Placing women's mental health in context

The value of a feminist paradigm

CPD

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Background
It is common for women to present to general practitioners (GPs) with mental health difficulties. Contemporary frameworks for understanding mental health often do not adequately incorporate attention to the gendered social contexts of mental distress in women. A feminist paradigm can support GPs to respond with holistic and empowering practices.

Objective
This article provides an overview of feminist principles for responding to mental distress in women, drawing upon a synthesis of the literature pertaining to the connections between gender inequality and women's mental health.

Discussion
Responding to mental distress is a core component of general practice. It is important that GPs validate women's disclosures of distress, conduct holistic assessments that incorporate women's social contexts (including previous or current exposure to gendered violence), make referrals to supports that can address the social determinants of distress, act with transparency and sensitivity to power, and prioritise women's self-determination.

IT IS COMMON to downplay the social components of mental health in favour of an emphasis on biological factors. A reluctance to engage with a holistic perspective on mental health has particularly significant implications for women, given the very high prevalence of gendered violence within a contemporary context, and its devastating impacts on women's lives and wellbeing.[1] Understandings of women's distress only in terms of biological and individual factors can lead to missed opportunities for more contextual and rights-based responses.[2] For example, it has been argued that a 'domestic violence-blind' approach has become entrenched in contemporary mental health practice.[3] In contrast, feminist perspectives on mental health aim to conceptualise mental distress in ways that incorporate the social contexts of women's lives rather than adopting a gender-neutral, universalistic paradigm of mental health.[4] Feminist scholarship has consistently pointed to the value of a gender focus in mental health,[5] which can attend to large social structures and sociocultural forces that shape women's experiences of mental distress,[6] especially the connections between gender inequality and mental distress in women.

Mental health consultations in general practice are on the increase.[7] This article discusses gender-linked mental health difficulties experienced by women. Although gender inequalities often have significant impacts on women's mental health, they are frequently overlooked.[8] This article seeks to address this gap, outlining the benefits of a feminist paradigm in general practice for shaping effective, holistic and empowering responses to mental distress in women.

Trauma and women's mental health

The connections between mental health and trauma are now well documented. Research findings include the strong links between psychosis and sexual, physical and emotional abuse;[9,10] intersections between childhood trauma and diagnoses of maternal depression and borderline personality disorder;[11,12] correlations between intimate partner violence and anxiety, depression, post-traumatic stress disorder and substance abuse;[1,13] associations between sexual violence and poor mental health in women across the life course;[14,15] and evidence regarding the impact of childhood trauma on suicidal ideation.[16] Despite this substantial body of research, the connections between traumatic life events and mental distress frequently do not shape mental health practices in meaningful ways; for example,

it remains uncommon for mental health professionals to ask questions about adverse experiences in childhood and adulthood.[17] There are several barriers that reduce the likelihood that practitioners will explore the links between trauma and mental health, including a lack confidence in asking about and responding to trauma[18] and a lack of specialised training.[19]

It is common for mental health assessments to ignore or downplay the role of social factors, including the impacts of trauma, loss, stress and disempowerment.[20] In Australia, as with many other countries across the globe, pharmacological treatment is the most likely course of action in response to a disclosure of mental distress.[7] A consequence of a medication-focused response to mental distress is that the social determinants of mental health, including gendered stressors and gendered violence, may be minimised.[2] Psychological interventions that are focused on changes at an individual level may also miss opportunities to explore the role of adverse environments on wellbeing.[10,21]

Feminist principles for practice

Provide validation and a non-judgemental approach

Despite some progress, women remain at risk of being dismissed as 'the worried well' when disclosing experiences of distress to healthcare professionals.[22] Further guilt and shame are likely unless women with experiences of gender inequality and mental distress are provided with acceptance, validation and belief in their experiences.[23] In addition to the importance of knowledge about the connections between gender inequalities and distress, women report the need for healthcare professionals to embody kindness and a non-judgemental manner in order to support them as they share painful experiences.[24]

Make connections to the social contexts of women's mental health

Research shows that articulating the intersections between social injustices (eg abuse and violence) and women's mental health can have empowering and validating effects, while also ensuring more effective and relevant responses and referral pathways.[23] Therefore, general practitioners (GPs) should ask questions about gendered violence and trauma as part of a holistic assessment of women's mental health, noting that some women may not realise that it is relevant to discuss such experiences within a healthcare context.[19] Providing women with a rationale for asking about gender inequalities is helpful in developing trust and a transparent approach that can better support women to tell their stories;[24] for example, 'We know that many women have experiences in their lives that make them feel frightened/ashamed ... Has this been part of your experience?' The Royal Australian College of General Practitioners' *White book* contains detailed recommendations for responding effectively to disclosures of gendered violence and abuse.[25]

A key strength of general practice is the capacity to develop trust over time through a continuity of care in order to facilitate such conversations, in contrast to other mental health services. Providing space for women to understand their distress within the context of adversity and trauma can have many positive outcomes. For example, women can be supported to normalise their distress and to consider the connections between distress and a lack of safety, thus increasing self-compassion, reducing stigma and allowing for a more holistic approach.[23] When women consent, documentation practices should include information about gendered social contexts and their impacts on mental health in order to contribute to a more comprehensive assessment and lead to more relevant interventions (Table 1).

Importantly, many women will not disclose after being asked on only one occasion about experiences of trauma/adversity.[24] It is crucial that practitioners do not ask overly invasive questions or insist on a disclosure, because this can be harmful, exacerbating power differentials and reducing women's agency. Reasons women may have for not disclosing current or previous abuse or trauma include disinterested practitioners, time limitations, feelings of shame and concerns about the consequences of disclosure, including fears about losing children.[19] GPs should not assume that trauma has not occurred if it has not been disclosed, especially given the high rates of abuse and trauma experienced by women with mental health difficulties. Feminist principles, including empowerment, transparency and collaboration,[23] can, of course, be used effectively in practice, whether or not a disclosure of abuse/trauma has been made. Information and access to resources can still occur in the absence of a disclosure.[24] Some women may welcome the opportunity to be asked again about trauma in a subsequent conversation.[26]

Address the social determinants of mental health

A holistic assessment is useful insofar as it informs and improves the responses and referral pathways that are offered

Table 1. Examples of decontextualised documentation and examples of contextual details

Examples of decontextualised documentation	Examples of additional contextual details
Mary is experiencing psychotic symptoms	Mary is hearing a male voice making derogatory remarks, similar in content to an abusive ex-partner
Gina has moderate depression	As a child and young person, Gina experienced emotional and physical abuse
Isabella is highly anxious	Isabella is currently experiencing coercive control within an intimate partner relationship

to women experiencing distress in the context of gender inequalities and trauma. GPs can play a role in improving referral pathways for women, through developing relationships with mental health professionals who use a feminist/gender lens on distress within their practice and who provide advocacy and social support in addition to medical/therapeutic interventions.[15] Further, GPs can consider practical supports that will make a difference to women's wellbeing, in addition to referrals to traditional mental health services.[21] Resources including access to stable housing, domestic violence services, financial security, education and employment, childcare and increased social supports can have substantial impacts on mental wellbeing and recovery.[27]

Understand the complex reasons why women may appear reluctant to access support

Research studies demonstrate that if women have negative experiences when accessing mental health services, this can affect the likelihood of disclosing distress and accessing support in the future.[28] When women experience involuntary inpatient admissions as a response to mental distress, such experiences can be extremely disempowering; indeed, involuntary mental health treatment often mirrors and replicates the dynamics of violence and abuse by taking away women's autonomy and choices.[29] In addition, women are at risk of experiencing further aggression and assault on mixed-gender psychiatric wards.[5]

A reluctance to access mental health support may be labelled as evidence of a 'lack of insight', but it is understandable that women who have experienced mental health interventions involving coercion and retraumatisation would find it difficult to regain trust in services and professionals.[30] GPs can play an important role in supporting women who have previously experienced involuntary inpatient mental health treatment and who may be receiving follow up through general practice. Frequently, women do not have opportunities to talk about such experiences or to access support after discharge due to a range of factors, including social isolation and stigma.[31] The contributions that GPs can make include acknowledging the impacts of treatment without consent and confinement within an inpatient setting[30] and supporting women to access relevant, voluntary supports within the community in order to reduce the likelihood of a readmission.[32]

Ensure agency and choice

As noted above, there may be significant negative impacts resulting from responses to mental distress that involve coercion or a loss of control,[27] particularly for women who have already experienced trauma, abuse and disempowerment in other areas of their lives. Therefore, it is imperative that women be given choices about the kinds of support that they would prefer or find most useful, rather than a paternalistic or expert-driven approach. This requires patience and collaboration and, wherever possible, avoiding an insistence upon any one pathway or intervention, because the use of coercion is a barrier to therapeutic rapport, which can lead to a mistrust of services and fears regarding help-seeking.[29]

Engage with multiple understandings of distress and recovery

It is crucial that women are provided with space to conceptualise their experiences of distress in their own way. Although some women will be comfortable with psychiatric language, others may reject the language of 'disorder' and instead view distress as an understandable response to injustice and inequalities.[33] Being positioned as a person with a mental illness carries many gendered risks for women; for example, mental illness is deployed in custody cases to undermine women's credibility, and a psychiatric diagnosis runs the risk of obscuring gendered violence by constructing women experiencing distress as 'dysfunctional'.[4] Mainstream mental health screening tools are not helpful for some women due to a deductive approach that reduces opportunities for active listening and to explore strengths in addition to 'risk factors';[34] indeed, an extensive body of literature has critiqued the limitations of clinical definitions of mental health recovery, and highlighted the need to create space for diverse conceptualisations and experiences[35] (Table 2).

Through respecting women's preferences regarding language and frameworks for understanding distress and recovery, practitioners can demonstrate an openness to reflecting on the limitations of one's own knowledge, in ways that make space for multiple perspectives.[38] A willingness to engage in self-reflection and humility allows for a more collaborative, respectful and dialogical approach, which is central to women's empowerment after abuse and injustice.[23]

Table 2. A non-exhaustive overview of different emphases within conceptualisations of recovery

Conceptualisation of recovery	Emphasis
Clinical	Symptom alleviation[36]
Personal	Person-centred goals/definitions rather than clinical priorities[36] (eg playing music, bushwalking, time with animals)
Relational	Interpersonal/relational components[35] (eg meaningful and supportive connections with others)
Social	Changing material conditions[37] (eg a safe home, access to education)
Critical realist	Removing unjust social structures[27] (eg addressing poverty and racism)

Conclusion

This article has described the value of bringing a feminist lens to understanding women's mental health, in particular the importance of a gender lens and attention to social contexts. This is pertinent for general practice, which has been identified as the most appropriate medical speciality to address the social determinants of health.[39] Relevant skills for general practice include validating distress and a non-judgemental approach, conducting holistic assessments, ensuring contextualised documentation, providing broad referral pathways, engaging in transparent practices, understanding the impacts of coercion, prioritising agency and choice, and respecting women's perspectives on distress and recovery.

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