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Lauren Mizock & Ellyn Kaschak

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Introduction

Women with Serious Mental Illness in Therapy: Intersectional Perspectives

LAUREN MIZOCK

Worcester State University, Worcester, Massachusetts, and Center for Psychiatric Rehabilitation, Boston University, Boston, Massachusetts

ELLYN KASCHAK

Psychology Department, San José State University, San José, California

The definition and treatment of serious mental illness in women have been crucial issues for feminist therapy. Women with serious mental illness experience elevated rates of abuse, trauma, poverty, and homelessness (Padgett, Leibson Hawkins, Abrams, & Davis, 2006). These women have been desexualized and hypersexualized in mental health settings. They have been objectified by their diagnoses instead of validated for their valued roles as mothers, partners, or community members (Joseph, Joshi, Lewin, & Abrams, 1999; Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001).

Furthermore, feminist therapy brings attention to intersectional stigma women with serious mental illness may encounter. Intersectional stigma refers to the overlapping, multiple levels of stigma and discrimination faced by women with serious mental illness from diverse backgrounds with regard to race, ethnicity, immigration, disability, sexual orientation, and other identities (Logie, James, Tharao, & Litfy, 2011). These women may be confronted not only with the stigma of mental illness, but also sexism, racism, classism, ableism, or homophobia.

Serious mental illness specifically refers to a major mental health problem leading to significant impairment in at least two areas—work, school, social functioning, and activities of daily living (National Institute of Mental Health [NIMH], 2008). These clients might include a woman struggling with severe depression who cannot get out of bed in the morning, a woman with complex PTSD who misses work because of paralyzing flashbacks, a woman with...
schizophrenia who avoids bathing because she fears she is being watched, or a woman with bipolar disorder whose episodes of unpredictable behavior have estranged her from her family.

While these clients are commonly served in therapy, therapists rarely realize they are working with women with serious mental illness. For example, in the development of the Women with Serious Mental Illness Task Force of the Society of the Psychology of Women, a number of therapists invited to serve on this committee who work with this population indicated that they were either unaware of this term or did not believe their clients fit this description (E. Carr, personal communication, February 19, 2014). The needs of women with serious mental illness are often overlooked in clinical settings, research and training, contributing to this lack of awareness.

Currently, there is a need for more research on therapy for women with serious mental illness, and much of the extant literature could benefit from an update. Prior to her death in 2005, Carol Mowbray brought a research focus to women with serious mental illness, and edited a special issue on this topic in Psychiatric Rehabilitation Journal in 2003. With this special issue, we revisit this subject from a feminist therapy perspective over 10 years later.

A number of authors have been invited to discuss the provision of therapy to women with serious mental illness using the feminist model of intersectionality (Crenshaw, 1993). This framework highlights the multiple social identities of women with serious mental illness that contribute to complex experiences of stigma or privilege. Articles in this special issue attend to cultural issues of race, ethnicity, and immigration. The authors explore issues of trauma, homelessness, and clinical bias experienced by these women. Several articles included in this special issue also focus on the sexuality and family relationships of these women, and the importance of exploring these parts of their lives in therapy. These are still far from all the influences on these women, but they begin to add a much needed complexity.

A NOTE ON LANGUAGE

Language is particularly salient in this special issue. “Serious mental illness” may not be the terminology that feminist therapists find familiar, comfortable, or preferred. As feminist therapists, we have often avoided traditional diagnoses and medical model language that ignores the contribution of social inequities to women’s mental health problems. We have often moved away from words that further pathologize already stigmatized identities (Brown, 2004; Greenspan, 1993).

This dilemma about terminology has been a concern to feminist colleagues who also specialize in therapy for women with serious mental illness. What we have found is that many of our clients favor the term, serious mental illness, finding it a validating and accurate representation of their experience.
Alternative terms to serious mental illness that are currently used in the field include “psychiatric disability” or “person in recovery.” The former shares a focus on functioning with “serious mental illness.” However, some of our clients have described this term as limiting by labeling their identities as disabled.

The latter term, “person in recovery,” has grown out of the ex-patients movement of the 1970s, leading to the current recovery movement. In this context, “recovery” refers to the notion that people can live meaningful and satisfying lives in the face of serious mental illness. The recovery movement shares many feminist principles that are anti-stigma and hope-oriented. However, other practitioners and researchers might not be aware of this connotation of “recovery,” and may associate it with sobriety or symptom elimination. Furthermore, one may use “recovery” to refer to an attitude towards or approach to coping with a mental health problem, as opposed to a name for one’s condition. For these reasons, the term, “serious mental illness” is used in this special issue, and this topic is addressed from a “recovery-oriented” perspective.

While the term, serious mental illness, raises linguistic challenges, we use it in this special issue to call attention to the specific needs and experiences these women may have. Providing therapy to someone with mild depression, anxiety, or an “adjustment disorder” can be quite different than working with someone who has difficulty functioning due to daily battles with belittling voices or images. Here, we newly introduce a term for this challenge of language and diagnosis, *diagnostic dialectic tension*. This term is informed by a Marxian understanding of a dialectic, a process that occurs through the conflict of opposing forces (Marx, 1867). In other words, it is vital that therapists are empowering and avoid further stigma with regard to the use of mental health diagnoses. On the other hand, a diagnosis may be important to naming a mental health problem to foster awareness, professional communication, identify appropriate care, and garner payment by third party providers. Diagnostic dialectic tension captures the conflict between the value of a diagnosis and the potential stigma it incurs.

The intertwined issues of serious mental illness and diagnosis have been controversial since the inception of feminist therapy (Kutchins & Kirk, 1997) when feminists organized to oppose certain diagnostic categories in the then DSM-III (American Psychiatric Association, 1980) among feminist practitioners (Caplan, 2012). The earliest advocates of the feminist paradigm struggled with the biases inherent in diagnostic categories and in diagnostic labeling. Others opposed the use of “illness” as a metaphor and the existence of “disorders” as all too orderly considering the treatment of women in context (Kaschak, 1992).

Additionally, over the years and even prior to feminist interrogation and criticism, there have been serious theorists and practitioners who have opposed mightily the construct of “mental illness” as a cultural invention
(Laing & David, 2010; Szasz, 2011). Some saw it as a complex and esoteric form of communication (Laing & David, 2010; Watzlawick, Bavelas, Jackson, & O’Hanlon, 2011). The proprietary nature of the diagnostic system, which is owned by the American Psychiatric Association and the method of adding diagnoses to the DSM by majority vote further call into question the empirical validity of this system.

Despite such critiques, the system is stronger than ever and buttressed by an overly involved insurance industry, who also benefit from it. We could easily undertake yet another critique of this system of cultural construction, but have chosen another, perhaps less perilous, route for this issue. We want instead to look at the experiences and treatment of women who carry these diagnostic labels and live the experiences described therein every day of their lives. It is with these critiques in mind that we undertake an intersectional analysis of the diagnosis and treatment of such “illness.”

GENDER AND SERIOUS MENTAL ILLNESS

One way women with serious mental illness differ from their male counterparts is with regard to gender oppression. Gender oppression is a central factor that impacts the development of and recovery from serious mental illness among women. For example, women experience higher rates of housing problems, work barriers, suicidality, and single parenthood that impact mental health (Jonikas, Laris, & Cook, 2003; Mowbray, Nicholson, & Bellamy, 2003). Women with serious mental illness also encounter high occurrences of physical and sexual abuse (Jonikas et al., 2003; Mowbray et al., 2003). Estimates have ranged from 51% to 97% of participants samples reporting a history of sexual and/or physical abuse (Goodman, Rosenberg, Mueser, & Drake, 1997).

Women have also commonly encountered insensitivity, bias, and exploitation from the mental health professionals they have sought for help (Ussher, 2011). Earlier theories on gender differences in men and women with serious mental illness were often attributed to biology, reinforcing gender bias (Gove, 1980). Women with serious mental illness have historically been identified as “mad” when not conforming to societal norms or have been designated as having inherent, inferior status, as in the case of Freud’s earlier work (Ussher, 2011). Contemporary diagnosticians often continue to be biased by stereotypes of women in mental health care, such as overdiagnosing affective and personality disorders and underdiagnosing substance abuse problems (Eriksen & Kress, 2008; Seeman, 2000).

INTERSECTIONALITY

Intersectionality theory is originally a critical race theory that can enhance understanding how various social identities of women with serious mental
illness contribute to stigma and oppression (Crenshaw, 1993). Largely credited to critical race theorist Kimberlé Crenshaw (Dee Watts-Jones, 2010), who originally used the term to refer to the “various ways in which race and gender interact to shape the multiple dimensions of Black women’s employment experiences” (Crenshaw, 1993, p. 1244). The term came to be used more broadly to understand “the confluence of multiple identities in each individual, as well as social location, the elevation, and subjugation associated with the identities” (Dee Watts-Jones, 2010, p. 406). Intersectionality demonstrates how constructs like race and class are not separate processes but intersecting social hierarchies that determine access to power (Collins, 2000).

Shields (2008) highlighted the particular value this theory holds for psychology, though the literature in psychology has often trailed behind the feminist study of this construct. Shields identified intersectionality as an urgent issue for researchers interested in promoting social change, given the value of research in informing policy regarding problems that impact people’s lived experience. Moreover, intersectionality is important to culturally competent psychotherapy (Brown, 2009). Intersectionality can capture more accurately the overlapping experiences of marginalization and privilege across different social identities among women with serious mental illness. For example, instead of just focusing on issues of race for a Latina woman in therapy, we would take into account her identity as a Latina, lesbian, upper class woman. Kaschak (2010, 2013) has contributed a relevant model and assessment instrument, which she names the Mattering Map.

THE SPECIAL ISSUE

In this special issue, we have invited a number of researchers and clinicians to address the specific needs, experiences, and identities that impact mental health services for women with serious mental illnesses. The issue begins with an award-winning article on the effects of intersectional stigma on the process of acceptance of mental illness for women. Here, I (Mizock) and Russinova understand the process of acceptance as developing awareness and actively engaging in the management of the symptoms and experiences associated with serious mental illness. We present case narratives from a qualitative study to bring to life the impact of sexism, racism, poverty, and classism for women with various social identities. Next, Millner continues this cultural focus with an in-depth case study that highlights matters of privilege and oppression in multidisciplinary therapy with a woman with schizophrenia. Millner discusses the intersection of her own identities and that of the client given their shared background as South Asian immigrants in the United States.

The following section focuses on the issue of sexuality of women with serious mental illness in therapy. We include another award-winning article by Carr, Green, and Ponce who discuss sexual objectification of women.
with serious mental illness and associated problems with depression, body image, substance abuse, and sexuality. These authors discuss the impact of sexual objectification on their mental health and provide guidelines for addressing these matters in therapy using the approach of multicultural feminist therapy. Next, Blalock and Wood review research on the sexual well-being of women with serious mental illness, as affected by psychiatric medications, sexual abuse, and restrictive policies in their inpatient treatment experiences. Blalock and Wood explain the PLISSIT model (Permission Giving, Limited Information, Specific Suggestions, Intensive Therapy) to explore these topics of sexuality in therapy.

Additional aspects of the lives of women with serious mental illness are investigated in the following articles on family and homelessness. Mesidor and Maru utilized qualitative methodology to examine the relationships between mothers with recurrent, major depression and their adult daughters. The authors move away from models of parentification that disparage the support daughters may provide to their mothers and validate the mutual support that these mothers describe as integral to their recovery. David, Rowe, Staeheli, and Ponce discuss the increased rates of homelessness among women with serious mental illness and substance abuse that might be used to cope with the symptoms and stressors in the daily lives of these women. They offer a number of recovery-oriented principles in addition to case vignettes to provide recommendations for therapy and program development.

In the final segment of the special issue, three articles concentrate on the experience of trauma of women with serious mental illness. Walton and colleagues discuss treatment of women veterans with PTSD and co-occurring serious mental illness in inpatient mental health settings, using case studies to highlight the management of provider burnout and diagnostic bias. Muenzenmaier and colleagues maintain this focus on diagnostic bias in therapy for women with serious mental illness. They present clinical vignettes that demonstrate empowering, interdisciplinary care to respond to the trauma histories of women with serious mental illness. Lastly, Hallett provides a case study of a woman diagnosed with Dissociative Identity Disorder and the intersection of gender, ability, and class identities of the client in the delivery of non-sexist and trauma-responsive care.

The focus of this special issue represents new directions in envisioning the care of women with serious mental illness from contemporary feminist frameworks. This special issue makes a unique contribution to the literature by using the lens of intersectionality to attend to the complex, multiple identities of women with serious mental illness. This perspective can help to understand the effects of marginalization and privilege on women’s mental health. With this approach, clinicians can work towards prevention of the mistreatment of women with serious mental illness and provide therapy that is sensitive to identity and power.
REFERENCES


