MAKING WOMEN MAD: Women, Crime and Madness

Denise Russell

Sexist assumptions pervade the areas of psychiatry and criminology, and they have an important influence in reinforcing sex-role stereotypes in general. These sexist assumptions also speak specifically to the women's movement when feminists are branded as irrational, and as responsible for the increase in the type and amount of crimes committed by women.

Steven Goldberg, in *The Inevitability of Patriarchy*, attacked feminists for their supposed irrationality:

The alacrity with which feminists invent some 'facts' and reject or accept others on the basis of their emotional appeal is illusion in the guise of intellectual investigation. Invocation of this illusion as rationalisation is self-indulgence parading as virtue. There is no doubt that American society demands some new answers quickly. But the readiness of increasingly large numbers of radicals to translate nearly any new idea immediately into action does not demonstrate rational response not even pragmatic desperation but betrays an emotional development so stunted that they are forced to navigate life on one engine.

Also relevant are some recent studies which reveal that "left-of-centre" political deviance is regarded by mental health workers as more indicative of maladjustment when the purported parent is female than male.

Not only are feminists accused of irrationality or maladjustment, there is also a growing assumption in writings on criminology that the
women's movement is a threat to the stable character of female criminality. This was put quite nicely by a Sydney veteran detective commenting on Sydney's first all-female bank robbery in June this year. (In every other case recorded, women bank robbers have worked with a male accomplice.) He said "It's a new fashion and a sign of the times — anti-male discrimination.

My emphasis will be on sexist assumptions that relate to notions of women's sanity or insanity or criminality — not because the other areas such as treatment are not important but because time considerations force me to limit the field.

Firstly, sexism comes into definitions of mental health in women. Numerous psychological studies have pointed out that what, in the West, is generally regarded as the woman's role, happens to coincide with what is regarded as mentally unhealthy. This relationship appears to hold for people unconnected with mental health work and for professional mental health workers. Broverman et al., in a 1970 paper, reported on a study done with a group of 79 clinicians: psychologists, psychiatrists and social workers. They found that the clinicians strongly agreed on the behaviours and attributes which characterise a mentally healthy man, a mentally healthy woman, or a mentally healthy adult independent of sex. The descriptions of a healthy adult independent of sex closely matched the description of a healthy man but not that of a healthy woman. This confirmed the notion that a double standard of health exists for men and women, i.e. the general standard of health is actually applied only to men, while healthy women are perceived as significantly less healthy by adult standards. Clinicians are significantly less likely to attribute traits which characterise healthy adults to a woman than they are likely to attribute these traits to a healthy man. These differences parallel the sex-role stereotypes in the West and also relate to what is socially valued. According to the Broverman study healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking maths and science. In general, these are traits that are devalued and, hence, the authors argue, the judgments involve a powerful, negative assessment of women.

These results were confirmed in a study reported in 1972 involving 982 subjects, both men and women, married and single, from different age groups and education and religious backgrounds. Such studies reveal that women are caught in an impossible situation. If a woman breaks out of the female role she may be regarded as mentally unhealthy as she is not fulfilling her role, but if she stays within the role she may be regarded as mentally unhealthy on an adult standard.

The Broverman studies have been criticised, but their general direction and tenor have been supported in later research. Some authors have made particular mention of the "Catch 22" situation that exists for women: "The very state of being a woman, it has been argued, contains so many contradictions and so much suffering that what appears as deviant behaviour is, in fact, an unwillingness or an inability to fit the oppressive stereotype of health." As Marcie Kaplan suggests, the double bind that exists here could itself drive a woman crazy. Other research has indicated that biases relating to class, skin colour, or sexuality may interact with a sex-role bias.

A variety of explanations has been proposed for the existence of different attitudes towards the mental health of women and the mental health of men. Such explanations try to give an answer to the question of why sex roles are the way they are. There is no space to do justice to these issues here. One interesting approach appeals to the early relationship between mother and child with the need for males to reverse their early helplessness and dependency on a powerful female object. This may be tied in with fantasies about women's destructive power. Sexism also comes into definitions of mental ill-health. Studies made prior to 1980 showed that women who are performing well in the female role by revealing emotional responsivity, naivete, dependency and childishness could have been subject to the diagnosis of hysteria.

In 1980, a new diagnostic scheme was accepted by most western countries — Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III). It has dropped the label of "hysteria" and replaced it by "Histrionic Personality Disorder", a disorder which is mainly diagnosed in women. We can compare the elements of the description of this disorder with the description of a mentally healthy woman that emerged from the Broverman studies and a very close overlap is revealed.

**DSM-III descriptions**

- self-dramatisation, e.g. exaggerated expression of emotions
- overreaction to minor events
- irrational, angry outbursts or tantrums
- vain and demanding
- dependent, helpless, constantly seeking reassurance

**Broverman et al. descriptions**

- being more emotional
- more excitable in minor crises
- more excitable, more emotional
- less objective
- more conceited about their appearance
- more submissive, less independent, less adventurous, more easily influenced

It would seem then that if we make it as a mentally healthy woman we are simultaneously fitting the diagnosis of "Histrionic Personality Disorder" —
i.e. a form of mental ill-health; or if we are not caught by that, there are two other diagnoses, in the new Scheme, which are also supposed to apply mainly to women and which also seem to be very close to the descriptions clinicians accept of "mentally healthy women". These are the borderline personality disorder and the dependent personality disorder. The "borderline personality disorder" is characterised by "instability in a variety of areas, including interpersonal behaviour, mood and self-image. No single feature is invariably present". Part of the definition of a mentally healthy woman was that she was "more emotional, more excitable, and more easily influenced". "Instability", the defining mark of "Borderline personality disorder" might not differ from these features that characterise a mentally healthy woman.

There are similar problems with the dependent personality classification. This diagnosis is supposed to apply to a person who passively allows others to assume responsibility for major areas of her life because of an inability to function independently; one who subordinates her own needs to those persons on whom she depends in order to avoid any possibility of having to rely on herself and one who lacks self-confidence perhaps regarding herself as helpless and stupid. This description is also very close to the description given of a mentally healthy woman.

Marcie Kaplan elaborates on the subjectivity of the description "dependent personality disorder", pointing out three major assumptions: (1) that dependence is unhealthy; (2) that extreme dependency in women marks an individual dysfunction rather than merely reflecting women's subordinate social position; and (3) "that whereas women's expression of dependency merits clinicians' labelling and concern, men's expressions of dependency (e.g. relying on others to maintain their houses and take care of their children) does not". She challenges these three assumptions. The head of the team who designed the new diagnostic scheme, Robert Spitzer, has responded, quite inadequately, by merely pointing out that the description is open enough to cover dependency in males as well as in females. This argument concerns the challenge to the third assumption but it does not counter Kaplan's point that specific male behaviours are often not acknowledged to involve dependency when they are just as good candidates for this description as certain female behaviours. Kaplan's challenge to the first two assumptions is simply ignored.

In summary, it looks as though women are crazy by definition and the leading experts in the psychiatric field are very happy to keep it that way.
leading experts in the psychiatric field are very happy to keep it that way.

Over the last ten years or so there has been a broadening and an entrenching of the assumption that mental illness or mental disorder is biologically based. Yet, in 1986, this assumption still remains speculative in the sense that there is no consistent body of scientific evidence which establishes a biological base for psychiatric disorders other than those where there is some obvious organic fault — such as brain tumours or lesions. I will not go into the argument for this view here, but there are some problems which may be raised with the biological orientation independent of a specific critique of the scientific evidence.

Take, for instance, the category of depression — another diagnosis which is supposed to apply mainly to women. Within psychiatry, depression is individualised. It is treated as an item of individual pathology, very often with a biological base. From an alternative perspective, one may see depression as a manifestation of a social problem. This is not to deny the depressed woman's suffering, but it is to acknowledge that, in order to understand her depression and suffering, we need to examine the social context. There are some present indications that this alternative perspective might have something going for it.

There is evidence that social discrimination against women and the restrictions of the traditional female role are related to the incidence of depression in women. It is more common in married women than in women who have never married, or who are divorced or widowed. Depression is less common in married men than in unmarried men. It appears then that marriage benefits men and harms women. A recent study suggests “that women wishing to avoid depression should not get married,

Open-line programs on the radio ... have made clear the loneliness and frustration of suburban housewives
and confiding relationship with another person and, if possible, be part of the middle class."12

Information about the Australian context is also in line with these findings. Open-line programs on the radio, at least since the 1960s, have made clear the loneliness and the frustration of suburban housewives. A university survey, conducted in three states in 1969, showed that housewives suffer more emotional disorders than any other occupational group, accounting for 83 percent of cases detected in the survey.

In 1971, a newspaper report on women who married and moved to the newer suburbs around Sydney claims that a very high proportion began to suffer "neuroses" and even more severe "mental breakdowns" within a year of moving house. This was put down to dissatisfaction with the life of home and children when other social contacts were minimised. Profound insights such as "Man is a social animal, and so is his wife" and "The devil makes work for idle minds" were uttered by Dr. Barrow, the psychological writer in The Sun (Sydney). In a study of suicide attempts in the western suburbs of Sydney in 1971, women outnumbered men two to one. Nearly all were married and in the 21-40 year age group. The suicides were attributed to loneliness and other problems in the marriage.

A survey conducted by the National Health and Medical Research Council in 1971, the most extensive study of problems of "mental health" to that date, revealed that doctors treated twice as many housewives for barbiturate and related poisonings than they did professional, managerial and clerical workers. (Barbiturates were used as tranquilisers.) Dr. Adams of Sydney University's School of Public Health and Tropical Medicine, said: "This might be taken as a measure of deteriorating mental health in Australian housewives". A study in Victoria in 1971 also showed that housewives have a higher rate of psychiatric disorder than other occupational groups.

Another large study conducted in 1980 covering 37,678 adults, conducted by the New South Wales Health Commission and Medicheck, came up with the following findings: Twice as many housewives as women with jobs outside the home have nervous breakdowns; one woman in 12 and one man in 20 have breakdowns; nervous breakdowns do not seem to be related to men's occupations.

In 1982, a study done in the psychiatry department of the University of Sydney backed up the overseas studies on depression: married women were found to suffer from depression more frequently than single women or than their husbands. Professor Tennant, in reporting on the study, claimed that "it has been well proven in many studies that women have at least twice the level of depression and anxiety neuroses as men". He pointed to the uncertainty about whether this was due to biological or social differences between the sexes. On the basis of his study and large ones in the United Kingdom, he said: "it is apparent that a woman's marital status affects her mental health". Another related finding from these studies is that men benefited from having children whereas 23 percent of women with children had depression problems, compared with 11 percent of women without children. Professor Tennant remarks, "Of course, kids aren't toxic in their own right. They are toxic in that they stop a woman having employment outside the home". All these findings suggest problems with the social role of women.

Research recently completed by Moffitt, a South Australian psychologist and Eisen, a Victorian psychiatrist, purportedly shows that women with mental problems are more likely to get married than those who do not have such problems; and that once married, the high rate of mental distress appears to fall. If women have such mental problems as depression prior to marriage, then perhaps a key causative factor is not the social role that women are supposed to perform, but rather a biological fault. This research, which is out of line with previous findings, was funded by F.H. Faulding and B.P. Australia. Obviously, further research is needed but, at this point, it is fair to say that the view that madness in women is crucially connected with the female role, has received a fair amount of support.

It cannot be denied that there are problems of depression, of anxiety, of social isolation, of unusual and unwanted experiences and so on, and it cannot be denied that many of these problems surface most visibly in particular individuals; but this is not to say that these problems are centrally located within those individuals. If the above comments on depression are correct then it may be more accurate to locate the problem of madness in the relationship between particular individuals and societal norms and demands. One indication that this might be the right direction to go is the utter failure of individualistic attempts at cure. The standard treatment for depression is drugs with their attendant side-effects. They do not solve the problems. When the person stops taking the drugs the problems reappear; but they act as a temporary blind, marginally decreasing the amount of discontent, so that efforts are not put into changing the broader situation, for example, providing child care, opening up employment for women, changing definitions of women, etc.

In summary, modern psychiatry is saying that there is a biological reality to madness in women. It may be one that is there just by the very fact of being female. Our inherited nature is assumed to channel us into ways of experiencing and behaving which will earn us the label of histrionic personality disorder; or, it may be that the biological fault is posited as specific, e.g. supposed malfunctioning of neurotransmitters as the cause of depression. In either case, the biological reality is unsubstantiated. These directions in psychiatry serve to reinforce sex-stereotypes and, in a particularly dangerous manner, as
they claim scientific respectability and obscure the sexism which imbues most aspects of psychiatry's theory and practice concerning women.

A parallel attack can be made on theories about criminality in women and the rise in popularity of biological explanations. I only have time to give some brief indications of how this would go.

Sexism comes into ideas about women and crime — firstly, in the marking off of certain offences as female offences and, secondly, in the tendency to see the crime as irrational, as going against the female role. These directions, then, serve to reinforce sex-role stereotypes especially if they are linked into biological theories.

There is only one crime which is sex-specific. This is infanticide: when a woman by any wilful act or omission causes the death of her child under one year old because the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child. The reason why this category applies only to women is because of some implied biological cause, but this is in fact still merely a conjecture. I believe the deeper reason for this crime being designated as sex-specific is that it cuts across the supposed maternal instinct.

**Even shoplifting may be seen as emerging from a mental disturbance**

There are some other crimes which are not sex-specific but where female offenders outnumber male offenders. These are shoplifting, prostitution in adults, and promiscuity and “ungovernability” in adolescents. Sexist assumptions pervade the way these crimes are conceptualised in that, if the crime fits the female role, the woman may be regarded as performing a wrong but not irrational act. If the woman commits a crime that goes against the female role, the label of irrationality is applied.

Women shoplifters steal food (usually of little value) and clothes — different things from those which men usually steal — and their actions are quite in accord with women’s role as providers of food and snappy dressers. Thus, their crimes may, in a sense, be validated, though they are seen as crimes nonetheless. Even shoplifting may be seen as emerging from a mental disturbance. In these instances, the woman will be regarded as suffering from kleptomania. Interestingly, in the new psychiatric diagnostic scheme, when describing kleptomania, the authors state, under the heading of “Impairment and complications”: “Impairment is usually due to the legal consequences of being apprehended, the major complication of the disorder” Note how legal notions become medicalised.
The other female offences are invalidated. They break with the female role, and so cannot be the result of a rational mind. This applies to conceptualisations of prostitution as well as to female juvenile delinquency. Prostitution is commonly viewed as a form of sexual aberration — an activity that a woman is compelled to perform because of her mental disturbance, rather than an activity rationally chosen. This is true also of the ideas about the juvenile female crimes.

In a study done of children's courts in New York, it was revealed that if girls committed acts against sexual taboos, or against parents, this was enough to lead the probation officer to assume that psychiatric help was needed, but not so for boys. Reporting on this study, in Women, Crime and Criminology, Carol Smart claims that "This attitude towards female delinquency reflects the commonly held belief that deviancy by a female is a sign of a much deeper pathology than deviancy by a male".14

The fact that promiscuity and ungovernability in adolescents are predominantly female offences is a reflection of attitudes about these activities in boys and girls. Sex bias determines whether promiscuity counts as an offence. It is much more likely to count as one and to be punished by institutionalisation if it is a girl who is promiscuous. A promiscuous boy may not be regarded as deviant at all. Similarly, "ungovernability" may be understood in terms of hostility and violence: features which may either not be regarded as deviant at all in boys or their importance may be played down. Thus again, sex-role stereotypes might influence whether the same behaviour is regarded as an offence or not.

The general tendency to see crime in women as resulting from a basic irrationality or mental disorder has the effect of entrenching sex-role stereotypes; if one is "a real woman" one could not possibly behave like that.

The treatment of women offenders is coming into line with these ideas about their supposed irrationality. For example, recently, the main women's prison in England, Holloway Prison, was turned into a psychiatric institution.

Biological theories have been used to try to explain the apparent irrationality in female criminality. Appeals are made to the true nature of women as passive, dependent beings with a maternal instinct, and then some biological impulse or hormonal imbalance is thought to cause a deviation from that true nature. In line with this, a biological explanation is presented for the lower incidence of crime in women than in men, and to explain why there are no great women criminals.

It is, of course, undeniable that women sometimes commit crimes when they are in a different physiological state than previously, say, after the birth of a child, but we are not forced to conclude that it is the physiological change which has caused the crime. There is a large element of conjecture here and just a little reflection reveals that this conjecture is based on sexism. Similarly, some writers assert that "abnormal chromosomal balance is at the root of female delinquency".15 This is pure invention. There is no scientific evidence for such a claim.

This biological orientation within theories about crime in women and within institutions which treat women offenders, though unsubstantiated, has very undesirable implications. It prevents us from seeing that the very description of the girl or woman as criminal might simply result from sex-role stereotyping, as I tried to show for "female juvenile promiscuity". It prevents us from seeing that explanations of women's crime in terms of social factors might have some plausibility e.g. prostitution may be looked at, not as a result of an abnormal biology, but in terms of certain broad social factors such as the relatively limited opportunities for women to earn a living wage, to win promotion, to achieve a secure career and to become economically independent of men. That orientation certainly seems to lead us into more enlightened directions than biological theories.

In summary, what I've tried to do is to show how certain sexist assumptions currently operate in parts of psychiatry and criminology and within biological approaches in these areas, and I have also tried to show that biological approaches within these areas, although not legitimated, reinforce these assumptions.

---

10. R.L. Spitzer et al., Diagnostic and Statistical Manual of Mental Disorders (Washington, 1990), 321.
13. Spitzer et al., 293.
14. Smart, 133.
15. Smart, 58.

DENISE RUSSELL teaches in the Department of General Philosophy at Sydney University.