Gender Issues as Indicators in Quality of Life Research of Women with Chronic Mental Disorder. Possible applications of feminist theories

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Preface: 'To see our understanding and interconnectedness is the feminine perspective that has been missing, not only in our scientific thinking and policy-making, but in our aesthetic philosophy as well' (Farlinger, 1996: 116)

Introduction

The purpose of this present paper is to highlight the possible application of feminist theories in mental health and quality of life research and has a dual focus: Firstly, it briefly discusses the three major feminist perspectives on social research. Secondly, it examines ways in which gender issues have been included in the recent mental health and quality of life literature. The first section refers to the three major trends in feminist theory, a) empiricism b) standpoint and c) poststructuralist/postmodern. The second section discusses recent quality of life studies in the field of mental health which have included gender issues as quality of life indicators, and ways in which feminist theories could possibly contribute to a better understanding of research outcomes. Conclusion supports the argument that feminist theories could make an important contribution on mental health research and on developing comprehensive community care that includes quality of life promotion. It is important to point to the fact that the emphasis of this present paper is to stimulate a debate about the need to include gender issues as indicators for quality of life and mental health research rather than exploring in detail recent literature in the field.

Feminist responses to traditional epistemologies

Despite the lack of consensus in the field of feminist social science research, there are some basic principles of feminist theory that are consistently offered as common views of feminist research. These are summarized as follows: Firstly, the recognition of the validity and importance of women's experiences, secondly, the challenge to traditional scientific inquiry, thirdly, the concern about power imbalances between the researchers and the research participants, and finally, the insistence on the political nature of research (Fawcett and Featherstone 2000). The first principle concerns the recognition **of gender as important variable** in social research. The second principle is the acknowledgement that **traditional scientific inquiry has biases and assumptions,** which must be identified and challenged. The medical model according to which, 'the only way to understand a person's problem, behavior or condition in terms of illness, is diagnosis and treatment through medication' (Thomas and Pierson 1995: 220) can be used as an example in this context as for a considerable period it was used as an example in order to understand and respond to any form of disorder, including mental distress. The third principle is the feminist concern about **power imbalances in research relationships**. This is a complex and multidimensional issue, as professional roles, and factors such as gender, race and educational background may influence power inequities (Fawcett 2000).

Feminists' responses to traditional epistemologies may be considered under three headings: a**) empiricist,** b) **standpoint** and c) **postmodern, poststructuralist** epistemologies. Harding

(1986, 1990), does not regard these strands as distinct and separate and she argues that there are many points of overlap.

For feminist empiricists, male stream social science is simply bad science, where, ‘andocentric’ values, assumptions and values are dominating as an objective account of the social world’. It is generally referred to as the ‘gender-as- variable’ approach and it is mainly based on quantitative methods (Trinder 2000). Standpoint feminism has arguably become the most dominant in feminist research literature and in particular in the literature used within social work research in the UK. It differs from the empiricist position in two key ways. Firstly, it has an explicit gender focus informed by radical feminism, which examines society critically with a view to promoting radical change. Secondly, for standpoint researchers, the research act is about power and empowerment and their main concern is to take into account the perspective of women’ experiences (Smith 1987). In terms of research methods, feminist standpoint research is mainly qualitative. This approach emphasizes the importance of acquiring a broader and deeper picture of women’s conditions and experiences of discrimination and oppression (Fawcett 2000). Finally, whereas feminist empiricism goes hand in hand with liberal feminism, the feminist standpoint research has more in common with radical and critical feminism and attempts to stimulate social change and emancipation (Fawcett and Featherstone 2000; Harding 1991).

Criticism of standpoint feminism has come from postmodern feminists who argue that there is no concrete "women's experience" from which to construct knowledge due to the fact that, the lives of women across cultures and histories are so diverse that it is impossible to generalize about their experiences (Benhabib 1995). Postmodern feminist epistemology conceptualizes the world in terms of a range of discursive resources available to individuals and groups. Postmodern, poststructuralist feminists have mainly examined language and the way notions are constructed. According to their position, genders are seen as social and linguistic constructions, limited in time and space, that is determined by existing ideas and conceptions about what ‘man’ and what ‘woman’ means (Alvesson and Sköldberg 2000). Most feminist perspectives of postmodernism are taken up with continuing a project of resistance to oppression. However, they differ on the role of the subject. Postmodern feminist perspective not only describes the “woman experience”, but also tends to challenge the professional view as the ‘expert’ who can make decisions on behalf of the client. It creates a demand in clinical research and practice for deep self-reflexivity about the problem of power (Fawcett 2000).

Gender as a variable in Quality of Life Mental Health Research

Gender is a critical determinant of mental health and mental distress and determines the different power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to mental health risks (WHO 2010). The effect of gender on subjective quality of life had been examined in the general population by previous studies (Andrew and Withey, 1976 ; Campell, 1981 ; Diener, 1984), and showed that gender had little influence on individuals’ perception of quality of life. Increasingly, schizophrenia research is focusing on gender to understand differences in symptom expression. Results outcomes have shown that both clinical and social situations seem to be relatively advantageous for women with mental disorder during the course of their disease (Priebe, et al. 1999). In particular, there is serious empirical evidence that their global adaptation is better, they more often have employment, they have family and occupational role functioning, more often they live with a partner and more often than men are heterosexually active and more independent. In general, to be female predicts better functioning in schizophrenia (Childers and Harding 1990).

Although gender differences in schizophrenic symptom expression have been widely established (Test, et al 1990; Childers and Harding 1990; Angermeyer, et al 1990), no systematic studies have documented if these differences extend to the perception of quality of life and if so, on what life domains. Despite the fact, that several studies (Lehman 1983; Barry and Crosby 1996; Zissi et al. 1998; Merinder 2005) have incorporated a social perspective that examined how quality of life variables of several life domains interact with mental health outcomes, a few quality of life studies differentiated results by gender. Gender as a variable in international research is overlaid by age and race (Rogers and Pilgrim, 1999).

This issue is particularly pertinent for cross-national studies, where social, political, economic and cultural factors influence client satisfaction with their quality of life. Vandiver (1998) conducted a cross-national survey in Canada, Cuba and USA, gathering data among 102 out-patient men and women with schizophrenia. Qualitative analysis of the data suggested that Canadian women were pleased with the social support provided by their mental health care providers, whereas Cuban women with schizophrenia seemed to feel that their social relationships were constrained by the multiple roles of care giver, housewife, and worker. In both settings service accessibility seemed to address the promotion of quality of life in the area of social relationships, as well as, symptom reduction. The above findings indicate that vulnerability factors, such as, social stress and burden of home and family care giving, may explain why women report low satisfaction on quality of life measures (Oakley 1993a). The dual focus on women as direct users and as providers of care and support, has led feminist research to be concerned with the “condition” of being a woman, with an emphasis on explanations and expectations of service users (Orme 1998).

Another study conducted by Mercier, et al. (1998), examined the effect of age and gender on the subjective quality of life of 95 male and 70 female Canadian clients with severe and persistent mental disorder who lived in the community. Participants were asked to report their satisfaction on certain life domains. The qualitative outcomes of the study revealed that despite the fact that gender differences among the participants on subjective quality of life were not significant, women were more willing than men to express their worries, desires for change and plans for the future. With regard to social integration between men and women with schizophrenia, research outcomes showed that women were able to find place for themselves in the society more easily than men, by accepting to remain within the boundaries of traditional feminine roles (Mercier, et al. 1998). Previous research conducted by Goldstein and Tsuang 1990, had noted the importance of differential sex roles (e.g. parenting, and caring role, for women, and career expectations for men) as stress factors for people who experience mental disorder.

Angermeyer, et al. (2001) examined if gender, among other variables – age, residence and the duration of mental disorder-, had an important influence on individuals’ definition of quality of life. According to the results, the odds that family was considered important for the quality of life were 2.5 times higher among female patients than among male patients while for the latter, the satisfaction of so-called oral needs seemed to be more important. Results’ analysis also indicated that both female service users and female psychiatrists more frequently considered the family as a source of quality of life, whereas the psychiatrists' concept of quality of life was more illness-oriented encompassing the absence of handicaps and disabilities due to the illness and emphasizing the importance of appropriate professional help and self-help (Angermeyer, et al. 2001). Similar findings were found by Evangelou (2007), who examined the effect of Community Care Programmes, on quality of life of 44 (28 male and 16 female) mental health service users in Greece. The above study utilized a combined method, quality of life questionnaires and semi-structured interviews. Although quantitative data analysis did not differentiate quality of life scores by gender, qualitative messages elicited differences which were gender related. Such messages indicated the value imposed on having a family, or the emotional reward that female respondents gained for them when they were able to care for other family members. Qualitative data in Evangelou (2007) also indicated that female participants had not been helped by their social and family environment to enhance their functional skills and their self-esteem. As a result, they had been experiencing a feeling of helplessness and dependence. Emotional and practical dependence on primary carers were indicative in many responses. Frequent comments were: *'My family receives the welfare benefit on my account. I feel neglected. My mother pays all the bills. I am a burden on my family'* (:203). Looking at the above findings from a standpoint feminist perspective, we could emphasise how women are shaped through social relationships, which are oppressive, exploitative, dehumanising, and patriarchal.

Traditional Western medical practice virtually ignored the problem of power and tried to explain deviant behaviour on the basis of individual pathology. Professional paternalism still dominates in the Greek mental health care field and service users are not generally allowed a voice leaving the "say" to their doctors who make decisions not only regarding their treatment but also regarding personal life plans. Qualitative outcomes in the above study, such as, "*"I do what my doctor says, he has the command'* corroborate this statement (Evangelou 2007:206). As mentioned before, with regard to mental health research and practice, postmodern feminism can contribute a perspective, which would allow mental health work to develop analyses, which does not depend on the divergence, of the individual and social sphere. This approach can lead to a concrete understanding of complexity that characterizes lived experience (Fawcett 2000).

Concluding Remarks

Feminist theories have contributed in providing opportunities to understand and privilege the experiences of women. With regard to mental health research their main contribution is that gender represents an essential theme in the attempt to understand virtually all social relations, institutions and processes. A feminist perspective can offer the researcher better access to women's ideas, thoughts and experiences and will provide women who suffer from mental distress the direct opportunity to express what is and is not working in their lives. As a result, an understanding of the effect of gender may challenge our favourite assumptions about the nature of mental distress as well as our favourite assumptions about gender. With regard to quality of life, the researchers must not only look at the statistical ratings but they must move towards the knowledge that is gained from 'listening to what people say' (Oakley 1993b).

It is important to point to the fact that, any form of theory or research practice, is of limited value if the understandings gained do not inform ways of intervening in the lives of service users. Mental health practitioners have to consider gender differences, as well as existing power imbalances, in order to reduce the risk of relapse and hospitalisation. Moreover, they should allow the subject's voices to determine quality of life promotion. For quality of life research, the challenge is to identify how the analysis of research outcomes, assist in addressing issues of empowering women through practice and interventions. Feminist mental health research and practice demands attention for both female and male practitioners/researchers and acknowledges the situations of both women and men who are users of mental health services. Finally, a research practice informed by feminist theories could have important applications in future mental health interventions which promote quality of life.

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