physiological importance became known; meanwhile, "men redefin[*ed*] patriarchy in order to ensure its continuance and bolster its foundations" (Harvey, 2002, p.905). [Italics added by author].

"The claim that bodies, gender, and sexuality were redefined because of debates regarding representational politics tends to subsume a wide range of historical phenomena under one" (Harvey, 2002, p.912). As history depicts, "gender roles as lived were a product of the interaction between ways of thinking about gender and a combination of social, economic, and political forces" (Harvey, 2002, p.915).

In conclusion, this chapter has reinterpreted historical depictions as containing gender bias. According to philosophy, medicine, religion, and spirituality, women were

traded, labeled, removed, and murdered. Hierarchical standards and bias beliefs dictated the very lives of women and the associated psychological subordination and mental health consequences.

In order to combat these historical, preconceived ideas, it is crucial to question the foundation in which they were anticipated. The next chapter suggests ways to interrogate, dispute, and reinterpret these initial theories to become less biased and all-gender inclusive. Furthermore, it will discuss recent research depicting the antithesis to biased historical premises.

Chapter III

Concerns in Epistemology, Rhetoric, and Hermeneutics

"Western biomedical and public health research on women's health continues to be shaped by attitudes towards gender... that can only be described as sexist" (Whittle & Inhorn, 2001, p.148). It is recommended that research and society interrogate "Eurocentric, masculinist" forms of knowledge production, including terms such as gender, in order to discourage social hierarchy which "constrain our understanding of women's (ill) health and well-being" (Whittle & Inhorn, 2001, p.149).

For historians, feminist theory is a powerful tool for revision and rewriting chronicled information (Shapiro, 1992). Feminist writers have studied knowledge and taken into consideration "what has gone unsaid," (Marecek & Hare-Mustin, 1991, p.526), assumed, and misinterpreted. If future readers and writers do not question past beliefs, then knowledge is maintained from the time that it was written. What we believe and practice today should not rest on the destiny from which it came. Gender neutrality must be questioned in order to proclaim necessary changes for the future (Philipson, 1985). "What science becomes in any historical era depends upon what we make of it" (Harding, 1991, p.10). This chapter will place particular attention towards reviewing initiated knowledge, verbiage, and interpretation corresponding to gender bias assumptions.

Knowledge and strategies of inquiry for producing knowledge are not gender neutral...Bias extends to the very philosophical foundations of how inquiry is conceptualized. It extends to theories about how we think and to judgments about what constitutes "good" thinking (Salner, 1985, p.46).

Therefore, in order to challenge our inquiring minds, it is crucial to ask epistemological questions about our beliefs associated with the origins of gender. In the 1960s and 1970s, feminist activists set about questioning everything thought to be known about women's health. "They challenged the fundamental view of biology as destiny, refuted the depiction of women as mentally and physically fragile, and raised questions about hazards to women's health at home and in the paid labor force" (Whittle & Inhorn, 2001, p.147). However, difficulty surrounds refuting historic ideas due to the abstract and qualitative nature, as well as the longstanding tradition of "theories without evidence" (McLellan, 1995, p.7). For example, the current medical society continues to believe Freud's initial sexist theories, sustained from his "insights" and "years of clinical experience" (McLellan, 1995, p.7). These topics still remain questionable to date.

In order to combat predetermined gender explanations, new ideas and verbiage were created. The word feminism was first used in America in 1906 in order to explain activities solely for women; however, the act of feminism primarily began in 1848 when the first wave female abolitionists questioned equality (Baumgardner & Richards, 2000). Today, feminism is defined as "Belief in the social, political, and economic equality of the sexes" (The American Heritage Dictionary of the English Language, 2000). "Public opinion polls confirm that when women are given the definition, 71% say they agree with feminism, along with 61% of men" (Baumgardner & Richards, 2000, p.56). The importance of feminism ideals replacing humanism is the conscious inclusion of women (Baumgardner & Richards, 2000).

Upon establishing this new opposing arena for equality, contributors instituted further verbiage and ideas, such as sexism and gender. The word "sexism" was contrived in order to help explain frustrations and questions about gender inequality (Willie, Rieker, Kramer, and Brown, 1995). Sexism is defined as "discrimination based on gender, especially discrimination against women. Attitudes, conditions, or behaviors that promote stereotyping of social roles based on gender. " (The American Heritage Dictionary of the English Language, 2000). Feminists claim sexism defines "social and emotional costs effecting women's identity, experience, and well-being" (Willie et al., 1995, p.27).

It is important to understand that sexism refers to 'gender,' not 'sex.' "Sex is dichotomized as 'male' and 'female.' However, 'gender' is a different construct, for it is a socially (human) constructed category, regarding culturally produced conventions, roles, behaviors, and identities involving notions of 'masculine' and 'feminine,'" (Whittle & Inhorn, 2001, p.155). "Gender relations in any particular historical situation are always constructed by the entire array of hierarchical social relations in which 'women' or 'man' participates" (Harding, 1991, p.14).

Renowned author, Sandra Bem, (1993), suggests genders incur concealed assumptions "embedded in cultural discourses, social institutions, and individual psyches that invisibly and systematically reproduce male power in generation after generation" (p.2). These perceptions assume "males and male experience as neutral standard or norm, and females and female experience as a sex-specific deviation from that norm. It is thus not that man is treated as superior and women as inferior but that man is treated as human

and women as 'other'" (Bem, 1993, p.2). These assumptions from antiquity are transformed into learned knowledge of the present. "Societal expectations are directly relatable to stereotyping by definition. Stereotyping can be defined as a means of ascribing characteristics to an individual based not on knowledge of the person, but rather, on a presumed knowledge of a group of which he [or she] is a member" (Maslin & Davis, 1975, p.87). [Italics added by author].

It is important to separate assumptions from facts when rationalizing gender as being sexist. As stated in previous chapters, gender positions reflect a social and political ranking system, assumed by initiated knowledge from men. "The assumptions associated with stereotypes can become automatic nonconscious ideology. Because of this, many aspects of gender role socialization are invisible" (Collins, 1998, p.98). As society acknowledges knowledge, with it come blind assumptions, stereotypes, and bias trends.

Learned biased traits begin shortly after birth. "Male and female infants are transformed into the kinds of masculine and feminine adults who willingly accept the different-and unequal-roles assigned to them in an androcentric and gender-polarized society" (Bem, 1993, p.137). Also, "during this time period, children are learning to label other boys and girls accurately... [according to sexism]" (Fagot, 1992, ¶2). [Italics added by author]. According to several studies, most children have mastered stereotyped labels by the age of two (Fagot, 1992). Gender identity construction is presumed to first be demonstrated by society and culture. This can be explained via "enculturation", which is the transfer of gender bias from culture and society to the individual (Bem, 1993). Although cultures and societies change over time, sexist trends remain and adapt.

Second, the predisposed child "constructs an identity which is consistent" to gender-bias

roles (Bem, 1993, p.138). Thus a gendered cultural native is transformed from male and

female children to masculine and feminine adults (Bem, 1993).

People in the fields of science and research are not excluded from gender bias.

Early scientists and physicians established "natural truths" in order to define norms about

human characteristics, behavior, and health and illness (Whittle & Inhorn, 2001). It is

important to acknowledge initial scientific claims and their authors (Harding, 1991).

However, it is more important to realize historical changes related to prior claims. This is

especially crucial when considering that some concluding experiments were initially

based on results from exclusively male data, according to Brett (1989), Leaf (1989),

Cotton (1990) and Levey (1991) (as cited in Willie et al., 1995). Middle-class European

and American males were prime research subjects for experiments until recently (Whittle

& Inhorn, 2001). Thus, many former results were illegitimately concluded to be

compatible for women.

Despite the dangerous health consequences for women, especially with

pharmaceutical medications and medical procedures, it also purported blatant violations

of obvious scientific rules of method and theory (Harding, 1991; Marecek & Hare-

Mustin, 1991). "Scientific method is supposed to be powerful enough to eliminate any

social biases that might find their way from the social situation of the scientist into

hypotheses, concepts, research designs, evidence-gathering, or the interpretation of the

results of research" (Harding, 1991, p.58). However, so long as power and hierarchy

decipher experiments, research, and conclusions, biased views allow for non value-free perceptions.

In conclusion, four decades of heightened feminist research and activism in women's mental health has only dented the legacy of prior bias-thoughts. The responsibility for balance and change exists in the individual learner. The unbiased learner believes (1) knowledge is only a subset of a larger context and interpretation, (2) the legitimacy and/or authority of the knowledge arose from only one linguistic and communicative source, and (3) truth claims via knowledge are inseparable from pragmatics (Flax, 1990). Every individual has the option and responsibility to embrace inquisition. "Where one stands as an inquirer, i.e., what particular set of conceptual assumptions one utilizes, determines to a great extent what and how one 'sees' and 'knows' (Salner, 1985, p.46). Only then can individuals produce social changes.

After all, it is the individual clinician, which holds the key to interpreting behaviors without gender bias, as well as diagnosis and treatment. The next chapter further explores etiological causes as well as the clinician's responsibility towards gender awareness.

Chapter IV

Theories of Etiology

Upon deciphering causal premises for women's current ill-fated mental health status, two perspectives are considered in this chapter. First, women are perceived unhealthy due to biased beliefs regarding ill-fated femaleness and superior maleness. The male originated theories and diagnoses which preface health standards parallel to normal male attributes, consequently reference women's characteristics as disease-like due to being dissimilar to maleness (Kaplan, 1983).

Similar studies suggest that women are also perceived disease-like when compared to femaleness and feminine-typed roles (Russell, 1986). As a result, this perspective states that numerous presumed etiologies for women's disease-like nature is essentially based on cognitive and rhetorical gender bias. Second, the antithesis states women are likely to suffer mental health problems due to the consequences of imposed femininity and overall oppression. Therefore, women are recognized unhealthy due to their containment and reaction to an inferior status related to male hierarchy. Both premises suggest that women are considered mentally unhealthy due to being a woman and acting female.

To be considered an unhealthy adult, women must act as women are supposed to act (conform too much to the female sex role stereotype); to be considered an unhealthy woman, women must act as men are supposed to act (not conform enough to the female sex role stereotype). Not only does this Catch-22,

[also known as a double-bind], predict that women are bound to be labeled unhealthy one way or another, but also the double bind could drive a woman crazy (Kaplan, 1983, p. 788). [Italics added by author].

This paradoxical perception supports the first etiological premise by concluding that women must chose to either act male or female in order to select a paradoxical healthy standard. "Masculine biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria," (Kaplan, 1983, p.786). According to the highly recognizable diagnostic categorization of the American Psychiatric Association Diagnostic Statistical Manual of mental disorders, (DSM-IV-TR), femininity resembles both normalcy and deviancy. Clinical gender bias suggest healthy women are "more submissive, less independent, less subjective, less aggressive, less competitive, more excitable in minor crises, more emotional, more conceited about their appearance, and having their feelings more easily hurt" (Brown & Hellinger, 1975, p.266). However, the catch-22 suggests that these are also ingredients for possible diagnosable disorders such as Dependant Personality Disorder or Histrionic Personality Disorder according to the DSM-IV (Kaplan, 1983). As stated above, "more emotional and excitable" behavior is similar to DSM-IV's criteria for Histrionic Personality Disorder which includes "pervasive and excessive emotionality" (American Psychiatric Association, 2000, p.711).

In addition, "more submissive, less independent, less subjective, and less aggressive" behavior is similar to "pervasive and excessive need to be taken care of" which is stated in the DSM-IV's criteria for Dependent Personality Disorder (American

Psychiatric Association, 2000, p.721). Research confirms that Histrionic Personality

Disorder and Dependent Personality Disorders are more commonly diagnosed in women

compared to men (Kass, Spitzer, and Williams, 1983), thus strengthening the underlining

bias. Self-defeating personality disorder, (SDPD), has been eliminated from the DSM-IV

due to the limited descriptive validity and inherent bias against women (LaBruzza &

Mendez-Villarrubia, 1997, p,384). As previously stated, hysteria, also contains tainted

gender bias within its context according to the prior DSM-III (LaBruzza & Mendez-

Villarrubia, 1997). In short, some diagnoses represent gender-biased assumption rather

than etiological explanations from biological, medical or sociological determinants.

The paradoxical perception confuses women further by dichotomous messages

from respected health members. Tomes (1990) states:

A famous 1970 study of therapists' definition of mental health showed

that their very conception of normality was biased in favor of men; to be a healthy

women was by definition to deviate from the psychological norm. Subsequent

studies suggest that therapists often encouraged women struggling with the

psychic and practical consequences of discrimination to conform to their

prescribed gender roles rather than to question them.

The majority of women, who follow socially prescribed and clinically suggested

femininity, surrender victim to oppression- and feminine-driven health consequences and

diagnostic labels. "The socialization of boys, but not girls, stresses the development of

instrumental, self-assertive traits such as independence and decisiveness" (Whiffen et al.,

2000, p.1103). One study shows the importance of these assertiveness traits as being

protective factors for depressive symptoms, whereas, other studies consistently confirm that individuals with fewer instrumental traits have lower self-esteem (Whiffen et al., 2000). This confirms other research that identifies major depression more commonly diagnosed in females (Williams & Spitzer, 1983). "From an epidemiological perspective, depression best merits the distinction of being the 'female malady' of the late twentieth century. ...Most researchers agree that sociocultural factors account for the marked sex differences in its incidence" (Tomes, 1990, p.147).

Possible determinants of increased depressive tendencies throughout women's life span could be related to the "learned helplessness hypothesis" (Kaplan, 1983, p.787) or assigned marital/homemaking factors. Nineteenth century gender norms encouraged passiveness, emotionality, and nurturing, which was continued into adulthood with major ego weaknesses (Tomes, 1990). This weakness matures into learned helplessness by way of oppressive and social prescriptions which dictate women believing that "marriage is a romantic relationship, motherhood is a mystical experience, and housewifery creative homemaking rather than drudgery" (Brown & Hellinger, 1975, p.267). Prescribed homemaking is considered a "frustrating, low-prestige job, inconsonant with the education and intellectual attainment of a large number of women" (Kaplan, 1983, p.786). Gove and Tudor (1972) explain how increased depression symptomology comes from women having less sources of gratification, such as family, whereas men have career, individuality, and family (Kaplan, 1983). According to marriage research, depression is more common in women who succumb to marriage when compared to married men and unmarried women (Russell, 1986). This idea of "total feminine

fulfillment as wife and mother counter to the need of self-fulfillment as a human being"
(Brown & Hellinger, 1975, p.267). Thus, women follow social pressures and false beliefs
to fulfill female-roles and feminine traits which consequent disease-like ramifications and
labels.

Some theories conclude, "women really are sicker because their disadvantaged
status in society makes them more at risk for mental illness" (Kaplan, 1983, p.786).
Research has found that "conditions in women are directly attributed to women's
powerlessness, invisibility and emotional deprivation" (McLellan, 1995, p.43). Kaplan
(1983) found that the Subpanel on the Mental Health of Women of the President's
Commission on Mental Health "documents ways in which inequality creates dilemmas
for women in certain contexts (e.g. marriage, child rearing, aging and work). Carmen,
Russo, and Miller (as cited in Kaplan, 1983), add that this same inequality facilitates the
occurrence of events (e.g. incest, rape, and marital violence) that heighten women's
vulnerability to mental illness" (p.786). Overall, a wide array of oppressive factors, such
as alienation and powerlessness, cause an increase in women's own mental distress.

"The fact is that all women are oppressed by violence and the threat of violence"
(McLellan, 1995, p.40), from young girlhood throughout maturity. Gender oppression
can begin in early childhood through witnessing an act of violence. Adolescent girls who
witness violence are more likely than boys to develop Post-Traumatic Stress disorder,
delinquency, and substance abuse (Ashcroft, Daniels & Hart, 2003, p.11). The
ramifications of actually experiencing victimization are reported as more serious.
Females age 12 or older experienced an annual average of 366,460 attempted or

completed rapes and sexual assaults in the United States; 91.3% of overall rapes and

sexual assaults are committed against females (Rennison, 2002).

In 2003, the National Institute of Justice reported "clear relationships between the

experience of youth victimization and mental health problems (i.e., PTSD and substance

abuse or dependence, and delinquent behavior" (Ashcroft, Daniels, & Hart, 2003, p.9).

"Adult victims of childhood sexual abuse, as a group, show impairment of some sort

when compared with nonvictims, and 20% of these victims show serious

psychopathology" (Maynes & Feinauer, 1994, p.165). The strongest evidence exists

between childhood sexual abuse and adult chronic and recurrent depression (Whiffen et

al., 2000). Some studies have found that "several behavioral and personality disorders

appear to be associated with the incidence of childhood sexual abuse, particularly incest,

and this association significantly exceeds the chance rate. These disorders include

multiple personality disorder *[currently known as Dissociative Identity Disorder]*, and

borderline personality disorder," (Maynes & Feinauer, 1994, p.166). [Italics added].

Similar research agrees that physical and especially sexual abuse is a major antecedent of

Borderline Personality Disorder (Bleiberg, 1994). These mental health consequences

continue into adulthood and worsen with time, further oppression, and a lack of resources

to gain resiliency.

The United States Department of Justice reports statistics of adult violence as one

in six women have been victims of completed or attempted rape and one in five women

have been physically assaulted by an intimate partner (Tjaden & Thoennes, 2000).

According to one survey, "sixty-seven percent of 177 respondents living with a husband

or partner experienced mental, physical or sexual violence on two or more occasions" (Weingourt, Sawada, Yoshino, and Maruyama, 2001, ¶20). Direct repercussions of rape and incest include extensive emotional and psychological trauma where the severity of the abuse was highly correlated with the patterns of dissociation and anxiety (McLellan, 1995). Over one hundred years ago, it was initially suggested that "sexual trauma spawned ideas and feelings that became unconscious and produced the hysterical symptoms" (LaBruzza & Mendez-Villarrubia, 1997, p.10). More recently, the mental health problems which have been identified with victimization are: clinical depression, somatization, anxiety, dissociative patterns, post traumatic stress, guilt, low self-esteem, drug and alcohol abuse, sexual problems, suicidality, panic and phobia disorders, and eating disorders (Backer & Benita, 2001; Maynes & Feinauer, 1994; McLellan, 1995; Weingourt et al., 2001).

"Women are forced down to be kept down" (McLellan, 1995, p.44), which leads to health consequences and negative coping skills. "Anxiety and panic conditions in women have been directly attributable to women's powerlessness, invisibility and emotional deprivation" (McLellan, 1995, p.43). Coping with violence related mental health consequences could further lead toward alcoholism and drug addictions. Prevalent dual diagnoses in victimized women are anxiety or depression combined with alcoholism (Backer & Benita, 2001).

According to a study "Detecting and addressing alcohol abuse in women," Backer & Benita (2001) found:

Childhood sexual abuse is associated with later development of alcohol abuse in women. The prevalence of childhood sexual abuse is approximately 70% among alcoholic women in treatment. Women who reported a history of childhood sexual abuse were three times more likely to have a lifetime diagnoses of alcohol abuse or dependency than women in the general population. ...Women who did not experience childhood sexual abuse but who had experienced victimization were also more likely to develop alcoholism (¶27).

It is suggested that women with alcohol abuse should automatically be screened for violence risk in the home (Backer & Benita, 2001). Similarly, clients presenting overall symptoms explicit of somatic (body) anxiety, and/or dissociation should be screened for childhood sexual abuse (Maynes & Feinauer, 1994).

Other predominant consequences of victimization include eating disorders and body-distorted images (Lyubomirsky, Casper & Sousa, 2001). According to Lyubomirsky, Casper, and Sousa (2001) results from an eating disorder test were positively correlated with sexual abuse history. "Twenty to sixty-nine percent of eating-disordered women report a history of sexual abuse or assault...whereas twenty percent to forty percent of eating-disordered women have experienced physical abuse or battering" (Harned, 2000, p.336). Overall, results indicate that victimization, including sexual abuse/assault, physical abuse, and sexual harassment, are significantly associated with body image and eating disturbances (Harned, 2000). Furthermore, research confirms that high concern with weight, which is suggested and demanded on women by society, produces a "collapse of self-esteem" and prolonged "passivity, anxiety and emotionality"

(McLellan, 1995, p.45). Therefore, "the gender-based nature of eating problems and the possible relation between such struggles and violence against women" should indicate immediate need for an intervention (Harned, 2000, p.346).

"This look at the most common emotional and psychological problem-areas for women-anxiety and panic conditions, depression and eating disorders-shows clearly that these and other such problems are the result of women's collective and individual oppression in a society determined to keep women weakened and in an inferior position" (McLellan, 1995, p.45).

In conclusion, this chapter suggests that oppressive factors, first, promote women's inferior status, and second, produce mental health consequences of such oppressive dispositions. Whether women are associated unhealthy due to a biased stigma of femaleness or guilty of facing consequential domination is undetermined. However, enough research has concluded gender-based causality against women and female mental health concerns.

The next chapter alludes to the specific oppressive influences, which are pronounced by clinicians and mental health professionals via assessment, diagnosis, and treatment. Socially learned gender bias can be severely consequential when practiced in the professional medium. Women are the target and result of such hierarchical measures.

Chapter V

Assessment, Diagnoses and Medication

Women's mental health status is dependent upon the accurate assessment and

diagnosis made by professional clinicians and therapists. An interpretation of normalcy

and abnormality reflects current professional consensus about the nature of pathology.

"How counselors label and address pathology in counseling are inevitably affected by

both societal values and counselors' professional and personal development" (Cook &

Warnke, 1993, ¶3). "Sexism among mental health practitioners has resulted in serious

oversights, inadequate treatment, and even mistreatment and harm" (Caplan, 1992, p.71).

This chapter suggests that gender bias is therapeutically practiced in two ways.

First, therapists rely on the legacy of Diagnostic Statistical Manuals, (DSM), which

inhabit assessments and diagnoses suggested from a lack of female-life experiences,

homologous developmental theories and male-biased norms (Cook & Warnke, 1993).

Second, the practice of gender bias is socially constructed from personal mis-education

and shared beliefs, which are reflected in an assessment and diagnosis (Cook & Warnke,

1993). An assessment intertwined with overall gender bias leads toward further damaging

diagnoses, treatment, and medication for the female client (Marecek & Hare-Mustin,

1991; Russell, 1986).

The gender-biased assessment of women has roots in past and present DSM's.

However, since the initial publication of DSM-I in 1952, the American Psychiatric

Association has made great strides, from foundational etiological changes to

nomenclature (LaBruzza & Mendez-Villarrubia, 1997). A political issue relating

homosexuality as a disease was successfully debated and removed before the publication

of the DSM-III-R manual. Also, the controversial category of premenstrual dysphoric

disorder, formerly known as late luteal phase disorder, was suggested to further its

studies. Most significantly, with the rise of possible diagnoses from 106 in the DSM-I, to

182 in the DSM-II, and 292 among the DSM-III-R, the DSM-IV publicly made aware of

the potential dangers of reification of diagnoses (LaBruzza & Mendez-Villarrubia, 1997).

The importance of clinical judgements upon diagnosing was quite possibly the best

clinical advice given amongst the DSM series.

Some suggested components that work against the DSM's reliability are

conceptual foundations and the narrowness of focus (Russell, 1986). The

conceptualization of mental illness has been a source of conflict arguing that it is either

"a mental illness with a basis in the mind or a mental illness with a biological basis"

(Russell, 1986, p.83). Furthermore, it is argued that DSM's narrow focus excludes the

effects of social environment when describing mental disorder symptomology (Russell,

1986). Feminist rebuttal suggest "psychopathology is neither exclusively biologically nor

socially determined, it is both" (Franks, 1986, p.221).

To argue about the relative importance of heredity and environment is to

sidetrack the real issues. If we want to understand the relative impacts of these

pressures upon men and women, we must understand the relative impacts of these

pressures upon men and women within the society. It is the interactions of all

these biological, psychological and social-cultural experiences, which determine

psychopathology (Franks, 1986, p.221).

When acknowledging potential symptomology from life experiences, women are disadvantaged by DSM's focus. The DSM has been criticized for its failure to emphasize the effects of traumatic life circumstances; furthermore, the DSM has been charged of inappropriately blaming victimized clients rather then condemning the life experience (Cook & Warnke, 1993). The DSM-III-R contains only two diagnoses that explicitly recognize traumatic life events: adjustment disorders and posttraumatic stress disorders; Violence against women and sexual harassment are two prime examples of life events, which are not taking into consideration when using diagnostic tools (Cook & Warnke, 1993).

Ignorance among gender dichotomy and DSM's criteria for a disorder potentially promote definition and language interpretation problems for the diagnostician. It is important to consider both sexes as separate entities with unique life experiences; otherwise, each gender is compared against each other, and gender differences and gender biases are confused (Cook & Warnke, 1993). "It is acknowledged that men and women have different biological milestones" (Franks, 1986, p.221), as well as unique psychological and emotional life experiences (McLellan, 1995).

"Diagnostic categories provide the language that therapists speak, and thus, the very framework for their judgements and actions" (Marecek & Hare-Mustin, 1991, p.524). "Traditionally, professionals have used male-biased norms to define healthy versus pathological behavior....Some experts have contented that the DSM-III-R maintains such a male-based bias" (Cook & Warnke, 1993, ¶7). Problematic outcomes of

male-presumed, biased theories suggest women's development to be "invisible" and "misperceived" (Philipson, 1985, p.219).

Specifically, the DSM-III-R is claimed to reflect "gender-stereotypic characteristics often associated with one sex" particularly with the personality disorders (Cook & Warnke, 1993, 8¶). The DSM-III was labeled "unsatisfactory" due to categories "created or deleted on committee vote rather than on hard scientific data" as well as labels having "strong judgmental qualities that frequently result in bias and social injustice" (Smith & Kraft, 1983, p.777). Some presume these diagnostic judgements to be related to the DSM-III committee being comprised of two-thirds men (Kaplan, 1983). Similarly, one study concluded diagnosticians using the DSM-II had profound biases relating certain disorders with gender and marital status (Walker, Bettes, Kain, and Harvey, 1985). Specifically, the study found that female patients scored higher on factors defined by DSM-II affective symptoms and cognitive disorientation; whereas male patients only scored higher on alcohol abuse (Walker et. al., 1985). If diagnostic categorization within the DSM consists of gender bias, beyond biological gender differences, the clinician strengthens a personal and professional gender prejudicial practice.

This thesis does not prove whether the diagnostician learns gender bias from the DSM's; however, it is possible that use of the DSM could initiate or enhance further gender-biased presumptions. Preceding diagnoses and use of the DSM, common gender stereotypes in assessments suggest that "women can be seen both theoretically and clinically as 'deviant cases,' wherein their needs, problems, and behaviors are judged

against a theory that is implicitly premised on male experience" (Philipson, 1985, p.219). If women's life experiences were taken into consideration during assessments, proceeding treatment and diagnosis may be different.

Gender-differentiated experiences for women include high numbers of sexual harassment, pornography, and violence against women, including incest, rape and battering, which lead to traumatic emotional consequences (Cook & Warnke, 1993; McLellan, 1995). "Feminist scholars have shown how presumed experts, such as Freud and Kinsey, failed to recognize (or covered over) evidence of incest, made light of its consequences, and blamed the victims (and sometimes their mothers) rather than the male perpetrator" (Marecek & Hare-Mustin, 1991, p.527). When the traumatic life experience is not considered or "treated lightly by those institutions in society that purport to be concerned with law and order," blame overrides the diagnosis (McLellan, 1995, p.40). "Some experts have charged that the DSM-III-TR inappropriately blames victimized clients rather than their traumatic life experiences for their distress....Is it disordered for women to become depressed because of battering or rape" (Cook & Warnke, 1993, ¶14)?

"While diagnosis is a useful tool, let us keep it in perspective. Like all tools, diagnosing is only as good as the craftsperson using them" (Johnston, 1994, ¶6). For example, "Psychiatry is a practice of 'normalizing judgements,' where people are assessed in relation to each other, opposed to a fixed standard" (Lunbeck, 1994, p47). Psychiatric and medical clinicians adhere to the medical model comprised of "diagnostic labels, drugs, institutionalization, shock therapy, and possible psychosurgery" (Wyckoff, 1977, p.14). The medical model, including psychiatry, has made great strides from initial

beliefs of disease origins such as evil spirits and demonic concepts (Alexander & Selesnick, 1966), as well as many new discoveries in medication and surgery.

However, the medical model is also considered "dangerous" via the possibility of misusing diagnoses and drugs. One perception towards the medical model states that "psychiatric diagnoses are nothing more than the consequences of attaching an illness label to various behavior patterns that deviate from conventional standards....In the absence of an organized professional group created for the purpose of designating specific forms of deviant behaviors as insane, there would be no such thing as mental illness" (Roth & Kroll, 1986, p.15 & p.40). Furthermore, "most diagnostic labels promote the illusion that the problem lies inside the individual and not in her life situation or world around her" (Wyckoff, 1977, p.5). "Once a person is labeled, he/she is locked into a stereotyped role and continues to behave according to social expectations of madness" (Roth & Kroll, 1986, p.40). Other dangerous perceptions of the medical model include the utilization of medication.

While medication has proved positive medical initiatives, "feminists have voiced strong concerns about possible misprescribing and overprescribing of psychoactive drugs for women" (Marecek & Hare-Mustin, 1991 p.525). "In many instances, there seems to be no thought at all given to possible alternative treatments nor to the possible negative effects of prescribing drugs for emotional difficulties" (McLellan, 1995, p.55). "Instead of helping people reclaim their power, psychotropic (mind-altering) drugs like tranquilizers, mood elevators, and antidepressants simply cover up problems and can have dangerous side effects" (Wyckoff, 1977, p.6). A deficiency of female-based

research until recently, lacked research studies proving "normal variations in the menstrual cycle [*which*] affected women's response to widely used psychotropic drugs" (An Absence of Alice, 1994, p.11). [Italics added by author].

In response to believed medical model problems, anti-medical model clinicians, therapists, and social workers prescribe "people for people" (Wyckoff, 1977, p.14) rather than predominate drugs and institutionalization. Furthermore, feminist-prone mental health practitioners compare women to women, while suggesting political, social and cultural changes from within the female-self (Collins, 1998; Katz, 1992; Wyckoff, 1977).

"Such socially-relevant variables as clinician race, values, professional background, and sex have come to be looked upon as potentially significant factors in the diagnostic equation" (Wright, Meadow, Abramowitz, and Davidson, 1980, p.241). For example, the severity of diagnostic impressions was positively related to the assessor's professional status, whereas doctor-level professionals evaluated more harshly (Wright et. al, 1980). One study concludes female therapists are less likely than their male counterparts to render harsher, psychotic diagnoses; In addition, the female assessors assigned a larger proportion to situational diagnoses (Wright et al., 1980). Individual clinician values may also contribute toward gender-based expectations during the assessment. Cook and Warnke (1993) indicate that:

> If counselors are accustomed to viewing certain characteristics or problems as more typical for one sex, it may be difficult to recognize their occurrence in the other sex as well. Some of these diagnostic problems are

attributed to failure to gather appropriate client information because of lack of knowledge or sensitivity to gender issues.

If "language is the mother of thought" (Johnston, 1994, ¶11), then it is important for the clinician to think without judgment, and assess and diagnosis without stereotypic values and verbiage. After all, "the true work of therapy is not in diagnosis, but in understanding" (Johnston, 1994, ¶14).

"To what extent are diagnoses a means of social control, ensuring conformity to the interest of those in power, denying the connection between social inequities and psychological distress" (Marecek & Hare-Mustin, 1991, p.525). If ignorance and/or bias are guiding the diagnostician, "the DSM could be used as a weapon to keep women in their place" (Russell, 1986, p.90). As long as women are judged, diagnosed, and treated comparatively against men, their mental health status is at an unjust risk.

In conclusion, this chapter summarizes the horrific ramification of potential clinical gender bias. The DSM, suggested both as a weapon and a useful tool, demands the professional attention and specialized clinical training it purports (LaBruzza & Mendez-Villarrubia, 1997). The last chapter will proclaim ways in which professionals can properly use the Diagnostic Statistical Manual, as well as female-friendly therapeutic assessments and techniques.

Chapter VI

Feminist Theory as a means for Therapeutic progress

This chapter postulates that women's mental health status is ill fated due to

present and historical, "sexist use of, psychoanalytic concepts and psychological

diagnoses" (Marecek & Hare-Mustin 1991, p.521), as well as "patriarchy and other forms

of oppression" (Willie et al., 1995, p.28). Upon concluding oppression and gender

stereotypes have significant, negative impact on women's mental health status, it is

necessary to reference a theory which contends with the etiological controversy of gender

and proposes a resolution for women. Furthermore, it is crucial to promote feminist

theory in the professional, academic, and licensure arenas.

Feminist theory is solution focused towards both past and present issues in

psychology, while prioritizing the importance of gender (Chaplin, 1988). First, feministic

trends continuously debate historical information with use of epistemology and current

research-based results in order to reestablish accurate perspectives regarding women

(Marecek & Hare-Mustin, 1991; Whittle & Inhorn, 2001). Second, feminist theory

prioritizes the study of women's biological, mental and emotional development,

including the significance of life experience, in order to improve future therapeutic means

for women (Miller, 1976). Finally, feminist theory practices egalitarian treatment styles

in accordance with individual and group psychological and counseling theories to

promote gender and social equality in professional relationships (Chaplin, 1988).

Altogether, feminist theory holds ideology, which work conjointly with other

psychotherapies, such as Adlerian, Transactional Analysis, Gestalt, or Person-Centered, in order to provide a comprehensive developmental theory regarding women.

"Voicing what has gone unsaid is the center of feminist scholarship" (Marecek & Hare-Mustin, 1991, p.526). In relation to women's mental health, feminism promotes theoretical concepts in which have been previously unconsidered, ignored, and purposely misdirected. "[*Women's*] understanding of all of life has been underdeveloped and distorted because [*women's*] past explanations have been created by only one half of the human species" (Miller, 1976, p.*xi*). [Italics added by author]. Feminist theory debates biased information and explanations, while promoting new researched concepts for and about women. Thus, "feminism is a form of oppositional knowledge" (Marecek & Hare-Mustin, 1991, p.524) which demands an open-mind, epistemological insight and modifiability in order to proceed forward.

Upon studying antiquated health information, "[*feminists*] explore what has happened historically at the margins of Western scientific medical research on women's health to recognize and better understand the conceptual models that may actually reinforce social hierarchies of dominance/oppression and constrain our understanding of women's (ill) health and well-being" (Whittle & Inhorn, 2001, p.149). [Italics added by author]. Feminists use epistemology, hermeneutics, linguistics, and pragmatics to debate hierarchical and stereotypical information, as well as societal expectations, resembling the concepts in this thesis.

Furthermore, feminist researchers, academicians, and practitioners highly promote societal and professional education in order to decrease inaccurate knowledge and biased

predictions about women and other groups. For professionals, this includes re-education on the DSM, diagnoses, treatment, and medications (Miller, 1976; Marecek & Hare-Mustin, 1991). For example, in the 1970's, feminist were among the group who successfully influenced and changed certain oppressive diagnoses, such as homosexual labels (Marecek & Hare-Mustin, 1991). In addition to professionals, non-professional women became educated about oppression and stereotypes through consciousness-raising (CR) groups. Starting in 1960 and 1970, mothers, daughters, lesbians and wives, joined CR therapeutic groups in order to share their stories about oppression and gain courage (McLellan, 1995). "Influenced by the consciousness-raising that was occurring at all levels, feminists who had some involvement with psychology or psychiatry, either as academics or practitioners, began writing about the institution of therapy and exposing it as an oppressive tool in the hands of the patriarchy" (McLellan, 1995, p.6). Consequently, an abundance of research began promoting women's therapy and women's politics (McLellan, 1995).

Overall, "feminist-informed women's health research involves a political commitment to identify and end gender oppression. It arises from the understanding that women everywhere, as gendered beings, face some form of oppression and exploitation, which may be deleterious to their health" (Whittle & Inhorn, 2001, p.160).

Specifically, the feminist research agenda involves numerous assumptions and practices, however, only a few will be mentioned in this thesis. First and most importantly, feminist research proposes that gender oppression is not deemed more or less important than other forms of oppression, (i.e. racism, classism, ageism, etc.);

furthermore, gender oppression is not considered an "isolated axis of domination," but rather, as part of "interlocking structures formed by destructive social divisions and hierarchies" (Whittle & Inhorn, 2001, p.160). These combined hierarchies collaborate and support each other through differences and superiority (Whittle & Inhorn, 2001).

Next, the feminist research agenda recognizes that although oppression is a female commonality, women remain diverse and unique within their personal experiences and struggles (Whittle & Inhorn, 2001). For example, Third World feminists encounter and combat different forms of oppression and abuse, such as female genital mutilation and dangerous reproductive technologies in addition to sexual abuse and domestic violence (Whittle & Inhorn, 2001).

Other prominent feminist research areas combine the study of women's biological, mental and emotional wellbeing with individual life experiences (Miller, 1976). Research suggests "that the close study of women's experience can lead eventually to a new synthesis which will better describe all experience" (Miller, 1976, p.xxi). Many of these individual life experiences reflect basic themes of masculine domination (Marecek & Hare-Mustin, 1991). "The collective oppression of women through the existence of violence, rape, pornography, reproductive technology and all other situations where women are demeaned, is played out on a daily basis in the personal lives of individual women. Everyday, individual women experience oppression in their homes, in the workplace, in education, and in society at large" (McLellan, 1995, p.43). While mainstream therapies suggest "blaming the victim" (McLellan, 1995, p.73), feminist theory suggests that the oppression is pathological, rather than the person

(Collins, 1998). Therein, women begin to see themselves as both equal and different, as well as gaining a "sense of themselves as women" (Miller, 1976, P.xv).

Additional feminist research indicates that comparing genders to each another creates a hierarchy, which impedes the development of so-called "subordinates" and blocks their freedom and expression (Miller, 1976). When comparing each gender to itself, such as female to female, many previous ill-fated perceptions are no longer justified. For example, feminist research reveals that "boys and girls arrive at puberty with a different interpersonal orientation and a different range of social experiences" (Gilligan, 1983, p.11), rather than retarded developmental stages when compared to each other.

Contrary to biased psychoanalysis, women do not have weaker ego boundaries compared to men; instead, feminist theory suggests that females develop more empathetically and have "a stronger basis for experiencing another's needs or feelings as one's own" (Gilligan, 1983, p.8). Nonetheless, these differences are considered normal for each gender's health, rather than quickly labeling them as sick when compared against each other.

According to research, feminist theory provides numerous theoretical concepts to be practiced alone or in collaboration with other psychotherapies. Feminist therapy is a concept for male and female professionals, to practice alone or in combination with other Psychological and medical theories (McLellan, 1995). The approach "not only incorporates an awareness of the effects of ideology and social structure on the behavior

of women but also contains several principles considered essential to the development of autonomous self-actualized women..." (McLellan, 1995, p.151).

Feminist therapy is based on "the personal is political" (McLellan, 1995, p.151). This demystification process includes (1) validation of the female experience, (2) exploration of values and attitudes, and (3) an emphasis on self-change for individual improvement (McLellan, 1995). Also, feminist therapy demands that "counselors are committed to transforming hierarchical relationships into more egalitarian ones, whether these be in society at large or in the consulting room" (Chaplin, 1988, p.7). However, equality is not to be confused with sameness, the counselor is not seen as the expert or the doctor; rather, the counselor empowers the client from a supportive role (Chaplin, 1988, p.7). Therefore, the gender-aware therapist's role is to "listen, empathize, be patient, be alert and respond appropriately to the women's expressed need" (McLellan, 1995, p.49).

Next, a feminist therapist replaces masculine hierarchical thinking with feminine mode of knowing (Chaplin, 1988). "This is an ancient wisdom recognizing the interconnectedness of opposites... balance comes with emotional cycles of life" (Chaplin, 1988, p.10). Another feminist theoretical suggestion insists that "every women who presents for therapy be seen in the context of her whole life, and that the problems she is experiencing in the present be seen in the relation to the fact of her oppression" (McLellan, 1995, p.45). Contrary to other therapies that condemns women as sick or "being responsible for her own problems," feminist therapy proposes the need for liberation from oppression (McLellan, 1995, p.45). Collectively, feminist therapy allows for story telling by the client, expression of sadness and helplessness, the

acknowledgment of oppression and possible anger and finally, the desire for self-change (McLellan, 1995).

Upon these implications for mental health professionals, it is also important to integrate these techniques into the graduate programs of Counseling, Social Work, and Psychology. The APA Ethical Principles of Psychologists and Code of Conduct describes specific education and training measures in ensure accuracy in teaching. Specifically, it includes providing appropriate and accurate knowledge, as well as taking steps to ensure there is a current and accurate description of program content (PsychoNet®©2003 American Psychological Association, 2003).

Some suggested guidelines for culturally adapted graduate programs include: teaching current information regarding the biological, psychological and sociological issues that impact women; discussing male-centered counseling theories; teaching skills that may be particularly appropriate for the needs of women; expanding career related choices available to women; and encouraging awareness of all forms of oppression (Sue & Sue, 2003). It may also be appropriate to conduct continuing education courses for instructors related to specific women's needs such as assertiveness training, gender role analysis, and consciousness-raising groups (Sue & Sue, 2003). Also, graduate programs can conduct and/or recommend students attending workshops to explore gender-related factors (Sue & Sue, 2003).

Overall, implications for the entire academic setting could include campus-wide policies against sexism or sexual harassment, as well as supporting institutional aids such as faculty women's groups and committees on the status of women. Other gender

promoting options for academic arenas include providing continuing education of gender

equality and sexual harassment, as well as seeking out and promoting women for

positions of academic leadership (Sue & Sue, 2003).

In addition to academic and professional mediums, it is just as crucial to include

the accrediting agencies and licensure boards in the implications with gender-bias. The

inclusion of stereotyping being unethical behavior is mentioned in the following National

code of ethics: American Counseling Association (ACA), American Psychological

Association (APA), and National Board for Certified Counselors (NBCC). ACA states in

A.2. Respecting Diversity, "Nondiscrimination. Counselors do not condone or engage in

discrimination. Respecting differences. Counselors will actively attempt to understand

the diverse cultural backgrounds of the clients" (American Counseling Association,

2003).

Similarly, the NBCC code of ethics includes two references in the first section,

stating, "Through an awareness of the impact of stereotyping and unwarranted

discrimination (e.g., biases based on age, disability, ethnicity, gender, race, religious, or

sexual orientation), certified counselors guard the individual rights and personal dignity

of the client in the counseling relationship" (National Board Certified Counselors, 2003).

The APA asserts combating unfair discrimination in their code of ethics, as well. "In their

work-related activities, psychologist do not engage in unfair discrimination based on...

gender, gender identity,... sexual orientation, or any basis proscribed by law"

(PsychNet®©2003 American Psychological Association, 2003). Aside from the inclusion

of these stereotyping ethical standards, it is crucial to uphold through strengthening and reprimand the misconduct against them.

"Revisiting the efforts by feminist clinical psychologist should give us pride in what has been accomplished…Feminists have produced powerful critiques, a substantial body of research, and a number of models of clinical interventions" (Marecek & Hare-Mustin, 1991, p.531). Jean Baker Miller (1976) suggests that:

> In the large body of new literature on the psychology of women, many writers have brought us a wealth of new knowledge…One is the growing tendency to focus on the close study of women and to describe women's lives and women's development in the terms in which it is lived rather than to force it into the categories which we have inherited, categories that originated in the attempt by men to describe all of life (p.*xviii*).

Feminist therapy has provided the foundation to initiate and fulfill an equal opportunity for women and other oppressed groups. "As psychology enters its second century, [*the*] hope is that feminist thought can disrupt psychology's gentle slide toward professional quietism. The history of the future should not be like the past" (Marecek & Hare-Mustin, 1991, p.530). [Italics added by author].

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