Medicating Gender

By Emma Hahn

ABSTRACT. This essay is a feminist critique of the modern psychiatric diagnostic method. While attempting to be holistic, the medical model and use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) are grounded in biological origins. Additionally, the psychiatrists that use them to make decisions for patients are often susceptible to societal assumptions about experiences of individuals of different genders as well as the power dynamics inherent in a field such as psychiatry. Therefore, mental health methodology today is unable to provide the information necessary to incorporate feminist principles to protect patients from these assumptions and hierarchies. Psychiatrists can apply feminism to their work by intentionally focusing on gender and its impacts on mental health during the diagnostic process, hopefully leading to more appropriate treatments for patients.

Introduction

How can psychiatry more actively and effectively embrace feminism? One way to answer this question is to look at how psychiatry exists as a medical practice. Currently, the modern psychiatric assessment process is often known as the “medical model.” The medical model was a term first used by Scottish psychologist R.D. Laing in 1971 in *The Politics of the Family, and Other Essays.* Laing describes the medical model as a sequence of, “complaint; history; examination; diagnosis; treatment” (Laing, 1971, p. 40). The medical model relies heavily on the idea that concrete physical problems are the cause of abnormal behavior in humans. However, many mental illnesses have been discovered that have not been linked to an organic cause.

Therefore, a discrepancy sometimes exists in clinical psychiatry in which a doctor must treat an illness without knowing its origin. The American Psychological Association's response to this discrepancy is the Diagnostic and Statistical Manual of Mental Disorders (DSM), which lists mental illnesses and symptoms of those illnesses, and provides a standardized guide for psychiatrists to diagnose their patients.

Unfortunately, the current DSM and diagnostic process inadvertently reflect the oppressive nature of present power structures, making healing difficult for marginalized individuals with mental illness. In order for psychiatrists to truly support their patients in recovery, treatment must be comprehensive enough to take into account how past experiences regarding identity have impacted a patient's mental health. Many feminist theories provide a foundation for understanding these impacts, so it is useful to look at the medical model through a feminist lens. Psychiatrists will be able to provide the best support to their patients if they better understand the impact of gender on mental health from a feminist standpoint.

Assumptions of Experience

Assumptions made by a psychiatrist in regards to a patient's prior experiences are often detrimental in engaging with gender during psychiatric examination. Psychiatrists unknowingly develop expectations regarding their patients as a result of social constructions of gender present in society. These gendered expectations then surface during clinical consultation, leading to inadequate interpretation of the information a patient provides, and potential improper diagnosis and treatment. Androcentrism, gender socialization, and gender essentialism are prevalent examples of biases that are present in Western consciousness and seep into psychiatric conversation.

Androcentrism refers to male-centered attitudes and the assumption that the male experience is equivalent to the human experience, with femaleness being an outlier. Peter Hegarty and Carmen Buechel, two psychologists of the University of Surrey, presented a study in 2006 that provided analysis of androcentrism in research published in psychological journals in the past 40 years. The study shows that the ratio between female and male participants in studies has balanced over time, meaning the experience of the female portion of the population has become a more prevalent part of psychological research, as a result of the setting of standards of practice in research, regarding women (Hegarty and Buechel, 2006, p. 381). However, in the studies in which gender differences were a main focus of the research at hand ("medium gender salient" and "high gender salient" studies), researchers were 24% more likely to attribute the differences to be "about women" than "about men" (p. 382). This means that the authors' considered the natural state of the female participants in the study to be the cause of the gender differences found. This reflects a conflation of femaleness and difference, and a conflation of maleness and normality in the minds of psychologists. This characterization of women and androcentrism present in psychology today is particularly damaging in the context of gender socialization.

The concept of gender socialization can be portrayed by Colette Guillaumin's feminist theory of "natural" characteristics. Guillaumin, a French sociologist and feminist, explains that natural characteristics are assumptions made about the identity of a person based on the social group they are perceived to belong to. In reality, Guillaumin states that it is actually the perception of being part of said social group that generates these "natural" characteristics. Others treat individuals as though they intrinsically have identity-specific attributes, and so individuals respond by internalizing these characteristics (Guillaumin, 1977, p. 42). This means that people who are perceived to be women are treated as though they possess

those attributes commonly associated with women. Then, they develop a set of distinct "feminine" characteristics, while those who are seen as – and are treated like - men develop a set of distinct, "masculine" characteristics in response to social pressures.

Therefore, women and men tend to diverge into two categories of personality, based on societal assumptions of gender and sex. Hegarty and Buechel's descriptions of androcentrism tie into this theory of "natural" characteristics because gender socialization is often overlooked as a cause of behavior. Women's experiences, which are products of both societal pressures *and* individual experience, are lumped together with outliers, rather than as a specific social group in and of themselves. Through this characterization, the stereotyped and anomalous woman becomes less important in research and, as a result, misunderstood in diagnosis.

One example of this process is that women are under diagnosed and diagnosed much later than men with Attention-Deficit/Hyperactivity Disorder (ADHD). This is because women express ADHD differently than men resulting from their socialization. Women are more likely to display internalizing symptoms of ADHD, such as inattentiveness, rather than the externalizing ones that are more common for men, such as hyperactivity or impulsivity (Quinn, 2014, Table 1). This can be explained by Guillaumin's framework in that women are assumed to have the *natural* characteristics of timidity, rather than assertiveness, which is assumed to inherently belong to men. When women are treated as intrinsically reserved, as they often are in Western society, they learn to internalize their ADHD in order to fit in socially.

Furthermore, male-centered psychological attitudes can result in research that indirectly labels this internalization as "uncommon for the standard ADHD patient," rather than a more gender-specific option, such as "normal for the standard woman with ADHD." Women with ADHD are then misdiagnosed because psychiatrists rely on

information from male-centered research to create the DSM. When psychiatrists look to the DSM, women are more likely to display the "uncommon" symptoms noted and therefore do not necessarily fit the "standard" criteria for ADHD, resulting in lack of diagnosis or misdiagnosis. This is just one example of the many ways that androcentrism and gender socialization can cause women to be improperly treated solely because of their gender.

A second group of assumptions that frequently affect psychiatric diagnoses are related to the doctor's perception of the sex and gender of the patient. This concept is illustrated by Gayle Rubin's theory of "sex essentialism," which is the assumption that sex is something innate. Sex essentialism arises based on the societal assumption that there is an inherent link between gender and sex (Rubin, 1984, p. 146). In reality, some people discover that they identify with a sex and/or gender that are not cohesive with the sex and/or gender they were assigned at birth, proving that gender and sex are not inherently linked. However, because the idea that that gender is linked to sex is a widespread, socially constructed assumption in Western society, and sex is considered biological, men and women are treated differently because they are perceived to be inherently biologically different. Paired with the assumption that men and women hold certain innate characteristics, this has huge implications for the way psychiatrists interact with the individuals they are treating.

For instance, trans women's experiences with psychiatrists are liable to be influenced based on the category of sex they are perceived to belong to. Trans women have higher rates of depression and thoughts of suicide than the general population, and this rate does not decrease after sex-reassignment surgery (Dhejne, 2011, p. 7). The way trans women are treated in society is thought to be at least partially if not fully responsible for this rise (Hoffman, 2014, p. 6). These individuals, however, may be treated differently before and after sex-reassignment in

part because of the biases psychiatrists hold about women. Due to essentialist assumptions, women are more readily given psychotropic medication and more readily assumed than men to need ongoing, in-patient treatment, among other differences (Poland, 2004, p. 11). Trans women who undergo sex reassignment surgery are classified biologically under a medical model. They would therefore be treated differently before and after transitioning based on their perceived gender and sex, even though their mental health issues due to societal oppression remain unchanged. Essentialist understandings therefore have an impact on medical treatment for many individuals.

These three examples show how assumptions regarding the gender of women and trans patients can be the cause of poor diagnoses and treatment in modern psychiatry. Additionally, research, training, and education of future psychiatrists focuses on the assumed state of male and female experience, but often prioritizes the male experience because of its presumed applicability to all human experience. This means anyone who is not a man or, does not fit the societal expectation of what a man is like, has increased risk of receiving diagnoses that are inaccurate or inappropriate. In a society such as the United States, where mental health disorders are some of the most common medical issues, it is important for psychiatrists to fully develop their perceptions of sex and gender to increase accuracy and efficiency of diagnosis.

Power Dynamics

There are also many issues with treatment related to the power dynamics involved in modern psychiatry. Many mental health professionals indirectly encourage systems that keep patients in marginalized positions. For instance, the relationship between therapist and patient is often inherently skewed to provide the therapist with more say in what happens between the two participants. Additionally, pharmaceutical companies have a strong

influence on treatment options for people (more often women) with mental health disorders. The following two factors in gendered power relationships generate a situation in which a patient can receive inappropriate or ultimately subversive treatment in response to the symptoms they provide to the psychiatrist.

First, the use of the medical model encourages the idea that the psychiatrist is the ultimate authority (from the DSM) on what is objectively wrong with the patient and what form of treatment the patient should receive. This generates a power dynamic that leaves the patient in a position of limited control. This power dynamic is not based in biology, rather societally inherent biases. For individuals whose personal, identity related experiences have affected their state of mind, this situation reaffirms personal marginalization, and could mitigate any chance of effective treatment.

This dynamic is akin to Ann Oakley's description of interviewing as a "masculine paradigm" (Oakley, 1981, p. 31). Oakley, a sociologist, feminist, and writer, argues that interviewing situations often reflect the power dynamics of Western culture by depicting an effective or normal interview as one in which the interviewer relegates the interviewee to a subordinate position. Therefore, interviewing follows the idea that masculinity and subordination is an acceptable standard for information exchange. Oakley describes how the assumed "male" traits of "objectivity, detachment, hierarchy, and 'science'" from the interviewer are considered necessary components of a proper interview (p. 38). While these elements may be helpful for an interviewer, expecting someone to use them treats the interviewee's comfort and knowledge as less important than the interviewer's quest for information. For psychiatrists acting as agents of diagnosis under the medical model, that means setting aside their patients' identification with a variety of experiences in favor of analyzing immediate behaviors which reflect symptoms that can assist them in reaching a simple diagnosis. This is

detrimental to a patient because it means losing the chance to understand how the individual grew to develop those symptoms, and why they may persist despite treatment. Therefore, a consultation by a psychiatrist is less effective when the psychiatrist assumes a hierarchical position that puts their goals over the patient's needs.

Secondly, pharmaceutical companies hold influence over psychiatrists' decisions, which can largely affect the frequency and conditions under which individuals with certain gender identities are prescribed medication. For example, many women may seek medication without ongoing therapy. However, that desire may be driven by societal or environmental depictions of the medication, rather than the patient's personal needs. Jonathan Metzl describes this phenomenon in his book, Prozac on the Couch. Metzl relays how women historically were often manipulated by advertisements into seeking out antidepressants to improve their sex drive, even though their mental state was healthy. Furthermore, as Metzl explains, "psychotropic medications are imbued with expectation, desire, gender, race, sexuality, power, time, reputation, countertransference, metaphor, and a host of important factors" (Metzl, 2003, p. 5). This quote nicely sums up the idea that biomedical treatment in the profit-driven health system of the United States runs the risk of encouraging certain "life-changing" medications for individuals who do not need them. For women, that may mean trying to increase their sex drive through antidepressants or antipsychotics in order to escape the male-driven influences that exist for them in society.

A psychiatrist therefore must understand that diagnosing and treating patients is not necessarily a goal-oriented process, but a means-oriented process. In order to avoid both the drive to diagnose too fast and the drive to treat patients with medication based on outside influence, psychiatrists have to approach their patients with an intentional attitude. When the goal of diagnosis is the focus of the conversation between a therapist and a patient, and

not the actual health of the patient, then a therapist's office becomes an apathetic track towards diagnosis and treatment. Therapists must account for internal and external power influences in order to gauge how to reduce their effects and provide patients with support first, and the right treatment if it seems to fit the situation.

Conclusion

Psychiatry today is an effort to find a quick fix for a complex medical problem. However, when the "medical problem" is interconnected with individual personality, identity, and experience, the situation becomes too nuanced for a single easy solution. Human experience is a compilation of a network of identities moving through a vast number of environments. The collection of all of these interactions culminates in the state of mind of a patient, but under the modern diagnostic method, only some of these interactions are considered valuable to diagnosis. While every experience of a patient cannot be communicated and considered, there remains a need to actively collect information in an intentional way so that gender identity is not forgotten, avoided, or misunderstood in clinical settings.

My solution to this problem is threefold. First, from an administrative and educational point of view, the training of clinical psychiatrists should include comprehensive study of the impacts of gender in society and in clinical settings. Psychiatrists should learn the nuances of gendered assumptions and how those assumptions relate to patient diagnosis and treatment. Additionally, they should be taught about the power relationships that inherently exist in both the psychiatric and pharmaceutical industries. This education is key for psychiatrists' ability to set standards during clinical discussion that indicate an active effort to effectively approach and treat patients.

Psychiatrists must be self-reflexive about which biases are salient for them, and actively focus on subduing the impulse to diagnose and treat based on those assumptions. Specifically, this may mean questioning the usefulness of a diagnosis, and working with or without the DSM on a case-by-case basis (Swartz, 2013, p. 46). This would mean the psychiatrist is focusing on the individual and their specific experiences, rather than what they assume the patient has experienced as a person of their gender, thus avoiding the kind of biases that are present in the DSM based on gender socialization and androcentrism. This allows the psychiatrist to take a step back from the goal of diagnosis, to actually listen to their patients and therefore provide them with self-controlled, unbiased support when it comes to their gendered experiences.

The psychiatrist must also strive to balance the power dynamics in the relationship between psychiatrist and patient. In reality, this may mean actively providing patients with treatment options outside of the realm of biomedical treatment, and stress that whichever form of treatment the patient chooses is acceptable. This approach is described as "narrative" because it focuses on the story of the patient, rather than what the psychiatrists views as the "right" solution (Lewis, 2014, p. 2). More than just changing the standard of medicine, this adjustment represents an active effort by the psychiatrist to empathetically treat their patient and regard them as a mutual actor in the diagnosis and treatment process.

Like any individual going into a clinical setting and expecting to receive effective and wholesome treatment, women and trans individuals need to be specifically supported in their efforts without assumptions or power relationships burdening that process. It is only through education, self-reflection, and active self-inhibition that psychiatrists can truly consider their work to be unbiased both between patients and between themselves and their patients. The balance created through these actions can aid

in genuinely assisting patients who are in a national environment in which they are systematically unsupported.

A psychiatrist may see the merit in passively finding a biomedical treatment, but this cannot be the sole focus of psychiatric conversation. A therapist has to primarily support and validate their patient emotionally in their identity-specific experiences, and only then should the therapist move on to diagnoses and treatment. The therapist should also actively incorporate their patient's attitudes in determining which type of treatment is right for them. Setting this standard of empathetic psychiatry is an essential step in fully appreciating gender, sex, and their impacts on the brain and mind so that individuals can be appropriately supported in their search for a healthy mental attitude.

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