E-ISSN: 2706-9117
P-ISSN: 2706-9109
www.historyjournal.net
IJH 2024; 6(2): 85-98
Received: 02-06-2024
Accepted: 05-07-2024

TA Rossman
Department of Justice Studies, San Jose State University, San Jose, California, United State

Harit Agroia
Department of Public Health, San Jose State University, San Jose, California, United State

Corresponding Author:
TA Rossman
Department of Justice Studies, San Jose State University, San Jose, California, United State

Disparities in mental health diagnoses and treatments among women: A historical and theoretical review

TA Rossman and Harit Agroia

DOI: https://doi.org/10.22271/27069109.2024.v6.i2b.297

Abstract
Historically, women worldwide have experienced disproportionate diagnoses of mental health conditions and related psychiatric institutionalization compared to men. The purpose of this historical review was to understand the extent to which these diagnoses have disproportionately impacted women within mental health systems, specifically their human and civil rights. The feminist and objectification theories served as the lens and framework to investigate this aim. Through this review, we present findings from several case studies such as those that explain how unconfirmed mental diagnoses (e.g., hysteria) were used as the basis for initiating treatments among women by medical providers, resulting in severe and harmful long-term impact. Such treatments include extensive or permanent internment in mental institutions, lobotomies, electric shock treatments, involuntary mind-altering injections and psychiatric drugs that cause short- and long-term cognitive and physiological damage. We further explore possible reasons for initiating treatment without confirmed diagnoses. Findings suggest that internalized patriarchal conceptions and financial incentives are two main drivers for premature treatment initiation. Overall results indicate that due to sociocultural and economic oppression, repression, abuse, enforcement of women's inferior status by patriarchal structures, and social class, women have been and continue to experience disproportionate diagnoses of mental health disorders compared to their counterparts. Themes of oppression, sexism, and adverse physiological alterations emerged when assessing how human and civil rights were violated. We recommend further increased awareness efforts among mental health care providers to facilitate improved understanding of the neurological and physical effects of psychiatric treatments and implementation of respective modification of services. Systems-level changes within socio-cultural, patriarchal, economic and insurance systems that marginalize women are necessary to mitigate the detrimental impact of such disparate experiences among women and their overall health.

Keywords: Historical review, mental health, psychiatric systems, patriarchal structures, social class, gender studies

Introduction

While men and women are equally affected by mental illnesses, some illnesses are more common among women (Recovery Across Mental Health [RAMH], 2020) [32], and disparities between men and women pertaining to risk, prevalence, and the course of mental disorders continue to persist (American Psychological Association [APA], 2017) [4]. Mental illness, which may often be referred to as a mental disorder(s), refers to any mental condition that may affect a person's mood, thought processes, and behavior (Mental Illness, 2022; Moller, 2018) [25, 27]. Examples include depression, anxiety, schizophrenia, and eating disorders. Women have also been subjected to extensive mental health treatments of all types for mental health symptoms, often more frequently and severely than men (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; APA, 2017; Kirchengast, 2016; Jumer, 2019) [36, 4, 20, 18]. The purpose of this historical review is to understand the extent to which these diagnoses have disproportionately impacted women within mental health systems, specifically their human and civil rights.

Disparities

Women are more likely than men to be diagnosed with eating disorders, sleep disorders, and borderline personality disorders (APA, 2017; Ussher, 2013; APA, 2011) [4, 41, 3]. Approximately 20% of women experience symptoms of depression, post-traumatic stress

disorder, or eating disorders each year, and women are twice as likely to experience symptoms of depression than men during their lifetime (APA, 2017) [4]; Figure 1. Research indicates that women comprise 65% of those diagnosed with binge eating disorders and nearly 95% of those diagnosed with anorexia nervosa.

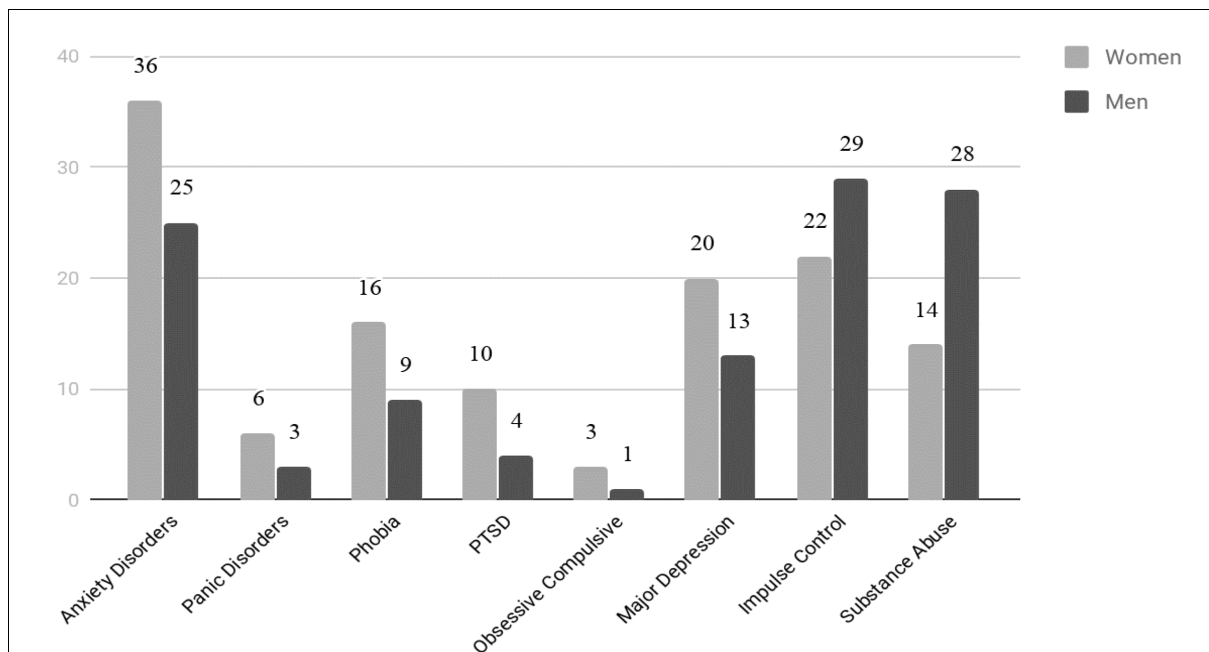


Fig 1: Rates of Diagnosed Mental Disorders in Women and Men 2005 (APA, 2017)

Historically, women have also been more than 1.5 times more likely than men to suffer from emotional and behavioral symptoms of Serious Psychological Distress (SPD) (SAMHSA, 2014) [36]. This finding includes all age groups from 18 to over 50, as summarized in Table 1.

Table 1: Serious Psychological Distress (SPD) Diagnoses in the Past Month among Persons Aged 18 or Older, by Age Group: Numbers in Thousands, 2011 and 2012 (SAMHSA, 2014) [36]

	Total (2011)	Total (2012)	Ages 18-25 (2011)	Ages 18-25 (2012)	Ages 26-49 (2011)	Ages 26-49 (2012)	Ages 50+ (2011)	Ages 50+ (2012)
Female	6367	7131	1545	1606	2923	3054	1899	2470
Male	4521	5118	1091	1247	2114	2414	1317	1457

Further, in 2017, the self-reported prevalence rate for suicidal thoughts among women was over 12% higher than for men, 4.6 per 100,000 vs. 4.1 (National Institute of Mental Health [NIMH], 2019) [30]. That same year, suicide attempts were 40% higher among women than men, 0.7 vs. 0.5, respectively (NIMH, 2019) [30]. However, the actual suicide rate for men is 267% higher for men than women: 22.4 vs. 6.1, respectively (NIMH, 2019) [30].

Factors Contributing to Disparities

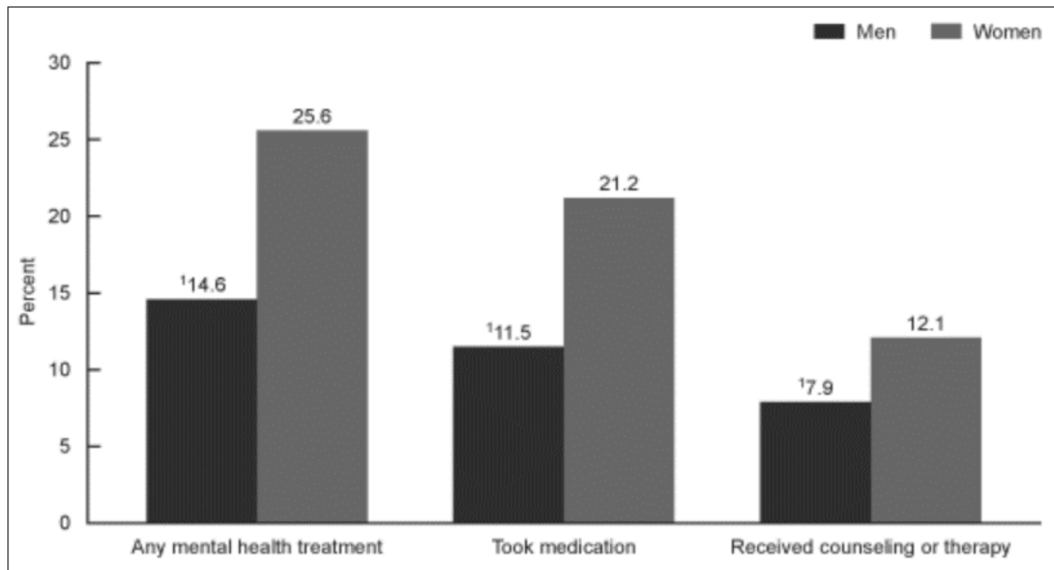
Eaton *et al*. (2012) [15] studied the prevalence rates and manifestations of common mental illnesses by gender. The authors found that women diagnosed with anxiety disorders are more likely to internalize their emotions in ways that lead to loneliness, withdrawal, and depression, while men are more likely to externalize their emotions, resulting in impulsive, coercive, aggressive, and noncompliant behaviors (Eaton *et al*., 2012) [15]. These differences may explain gender differences in prevalence rates for diagnoses of anxiety and mood disorders (females) versus diagnoses of antisocial personality disorders and substance abuse (men) (Eaton *et al*., 2012) [15].

Women are more likely than men to seek and receive mental health services across all degrees of diagnosed illness (Figure 2), which may further explain the disproportionate rates of diagnosis compared to men (SAMSHA, 2014; Breggin, 1991; Breggin, 2008) [36, 10, 11]. While women generally seek services for emotional, behavioral, and/or circumstantial issues through their primary care provider, men will seek help directly from a mental health specialist if they choose to do so. (Ussher, 2013; APA, 2017; Pattyn, 2015) [41, 4, 31]. Women are also less likely to disclose interpersonal violence victimization than men, while men are less likely to disclose substance abuse problems (Ussher, 2013; APA, 2017) [41, 4]. Men generally tend to have more negative and stigmatizing attitudes toward help seeking and have also been main contributors to structured social norms rooted in patriarchism (Pattyn, 2015; Women and Psychiatry, n.d.) [31].

Women are also more likely to be diagnosed with depression compared to men, even when clinically presenting with or reporting nearly identical symptoms standardized assessment instruments (Ussher, 2013; APA, 2017) [41, 4]. Once diagnosed, differences in treatment can further be observed, such that historically women have been much more likely than men to be provided lobotomizing electroconvulsive therapy (ECT), hospitalized for psychiatric illness with or without their consent, and prescribed brain-damaging psychotropic medications(e.g. selective serotonin reuptake inhibitors (SSRI)s, such as

Prozac and Zoloft), neuroleptics (antipsychotic) drugs which cause tardive dyskinesia (e.g. Haldol and Zyprexa), and highly-addictive benzodiazepines (such as Xanax and Halcion) (Ussher, 2013; APA, 2017; Breggin, 1991; Breggin, 2008) [41, 4, 10, 11].

Figure 2. Percentage of Adults Aged 18 and Over Who Had Received Any Mental Health Treatment, Taken Medication for their Mental Health, or Received Counseling or Therapy from a Mental Health Professional in the Past 12 Months, by Sex: United States 2020 (CDC, 2020).



[1]Significantly different from woman ($p < 0.05$).

Even though women seek and receive mental health services more often, it is not uncommon for them to encounter significant barriers to receiving adequate treatment from mental health professionals (APA, 2017) [4]. These barriers are further exacerbated in women who are among communities of color, racial and ethnic minorities, and who have low socioeconomic status (Shaddox, 2018; WHO, 2001, 2019; Abdelgadir, 2012; Thyloth & Singh, 2016) [35, 47-48, 1, 39]. Specific barriers include a lack of affordable health care (consistent with lower pay for women in jobs that do not provide health insurance); health insurance caps on psychological and other services, a lack of awareness about emotional and behavioral symptoms, available treatments, and service providers; the cultural stigma that comes with mental illness diagnoses; and the time pressures associated with caregiving, transportation, and taking time off from work. Because most women access mental health services through a primary care doctor, the absence of primary health care and mental health services integration in many health systems is another important barrier to medical mental health treatment (APA, 2017) [4].

Treatments for Mental Illness

In many cases, the long-term effectiveness of psychiatric treatments is shown to be more detrimental than the emotional and behavioral problems patients initially present with (Breggin, 1991; Breggin, 2013) [10, 12]. For instance, the "chronic brain impairment" (CBI) that came with initiating neuroleptic treatment was often mistaken for worsening of psychiatric disorders by clinicians and family members (Breggin, 2013, p. 21) [12]. Given the aforementioned disparities in diagnoses for these problems by gender, women are more likely to experience long-term problems associated with treatment. Additionally, women who receive treatment within both inpatient and outpatient psychiatric facilities reported experiencing lethargy, apathy, memory lapses, cognitive dysfunction, affective dysregulation, drug-induced tardive dyskinesia, intestinal damage, brain shrinkage and/or atrophy from psychiatric tranquilizer use, and the emotional instability that occurs after years of CBI (Breggin, 1991; Breggin, 2013) [10, 12].

Research suggests antipsychotics used for acute treatment have little to no long-term benefit (Moncrieff, 2013; Moncrieff, 2020) [28, 29]. Moreover, long-term use of antipsychotic drugs may result in more negative outcomes for people being treated for schizophrenia or psychosis (Whitaker, 2004) [44]. Reputable studies indicate that women with emotional and/or behavior problems and subsequently treated with antipsychotic drugs are being harmed rather than helped (Breggin, 1991; Breggin, 2008; Moncrieff, 2013; Moncrieff, 2020) [10, 11, 28, 29]. The potential harm of antipsychotic drugs, also called neuroleptics, can contribute to devastating physical problems. Approximately 40% of patients taking neuroleptics experience tardive dyskinesia, a long-term effect characterized by involuntary, spasmodic muscle movements of facial and/or other muscles (Breggin, 1991) [10]. Neuroleptics in general and tardive dyskinesia in particular are also associated with brain shrinkage and more generalized intellectual impairment (Moncrieff, 2013; Moncrieff, 2020) [28, 29]. As a result, patients taking these medications are less capable of managing their care, less emotionally stable, and highly likely to experience more severe symptoms, including CBI (Breggin, 1991; Breggin, 2008; Moncrieff, 2020) [10, 11, 29].

Until comparatively recently, women have been underrepresented in clinical trials for a number of medications proposed to treat mental illness, especially in stages II and III (Labots *et al*., 2018) [21]. The efficacy of SSRIs to treat depression is one such example where the Food and Drug Administration (FDA)'s original trials involved small groups of men, yet today these drugs are marketed largely to women with minor depression (Ussher, 2013) [41]. Psychiatric drugs are over-prescribed for women, and they have serious side effects, including increased risk of suicide, sexual dysfunction, and agitation (Ussher, 2013) [41]. The practice of over-prescribing is directly linked to the

Diagnostic and Statistical Manual of Mental Disorders (*DSM)*, which is the taxonomic and diagnostic tool that mental health professionals rely on for diagnosing their patients (APA, 2017; Cosgrove, 2011) [4, 14]. However, there has been concern that the APA, the organization responsible for publishing the DSM, may be influenced the pharmaceutical industry, a major funder of the organization. This suggests that the pharmaceutical industry may play an underlying and critical role in the historical increased rates of mental health diagnoses and treatments among women (Ussher, 2013; Cosgrove, 2011) [41, 14].

Role of the Pharmaceutical Industry

In the United States, the pharmaceutical and biotechnology sales industry was estimated to receive $775 billion in sales revenue in 2019, a 31% increase from the $535 billion revenue that was estimated in 2006 (U.S. Government Accountability Office, n.d.). Drug manufacturers of the five most frequently prescribed SSRIs conduct promotional campaigns that primarily target women and generate sales profits of over $10 billion per year as a result (Ussher, 2013) [41]. Some sources state that the pharmaceutical industry has directly influenced the diagnostic criteria and treatment recommendations found in the modern *DSM* (Ussher, 2013; Cosgrove, 2011) [41, 14]. In Cosgrove's analysis, it was found that a majority of individuals serving on the diagnostic and treatment panel had connections to the drug industry (2011). In fact, all of the individuals on two *DSM* panels, schizophrenia and psychotic mood disorders, either directly received funding or held leadership roles within the industry. Moreover, at least 56% of panel members who developed criteria for the *DSM-IV* diagnoses received funds from the drug industry (Ussher, 2013) [41]. For the newest edition, *DSM-5*, that figure is 70%: a substantial increase from the prior edition (Ussher, 2013) [41]. These *DSM* panel members may receive a range of benefits including research funding, speaker fee reimbursements, and consultancies. While the APA has stated its intention to make relationships like these more transparent (Cosgrove, 2011) [14], there are clear and direct funding connections even in this latest version that have problematic implications for the diagnosis and treatment of mental disorders. For example, 81% of *DSM-5* panel members for anxiety disorders had financial ties, 83% of panel members for eating disorders had financial ties, and 100% of panel members for mood disorders received funds from Big Pharma; women have historically had more diagnoses of these mental disorders specifically, when compared to men (Ussher, 2013) [41]. This appears to correlate with the increases in psychiatric diagnosis of women and medications prescribed to women between 1992 and 2012 (Ussher, 2013) [41]. Consequently, considerations about billing to health insurance companies with diagnosis codes, may have played a role in the decision to not incorporate recommendations based on lessons from previous *DSM* editions, such as moving away from traditional disease entities to syndromic/dimensional diagnostic systems, (Moller, 2018) [27]. These are a few ways that the *DSM-5* has contributed to a lucrative and expanding market for the psychiatric pharmaceutical industry (Ussher, 2013) [41]. For example, the five most frequently prescribed SSRIs - again, marketed mostly to women - account for over $10 billion in profit a year (Ussher, 2013) [41].

This overall data on the disparities in mental illness prevalence, treatment options, and pharmaceutical industry's role presents a need for this historical review in applying a theoretical lens to understand how current systemic structures, including the interests and viewpoints of those involved in establishing these structures, have contributed to adverse mental health outcomes observed among women.

Feminist and Objectification Theories

Feminism is about equality; this includes equal social and human rights and shifts in perspectives to include how people socially construct reality (McAfee, 2018) [24]. Since most cultures embrace a masculine view of the world, including placing greater value on traditionally masculine characteristics (e.g. autonomy, power, and a sense of inherent superiority), characteristics associated with a feminine perspective (e.g. sensitivity, caring, and community) are minimized and given less value (Breggin, 1991) [10]. This worldview has been detrimental to both men and women: men because of the social and cultural prohibitions against cultivating compassion and intimate relationships, among others; and women because they have systematically been subjugated and excluded from many forms of power and control (Breggin, 1991) [10].

A branch of feminist theory, objectification theory, seeks to understand and explain the ways in which women are socialized, including experiencing sexual objectification (Szymanski, 2011) [37]. Both these aspects are linked to mental health problems, including depression, sexual dysfunction, and eating disorders, all of which are more common diagnoses among women than men (Fredrickson & Roberts, 1997) [16]. This theory suggests that, as a result of living in a society, the female body is objectified – that is, reduced to an object. Internalizing the idea that one's value is mainly that of an object often results in significant mental health risks for women (Frederickson & Roberts, 1997; Kaschak, 1992).

In the United States, women are objectified in almost all forms of visual media content (e.g. advertisements, music videos, and films), in social contexts such as whistling or shouting, and as victims of physical and sexual violence. These examples become problematic when the objectification becomes internalized as a form of self-objectification (Frederickson & Roberts, 1997) [16]. When women self-objectify, they see and treat themselves as an object, placing a high value on appearance, often leading to the perception that they do not meet social standards based on their physical appearance. Fredrick and Roberts (1997) [16] suggest that this self-objectification can result in body shaming and lead to adverse psychological outcomes, such as anxiety, eating disorders, depression, and sexual dysfunction, further reinforcing a negative self-perception.

Objectification theory provides a lens through which one can view women's mental health problems external to the individual. The process of socialization that involves the objectification of women's bodies, including their sexual parts and functions, is not limited to females; males are socialized as well, giving license for the catcalls and violence noted above, as well as obsessive bodybuilding and preoccupation with outward appearance. Objectification theory helps explain how reducing women to their looks and sexual parts has allowed those in power, be it social, economic, or political power, or power over mental health systems, to define women's mental health in terms of sexual

parts and functions: a practice that has existed for millennia. The basic premise of these two theories is further applied to understand the disproportionate rates of mental illness among women, as well as mistreatment in mental health systems, through this historical review.

Purpose and Methods

The purpose of this historical review was to explore the history of the diagnosis and treatment of perceived and real mental disorders from 2000 BC to the 21st century; understand the extent to which mental illness diagnoses continue to disproportionately impact women; and discuss implications of findings through the framework of feminism and objectification theories. To perform the review, authors identified peer-reviewed articles and government and professional publications that described mental illness diagnosis and treatments among women during discrete historical periods from roughly 5000 BC to present. Such articles also discussed mental health systems practices, focusing primarily on the United States and contrasting diagnosis and treatment data for women and men to a limited extent. Peer-reviewed journals, scholarly books, and publications by reputable professional and government organizations were included.

Results

Early History to Colonial Period

Between 5000 B.C. and the early 1600s the term mental illness included psycho-spiritual mental disorders such as demonic possession. For these disorders specifically, women were diagnosed more often than men and subsequent treatments were purely physical, rather than physiological, and were aimed to rid demons from the brain (Kirchengast, 2016) [20]. There is evidence that mental disorders thought to be associated with demonic possession were treated with trepanation for thousands of years which entails drilling a hole in a person's skull to release the demons (Kirchengast, 2016) [20]. This practice continued until the 15th century at which point asylums were created, first in Europe, to serve as a warehouse for those who were considered to have a mental illness (Kirchengast, 2016) [20].

From the Middle Ages and Renaissance through the Modern Period (1860 to 1945), female reproductive function/female reproductive organs were said to be the cause of women's mental diseases (Kirchengast, 2016; Bergman, 2013) [20, 6]. Although reproductive bases for diagnosing women with mental illness have lessened, they are still in use today (Breggin, 1991; Kirchengast, 2016) [10, 20]. The postulated association between female sex, female reproduction, and mental illness/insanity has been strong since ancient times (Kirchengast, 2016) [20]. Beginning in 2000 BC, a significant number of women worldwide were most typically diagnosed with hysteria, the mental disorder that mental health professionals of the time believed was caused by wandering uteri (Kirchengast, 2016; Jumer, 2019) [20, 18]. From 2000 to 1001 BC, the first described mental illness attributed to women is hysteria, as noted in both ancient Greek and ancient Egyptian literature (Kirchengast, 2016; Jumer, 2019) [20, 18]. The term hysteria, coined by Hippocrates in the 5th century BC, was taken from the Greek word ὑστέρα, or "hysteria," meaning uterus; this philosopher believed the mood disorder was caused by uterine movements, or "hysteron" (Kirchengast, 2016; Jumer, 2019) [20, 18]. Because hysteria was said to be due to a wandering uterus or womb, or being dissatisfied with sex or pregnancy, Greek doctors attempted to cure hysteria by fumigating women's' vaginas in hopes of luring their uteri back into their correct position (Kirchengast, 2016; Jumer, 2019) [20, 18]. Given that hysteria was the most typical female mental illness, Roman physicians focused on it as well (Kirchengast, 2016) [20]. Accurate clinical descriptions of hysteria were provided by Celsus in the 1st century BC and Galen in the 2nd century AD Soranus (2nd century AD) revolutionized cures for hysteria (Kirchengast, 2016) [20]. Mental associations that dominated medical research through the Middle Ages and Renaissance until the Modern Period (1860 to 1945) were between female reproductive function/female reproductive organs and mental diseases (Kirchengast, 2016; Bergman, 2013) [20, 6].

Colonial Period to 18th Century

In the Victorian period, non-feminine behavior could be considered evidence of insanity; this constituted a potential risk of being locked away for women who rebelled against the patriarchal norm (Women and Psychiatry, n.d.). Domination by asylum patriarchs was considered mentally and emotionally therapeutic. This was based on the then-prevalent concept of moral treatment, which enforced the idea that women with mental illness should be treated like children rather than animals (Women and Psychiatry, n.d.). Victorian physicians believed women were fragile and much more sensitive and susceptible to neurasthenia nervous breakdown than men. Hysteria, the quintessential "female malady," included nervous symptoms and odd behaviors. It was diagnosed mostly in women and only occasionally in men who were considered feminine (Women and Psychiatry, n.d.). The most prescribed treatment for an unmarried woman showing signs of hysteria was to find a husband (Women and Psychiatry, n.d.).

A specific and well-known example of hysteria was in Salem, Massachusetts in 1692 when at least 100 women were imprisoned and 19 executed by hanging after being accused of being witches and placing curses on a group of young women (Jumer, 2019) [18]. Experts now believe more probable causes for the Salem Puritan girls' hysterical symptoms and outbursts were ergot poisoning (from a fungus that grows on rye), their shared occult beliefs, boredom, and/or disputes and rivalries with accused neighbors ("List of 5 Possible Causes of the Salem Witch Trials," 2019) [22]. In 1887, journalist Nellie Bly uncovered misogynistic perceptions of women, as well as the all-to-often applied ability of well-respected psychiatrists to control women using unconfirmed mental diagnoses and subsequent life-long captivity (Bonanno, 2019) [8]. Bly's objective reporting from inside a typical insane asylum showed that women who did not conform to social norms were too easily institutionalized, treated worse than criminals and horribly abused, sometimes in life-threatening ways, daily (Bonanno, 2019) [8].

Eighteenth to Nineteenth Centuries

While physicians diagnosed hysterical symptoms for millennia, it was not until the late 1800s for "hysteria" to be recognized as a specific disease and the focus of intense medical attention (Women and Psychiatry, n.d.). During this period, the concept that hysteria was caused by a "wandering uterus" was rejected and the focus of the causes moved to the brain (Jumer, 2019) [18].

Since the 18th and 19th centuries, women also outnumbered men in overall diagnoses of madness (Kirchengast, 2016) [20]. For example, in Scotland's Edinburgh Royal Infirmary, women made up 98% of all hysteria cases in the late 1700s (Kirchengast, 2016; Royal Infirmary of Edinburgh History, 2020) [20]. In 1840, Laycock, considered by some to be a pioneer in psychoneurology, published essays exploring the very ambiguous, long-debated disorder of hysteria (Miller, 2019) [26]. One of these was *An Essay on Hysteria: Being an Analysis of Its Irregular and Aggravated Forms; Including Hysterical Hemorrhage, and Hysterical Ischuria. With Numerous Illustrative Cases.* According to Miller (2019) [26], "For those investigating the era's institutionalized sexism, this monograph is an exquisitely rich vein to tap" (Miller, 2019, para. 1) [26]. Notably, Laycock asserted that hysteria is women's natural state (Kirchengast, 2016) [20].

In his essay on hysteria, Laycock reported on his efforts to diagnose the condition scientifically through observation and direct evidence. However, his overall conclusion that hysteria was exclusive to White women was based on selective evidence (Briggs, 2000; Miller, 2019) [9, 26]. This specific limitation was based on the reality that White women were perceived as more privileged, decadent, and soft as well as more prone to debility, nervousness, periodic depressions, and daily worry (Briggs, 2000) [9]. Such qualities were attributed to the instability of affluent women's lives in the U.S. in the late 1800s; all were said to weaken women's childbearing ability, which Laycock believed contributed to hysteria (Briggs, 2000) [9]. Charcot, the French founder of neurology, is known for ushering in the hysteria epidemic in the late 19th century (Von Plessen, 1996) [42]. He diagnosed and treated about 900 female hysterics while treating only 90 males (Von Plessen, 1996) [42]. In the 1880s, he proposed that hysteria was a nerve disease like multiple sclerosis (Von Plessen, 1996) [42]. He said it was not a 'sexual problem' unique to women, and this opened the possibility that men could also exhibit hysterical symptoms (Von Plessen, 1996) [42].

The 19th century was also dominated by sexism, discrimination, and hostility (Jumer, 2019) [18]. Male physicians began to displace midwives, and many women died from infections transmitted by doctors who refused to wash their hands prior to examinations (Jumer, 2019) [18]. It was not unusual for women to be admitted to asylums by psychiatrists, who used them to develop models for insanity, and their husbands when they did not meet their expectations (Breggin, 1991; Jumer, 2019) [10, 18]. One notable example of locking-up unwanted wives is Elizabeth Packard. In 1860, her husband had her committed to an asylum for engaging in "free religious inquiry" - teaching in Bible class that humans are born good, not born evil (Breggin, 1991, p. 322) [10]. Packard was able to keep a detailed record of the brutal treatment by doctors and staff, comparing the asylum to the Inquisition (Breggin, 1991) [10].

The misogynistic perceptions of women and ability of psychiatrists to diagnose women with mental disorders that require life-long captivity were disclosed in an 1887 undercover news report by journalist Nellie Bly (Bonanno, 2019) [8]. By faking a hysterical outburst, Bly arranged for her commitment to a typical insane asylum where she documented daily abuse of female patients by doctors and staff, including female staff (Bonanno, 2019) [8]. She kept detailed notes of women whom she perceived to be normal and mentally healthy despite their diagnosis. Female patients were poorly fed and clothed as well as verbally and physically abused as a means of manipulation and control (Bonanno, 2019) [8]. Bly later shared her experience and findings, stating specifically that women who did not conform to social norms could easily be institutionalized, treated worse than criminals and horribly abused daily (Bonanno, 2019) [8]. Her research validated the stigmatizing and life-threatening effects of being labeled insane, both inside the asylum and in society (Bonanno, 2019) [8].

During the mid-19th century, menstruation became a defense for homicide. This defense was supported by one of the founders of modern criminology, Cesare Lombroso (famous – or infamous – for his views on anthropometry and atavism), who postulated that women who committed homicide were menstruating at the time (Kirchengast, 2016) [20]. While the theories of Allan and Lombroso, among others, have since been discredited, there remains a strong thread through modern psychiatry that links female hormones with depression, pregnancy and postpartum depression, eating disorders, and menopause-related disorders (Kirchengast, 2016) [20]. Research on hormone-specific mental disorders is still in its infancy (Altemus, 2010) [2]; it is likely that the continuation of this hypothesized link between female hormones and mental disorders is due to the residual effects of the influence of patriarchy in psychiatry.

Views on the nature of mental illness remained largely unchanged through most of the 19th century. That is, that women's mental illness was primarily a (dys) function of menstruation and reproductive functions (Kirchengast, 2016) [20]. A good example of this view is found in a lecture to the London Anthropological Society in 1869 by James MacGrigor Allan. In his lecture, Allan attributed women's "languor and depression," "inconsequent conduct...petulance, caprice and irritability" to "menstrual excitement" (Kirchengast, 2016) [20]. These qualities, argued Allan, made women unsuitable for physical or mental labor, or any other socially responsible role, including education and voting (Kirchengast, 2016) [20].

Twentieth and Twenty-First Centuries

In the early twentieth century, women's reproductive systems continued to be seen as the source of female mental problems; many 19th and early 20th century antifeminists, psychiatrists, and psychologists believed reproductive dynamics and organs caused female insanity (Kirchengast, 2016) [20]. In 1900, German neurologist Möbius published his infamous book *On the Physiological Idiocy of Women,* defending maintenance of social order and affirming what he saw as the dangers of women's emancipation (Loh & Coeckelbergh, 2020) [23]. Likewise, in 1903, Austrian philosopher Weininger called hysteria "the organic crisis of the organic mendacity of women" (Kirchengast, 2016; Tanabe, 2019) [20, 38].

Sigmund Freud developed the theory that hysteria was rooted in unconscious emotional conflicts rather than weak nerves (Women and Psychiatry, n.d.). Unlike Charcot, Freud listened carefully to patients and recorded what they discussed, seeking clues to their symptoms (Women and Psychiatry, n.d.). One early patient, Bertha Pappenheim (Anna O), called this the "talking cure" (Women and Psychiatry, n.d.). It became a nickname for psychoanalysis (Women and Psychiatry, n.d.; Jumer, 2019) [18]. Freud greatly shifted the explanation of hysteria from being caused

by not conceiving to the reason for a lack of conception (Women and Psychiatry, n.d.). He attributed hysteria to the Oedipal complex - a daughter's repressed sexual feelings for her father (Breggin, 1991) [10]. If these repressed feelings were not addressed, a woman would experience diminished libido and hysteria (Breggin, 1991) [10]. As other scholars began building on Freudian theory (including psychosexual stages), mental health treatment of women focused progressively more on sex (Jumer, 2019) [18]. Freud believed that as young girls mature, a transfer occurs in their erotic zones from clitoral to vaginal; many mental health professionals subscribed to this theory (Jumer, 2019) [18]. Feminism, lesbianism, and other sexual behaviors outside the norm were also attributed to clitoral sexuality (Jumer, 2019) [18].

In the early 20th century, there was the development of evolutionary psychology and its logical, subsequent extension: evolutionary psychiatry. Grounded in the theory of Darwinian evolution, the new goal was to understand how and why natural selection has resulted in the growing incidence and prevalence of mental disorders (Kirchengast, 2016) [20]. This goal seems especially important given the prediction by the World Health Organization (WHO) that those diagnosed with major depressive disorders were expected to account for the second greatest number of disease victims worldwide in 2020 (Kirchengast, 2016) [20]. The question for Darwinian psychiatry was: In what ways can mental disorders be considered a form of adaptation? (Kirchengast, 2016) [20]. According to Darwinian theory, species evolve – adapt – as a means of perpetuating that species. Human history is the history of adaptation, from hunting and gathering, the development of tools, domesticating animals, and the development of subsistence agriculture which led to the recent development of more permanent settlements (Kirchengast, 2016) [20]. As Kirchengast (2016) [20] observed, much of human evolutionary history was spent as hunter gatherers in small, nomadic groups.

Evolutionary psychiatrists believed homo sapiens were well-suited to this lifestyle and that relatively rapid industrialization and urbanization caused the natural evolutionary and adaptive processes to be overwhelmed (Kirchengast, 2016) [20]. The environment to which our species adapted no longer existed, leading to an array of depressive disorders and dysfunctional adaptations (e.g. disengaging when fight or flight are not viewed as options) (Kirchengast, 2016) [20]. Some psychological research hypothesizes that postpartum depression might be one such adaptation as it can increase participation of women's partners and relatives to care for a child. Similarly, other forms of depression were said to strengthen social networks, not unlike what existed 10,000 years ago (Kirchengast, 2016) [20]. Kirchengast (2016) [20] also explores what others have discussed as the cultural dimension to mental disorders among women. This is not just limited to discussions about reproductive issues, though these still exist in several forms. Women also face lower social status and gender discrimination, leading to increased stigma and stress (Kirchengast, 2016) [20]. A cultural environment which is characterized by gender discrimination and low social status of women increases stigma and may increase mental disorders (Kirchengast, 2016) [20].

Shift to Pharmaceutical Drugs for Treatment

Closer to the mid-1900s, frontal lobotomies, insulin coma therapy (ICT), electroconvulsive therapy (ECT), amphetamines, neuroleptics, and anxiolytic drugs (for anxiety and phobias) were used to treat mental disorders much more often than previously. Psychoactive drugs, such as chloral hydrate, bromides, opiates, and paraldehyde, gained popularity as a means for controlling disturbed patients (Moncrieff, 2013) [28]. Such drugs may also have been viewed as preferable by hospital staff, some of whom appear to have experienced guilt from the use of restraints and more brutal methods of control (Moncrieff, 2013) [28].

In the last 50 years, extensive focus on biopsychology, biopsychiatry, and psychoneurology has progressively replaced Freudian, Jungian, and other prominent psychologists' concerns about the psychological and psychiatric importance of human community and human spirit (Breggin, 1991) [10]. In 1990, US mental health systems ushered in the well-advertised "Decade of the Brain": psychiatry's promotional theme used to sell hospital and biological psychiatry to citizens and garner more funds for research on the brain (Breggin, 1991; Moncrieff, 2013) [10, 28]. Psychiatrist and doctoral educator Breggin (1991) [10] noted that the psychiatry residents he instructed were extremely threatened by the suggestion that mental health patients have psychosocial problems for which neurological treatments were likely to be more detrimental than beneficial.

In the 20th century, Freud revolutionized the treatment of mental disorders through psychoanalysis. While his theories of psychosexual stages have been largely discredited, those theories helped to shift the focus from the uterus to the brain as the source of mental disorders (Jumer, 2019) [18]. In 1990, US mental health systems in the US ushered in the well-advertised Decade of the Brain: psychiatry's promotional theme used to sell hospital and biological psychiatry to citizens and garner more funds for brain research (Breggin, 1991) [10]. In the late 20th and early 21st centuries, the psychiatric industry, driven by the desire to keep profits high, expanded their market to many more women by allowing psychiatrists to prescribe drugs to vulnerable and/or unhappy women (Breggin, 1991) [10]; this was enabled by the APA's expansion of diagnostic categories in their *DSM-V* (Ussher, 2013) [41]. Many of the psychiatric drugs, however, caused major long-term damage to patients' bodies and brains, including chronic brain impairment (CBI), organ damage, tardive dyskinesia and other nervous system disorders (Breggin, 2008; Moncrieff, 2013; Moncrieff, 2020) [10, 28, 29]. Other psychiatric treatments still in use included ECT, which experts called the equivalent of an electrical lobotomy, and institutionalization, sometimes without women's consent (Breggin, 1991; Moncrieff, 2020) [10, 29]. Notably, women were more likely than men to be given lobotomizing electroconvulsive therapy (ECT), hospitalized for psychiatric illness with or without their consent, and prescribed brain-altering psychotropic medications, selective serotonin reuptake inhibitors, neuroleptics, anti-psychotics, highly addictive drugs (including sedatives and benzodiazepines), many of which cause the aforementioned physiologically damaging effects (Moncrieff, 2013) [28].

During this period, substantial numbers of parents and teachers surrendered responsibility for education and care of children to mental health facilities and/or professionals when problems arose in school or home (Breggin, 1991) [10]. Millions of children ended up on legal psychiatric drugs and/or in inpatient or outpatient psychiatric facilities

(Breggin, 1991) [10]. Substantial numbers of adults and children were saddled with a false conviction that their brains had "crossed wires" which would last their whole lives in the form of "biochemical imbalances" and genetic defects (Breggin, 1991, p. 17) [10]. Many adults, a majority of whom were female, whose personal problems were formerly solvable via non-chemical means, ended up locked up in mental hospitals, taking psychiatric drugs, receiving shock treatments, or combinations of these (Breggin, 1991; Busfield, 1982) [10, 13]. Untold numbers of elderly people, most often in nursing homes, were shocked till they became oblivious and/or drugged unnecessarily, rushing them to premature deaths (Breggin, 1991; Moncrieff, 2013) [10, 28]. Additionally, psychiatrists renewed calls for more psychosurgeries, including lobotomies (Breggin, 1991; Moncrieff, 2013) [10, 28]. Droves of people experiencing homelessness were forced into state mental hospitals and, though mental hospitals had improved since earlier decades, they were still dreadful (Breggin, 1991) [10].

Organized psychiatry became increasingly dominated by pharmaceutical industry interests and developed dependence on pharmaceutical industry contributions for survival (Breggin, 1991, p. 17) [10]. Subsequently, millions of US citizens endured the brain damage caused by electroshock treatments, lobotomies, and psychiatric drugs while the psychology and psychiatry professions consistently denied that this was happening (Breggin, 1991; Moncrieff, 2013; Moncrieff, 2020) [10, 28, 29]. Two-thirds of psychiatric electroshock patients were women (Breggin, 1991) [10].

Diagnostic and Statistical Manual (DSM)

Attempts to classify mental disorders in the U.S. started with the 1840 census by recording the incidence of "idiocy" and "insanity" (APA, 2020) [5]. Four decades later, the census included seven categories of mental disorders (APA, 2020) [5]. During this time, the APA collaborated with the New York Academy of Medicine in 1921 to develop the first true mental illness classification system published in the American Medical Association's Standard Classified Nomenclature of Disease (APA, 2020) [5].

In 1952, the APA published the first edition of their *DSM,* modeled after the WHO's sixth edition of the *International Classification of Diseases (ICD);* it included criteria for 128 hierarchical categories of mental disorders and the U.S. Army's classification system to help treat male veterans of World War II (APA, 2020; Blashfield *et al*., 2014) [5, 7]. Notably, it was applied to women as well as men. This development of diagnostic criteria, first applied through the US Census in 1840, led to the development of the *DSM*. Over the next 180 years, the *DSM* evolved and expanded from 132 pages and 128 diagnoses to the most recent edition with 947 pages and 541 diagnoses (Blashfield *et al*., 2014) [7]. The new *DSM-V*, subscribed to by most U.S. mental health professionals, prescribed extreme biological treatments (e.g., lobotomies, electric shock treatments, brain-damaging drugs and long-term institutionalization) for the disorders most typically attributed to women (Breggin, 2008; Moncrieff, 2013; Ussher, 2013) [11, 28, 41]. These included, but were not limited to, lobotomy, electroconvulsive therapy (ECT), and many types of psychiatric drugs that are now considered dangerous (Breggin, 2008; Moncrieff, 2013; Moncrieff, 2020) [11, 28, 29].

British psychiatrist Stengel analyzed psychiatric classification systems worldwide; he found most countries had their own classification system and some had multiple systems (Blashfield *et al*., 2014) [7]. Given this diagnostic multiplicity, he proposed a universal psychiatric classification system be adopted by all countries. Stengel's review prompted the *DSM II*; it includes 193 categories, only 120 of which were defined (Blashfield *et al*., 2014) [7].

Much more explicit diagnostic criteria appeared in the *DSM-III*, published in 1980 (APA, 2020). Its system of 228 categories of mental illness was multiaxial, insisting that each patient be diagnosed along five distinctly defined axes (Blashfield *et al*., 2014) [7]. Table 2 shows *DSM-III* substantially increased revenue generated for the APA (Blashfield *et al*., 2014) [7].

Table 2: Description of the Editions of the Diagnostic and Statistical Manual of Mental Disorders

Edition	Publication Date	Number of Pages	Number of Diagnoses	Revenue for the APA
DSM-I	1952	132	128	Unknown
DSM-II	1968	119	193	$1.27 million
DSM-III	1980	494	228	$9.33 million
DSM-III-R	1987	567	253	$16.6 million
DSM-IV	1994	886	383	$120 million
DSM-IV-TR	2000	943	383	Unknown
DSM-5	2013	947	541	Unknown

APA produced more detailed criteria for diagnosis in 1987 in the *DSM-III-R* (APA, 2020). Seven years later, the *DSM-IV* was published, with each subsequent edition generating progressively more income for the APA (APA, 2020; Blashfield *et al*., 2014) [5, 7]. Over a decade later, the current *DSM-V* was published. Importantly, as discussed later in this paper, the *DSM-V* lists criteria used to diagnose; no actual biological, chemical, or genetic test exists to diagnose mental disorders (APA, 2020) [5].

As shown in Table 2, the APA has not made all its financial records regarding the *DSM* available to the public (Blashfield *et al*., 2014) [7]. This includes reporting any honoraria and royalties paid to individuals and groups involved in *DSM* editions as well as funds from pharmaceutical and/or other companies that stand to experience a financial impact due to *DSM* decisions (Blashfield *et al*., 2014) [7]. Doing so would alleviate suspicions that financial decisions played a significant part in *DSM* diagnostic criteria (Blashfield *et al*., 2014) [7]. Importantly, "many *DSM-5* task force members reported financial ties to pharmaceutical companies" (Blashfield *et al*., 2014, p. 44) [7].

Medical types of diagnostic labels taken from the *DSM* were and are applied to women and men in mental health settings as standard practice (Moncrieff, 2013) [28]. Many psychiatrists diagnosing patients based on the guideline-driven, medical model prescribed by the *DSM* showed little regard for the circumstances and/or personal history of women and men being treated (Moncrieff, 2013) [28]. A primary use of *DSM* diagnostic concepts in the U.S. is translating them to corresponding ICD codes for insurance reimbursement (Blashfield *et al*., 2014) [7].

Discussion

Historically, women have experienced mistreatment by mental health systems. The differences in the incidence of emotional/behavioral symptoms and prevalence of mental disorders between men and women is multifaceted. Clinical

psychologist Ellen McGrath characterizes risk of the emotional and behavioral symptoms that allow for easy psychiatric diagnosis of mental illness as a consequence of "being female in our contemporary culture" (Breggin, 1991, p. 319) [10]. Many of the factors that put women at risk are cultural and socioeconomic. Women who are employed full time earn approximately 75% as their male counterparts and are much more at risk to live in poverty: 14.2% of women aged 18 to 64 versus 10.5% for men (APA, 2017) [4]. Over their lifetime, approximately one-third of all women will be victims of physical or sexual violence, or stalking by an intimate partner, including child abuse which directly contribute to the significant difference in rates of Post Traumatic Stress Disorder (PTSD) (APA, 1990; APA, 2017) [6, 4]. Women are far more likely than men to be caregivers (65% v. 35%) and spend 50% more time providing care, contributing to stress (APA, 1990; APA, 2017) [6, 4]. As a result of gender socialization, women are more likely to be pessimistic, have negative cognitive styles and behavior patterns, and to be passive, all of which contribute to a greater focus on depression rather than action (APA, 1990) [6].

Moreover, because women are more likely to ask for help for these problems from medical and mental health professionals (Pattyn *et al*., 2015) [31], they are more likely to receive a diagnosis. The mental health industry often labels women with diagnoses of mental illness because it serves them in terms of continued profits, maintenance of business operations regarding client caseloads, status, and power. This is not always intentional on the part of participating mental health professionals and family members/husbands, who sometimes wield patriarchal power over female mental health patients in the name of doing what they believe is in the patient's best interest. As for mental health associations, related for-profit companies and patriarchal institutions that participate in this harmful, often life-robbing process, the research of doctors Breggin, Moncrieff & Ussher reinforce the findings of this research data: such institutions are fully aware of the cumulative, often irreparable physiological, psychological, and neurological damage caused to mental health patients by years of harmful psychiatric treatments and/or institutionalization.

Due to women's lower-class status, it was and is easy for those with a vested interest in controlling women (financially and otherwise) to do so via mental health systems. For many women, those with a vested interest in controlling their disturbing emotional and behavioral problems and/or resulting financial gains include but are not limited to the following: psychiatric associations, mental health associations, mental health institutions, psychiatrists, some other types of mental health professionals, such as: psychiatric nurses, inpatient and outpatient psychiatric staff, husbands, and family members. For these reasons and others cited in this paper, the cumulative body of research supports the contention that women have historically been and continue to be mistreated in the context of mental health systems in various ways and to a significant extent. From 5000 B.C. through the 19th century, such mistreatments have included forced institutionalization, marginalization, and stigmatization. From the 20th century until today, mental health mistreatments have included frontal lobotomy, electroshock therapy, institutionalization (voluntary or against women's wills), discrimination, objectification, more stigmatization and marginalization, brain-damaging medications (including those that cause CBI, intestinal damage, tardive dyskinesia, and other long-term effects) and chemical control. Based on these findings, the hypothesis that women have been severely mistreated by mental health systems has been sufficiently supported, at least for those who perceive or experience such mistreatments to be severe.

Based on the cumulative research data, it appears unlikely that reasons women are diagnosed with mental illness are due to bona fide mental diseases. Instead, past studies and evidence point to negative emotions and behaviors sourced from women's social and economic inferiority, cultural and economic oppression and repression, as well as familial/spousal/institutional abuse (among other common socio-cultural problems). Although women do appear to have and express more emotional problems, these are more likely to stem from how they have been treated in their families and in society (Moncrieff, 2013) [28]. As such, their feelings and resulting behaviors seem justifiable and not necessarily caused by actual mental illness (i.e., psychological, neurological, or physiological defects). Whether the majority of diagnoses are based on justified emotional problems caused by their respective socio-cultural histories and socio-economic status rather than a biological defect, as mental health professionals imply and/or verbally confirm when they bestow stigmatizing diagnoses of incurable mental illness upon women, is unclear and unproven. This concurs with historical research about the mistreatment of women in every historical time period described above where diagnostic labels played a major role in the facilitation of psychological and psychiatric mistreatment. Additionally, there is insufficient evidence of actual mental disease among women during any of the historical time periods since 5000 B.C.

Consider the large number of APA psychiatrists who wrote diagnostic criteria for the *DSM* diagnoses typically applied to women while simultaneously receiving funds from psychiatric drug companies. These psychiatrists could have had a vested interest in making sure women and their health insurance companies continually purchase psychiatric drugs that may be used to treat the same diagnoses for which the pharmaceutically funded APA members wrote respective pharmaceutical treatment plans; in turn, this could have added bias when developing psychiatric treatment plans for women's diagnoses given the potential for pharmaceutical sales as opposed to medical and psychological science. From the historical review, it appears that some of these treatment plans may not have been designed to help women with emotional problems. Instead, they contributed to the profit gained from the mental health industrial complex, most of which is comprised of psychiatrists, psychiatric organizations and institutions, and Big Pharma.

Further, it may have historically been advantageous for mental health professionals, organizations, related businesses, and government organizations to have potential mental health consumers believe that a majority of women are mentally ill in ways that their emotions and behaviors need to be controlled, often via involuntary or coerced treatment, lobotomizing medications, insulin coma therapy (ICT), lobotomizing ECT, and/or institutionalization at inpatient and outpatient mental health facilities. Those who consistently profit from the acceptance of these ideas by women include: psychiatrists, mental health associations (e.g. APA), government organizations that receive funding

from profitable mental health organizations (e.g. NIMH), public and private mental health institutions (inpatient and outpatient), Big Pharma, suppliers of medical and psychiatric equipment, neuropsychologists, mental health nurses and staff, the medical industry, and others.

Consumer watchdogs who work in mental health, including psychologists and psychiatrists whose work contributed to the body of research, have produced clear evidence of many such financial conflicts of interests, as well as evidence of psychiatric drug studies that were purported to be objective and impartial, yet were instead highly subjective in favor of respective financial connections, complete with distortions and omissions of crucial study data in ways that experts say have allowed sales of psychiatric products and services that have been shown in newer studies to cause severe long-term damage to brains and bodies (Breggin, 1991; Moncrieff, 2013) [10, 28]. This finding is well-supported by research studies cited in the publications of mental health industry experts which provide substantial evidence for the many ways pharmaceutical and psychiatric companies and supposedly non-biased psychiatric researchers have succeeded in avoiding and denying financial, physiological, and psychological truth of psychological and psychiatric damage on a mass scale (Breggin 1991; Moncrieff 2013; Ussher 2013) [10, 28, 41].

The results of this research support the findings of Leonard Roy Frank: author, editor, publisher, psychiatric survivor and activist, and co-founder of the Network Against Psychiatric Assault (From the files of Leonard Roy Frank, n.d.). His research on U.S. psychiatric treatments and the experiences of hundreds of psychiatric survivors found that mental health systems were rarely systems of health or healing; instead, they were systems of social medical control based on fear, fraud, and force rather than on actual medical science (Weitz, n.d.). According to this research, Frank's findings and the findings of other anti-psychiatry researchers and doctors have been relevant for women diagnosed with mental illness from historical times to the present.

Theoretical Explanations

If one were to apply theory to explain the mistreatment of women in mental health systems using a grounded theory approach – that is, collect data over several thousand years and analyze those data looking for themes to create a theoretical framework to explain those data – the result would be objectification theory, and more broadly, feminist theory. The practice since 2000 BC has been to objectify each woman’s body, reducing her to an object defined by her sexual and reproductive parts. For even longer, women have been dominated and exploited by men; the masculine worldview plus the characteristics and qualities it values have prevailed in most cultures. The very definition of what constitutes “normal” behavior has long been viewed through the lens of masculinity.

In ancient Greece and Egypt, women who did not fit the cultural definition of passivity and inferiority were characterized as hysterical, a term first coined by Hippocrates, which means uterus in Greek. Given the patriarchal orientation of medicine, the obsession of defining women in terms of their uterus has dominated psychiatry well into the 20th century. For centuries, physicians attributed any behavior considered non-feminine to be linked to women’s reproductive organs. In the Victorian era, any form of emotional disturbance – broadly defined – was attributed to hysteria. Husbands who found their wives to be an irritation or an inconvenience could have them locked away in an asylum. Hysterical women were imprisoned and executed in Salem, Massachusetts.

Throughout the 19th century, lack of understanding of mental illness continued to objectify women as little more than flawed uteri. Women continued to be institutionalized for hysteria, with the etiology always linked to problematic sexual and reproductive parts. Locking women in asylums and administering brain-damaging psychiatric treatments, often against their wills, was not only stigmatizing; it was a dehumanizing human rights violation. Accounts from Elizabeth Packard and journalist Nellie Bly reveal how easy it was for doctors and staff – and society in general – to see women as less-than-human: mere objects who were not worthy of compassion or care. Freud’s theory of psychosexual stages shifted the focus away from the uterus, but not very far: he instead attributed the so-called tragedies of lesbianism, feminism, and non-normative sexual behavior to clitoral sexuality.

Objectification theory also helps explain many current differences in the prevalence of mental illness diagnoses of men vs. women. For the reasons denoted in the above research data as well as the fact that “being female in our contemporary culture” places women at risk for being diagnosed with mental illness (Breggin, 1991, p. 319) [10], women are constantly objectified by the dominant, masculine culture. Females are socialized in a culture in which the media portrays women as weak, submissive, inferior, sexual objects; as females develop their gender identity, receive these messages countless times daily from the media and all those who communicate with them. As objectification theory suggests – similar to the process of theory’s secondary labeling – these messages are internalized, and females learn to judge their value against impossible social and cultural standards.

The misdiagnosis of women with various mental disorders could historically have been done to gain and maintain social and economic power over women, as discussed by other authors. Those in power and those who wish to profit (financially and otherwise) by gaining and maintaining power over women who present an emotional or social challenge cite women’s justifiable emotional difficulties and subsequent emotional expressions and behaviors as proof of what they may label or perceive as mental disease. Based on the work of Breggin, Moncreiff, Whitaker, journalist Nellie Bly, Ussher, and many other professionals, there is no logical or scientific basis or evidence for such diagnoses. In fact, these doctors, mental health experts, and professionals and many others cite evidence to the contrary. Moreover, they pinpoint the source of women’s emotional difficulties as sociocultural and economic: patriarchal systems, which did not allow women to express themselves except in designated, acceptable ways, and in expected roles.

Historically, patriarchy has been a component of the United States mental health systems. Today, a majority of these are notably influenced in part by the APA, whose male dominated *DSM* task groups (Blashfield *et al.*, 2014) [7] wrote diagnostic criteria into current and past psychiatric manuals in ways that did not benefit women (Ussher, 2013) [41] but instead could have contributed to addiction to psychiatric medications and other negative treatment effects. While the literature also suggests that men generally have

more stigmatizing attitudes compared to women toward accessing mental health services, including having open conversations with their medical providers about their emotions (Pattyn, 2015) [31], the formation of these attitudes may be deeply rooted in centuries long history of patriarchism. Methods for keeping women in psychiatric bondage have included involuntary commitment to asylums, frequent involuntary treatments at outpatient mental health facilities, insulin coma therapy (ICT), surgical lobotomy, electrical lobotomy (via electroshock "therapy"), and the most popular contemporary treatment: chemical lobotomy via brain-damaging psychiatric drugs, coercion, force, and/or brainwashing used to ensure women will ingest antipsychotics, restraint drugs and other neuroleptics, sedatives, anxiolytics and others: most often combinations of several types of dangerous psychiatric drugs simultaneously (Breggin, 2008; Moncrieff 2013) [11, 28].

This research supports the idea that women often have historically become products of patriarchal mental health systems due to the social, cultural, emotional, and economic incentives for gaining power over women that abound in most societal institutions, as they have since ancient times. These include, but are not limited to: profits from pharmaceutical companies; profits from health insurance companies; the intentions behind using women's expressions of negative emotions; gaining control or domination over women who have hurt or posed a challenge or threat to a husband, family member, or patriarchal institution; the ability to dominate or practically dispose of women who don't conform to gender or societal roles; and the ability to avoid dealing with women's sometimes difficult emotional expressions.

The results are broadly recognized for those that have experienced these historical mistreatments: a sense of helplessness and inferiority, the tendency towards passivity rather than assertiveness, making choices that can lead to physical and sexual violence and staying with her abuser, and many more. All these consequences may place women at greater risk for symptoms of and/or mental health industry diagnoses of anxiety disorders, depression, PTSD, eating disorders, and sleep disorders.

Strengths and Limitations

This study is one of few studies that presents a historical analysis of women's experiences with mental illness, seeking help and receiving treatment. The evolution of these experiences are drastically evident as a result. Second, findings can generally be useful for any entity or mental health system nationally due to the wide range of studies examined in various regions and at different points in time. This will provide any mental health care professional or stakeholder with evidence to improve their current delivery of care and builds increased urgency to advocate for policy change that will provide for more equitable treatment for women compared to men.

Limitations include the quantity, quality, and currency of research available on the treatment of women in mental health systems. However, a greater limitation is the need to focus on a limited number of sources. It is likely that there may be additional, more influential publications which were not included in this historical review. It is also important to note that, except for some historical references, this research is limited to the United States. This research also does not provide extensive comparisons to the treatment of men in mental health systems - an important topic, but one that is beyond the scope of this review. This review is broad and captures research that reports negative mental health experiences among women generally; it may not be relevant or relatable by every person that identifies as a woman.

Implications and Future Directions

This historical review supports the hypothesis that women, historical and contemporary, have often been misdiagnosed and treated with mental illnesses. The emotional and behavioral symptoms most exhibited, often due to sociocultural and economic oppression and repression, familial and spousal abuse (commonly since childhood), their inferior status, and other problems they dealt and deal with in patriarchal societies (including forced servitude/subservience to husbands, family members, and/or patriarchal institutions) contributed to the notion that they had the popular mental illness of the day and age. Implications of this research include the reinforcement of the negative impact on women of patriarchal social, political, and economic systems has continued to exploit and marginalize women in more recent centuries. Mental health systems are an additional institutionalized form of oppression that seek to maintain and consolidate power among those currently in power. This research reveals the importance of exposing the widespread and multifaceted objectification of women in our society and the insidious impact it has on the socialization and development of girls and women.

Solutions include cessation of psychiatric diagnoses of neurochemical imbalance on the basis of written and or verbal questionnaires, given that prospective patients' answers could be influenced by passing emotions, hormonally influenced thoughts/feelings, circumstantial events, and/or a history of trauma, abuse, and addiction. Instead, appropriate medical testing, including MRI or equivalent brain scans, is recommended to be performed to determine brain chemistry before diagnosing each patient with chemical imbalance (i.e., mental illness), considering the brain-damaging effects of typical psychiatric treatments (Breggin, 2008; Moncrief, 2020) [11, 29]. Additionally, rather than immediately advising and prescribing potentially dangerous psychiatric drugs based on the idea that patients' subjective written test results suggest severe mental illness, psychiatric professionals should provide and explain brain scan (e.g., MRI) results and available options objectively to each patient. Moreover, it is ethically incumbent upon them to inform each prospective psychiatric patient of potential short and long term cognitive and physiological effects of treatments. These medically-just practices have never been required and have rarely been implemented; nor have psychiatric professionals been trained or equipped with the necessary information to do so. Respective mental health policies and objective psychological brain scan training should commence at both educational and professional institutions. Additionally, medical professionals need to be thoroughly trained in psychiatric drug withdrawals, as opposed to the currently common practice of informing patients that such withdrawals evidence their need for psychiatric treatments in order to function (Moncreiff, 2020) [28]. Rehabilitation centers for patients withdrawing from psychiatric drugs should be readily available in every region that dispenses psychiatric drugs. Some European nations currently have such facilities available to their citizens, and

the U.S. has at least two (Residential Treatment Centers, 2014) [33]. However, most countries where addictive psychiatric drugs are prescribed do not.

Medical insurance companies have historically supported psychiatric institutionalization and mistreatment of women on a large scale and at a monumental cost. It is worth exploring whether these treatments were medically justified, given that they were based on verbal and written tests used to prove neurochemical imbalances and various DSM diagnoses of mental illness. Insurance companies stand to gain significantly by changing their medical coding to exclude all diagnoses that are not scientifically justified via bonafide chemical imbalances shown in MRI or other brain scans. This cost savings will be significant even when insurance companies pay for beneficiaries' brain scans, considering the majority of psychiatric insurance funds currently pay for repeat psychiatric and psychological practitioner visits, psychiatric medications, tests to check safety of blood or urine levels of these medications, various psychiatric treatments/therapies, and or institutionalization.

By ceasing their support of the patriarchal and socio-economic institutions that control women via psychiatric diagnoses that are not scientifically based, insurance companies have the power to change dynamics of traditional mental health treatments used to limit women's ability to express their thoughts and feelings and stand up for their human and civil rights. As mentioned, such treatments include electroshock therapy and psychiatric drugs that cause cognitive brain impairment (CBI) and numb emotions, severely limiting women's voice, mental capacity and motivation (not to mention their motor and coordination skills, proper functioning of their intestines, kidneys, and heart, depending on the psychiatric treatment).

Equally important are FDA-mandated, objective randomized controlled trials (RCTs) for the typical length of time patients are medicated for (e.g., two years), rather than the current standard of 10-to-12-week studies. Many prior studies of psychiatric medication conducted by the pharmaceutical companies who hold the patent on these medications have been shown to be subjective (Moncreiff, 2013) [29]. As such, RCTs should be conducted by objective medical researchers rather than the same pharmaceutical companies which stand to gain from FDA approval of the psychiatric drugs(s) being studied, as is the current practice. For instance, under current FDA standards, psychiatric drugs such as Xanax would no longer pass FDA standards for safety; instead, this and other approved psychiatric drugs would now be classified as highly addictive/unsafe (Breggin, 1991) [10]. Their previous FDA approval may have had pharmaceutical industry's influence to push the FDA for approval for political reasons that are not aligned with scientific evidence; often, politics prevailed over science at the time of their FDA approval. (Breggin, 1991) [10]. Since FDA standards have become more stringent, currently approved psychiatric drugs should undergo additional testing to meet these new FDA standards. Instead, they continue to be allowed under a legal grandfather clause, unbeknownst to citizens.

Although the cost of training physicians, psychologists, and nurse practitioners, to disclose both short and long-term effects of each psychiatric treatment, training mental health professionals in psychiatric drug addiction and withdrawal treatment, and the results of long-term studies/RCTs would be high it would spare countless mental health patients from the long term cognitive and physiological effects of psychiatric treatments. These include, but are not limited to brain damage, intestinal, kidney, and heart damage, as well as impairment of balance, motor skills, and coordination. Additionally, insurance companies and patients would no longer need to pay for institutionalization, mental health practitioner visits, and various psychiatric tests and treatments, resulting in more immediate cost savings on a large scale. Women and former psychiatric patients who have mental/emotional problems could receive great psycho-social benefits, at low cost or free, from 12-step fellowships and psychological groups. Additionally, various types of psychological therapies, social groups, and naturopathic practitioners can facilitate beneficial emotional, behavioral, cognitive changes for a financial fee; such fees should be covered by mental health insurance, given that they will not cause the long-term physiological or cognitive damage and/or trauma that psychiatric treatments and mental institutionalization have been shown to. In these ways, all of the above will result in a net cost savings to health insurance companies. These actions would not only address psychiatric mistreatment and oppression of women; they would greatly reduce psychiatric mistreatment and oppression of all those who have been diagnosed or misdiagnosed with mental illness, including men, transgender individuals, and minors.

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