British Sociological Association Sociology of Mental Health Study Group symposium, *A Difficult Alliance? Making Connections between Mental Health and Domestic Violence Research and Practice Agendas*, 7th June 2011, Edge Hill University.

<u>Notes from workshop 5: Gender and mental health services,</u> facilitated by Lydia Lewis, Lisa White and Jackie Patiniotis

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KEY POINTS

- When it comes to dealing with the impact of violence on mental health, there is a need within health service contexts to 'expand space for action' for women through providing more opportunities to speak about experiences of violence in a supportive, women only situations informed by an understanding of gender power relations.
- Difficulties in the gender politics of the area of violence and mental health should be addressed through an argument about gender and power relations that adversely affect women more; this can help to identify men's needs as well, which are not necessarily reciprocal to women's.
- There is a need to translate sociological and feminist knowledge about gender, violence and mental health into mental health service contexts and this can be helped through building more bridges between disciplines, between the sexual and domestic violence and mental health sectors, and between academic disciplines such as sociology and practice settings. In this context, we need to consider practical ways we may interpret and use concepts that can be difficult to understand while policy makers must engage with feminist academics and women working on the ground with women who have experienced abuse.

PARTICIPANTS

The group included delegates from a range of disciplinary backgrounds, including nursing, social work and sociology, and those working in the third sector (women's and mental health sectors) and in the NHS.

KEY THEMES

- **Space for action**

This theme, raised by Professor Liz Kelly in her plenary address earlier in the day, recurred for the group and was discussed in relation to people's understandings of their experiences and views of the world as related to actual spaces within the fields of mental health and domestic violence services which engender action.

It was pointed out that the symposium created a place which was affirming of delegates' understandings of violence and in which people didn't feel like they were a "lone voice

shouting in the dark". This point was related to the presentation about the Joint Forum Women's Group which provides an example of how women's 'space for action' can be expanded.

The importance of creating an environment within health services that enables space for people to talk about experiences of violence, and of supporting staff in this context, was noted. There is a need to offer people repeated opportunities to disclose their experiences, and, at key points when they are in contact with statutory services e.g. discharge, to provide information about services or groups where they may be able to talk about these experiences in supportive environments informed by an understanding of gender power relations. This is central to achieving implementation of policy goals relating to gender, violence and mental health.

Experiences on a women only ward were described as so much better than a mixed ward experience and the importance of the arts in the context of mental health was emphasized. It was pointed out that women only spaces for occupational therapy would also be advantageous.

Difficulties and considerations noted in relation to implementation included the fact that care co-ordinators can act as gatekeepers preventing voluntary organisations working with women within the mental health system. It was also noted that it's *how* people ask about violence and sexual abuse that's important and care plans can make it difficult; there is a need to establish trust before a person can disclose. There is a need to be aware of power and how questioning can put a woman in danger, and of cultural issues. There is a right place and time for asking the question. Oppression can be reproduced within state systems of regulation and care so this must be handled very sensitively.

In terms of constraints to overcome, the issue of psychiatric approaches, gender and agency was a key point of discussion. In the context of gender constructions, the importance of asking why men are more likely to be diagnosed with schizophrenia while women are more likely to receive diagnoses of anxiety and depression was noted. There is no doubt, it was stated, that women who suffer violence and abuse often end up with diagnoses of borderline personality disorder. This label is often given if women step outside their expected gender role. The label itself "shrinks the space for action" (Kelly, 2011). It denies space for speaking, especially if a woman then feels she is not a proper woman because she lacks empathy. This is a gendered political issue.

Reference was made to Simon Baron Cohen's work on empathy and it was pointed out that if young people have suffered trauma at an early age, there is a danger that contact with services can further pathologise them. It was also noted that in mental health services, there is increasing evidence that what is called 'schizophrenia' may be a reaction to childhood abuse. Men and lots of women can end up in positions where they are psychiatrised. In this context, it is interesting to consider what a 'normal' response to

experiences is; explanations for actions often relate to limited choice. This again suggests that service responses need to be about expanding the possibilities for action and meaningful choice-making (agency).

The emphasis on measuring outcomes and what counts as evidence and the neo-liberal agenda driving this was another point of discussion. Within the current system, it was noted, diagnoses are used to secure resources. So in this context they can be helpful for this purpose but there can be a backlash. So commissioners are left with the dilemma of how to play the economy game without causing harm; again there is a sense of actions being constrained by the framework within which those working within the mental health system are forced to act.

The confining nature of competition for resources within the mental health field, and between women in wider society, was also noted. This, alongside an emphasis on appearance can be very damaging to women. Our slow societal progress was noted, since Mary Wollstonecraft wrote about his issue of women policing one another, and adopting the male gaze.

Lastly, the ways in which power is bound up with normativity and so all of our discourses and actions are shaped and constrained by normative ideas was discussed. For example, violence in LGBT relationships, as discussed by Professor Catherine Donovan in her plenary address, may be viewed through the lens of heterosexual couple violence while, as Professor Linda Mckie had noted in her presentation, women's violence may be viewed through the lens of that of men. In addition, normative assumptions about couple relationships in society underpin our discussions of domestic violence and our own actions and choices about how we live our lives. The question was asked as to whether expectations of 'coupling' and relationships bear more on women. These are all areas which need to be challenged if we are to expand debate and the possibilities for our lives.

- **Translating knowledge into practice and building bridges**

This discussion centred on the issues of translating knowledge about gender and violence into practice and building bridges between disciplines and between academia and practice settings.

It was noted that big policy documents recognise gender equality and human rights, but what seems to be missing in translation into service contexts is understanding of gender inequalities; this gap is exemplified in the use of the *Scale of Conflict and Action* or in thinking that 'we can't have a women's only group' or if we have a women's group we need a men's group. There are also gender regimes (Connell, 1995) within services that require critical scrutiny and action to change. Gender is difficult for the mental health system to deal with; there can be a difficulty is envisioning what is gender appropriate care. So the point of implementation and provision was seen as a problem and to be letting things down.

The issue of how and whether gender and social issues can be properly considered within and integrated into the existing mental health service framework and how to translate this consideration and integration into practice was discussed. The importance of bringing a politically engaged view of the world to bear on 'therapy' was noted. However, translating knowledge to people delivering care was seen as difficult, since systems and people struggle to change, although it is important to think about practical ways we may interpret and use concepts that are difficult to understand. It was also posited that if services are to be properly informed by social and gender perspectives, this may require a different approach which stands apart from 'mental health' frameworks.

It was pointed out that it can be very difficult for the psychological and the social to recognise the other. In some sectors the political has power; in the health service the psychological and personal are prominent and gender and the social are dismissed (Herman). Furthermore, dominant sociology of mental health has bought into evidence based thinking and epidemiological approaches, not deeper understandings and haven't taken on board feminism. There are more sophisticated critical psychologies that have been more 'social' than some sociologies which have been reluctant to take on board more critical and feminist perspectives. It was pointed out that there is a need for integration between concerns in the sexual violence, sociology and psychology fields.

Discussion then moved to the anti-feminist backlash which has been concerned with highlighting violence against men and gender neutrality, which has been quite pernicious. It was acknowledged that there is a need for a feminist understanding of male victims of domestic violence and sexual violence as well, however. If power is taken as the central issue, we can gain an understanding of how some men can be put in positions in which they are powerless. But the problem at the moment is that we are in two camps which are not conversing. It was stated that we need an argument about the importance of gender and power and how this social order adversely affects women more, so as to achieve an understanding of why people are doing what to whom. This has been lost to a great extent. Official definitions of violence can be so insipid and diluted, and have lost a sense of gender and power as people start looking at domestic violence as a matter of 'interpersonal style'. It needs to be reinstated that it's about societal power, gender, patriarchy – this has got to be understood if we are to be able to move forward.

For anyone who's experienced violence, the response in the mental health field, it was argued, should be about *how that made them feel*. From the group point of view, responses should be about campaigning on the causes of mental health issues, using numbers where necessary, to point out the endemic nature of violence against women. Unless we have a gender analysis of mental health that takes account of all forms of social oppression and how that impacts severely on people's mental health, we won't be able to formulate the correct responses. This also needs to deal with intersections – the interplay of 'race', ethnicity, class and other inequalities with gender and the intersection of sexuality and

gender. As Marai Larasi commented, there is a need to consider in this context who has permission to be distressed. The question of what are men's needs should also be posed. These are not necessarily reciprocal to women's.

It was pointed out that there is a lot of male on male violence in our society. Connell (1995) on hegemonic masculinity in which men can become power victims within a hierarchy was seen as useful for understanding here. The notion of gender regimes (Connell, 2009) and how gender is constructed in particular contexts can be very illuminating. Gender dynamics can be played out on wards, for example – by whoever embodies that gender construct. The fact that issues of gender and violence often underpin distress and are bound up with psychiatric classifications, and that knowledge surrounding this needs to inform mental health service provision, was discussed.

It was argued that there is a need for much more sharing of knowledge, skills and experience between those working in different sectors in the mental health and domestic and sexual violence fields. Policy makers must engage with feminist academics and women working on the ground with women who have experienced abuse.

Institutional violence, a wider societal view of violence and problems of 'compartmentalisation'

The group's discussion of gender and violence broadened out to bullying at work as institutional violence and the wider societal context of violence which affects women and men differently**.** Current 'mental health training' for managers being piloted in the context of the new mental health strategy was criticised for being underpinned with medical understandings and for its potential to make (often gendered) situations in which people are experiencing bullying or are distressed for other reasons considerably worse, providing ammunition for managers who may not always have their employees' best interests at heart. The issue of how violence can become compartmentalized e.g. as 'domestic' and lead to a false separation between this and other arenas in which gender based violence occurs was commented on and in this context of a wider societal view of gender and violence, there was discussion of Liz Kelly's (1988) idea of a continuum of violence. This was seen as potentially helpful for understanding the links and commonalities between different forms of violence affecting women and men and how these both underpin and are a consequence of gender power relations.

References

Connell, R. (2009), *Gender,* Cambridge, Polity Press.

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Kelly, Liz (2011), Reasonable responses to unreasonable behaviour? Medical and sociological perspectives on the aftermaths of sexual violence. Address to the British Sociological Association Sociology of Mental Health Study Group symposium, *A Difficult Alliance? Making Connections between Mental Health and Domestic Violence Research and Practice Agendas,* 7th June, Edge Hill University.

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