Lecture 5 – Gender, Sexuality, and Mental Health

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1

Introduction

- Do women and men express distress in same way?
- Do men and women experience same rates of mental pathology? What's at stake? How could we explain it?
  - Is mental illness naturally occurring or the result of gender dynamics in society?
- What is the impact of marginalized gender and sexual identities on mental health?

2

Gender & Sexuality

- Gender something one *does*, sex something one *has*.
- *Hegemonic masculinity*
- *Emphasized femininity*
- Both HM and EF work to facilitate patriarchy.
- Multiple masculinities and femininities – dominant forms subordinate other expressions.
  - E.g., heterosexuality held as superior to "inferior sexualities."

3

Sources of Difference

- Real differences in wellbeing and psychopathology, based on physiological differences.
  - PMS & post-partum depression to ASPD.
  - Assumptions linked to hormones:
    - Empathy, cooperation, nurturing as products of female sex hormones.
    - Rational and spatial understanding, competitive behaviour, violence a result of male sex hormones.
- Real differences based on socialization and social conditions.
- False differences based on research/diagnostic bias.

4

History

- Post IR, belief that women inherently more mentally ill than men.
  - "Sickly" condition of women related to reproductive system, "sensitive" nervous system.
- Hysteria: catch-all diagnosis, symptoms including faintness, sleeplessness, irritability, nervousness, pain, sensory change, etc.
  - Micale: "dramatic medical metaphor for everything that men found mysterious or unmanageable in the opposite sex".
    - Shifting physical symptomology represented the unpredictable nature of women.
    - Exaggerated emotionality was simply natural feminine sensibility intensified.
    - Hysterical fits were "spasms of hyperfemininity" – childbirth and female orgasm rolled into one.

5

Uses of Hysteria

- Hysteria both "pathologized and protected" by identifying difficult or abnormal behaviour as problematic, but explaining it via medical conditions.
- Freud: painful memories and thoughts converted into bodily symptoms. Recognition of society's central role in causing mental disorder.
- Hysteria as resistance:
  - Diagnosed in those who transgressed gender norms: suffragettes, divorcees, educated women. A defensive (male) response to female assertiveness.
- Fugue as the male form of hysteria?
  - Accepted norms relating to independence, travel, purpose.

6

Gender and Mental Health

- "Intropunitive" emotions self-reported more often by women than men.
- Women more likely than men to be diagnosed with anxiety disorders, depression, some PDs.
  - Less divided among non-Caucasian pop.
- Men said to be "externalizers" - more likely to be diagnosed with substance-related disorders, anti-social behaviours.

- Although men believed to experience traumatic events more often than women, women are more likely to be diagnosed with PTSD. Why?
- Picture is much more complicated than it would seem…

7

Expressing Mental Disorder

- Are differences in rates due to symptom expression, rather than actual differences?
  - "Female depression" – internalized behaviours (sadness, guilt, worthlessness), somatic symptoms.
  - "Male depression" – exhaustion, irritability, restlessness, anhedonia.
- Perhaps women express depression through mood and body complaints, men turn to substance abuse. At root, the same thing.

- But depression and substance use go hand-in-hand for women AND men. It's not that people experience one or the other.
- Some suggest that the notion of gendered responses has been overstated – we should be cautious.

8

Suicide

- Women attempt more, men complete more. What might explain this?
  - Testosterone/aggression?
  - Masculine ways of performing gender may make successful suicide more likely.
  - Men might opt for more lethal means to avoid (non-masculine) identity of a failed suicide attempt. Women's methods might act to preserve beauty.
- How one performs gender might also make suicide a more likely possibility, e.g. familiarity w/ guns, accessing healthcare services, drinking, etc.

9

Is It Just Reporting?

- Women report mental health concerns to GPs far more often than men.
  - Is this about broader help-seeking behaviour and masculinity?
  - Men are less likely to report specific types of mental health problems (EDs, depression) due to "feminine" nature.
    - Men may respond more favourably to "burnout" than being described as depressed.
  - Not solely masculinity – other factors matter:
    - more educated men more likely to report
    - men with intimate partners more likely to report
    - men w/ chronic illness & disability more likely to report

10

Diagnostics and Treatment

- Women less likely to receive advanced diagnostic and therapeutic interventions.
- With non-immediately observable complaints, MDs tend to assume that male problems are organic, female problems are psychosomatic.
- Women far more likely to receive psychopharmaceutical prescription.
- Not simply about female requests – video vignettes where physician watches and makes decisions confirm this data.

11

Sources of Stress

- If women experience more distress, why might that be?
  - Less fulfilling jobs and fewer resources.
    - Lower pay, less flexibility, more precarity.
  - Dual burden.
  - "Female roles" more stifling, less socially rewarding.
- Case study: Supermoms
  - "Intensive mother ideologies" have negative effects on women's mental health.
  - Increased stress, anxiety, decreased sense of self-efficacy, excess guilt for not living up to expectations.
  - Not just those women who bought into "perfect motherhood" ideals – those around them too.

12

Gender and Anorexia

- Popular view: thinness and beauty.
- Hilde Bruch: good girls - anorexia an attempt to take control.
  - Some feminist theorists buy into this theory, others reject it b/c it values "male" personality traits as ideal: autonomy, independence, emotional distance.
- Post-structural feminists (Bordo, etc.): anorexia as resistance to maternal body, powerlessness, "suffocating destiny of reproductive motherhood."

13

Female Sexual Dysfunction

- Orgasmic Disorder
  - "Any difficulty or delay in reaching orgasm that causes the woman personal distress."
  - Diagnosable if a woman doesn't orgasm from "sufficient stimulation"…
  - Does this limit notion of sex's "purpose?"
- Sexual Interest/Arousal Disorder (hypoactive sexual desire disorder)
  - US data: 32% of women have hypoactive sexual desire, more than 2x the rate of men.
  - "Discrepancies in desire" and "typically unreceptive to a partner's attempts to initiate" both indications of disorder.
    - In cases of "severe" relationship distress (i.e. violence) this isn't the case, but other relationship factors (poor communication) do not preclude diagnosis.
  - Could this distress not be the result of a frustrated partner, poor relationship, or bad sex?

14

LGBTQ Mental Health

- Identities that do not fit within heteronormative ideal.
- Homosexuality in DSM until 1980, "ego-dystonic sexuality" replaces it until mid 1980s.
- LGBTQ individuals appear to be at higher risk for poor mental health:
  - mental disorder (50% more likely)
  - suicidal ideation (2-4x heterosexual population)
  - substance abuse
  - self-harm

15

Sources of Distress

- Prejudice, social exclusion, coming out process, violence, internalized stigma, heteronormativity.
  - E.g. 20% of all trans individuals in Ontario subject to physical and sexual assault. Far more likely to be homeless.
- Social determinants also matter.
  - E.g. In Ontario, >50% of all trans individuals live on less than $15 000.
- Discrimination within care system stemming from: lack of knowledge, provider discomfort, institutional barriers (e.g. forms), lack of research on specific mental health issues, etc.

16

When Care Causes Distress

- Gender identity disorder first appears in DSM III, one diagnosis for children, one (transsexualism) for adults.
  - DSM-IV, examples included boys who wanted to wear dresses and girls who refused to wear them.
  - Boys roughly 6x more likely than girls to be diagnosed with GID.
- DSM-5 shifts to gender dysphoria - desire to be treated as a gender different than what society has assigned, to rid oneself of sex characteristics, or strong conviction that one belongs to a different gender.
  - "Gender nonconformity it not itself a mental disorder. The critical element is the presence of clinically significant distress."
  - Removed from section on "sexual dysfunctions."
  - Defenders: allows access to treatments, recognizes the distress.
  - Critics: affects a person's identity.

17

"Treating Sexual Deviancy"

- Long history of failed treatments, including conversion/reparative therapy.
- December 2015, CAMH's Child and Adolescent Gender Identity Clinic started 'winding down.'
  - Critics: operated reparative/conversion psychotherapy for trans children.
  - Defenders: political correctness, not science, guiding decision.

18

Conclusions

- Mental health differences between sexes and genders complex, related to social determinants, medical assumptions, and perhaps physiological differences.
- Throughout recent history, transgressing gender norms identified both as “proof” of mental disorder, as well as cause of distress.