Section 1 The social, genetic and environmental aspects

Chapter 1

Surviving their lives

Women's mental health in context

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Introduction

This chapter sets out a perspective on women and mental health that is radically different from that presented in the rest of the book: a book blatantly discussing mental health and mental illness. Here the reader is asked to understand women's psychological distress as evidence of their active struggle to survive lives shaped by abuse, exploitation, neglect and oppression. Evidence is presented to make the case that women's vulnerability to these experiences, and their efforts to survive them, are best understood within a framework that gives centrality to the existence of gender and other social inequalities. We aim to show that knowledge of these matters helps us to work well with women and to develop services for them that are acceptable and effective.

We begin with a reminder that social inequalities and hierarchies are still with us. Even in modern democracies where persistent efforts are made to extinguish inequalities, access to opportunities, rewards, power and status continue to be affected by the social categories to which we belong. Gender inequality is especially potent because of its centrality to identity and personal life; it also intersects with other systems of inequality including those founded on class, race, ethnicity, age and sexuality. The literature that explores the links between social inequalities and women's mental health is well-established and extensive, and is explored here under broad headings:

Risks and resources: This research focuses on social structural factors known to undermine or promote mental health and traces the ways gender and other social inequalities affect women.

Gender identity and socialisation: These matters have attracted the concern of researchers and clinicians for many decades. They draw attention to the detrimental effects of gender socialization on the ways women look after their own interests and cope with trauma, conflict and other challenges in their lives.

Ideologies: Social inequalities, especially gender, are sustained and hidden by ideologies that justify their existence and discourage their opposition. These systems of belief are woven into the fabric of society and tolerated as part of everyday life. So, when social inequalities cause mental health difficulties, it is difficult for people to make sense of what is happening and to find healthy ways forward. There is a persuasive body of research that shows that women and men's difficulties are likely to be compounded if they are given help from mental health services that are not gender-informed.

Survival: There is growing evidence that simply viewing women as victims of gender-based injustice and oppression is a partial account. There also needs to be acknowledgement of women's resilience and resistance to injustice, and especially their survival strategies, which frequently may be mislabeled abnormal or deviant behavior and disorders of personality.

Risks and resources

There is a wealth of evidence that alerts us to the risks embedded in women's lives that originate in systems of inequality. Some of these receive attention elsewhere in this book (e.g., Chapters 2, 3, 7, 17, 18). Selected for attention here are those that are commonplace and influential and that can usefully inform our work with women who have mental health needs.

Interpersonal violence and abuse

Gendered power relations

Gender inequality is perpetuated by processes that define women and men as different and that provide

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the justification and conditions for men to be accorded greater power, status and value than women. As Baker-Miller observes, "whenever one person or group has more power than the other(s) in a relationship, the danger of harm increases" (Baker-Miller 2008b, p. 375). Physical and sexual violence and abuse towards women and girls are common and often a covertly sanctioned means of expressing and maintaining dominance in family and community settings or of sustaining masculine identity (World Health Organization 2013a). Consequently, some of the most severe abuse of girls and women occurs within the most male-dominated families, subcultures and coercive contexts – including trafficking and gangs (McNeish and Scott 2014). So-called honor killing is an extreme example of this (Chesler 2010).

Gender inequality also underpins the commonly held belief that men should have their needs – including their sexual needs – met by women (Hill and Fischer 2001), including young women (Hlavka 2014); that what they do or want takes precedence over the needs of women; and that their prerogatives should not be questioned. Such a sense of entitlement, explicitly stated in widely accessible pornography (Office of the Children's Commissioner 2014), has been linked to rape, domestic violence, sexual abuse of children, sexual harassment and economic abuse.

A wealth of evidence also shows how women's lives, work and activities are systematically accorded less status and value than men's, the consequences of which are ameliorated or accentuated by the interactive effects of other aspects of a woman's life such as her class, ethnicity, age and sexual orientation. Femicide (World Health Organization 2012) is the most extreme form of gender-based devaluation and violence. This includes infanticide (World Health Organization 2011), which culminates in the far higher murder rate for female than male infants and is often linked to torture, mutilation, cruelty and sexual violence.

Scale of the problem

Findings about the prevalence of gender-based violence are readily available and can help us to gauge the scale of the problem and to think through the implications for mental health services. It is estimated that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime (World Health Organization 2013a). On the basis of findings from the 2011/12 Crime Survey for England and Wales, it was estimated that 7% (1.2 million) of women had experienced domestic abuse in the previous year (Women's Aid 2013) (see Chapter 14). Most recently, analysis of the Adult Psychiatric Morbidity Survey, a large scale general population study carried out in the UK (NatCen 2014), found that 1 in 25 of the population had experienced extensive physical and sexual violence, with an abuse history extending back to childhood. Women were 80% of this group, nearly all of whom had been assaulted by a partner. Half had been threatened with death. Most had been sexually abused as children and some severely beaten by a parent. Many had also been raped as an adult. While domestic violence, child sexual abuse, rape and sexual assault occur throughout and across societies, poverty and social divisions such as class and minority ethnic status also affect their prevalence (Humphreys 2007).

Implications for mental health

Much has been written about the processes that connect gendered violence and mental health and that differentiate it from post-traumatic stress disorder (PTSD) (van der Kolk, Roth et al. 2005). When a girl or woman experiences violence and abuse in a relational context that is complicit or indifferent to what is happening, then a common negative effect of this trauma is that she disconnects herself from others (Baker-Miller 2008b). Children experiencing abuse may believe they are responsible for their abuse – beliefs that are often fostered by abusers – and feel fearful, silenced, shamed and stigmatized. Childhood and adult abuse are major causes of the profound psychological and emotional difficulties that are subsequently diagnosed and labeled as pathologies (see also Chapter 17).

Research reviews (Chen, Murad et al. 2010, Cashmore and Shackel 2013) and landmark studies (Briere and Elliott 2003) provide strong confirmatory evidence that violence and abuse places mental health and personhood at risk, with effects that can be detected across most forms of adult distress and dysfunction (see also Chapter 17). Most recently, the UK Adult Psychiatric Morbidity Survey (NatCen 2014) identified a number of discrete groups of people with severe and sustained abusive experiences who experienced a wide range of distress and difficulties eligible for definition as psychosis, PTSD and eating disorders. For example, more than half of the people who had experienced the most relentless interpersonal trauma could be defined as clinically depressed or anxious – making them five times more likely than those with little experience of abuse to develop problems defined as a common mental health problem

and 15 times more likely to have three or more such difficulties (NatCen 2014).

Confirmation that violent and abusive experiences are a predictor of subsequent psychological and emotional disorder and contact with mental health services is also provided by studies of clinical populations. An early study (Carmen, Ricker et al. 1984) found that almost half of the women using an inpatient service had histories of childhood sexual and physical abuse, findings that have continued to be replicated and elaborated (Chen, Murad et al. 2010). Abusive experiences are so highly prevalent as to be normative in the lives of women living in secure psychiatric services (Bland, Mezey et al. 1999). More recently, Abel et al. (2012) reviewed women in medium- and high-secure forensic mental health services in England and Wales. Over 90% of these women reported a history of childhood abuse (physical and sexual).

It is also important to be aware that women experiencing mental health problems are also at increased risk of violent victimization (Trevillion, Oram et al. 2013). Lifetime prevalence of violent victimization among women with serious mental problems may be as high as 97%; many of these women will have experienced multiple traumas (Goodman, Rosenberg et al. 1997). There is also consistency in the chronological ordering of experiences with histories of abuse, mental health problems and substance misuse generally preceding experience of homelessness, social exclusion and further revictimization (Fitzpatrick, Bramley et al. 2012).

Poverty

The relationship between poverty and mental health problems is one of the most well-recognized in psychiatric epidemiology (Wilkinson and Marmot 2003). It requires little imagination to identify the factors that can mediate this relationship, including living in poor housing in neighborhoods that do not offer a safe, cohesive community; worry over paying for essentials such as caring for children; poor diet; risk of exploitation at work; the psychological impact of racism; and negative and blaming attitudes toward the poor. People living in poverty who rely on the state also need to contend with the associated stigma of receiving benefits. Researchers report that "recipients often describe experiences of humiliation, dehumanization, denigration, depression and shame" (Belle and Doucet 2003, p. 108). Black and minority ethnic women living in persistent poverty are also at increased risk of victimization and of their mental health being affected by multiple traumas including sexual violence and abuse (Bryant-Jones, Ullman et al. 2010) (see also Chapter 2).

A substantial body of evidence supports the conclusion that the impact of social inequities on mental health is affected by the size of the gap between rich and poor, with the most unequal societies being the most toxic (Friedli 2009). Friedli (2009) comments: "For this reason, levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing" (p. iii). It is important, therefore, to be mindful that gender inequality means that many women have restricted access to money. To illustrate: figures for 2012 in the UK show that for every £1 a man takes home, a woman takes home 85p; and that 63% of people earning under £7 per hour (equivalent to ~$10 per hour) are women (Office for National Statistics 2013b). This pay gap persists because women tend to work in care-related services, work which is typically undervalued, underpaid and often part-time. This affects access to savings and pensions; women save considerably less than men and only 40% have adequate pension plans compared to 50% of men (Scottish Widows 2013).

Most at-risk of living in poverty are women who are lone parents, are older women, have disabilities (Macinnes, Aldridge et al. 2013) and are from ethnic minority groups (Kenway and Palmer 2007). Also included here are women living in nonpoor households where money is not distributed equally and where it is used by men to coerce and control their partner (NatCen 2014). There is also evidence (Byrne, Resnick et al. 1999) that women who live below the poverty line are at increased risk of violence and that physical and sexual assault increases the risk for poverty, divorce and unemployment (Goodman 2009). These dynamics, and the effects of these cumulative inequalities, are very evident in the backgrounds and life stories of women using mental health services (Goodman, Rosenberg et al. 1997, Goodman, Salyers et al. 2001, Williams, Scott et al. 2004).

Working lives

Paid work

Paid work provides a potential source of resilience for mental health through supporting self-esteem, a sense

of identity and meaning, financial and emotional independence and social support. It can also be a source of overwork, conflict, dissatisfaction, insecurity, exploitation and harassment (MacDonald, Phipps et al. 2004). The impact of gender, ethnicity and other inequalities on the world of work means that women are more likely to experience the negative effects. Women continue to be concentrated in lower-skilled, part-time and lower-paid jobs than men, with less access to vocational training and education (TUC 2012). Those women whose lives are already most disadvantaged by social inequalities are most likely to experience the psychological disadvantages and least likely to experience the psychological advantages of paid work.

Unpaid work

Research consistently finds that men do less housework than women partners, and unsurprisingly, that women are less happy than men with this state of affairs. The most recent set of national UK statistics (Lanning, Bradley et al. 2013) found that women are continuing to spend more time on work within the home than men, regardless of income or whether they work full time. Women still carry the overwhelming burden of household tasks, even when they are cohabiting (Miller and Sassler 2012); this is particularly so after they have had children.

In terms of childcare, although there are indications that men are becoming more involved in the lives of their children (Fatherhood Institute 2011), data also suggest that there can be important differences in the quantity and nature of care provided by women and men even when women work full time (Craig 2006). Mothers give more time to childcare and are more likely to be alone with children, to multitask and to carry the overall responsibility for parenting.

Women also assume greater responsibility for caring for sick and incapacitated relatives, neighbors and friends than men – 58% of carers are female and women predominate in those groups with the heaviest commitments. They are also more likely to leave paid work in order to undertake care commitments (Carers UK 2012). While caring for others can be meaningful and intrinsically rewarding, it carries risks to mental health when it is associated with lack of social value, powerlessness, isolation, stress and poverty and when it is juggled with paid work outside the home (MacDonald, Phipps et al. 2004). The reader is referred to Chapter 3 for a broader discussion of women's role as caregivers.

Embodied distress

Women's bodies also need to be understood in the context of social structure and constructions of gender. As discussed in Chapter 16, the connection between social value and physical appearance is particularly potent; research consistently finds that women have lower body satisfaction than men, regardless of age or ethnicity (Burrowes 2013a). Many women also attempt to control their lives and distress by controlling their bodies and what they eat; bodily disgust and disordered eating can add to these burdens (Bordo 2004) (see also Chapter 16).

Gender inequality and misogyny also affect women's experience of their reproductive lives, so that menstruation, fertility, childbearing and the menopause can become sources of disempowerment and distress (Ussher 2006). When women's embodied distress is named as, for example, psychosomatic, or eating disorders or self-harm, it becomes harder to detect the origins of this distress in gender and other inequalities and much easier to blame the woman herself. Wikund and colleagues (2014) remind us that we can avoid this trap by listening carefully to women's own narratives of their body-anchored responses and experiences within the context of their lives. This should include listening for experiences of violence and abuse in childhood and adulthood and to what women have to say about the effects of psychotropic medication they may have been prescribed (Jacobson 2014). The impact of psychotropic associated weight gain is discussed in more detail in Chapter 23.

Resources

Despite changes in the home and work roles for women and men over the last half century, women's restricted access to valued material and social resources continues to be a striking feature of gender relations in western countries. Women have less access to resources known to support and promote well-being, most notably physical and psychological safety, money, status and power. The effects of social inequalities on women's access to material, social and psychological resources are typically detrimental. An exception to this is their potential access to valued relationships with other women. Like members of

any disadvantaged group, women are well-placed to seek support and value from each other.

It is well-documented that women's relationships with each other, both within (Watson, Scott et al. 1996, Burrowes 2013b) and outside (Giuntoli, South et al. 2011, Economic and Social Research Council 2013) mental health services, can be a source of therapeutic support. Opportunities to share experiences can enable women to see similarities among their difficulties, and to have their own experiences and feelings validated. This is particularly important when different diagnoses can make it difficult for women to find shared realities and commonalities with other women. Groups can help women to shift from believing their distress is a function of their personal abnormality and inadequacy to viewing it as an understandable reaction to the hardship, trauma and injustice in their lives. Importantly, groups can enable shared experiences of the injustices of racism, violence, abuse, loss, disadvantage and disappointment to be identified and named. Groups offer women a very different experience from that provided by their family networks: regular contact with a large family network does not necessarily lead to a higher level of well-being in women as it can place more obligations and burdens on them (Economic and Social Research Council 2013).

Socialization and identity

Gender socialization encourages women to develop characteristics and competencies in preparation for providing services to their families and society, which are compatible with a position of subordination. Ironically, there are indications that gender socialization has become increasingly robust as legislative barriers to equality have been removed. For example, babies are now enthusiastically color coded to remind everyone, especially the baby, of their gender (Eliot 2010). Shared understanding of what women are expected to be like include words such as empathic, emotionally expressive, deferential, dependent, passive, cooperative, able to multitask, mothers, attractive, warm, "nice" and ready to smile. Characteristics that can evoke disapproval, punishment and other negative responses towards women continue to include being too clever (except at school), ambitious, competitive, noisy, selfish, assertive, sleeping around, drinking heavily, being angry or violent, and being disinterested in or neglecting family life. Women continue to be considered more irrational, incapable and incompetent than men – all characteristics that suggest that women are ill-suited to acting autonomously or to exercising power.

By contrast, men continue to be socialized to develop psychological characteristics that are consistent with the exercise of power (Seguino 2007, Connell 2011). The defining features of masculinity such as individualism, competition, acquisition, bravery and domination further the interests of global capitalism and nationalism, and when required, large numbers of men can be delivered to military life (Sjoberg and Via 2010). Although while shaping men's identities and lives in this way may serve the collective interests of some groups, this may be at considerable cost to the mental health of disadvantaged men, including Black and minority ethnic (BME) and working-class men who, along with the women and children in their lives, are held outside systems of power (Williams, Stephenson et al. 2014). The central requirement of hegemonic masculinity that is crucial for perpetuating the gender system – that men are strong, independent, heroic, winners and providers – has important mental health ramifications not least because of the link with interpersonal violence (Hearn and Whitehead 2006).

Being a 'good' woman

For many women, the dominant themes in their lived experience of inequalities are those of abandonment, abuse, disappointment, frustration and powerlessness. These experiences, which assault the self, can be a source of powerful emotions and distress including great sadness, shame, fear and rage. Yet, one of the injunctions that support the perpetuation of gender inequality is that women should not express rage or anger. In contrast, men are likely to be "authorized to be angry"; this anger is often associated with violence between men and from men towards women (Connell 2011, Williams, Stephenson et al. 2014). Angry women, on the other hand, are typically seen as a challenge to the gender system and to male dominance and may risk being viewed as bad or mad (van Wormer 2010). Too often mental health services medicate angry women and label them as problematic and personality disordered (Shaw 2005, Warne 2007, Ussher 2013). As Claire Allan (2011), a woman diagnosed as having borderline personality disorder, observes, "'inappropriate anger' is a classic symptom of a 'borderline personality.'"

The risk to women of being socialized to defer to men, to please men and to accommodate the wishes of others, is that they neglect their self and their needs and do not have a sense of their own entitlement. Jack (1991) called this "silencing the self." This can affect women's mental health and well-being in a number of ways. For example, a woman can feel that it is dangerous or disallowed to express anger or disappointment openly and instead express anger indirectly in covert ways that minimize the risk of conflict, hostility or backlash. Direct conflict is avoided when these well-documented, underground power processes (Smith and Siegel 1985) are used, but their success is contingent on the woman remaining silent about the causes of her distress, disappointment, loss or rage. Finally, gender expectations can also inhibit self-directed action so that a woman living in toxic circumstances may not feel entitled to look after her own interests (Grant, Jack et al. 2011).

Ideologies

The ideologies and relational processes that sustain systems of inequality, especially gender inequality, have far-reaching psychological implications. Although gender systems are shaped by culture and context, they are also consistently underpinned by expectations that women and men should differ in terms of personality, aptitudes, interests, responsibilities, rights and value. Women are positioned so that they have less access to resources, opportunities and decision-making power than men. Justifications and explanations for this are woven into the fabric of societies and daily life. Everyone – the privileged as well as disadvantaged – is enlisted in participating in systems and practices that sustain these inequalities: this is "normal life" (Fine 2010). Although dissenting and alternative realities exist and emerge from a range of sources, attempts to scrutinize and oppose inequality may be systematically challenged, discouraged or thwarted (Sidanius and Pratto 1999).

Ideologies, rules and practices may not only affect the mental health of individuals, but also the mental health services that try to meet their needs. Over the past four decades, important and powerful perspectives have emerged that view mental health services as no different from other social institutions in being shaped by ideologies that serve the interest of privilege and deflect attention from the existence of inequalities (Penfold and Walker 1984, Williams and Keating 2002). This is particularly manifest in the ways women's distress is defined and processed within mental health systems. The power to name is profound and is evident in the enduring emphasis on psychiatric diagnosis, individualized pathology and medicalized responses to social distress (Cutting and Henderson 2002, Warne 2007, Platform 51 2011). Diagnosing a mental illness such as a borderline or emotionally unstable personality disorder, bipolar disorder, depression, anorexia or psychosis is a serious misrepresentation of a woman's experience. The powerful connections between a woman's distress and her lived experience are severed and without these understandings, her rightful distress and associated struggles to survive are easily misunderstood as abnormal, dysfunctional, unhealthy, out of control or dangerous. It becomes easy to assume that there is something fundamentally wrong with her, rather than that something has gone badly wrong with her life.

Survival

If the illness model does not accurately reflect the processes at work in women's distress (Williams and Paul 2008), what are the alternatives? One important and viable approach that is consistent with the evidence presented here conceptualizes women with mental health needs as survivors of their lives. From this perspective, symptoms and feelings typically labeled as illness, pathologies and disorders of personality represent manifestations of the costs of inequalities for women and of their resilience in surviving these injustices. This perspective is supported by growing evidence that women do not respond to the trauma of abuse, exploitation, racism and oppression with passivity, but engage in an active struggle to survive physically and psychologically. Depression, hearing voices, somatization, dissociation, self-harm (Crowe 2004), eating distress, misusing alcohol, prescribed and non-prescribed drugs (Markoff, Reed et al. 2005, Bland, Mezey et al. 1999) are all common ways that women (and men) may manage unbearable feelings of terror, anger, fear, profound sadness, shame and loss when they have limited control and when they do not feel entitled to speak, or safe enough to do so (Briere and Elliott 2003, Baker-Miller 2008b, Larkin and Read 2008, Chen, Murad et al. 2010).

Gender-informed mental health provision and practice

Mental health services dominated by medical and other reductionist models are difficult contexts within which to meet the mental health needs of women, and indeed men. Furthermore, when staff are not trained and encouraged to think about the psychological implications of inequalities and power abuses, there is a heightened risk of re-traumatization. Nonetheless, the accumulating evidence base summarized earlier and the persistence of writers, clinicians and women service users is beginning to have a positive impact on policy, research and practice guidance. This is evident in work emerging from Australia (Kezelman and Stavropoulos 2012), the United States of America (APA 2007), the UK (Department of Health 2002, Itzin, Bailey et al. 2008, NHS England 2013, NHS Confederation 2014), as well as from some international bodies (World Health Organization 2013).

Innovations in service provision and practice have been stimulated by gender analysis of women's mental health, and achieved through service development and training interventions (Scott and Williams 2004, Read, Hammersley et al. 2007, Greater London Domestic Violence Project 2008, Nelson and Hampson 2008, Scott and McNeish 2008).

Service provision

Evidence that social inequalities and associated abuses of power are a root cause of mental health problems has helped identify processes of collaboration, mutuality and empowerment as defining characteristics of effective services for women. This is supported by evidence from a number of quarters. For example, it is well-recognized that service development should be shaped in collaboration with women who have experienced mental health difficulties and used mental health services (ReSisters 2002, Kalathil, Collier et al. 2011). Collaborative work in communities has also been shown to strengthen women's resilience through building relationships (Hartling 2008), providing trauma-informed peer support (Blanch, Filson et al. 2012) and groupwork (Watson, Scott et al. 1996, Ryan 2005, Burrowes 2013b).

Well-funded evaluation studies have an important contribution to make to developing services in this field. Research demonstrating the value of trauma-informed cognitive behavior therapy (CBT) in community settings (Cohen and Mannarino 2008) and of gender-informed service responses to women whose problems include substance misuse (Toussaint, VanDeMark et al. 2007) provide good examples. Gender-informed responses to women admitted to acute wards (Williams and Paul 2008, Judd, Armstrong et al. 2009) and with housing needs (Howard, Rigon et al. 2008) are advocated but need further support and evaluation. In recent years, there has also been specific guidance, including that led by government, that addresses domestic violence and its impact on women and young people (Humphreys, Houghton et al. 2008, Trevillion, Howard et al. 2012, NHS Confederation 2014); the importance of building links with developments in the domestic violence sector is now widely accepted. The reader is also referred to Chapter 14. Finally, there is recognition that effective responses to the complex needs of severely traumatized women requires trauma-informed commissioning (NHS England 2013) and collaborative, flexible commissioning between sectors and across agencies (NHS Confederation 2014).

Gender-informed mental health practice

The evidence presented in this chapter makes a strong case for concluding that mental health practitioners need to understand women's distress in the context of the complexity of their lives and with an appreciation of the ways gender, ethnicity and other social inequalities affect service responses to women. In short, they need to take a gender-informed approach to working with women. This includes being knowledgeable about the ways in which power abuses can shape the lives and mental health of diverse communities of women – for example, black and minority ethnic women (Edge and Rogers 2005), migrant and refugee women (Women's Therapy Centre 2009, Latif 2014), sexual minorities (Women's Resource Centre 2010), women with learning difficulties (Taggart, Mcmillan et al. 2008), women in prison (Marcus-Mendoza 2011), women whose psychological distress is linked to substance misuse (Markoff, Reed et al. 2005, Toussaint, VanDeMark et al. 2007, Covington 2008) and homelessness (St Mungo's 2014).

Mental health practice needs to be thoroughly grounded in knowledge and understanding of the workings of power in the context of largely Eurocentric, patriarchal mental health services. As mental health workers, we must develop an awareness of

our use and misuse of power and privilege (Jordan, Kaplan et al. 1991, Baker-Miller 2008a, Jordan 2008) and of the boundaries of our relationships (Royal College of Psychiatrists 2007, Council for Healthcare Regulatory Excellence 2008). Mental health workers must actively avoid reproducing harmful dynamics in relationships where there is an imbalance of power, seeking instead to bring authenticity, mutual empathy and mutual empowerment to the relationship (Baker-Miller 2008a). Gender-informed practitioners enable women to feel safe to speak in their own voices about trauma and difficulties in their lives and to find safe ways to express anger, sadness and loss (Brown 2004). Working with women in these ways creates opportunities for them to strengthen their resilience in the face of oppression and abuse and find their path to recovery (Hartling 2008).

Unfortunately, as yet many mental health services are not capable of responding to women's distress in gender-informed ways. This is most evident in research exploring whether workers had tried to find out whether a woman client had experience of abuse and violence, information that is one of the keys to providing gender-informed care. While the majority of women service users (Feder, Hutson et al. 2006, Morgan, Zolese et al. 2010) and mental health workers (Hepworth and McGowan 2013) believe it is appropriate routinely to ask women about these matters, there is little evidence this is happening in practice (Scott and McNeish 2008, McLindon and Harms 2011, Hepworth and McGowan 2013). This is hardly surprising: most people working in the field of mental health have not been trained to work with the mental health consequences of abuse and violence; neither do they have access to the kinds of supervision and support they need to work safely as gender-informed practitioners. It is encouraging that the case for change has been acknowledged (Department of Health 2010, NICE 2014) and that open-access web resources aimed at mental health practitioners have recently been made available to support better practice (www.scie.org.uk/publications/elearning/sexualhealth; www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/trainer-resources). However, it seems unlikely that fundamental change will be achieved without corresponding developments in the curricula of courses used to prepare all mental health practitioners for their work. The body of evidence presented in this chapter, and elsewhere in this book, makes it clear that this should happen.

Conclusion

The approach to women's mental health that has been outlined here confronts us with the difficulties of redressing profound inequalities of power in society and in systems. It also reminds us that these inequalities have largely been unrecognized, ignored or underrepresented in mental health provisions. A social inequalities perspective alerts us to the fact that understanding effects of inequalities requires us to recognize that each of us derives varying amounts of privilege and penalty from the intersections of multiple systems of potential oppression. There is much to share and learn together. We need to strengthen our capacity and confidence to understand the connections between inequalities and mental health and our ability to have appropriate conversations with women about their lives, their experiences of injustice and power abuses and how it has made them feel. The value, benefit and efficacy of mental health services rests on their capacity to offer women the help they need to survive such systems in transformative ways that can justly be named as recovery.

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