Powerlessness, marginalized identity, and silencing of health concerns: Voiced realities of women living with a mental health diagnosis

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ABSTRACT: Using a feminist qualitative approach, this study substantiated many earlier research findings that document how women with a mental health diagnosis experience unequal access to comprehensive health care compared to the general population. Accounts of this disparity are documented in the literature, yet the literature has failed to record or attend to the voices of those living with mental health challenges. In this paper, women living with a mental health diagnosis describe their experiences as they interface with the health-care system. The participating women’s stories clearly relate the organizational and interpersonal challenges commonly faced when they seek health-care services. The stories include experiences of marginalized identity, powerlessness, and silencing of voiced health concerns. The women tell of encountered gaps in access to health care and incomplete health assessment, screening, and treatment. It becomes clear that personal and societal stigmatization related to the mental health diagnosis plays a significant role in these isolating and unsatisfactory experiences. Lastly, the women offer beginning ideas for change by suggesting starting points to eliminate the institutional and interpersonal obstacles or barriers to their wellness. The concerns raised demand attention, reconsideration, and change by those in the health-care system responsible for policy and practice.

KEY WORDS: marginalization, othering, powerlessness, silencing, stigma.

INTRODUCTION

A feminist approach is used in this paper to highlight health challenges faced by women living with a mental health diagnosis. It shares important preliminary information from a feminist qualitative research study in which female participants speak about their experiences with primary health-care services. Shared in the paper are participating women’s voices, their health-care experiences, and their initial thoughts of how health-care services need to change so that their wellness needs can be met. Discussion of the findings is illuminated through the simultaneous mingling with the women’s voices.

The current literature suggests that people with a mental health diagnosis have a higher incidence of chronic illness, comorbidity, and mortality than the general public. The literature highlights gaps in health-care coverage and service provision, which coincides closely with local community practitioners’ experiences. Remarkably absent in the literature are the actual voices of women discussing the challenges of accessing health care.

Background literature is introduced in the paper before situating the study. The impact of stigma is exposed, leading to the uncovering of other ideological factors underpinning health-care practitioners’ everyday practice. Some of the taken-for-granted practices that
affected the women’s health and well-being are raised through their stories, such as the impact of health professionals’ language on the women’s self-understandings, or the way the health professionals relate to the women or to each other and how this shapes the women’s care. In telling their stories, the participating women unveil incidents of marginalized identity, powerlessness, and silencing of their voiced health concerns. These themes surface frequently in their stories and are closely linked to marginalized identity, stigma, taken-for-granted practices, and ‘othering’. The organizational and interpersonal obstacles commonly faced by the women in this study are described in this paper. The women offer insights and starting points for possible remedies to their situation that will assist others with similar challenges when accessing health care.

BACKGROUND

Research, literature, and clinical commentaries conducted over the last 20 years point to how inadequate health assessment and treatment leaves individuals with mental health concerns at greater risk of physical illness, chronic illness, and earlier death than those without a mental health diagnosis (Brugha et al. 1989; Colton & Manderscheid 2006; Farmer 1987; Felker et al. 1996; Harris & Barraclough 1998; Kirby & Wilbert 2006; Koranyi 1979; 1982; McDevitt 2004; Muir-Cochrane 2006; Osborn 2001). Several studies further examine the limited and marginal physical health care provided to individuals with a mental health diagnosis (Chafetz et al. 2005; Osborn 2001; Perese & Perese 2003), noting that ‘blame’ for poor health could be aimed at either the client, the GP, the psychiatrist, and the health-care system, without consideration of context or relational issues.

In spite of the plethora of research, little change has occurred to lessen these inequities (Allison et al. 1999; Brown et al. 1999; Felker et al. 1996; McCreadie & Kelly 2000; Muir-Cochrane 2006; Perkins & Repper 1999). As Goldman (2000) suggests, many other sociopolitical factors may affect health, including the professional’s relationship with the client, a relationship that is underpinned by the practitioner’s ‘health-care view’ of the world. Health-care professionals are frequently deeply enculturated in the medical–empirical lens, a view that only considers physical or psychiatric explanations for mental health concerns (Chesler 2005; Faugier 1992). These common enculturated ways of being include ignoring or silencing a mental health client’s voiced physical health concerns, and the medicalization of sociopolitical problems, such as poverty, decreased access to education, and lack of social supports. As well as assumptions based on stigma, these enculturated ways contribute to women with a mental health diagnosis experiencing poorer physical health than women without mental illness (Currie 1997; Kirby & Wilbert 2006; Morrow 2006; Raphael 2004).

Marginalized identity

Meleis and Im (2002) describe the mark of marginalization as ‘the extent to which they (people) are stereotyped rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around’ (p. 96). Vasas (2005) argues that marginalization is seen as a concept rather than a process; nurses and other health-care professionals will treat people, and in this case, women with mental health challenges, as ‘other’, leaving them on the fringes of health care. This position perpetuates marginality and isolates them from receiving adequate health services. As a consequence of society’s attitudes or stigmatization toward individuals labelled with a mental health diagnosis, they are then seen as incapable of achieving life goals and are affected by what determines their health, such as access to education, obtaining meaningful employment, and connection to family, with support in maintaining their social responsibilities (Corrigan 2004; Raphael 2004).

The Canadian Health and Welfare Agency (Epp 1986) and the World Health Organization (WHO) have stressed the need for health care to be provided to all citizens in an equitable and comprehensive fashion (Kirby & Wilbert 2006; Raphael 2004; Romanow 2002). Decades of research show that healthy populations require policies that address issues beyond medicine and health care to include complex interrelated social, economic, environment, and other factors that determine one’s wellness. These determinants of health (DOH) include gender, housing, education, social relationships, biology and genetic endowment, personal health practices and coping skills, along with other factors impacting wellness (Public Health Agency of Canada 2001).

The WHO (1978; pp. 1–2) states that health-care delivery must not only use ‘scientifically sound and socially acceptable methods and technology’, but also be ‘universally accessible to individuals and families in the community through their full participation . . . at every stage of their development in the spirit of self-reliance and self-determination’. These notions of health delivery nationally and internationally are not new. Earlier critics, such as Fanon (1964), stress that the provision of care to an individual client must also include interventions for the cultural, political, and socioeconomic contexts in which people live. More recently, Canadian writers, such as
Raphael (2004), Morrow (2006), and Smith (1990), have argued that health-care provision has remained the same, especially for marginalized individuals.

In Western society, tensions arise in many women, especially those socialized into a dependent role, yet labeled ‘dependent’ when they ask for help in times of distress (Morrow 2006). In North American society where the general narrative of a ‘self-made woman/man’ is an ideal (Gadow 1996), asking for help is viewed negatively and the person is seen as weak and dependent. Alternatively, the woman who moves ahead independently, risks societal ostracizing for her reluctance to participate in the socially-accepted or expected subservient role (Morrow 2006). As Caplan (1995) notes, health-care professions often medicalize or diagnostically label women whose behaviours are employed to survive their social or economic situation.

Incongruent societal expectations influenced by a patriarchal agenda continue today (Morrow 2006), particularly for disadvantaged women living in developing countries, women of colour in the ‘developed world’ (Hooks 1994), and women who become ill with mental health challenges. Women whose behaviour is viewed in the absence of knowledge about historical events can bear the brunt of stigma. Without a cultural context or explanation to help others appreciate what occurred in historical events, such as the residual effects of colonization (Farmer 2004) and abuse (Tester 2007), ‘historical amnesia’ (Farmer 2004) then supports the perpetuation of society’s inaccurate stigmatizing and discriminatory opinions. This type of ‘stigmatization or labelling is an aspect of marginalization that marks’ the person as other or outside and ‘disqualif(ies) the person from full social acceptance’ (Corley & Goren 1998; p. 101). Since many or most health-care workers’ daily realities are informed by education, cultural background(s), and social standing, combined with the privilege and power bestowed on them by their position in health institutions, a gap in understanding (perhaps unintended) persists between the professional and those who are marginalized (Giddings 2005a; Kirkham & Anderson 2002; Kurtz et al. 2008).

For women with a mental health diagnosis, marginalization equates to a decrease in power (personally and socially), resulting in unequal access to employment, health care, education, and welfare, as well a lack of safe housing, reliable social connections, adequate nutrition, and clothing, creating some trouble with everyday issues with which the women must contend with. Not surprising are the results of inadequate health care, insufficient social and health supports (Perese & Perese 2003), and the lack of primary health-care provider support. According to Corrigan (2004), people with mental illness fail to receive appropriate care, and the care they receive is less in-depth and comprehensive compared to those without a mental health diagnosis (Perese & Perese 2003).

**Stigma**

Stigma plays a significant supporting role to health-care workers’ enculturated ways of being. Stigmatization within the health context is a multifaceted deep-seated issue involving not only the attitudes, feelings, and behaviours of the person who is stigmatized, but also those of the people (such as health-care professionals, family members, and society) who stigmatize them (Corrigan 2004; Penn & Martin 1996). Stigma enacted toward people with mental health concerns occurs through prejudice, discrimination (Hinshall & Cicchetti 2000), and stereotyping. It seems reasonable then to suggest that stigma often underpins health professionals’ ignorance of the marginalizing effects on mental health clients through the use of professional language and activities that health-care professionals engage in as part of their everyday work, and through the social/professional relationships they cocreate with clients. Researchers note that no matter how mild or severe the stigma, the experience generates a type of imprisonment in which unwell clients find their life controlled by the medical system (Corley & Goren 1998; Frank 1991; Rogers 1997). Employing solely the medical-empirical–scientific lens for the diagnosis and treatment of signs and symptoms without considering the social, political, cultural, and historical contributing factors further adds to stereotyping and the stigmatization of individuals (Caplan 1995; Chesler 2005; Morrow 2006). This ‘positions the responsibility for the stigma on the person with mental illness rather than where it belongs – on the public’, where it structurally occurs (Corrigan 2004; p. 621).

Health researchers seeking explanations for documented poorer physical health of people living with mental health challenges have questioned the role of the GP, psychiatrist, case manager, and nurse. What surfaces is that the GP may not consider the presenting physical problem and underlying cause of the physical problem, but instead becomes distracted by the mental health challenges. Likewise, the psychiatrist’s empirical gaze is on mental health rather than the physical complaint, perhaps because they have lost the skill or comfort to conduct a comprehensive physical examination (Koranyi & Potoczny 1992). Some studies suggest that mental health case managers and nurses are not sufficiently educated in physical assessment. They contend that these individuals lack the comprehensive assessment focus in their practice...
or are not employing the assessment skills necessary to highlight physical health conditions apart from a previous or current mental health diagnosis that may or may not be the presenting issue (Carney et al. 1998; Farmer 1987; Lambert et al. 2003; McDevitt 2004). While these suggestions may in part reflect the reasons why women with a mental health diagnosis are more likely to have poor physical health, other activities, such as those that constitute institutional taken-for-granted practices, contribute to inadequate or poor physical assessment and treatment.

**Taken-for-grant practices and ‘othering’**

Health-care professionals reflect, and at the same time, shape the culture(s) of their sociopolitical worlds. Health-care professionals have particular ways of acting, using language, and participating in social relationships that mask underlying sociopolitical agendas (Mohr 1999). These taken-for-granted ways of engaging increase health disparities for those who are marginalized (Giddings 2005b; Vasas 2005), precisely because health-care professionals’ practices differentiate the self from the ‘other’, figuratively pushing the ‘other’, in this case, women with a mental health diagnosis, into the margins of invisibility (Fay 1996; Hall 1999). Practices, especially organizational ones (such as impersonal care and being treated as a number) that support institutional privilege by ‘othering’ the client, are very difficult to challenge, particularly by those who are vulnerable (Giddings 2005a).

Acts of ‘othering’ and the effects of stigma also place women labelled with mental health challenges into a situation of double jeopardy (Chesler 2005; Morrow 2006). She is seen by society and through the medical lens of mental health (psychiatry) as less capable, and therefore, unable to represent herself within the health-care arena. Her voice is silenced and she is marginalized. Devaluing people with mental illness through stigmatization also results in individuals’ hiding or reluctant to disclose their mental health diagnosis history. Worse still is that the individuals do not seek the health services they so desperately need, to avoid facing prejudice and discrimination that might actually jeopardize their health (Ananth 1984; Freidl et al. 2003).

Ignoring the social or political inequities faced by many clients with mental health concerns, health-care professionals often label clients as being difficult or non-compliant stigmatizing them as ‘other’ through names or stereotypes that place them as different from the health professional’s own status (Barnes et al. 2006; Hall 1999; Johnson et al. 2004; Mohr 1999; Vasas 2005). Therefore, it seems that health-care professionals continue to support the status quo unquestioningly using stigmatizing labels, such as ‘frequent flyers’ for those who regularly present in emergency rooms, or ‘crows’ or ‘difficult patients’ for those that do not ‘fit’ the ‘expected’ client ‘role behaviours’ (Corley & Goren 1998; p. 100). These social and political ideologies underpinning practitioners’ everyday realities get in the way of providing access to appropriate health care and furthers the stigma (Bethune-Davies et al. 2006) experienced by women with mental health challenges.

This paper intends to expose the societal and political context within health-care structures, and health-care professionals’ practice impacts, in particular, women living with a mental health diagnosis.

**SITUATING THE STUDY**

The need and urgency for this study arose from informal conversations with local female mental health consumers and health-care professionals, such as community mental health agency personnel, mental health practitioners, and our own nursing practice. The concerns raised by health-care professionals (Currie 1997; Kurtz et. al. 2008) working with women living with a mental health diagnosis described incidents where many physical health concerns were being ‘missed’, under-diagnosed, or not recognized. We saw the need to formally work with women with a mental health diagnosis to explore their stories to gain a clearer understanding of their health-care experiences and to explore ways to initiate changes for improved health care and treatment. Before commencing the study, institutional ethics approval was received from the University of British Columbia (Okanagan, Canada). This feminist study foregrounds women’s voices and applies key elements consistent with feminist research (Fonow & Cook 2005; Lather 1991; Ogle & Glass 2006).

**Process**

As qualitative researchers with backgrounds in acute hospital care, community, and mental health nursing, we became increasingly interested in the issues surrounding women with a mental health diagnosis and their attempts to achieve wellness. It appeared that many social, cultural, economic, and gender issues impacted the participating women’s efforts for wellness in a number of ways. To further explore this issue, we approached the Peer Outreach Group, a Canadian Mental Health Association (CMHA) group, in a small British Colombian interior city, that develops and provides programs for individuals with mental health challenges. Invited to participate in the project were women who attended the CMHA Peer Outreach Group, were over the age of 19 years, deemed...
competent according to the British Columbia Mental Health Act (1996), lived independently, had no ‘extended leave’ from hospital (related to mental health challenges), and had a minimum period of 6 months since their last ‘certified’ admission hospitalization related to a mental health challenge. All participants signed an informed consent form prior to participation in the project.

Interested women came together to share their experiences of accessing health-care services, following the process of informed consent to participate in the study. Each of the three researchers met with separate groups of three to four women for approximately 1 hour on two to four occasions, to discuss the women’s experiences. A total of seven women participated in meetings, where they agreed to respond to specific stem questions. They were asked: ‘How has the mental health diagnostic label affected your life and your well-being?’ ‘What was it (health-care service) like before being diagnosed with a mental health concern?’ ‘What happened after your diagnosis?’ ‘What is it like when you seek advice about physical concerns from health-care professionals?’ ‘Are there things that need to be changed so that your health and well-being concerns can become recognized?’ In-depth discussions and examples of their experiences with health care ensued following the stem questions. The women clearly suggested changes that they felt were needed in the health system that would comprehensively meet their overall physical and mental health-care needs.

Two additional meetings were held 1 year after the small group meetings with the women. A final large group meeting was conducted to share the study findings with the female participants to receive their feedback and to add any last thoughts. Another meeting, a community forum, that included the female participants and other interested female Peer Outreach Group members, was held to share the insights from the study findings and to discuss ‘where to from here’.

Feminist methodology (Chinn 2004; Cook & Fonow 1986; Fonow & Cook 2005; Smith 1990) informed the approach of this research; the starting point was the valuing of the women’s subjectivities, day-to-day experiences as knowledge, values, voices, and participation to support their emancipation and empowerment.

Reflexivity was also used to raise awareness and initiate change (Aranda 2006; Fonow & Cook 2005; Henderson 1995). The meetings provided an opportunity for women to speak about their experiences and tell their stories in a process that honoured their voice and subjectivities (Fonow & Cook 2005). Consciousness raising (Henderson 1995) enabled the women to share the impact of a mental illness label on their everyday lives. They spoke often about the relationship between their self-identity, their physical well-being, and their body knowledge.

During the course of the study, the researchers worked with the women to affirm these relationships and legitimate their understanding as part of the feminist process (Fonow & Cook 2005). The transcribed data were individually coded and collectively examined for conceptual categories from which themes emerged (Lather 2007). The women’s stories are presented under a pseudonym, along with the interview number to protect their confidentiality.

Ongoing reflexive dialogue highlighted what women faced when they accessed health care and how previous experiences shaped their engagement with health professionals. Problematizing their experiences revealed hegemonic and reified understandings located in the language, practices, and social relationships of health-care professionals as well as in institutions, enabling the researchers a better appreciation of the nature and challenges of having a mental health diagnosis. The critiquing of bureaucratic practices that affect the women’s lives aided the participants and the researchers in recognizing why the female participants’ voices are a submerged discourse (Smith 1990). In addition, the power imbalances associated with sex also emerged, highlighting the persisting patriarchal environment of health-care services (Barnes et al. 2006; Woodward 1998).

Insights highlighted through the women’s voices
Throughout the women’s narratives, issues of poverty, changes to/family relationships, and work/careers, along with evidence of sex asymmetry were highlighted. All of these conceptual categories contributed to the themes. The in-depth and ongoing conversations were intended to support the women’s understandings of their situations and help them gain an increased sense of control over their past, present, and future. This was demonstrated in subsequent meetings where the women frequently retold their narratives, weaving a rich fabric of insights (Barnes et al. 2006; Fine 1994; Herndl 2006). Also highlighted in these stories were feelings of powerlessness, how identities had become marginalized, and the women’s feelings of not being heard or being silenced by the agency or others. Each of these areas comprises the next sections of the paper in which we address how the women felt, findings that have implications for health-care providers.

Powerlessness
Health professionals’ everyday activities and social relationships mediate discriminative texts and disciplinary
power, which may contribute to clients feeling that they have little say in their own care (Foucault 1979). This creation of health professional power over the client is also embedded in professional texts, such as organizational rules or procedural requirements. The lack of power in social relationships for all women is historically located (Wittmann-Price 2004). For women with mental health challenges/diagnoses, lack of power is an even more dire situation (Caplan 1995; Chesler 2005; Morrow 2006). One of the female participants commented on how her relationship (and her sense of power) with her health-care provider changed once the provider was aware she had a mental health diagnosis. The relationship became focused on the mental state and ignored her physical health: ‘I don’t have a good relationship with my family physician. I did until (I got) sick (mental health illness) then he kinda took this king pin position, I was put on lithium . . . I am still with him only because . . . you don’t have much choice. The other doctor’s office is full so you stay . . . I started getting lithium toxicity and when I would tell him what my symptoms were (he would say) . . . “Oh, you need more lithium”, so I went from 3 to 4 mg of lithium a day, to 8 mg in the course of a year. I (became physically) . . . SO sick . . . ‘ (Nikki)

Nikki would not have become toxic on lithium if the routine protocol recommended by the pharmaceutical company or the British Columbia Health guidelines had been followed when Nikki had disclosed her symptoms: ‘But he (my doctor) continued to increase the lithium . . . more concerned with getting my lithium blood level up than looking at me as an individual and assessing how I was doing . . . He wasn’t looking at where there were pitfalls . . . I had diarrhoea and I couldn’t sleep . . . so frustrating that he did not hear me when I was telling him I was having these difficulties with the lithium.’

The increased sense of powerlessness, along with higher comorbidity of illness (Felker et al. 1996), often become more complex and/or exacerbated by the psychotropic medications that individuals with a mental health diagnosis are prescribed (Allison et al. 1999; Gianfrancesco et al. 2002; Kendrick 1996; Sernyak et al. 2002). The side-effects of these drugs confound the women’s sense of self and often cause deeper and more serious physical problems, adding to their experience of marginalization.

Priscilla commented on her frustration, having the power of knowledge as a highly-educated and experienced health-care professional, yet powerless to intervene or promote significant change or responsiveness in the system to support a client’s needs: ‘A lady kept falling on the psych ward and she was diagnosed with histrionics. She has MS (multiple sclerosis). Again, good assessment and diagnostic examinations would have avoided the poor care witnessed here along with the damaging effects of stigma to the client. We (staff) were told: “Ignore her on the floor. Step over her”. . . The unfortunate thing is that I used (to be a health-care worker). . . I actually do know what good clinical care is and it just drives me nuts, just nuts; we run into it all the time. Oh, we (health-care personnel) are going to give that person a chance to resolve that problem on their own, but (they) never give the person the skills; never telling the person that they are going to be doing this (and that). They are not going to respond to the phone calls . . . the person feels permanently abandoned, rejected.’ (Priscilla)

Priscilla notes further frustration with the lack of support from the health-care system: ‘I have less and less faith in the health-care system and health-care politics. You learn to do a lot on your own with little information. They don’t tell you very much. They don’t tell you why you have to take your meds or how they work or they think the little information is going to (help).’ Professional colleges in British Columbia for medicine, nursing, and pharmacy stress the importance of informed client consent, yet how can someone be informed with inadequate information with which to monitor the effects of their prescribed medications?

Marginalization

Consistent with the literature, the female participants recounted situations of being marginalized and excluded. An example is found in the following excerpt from one participant’s description of her engagement with a health-care provider. As Shelia states: ‘I changed doctors . . . I got a new GP and he sent me for all the tests all over again and it ended up that I had blood pressure that was going through the roof . . . (he) asked, “When was the last time (your former GP) took (your) blood pressure?” And I said, “He has never taken my blood pressure. Never, never for anything!” You know that Effexor (antidepressant medication) makes the blood pressure to go higher . . . I was an accident waiting to happen!’ (Sheila 1)

Sheila describes another dimension of her marginalization. Her physician denied her ethnicity – the familial roots – her unique individuality, health-care needs, and personal credibility were all at risk, threatening her identity (Bethune-Davies et al. 2006): ‘(H)ere was (my) file . . . My fasting blood tests were . . . 10 and over . . . He put down “She is lying, you know. She is not fasting. She is lying” . . . he had never believed anything that I had said, “this person will always be a victim”. . . I can’t remember, (all of it) really. Derogatory
comments. . . . The first thing he said to me (at the first visit) was to go through First Nations (to access assistance and benefits) . . . I said, “I don’t have any native blood in me” . . . he said, “Are you sure?” . . . He put that in the file that I was denying my . . . what do you call it (native heritage)? I can’t remember what the word was, but I was denying it, and I am Russian/German, actually. . . . But what I mean is if he didn’t like me from the beginning, why didn’t he just say so and tell me to see somebody else? So . . . I got a new GP.’ (Sheila)

Many of the women reported not only being invisible and having their voice silenced by the health system and professionals in it, but also by their families. This invisible identity is noted by Mary as she describes her feeling of being an ‘other’ within her own family. ‘It is hard to talk to . . . I am thinking of my family . . . they can’t see it (mental health issue). . . . They have never been depressed. (In) my immediate family, I am the black sheep and it’s only again in this last . . . year maybe that my family talks to me without talking down or without talking. You know, taking special care to use certain words. . . .’ (Mary)

The common practice of ignoring signs and symptoms of physical illness in people diagnosed with a mental health illness by health-care professionals occurs particularly in the emergency room, yet they are at times ameliorated by the presence of family members (Clarke et al. 2007). The voice of the client is ignored because the family is recognized by the health-care professional to be the voice of the ‘other’ because the ‘other’ is assumed to be incapable of having a valid or legitimate voice (Wendell 1996). The person (woman) is not only marginalized by the health-care system, but also by family members who are attempting to advocate for the woman, instead unintentionally silencing her.

‘I am getting a little bit better. . . . I am going through this (physical illness) and that is a big deal. . . . I was still afraid to go to a different GP. I didn’t want to talk to anybody else . . . to go through (my) background with anybody else. My family, my girls totally deserted me.’ (Sheila)

The women’s experiences in this study are similar to those in Sirey et al.’s (2001), where the patients avoiding health-care personnel or situations because they made them feel badly about themselves, and in doing so, the women ignored their important health-care needs; for example, ‘Diagnostic labels have affected me in the way I determine and how I define my self. So not only is it a type of prejudice or marginalization from others, my self definition is really quite marred at this point. . . .’ (Pandora)

When her mental health challenges required health intervention, Pandora asked for assistance from important people in her life; those she trusted. She now needs them to become her voice. Acquiescing her own power, however necessary, often has negative results. As a consequence of exposing her vulnerability, she may be labelled dependent or inadequate; her children may be removed from her care by the mental health or social services agency. At this time, husbands, partners, and extended family may distance themselves or use her diagnosis as a means to dominate in legal matters (Caplan 1995; Morrow 2006).

In exploring this shift to an ‘othered’ location, as noted earlier, one must consider the societal and political factors that keep women oppressed (Farmer 2004), and in doing so, raise questions about the social constructs or structures that maintain power-over relationships keeping women, in particular, marginalized, silenced, and sick (Fangier 1992; Ussher 1991).

Why is it that people who are at greater risk of having physical health challenges than the general public come to experience such negative treatment at the hands of well-educated professionals? One of the women shared her feelings of the treatment she received as a mental health client: ‘I don’t know if it is just because I have got a stigma of this mental thing or not, because they are verycondescending in the hospital; they are very patronizing any way they treat you, like non people most of them, most of the staff does. But it seems to me more so when they find out you have been downstairs (to the Mental Health Unit), you know or that you have a mental problem.’ (Shelia)

What is clear from the women’s experiences is that being marginalized in a health-care setting not only silences and invalidates the self, but also places their physical health at greater risk.

Silencing of health concerns

Without exception, the women in this study commented on the struggle to effectively communicate their health concerns to their health-care practitioners or be heard and acknowledged by them. The women’s experiences of being marginalized or having their stories discounted or not taken seriously were common occurrences and noted in other studies (Barnes et al. 2006; Mohr 1999). Following a period of ill health, one woman said she did not receive the follow-up services she desperately needed to stay well and prevent subsequent hospital admissions. The silencing and invisibility of women’s physical health problems and dangers of this kind of invalidation are apparent in Pandora’s description of the
consequences to her health because of being silenced by health-care professionals: ‘Gallbladders are a thing in our family. . . . I ended going into emerg (emergency department) after a night of being sick to my stomach. . . . The emergency doctor (said) . . . “We have to take you off your Paxil” (medication) just to see, because they didn’t (think) it was the gallbladder, the liver, the pancreas or whatever. . . . I got X-rays and everything; (I got moved to) the ward and I kept asking . . . “Put me back on the Paxil”. (Finally another doctor) said “ok, I will put it on your chart” and it didn’t happen. So after 5 days I started hallucinating and (was) very paranoid and it is the scariest feeling ever um. . . . The whole ward knew. . . . It seemed like, oh (that) . . . weirdo.’ (Pandora)

Clearly, Pandora knew she needed the antidepressant medication to maintain her mental health while her physical health was challenged. While her physical health problems were finally heard, assessed, and treated, her overall health, specifically, her mental well-being, was harmed by the medical team who silenced and ignored her voiced health needs.

Throughout the study, women spoke clearly and strongly about necessary changes needed in current health-care practice to support the improved health of women living with mental illness. They articulated the importance of their knowledge of self, learning about their own body and wellness, and being able to voice and discuss their health issues and participate in the directing of their own health care with health professionals. They recommended further education for health-care professionals and other service providers, noting that it was critical to change attitudes and practices where clients are marginalized, silenced, and left powerless because of health-care professionals’ lack of knowledge. Education of health-care professionals must move beyond ‘book learning . . . (to) . . . people that actually experience it (mental health challenges can) . . . really say what it is like to live with an illness and they should be relying on our information.’ (Pandora) Faugier (1992, p.63) concurs that professionals must ‘listen more carefully, without any labels in our heads’. Morrow (2006) points to Ontario Mental Health Services experiences, where women’s voices have been heard relating to their health-care needs, and positive changes in programming and practice have occurred.

The female participants were also confident that substantive improvements to their own and other women’s health-care experiences and outcomes would result when people with a mental health diagnosis and health-care professionals worked together to develop and utilize educational materials for clients, written in layman’s terms and inclusive of strategies and tools to promote health maintenance; for example, tools that describe everyday and ongoing health promotion activities, such as annual health assessment examinations, and awareness and prevention of health problems, such as medication side-effects (e.g. hypertension). The women generally felt that the changes did not require an increase in funding in the system, but rather changes in relational capacity where clients and health-care professionals communicate with mutual respect, reciprocal listening, and acknowledge-ment of difference, while clients improve their knowledge of their own health and well-being (McDevitt 2004; Morrow 2006; Muir-Cochrane 2006).

Reflections

In the present paper, we have shared excerpts from the stories of a small group of women living with mental health challenges. Their excerpts clearly describe organizations (hospitals and health clinics) and intra/inter-personal challenges (family, GP, psychiatrist, nurses, and mental health case managers) that they faced when seeking health-care services for physical health concerns. Their stories describe their experiences of marginalization, stigmatization, oppressive relationships, and silencing that prevent them from equitable access to health care and comprehensive health assessment, screening, and treatment, a right for all Canadians. Clearly, their narratives can be employed to raise awareness and help practitioners develop a broader understanding of what contributes and sustains poor overall health status. The women’s experiences, in conjunction with historical and current literature, expose how stigma works to marginalize and silence women’s voices through health-care practices embedded in culture, politics, practices, language, and professional and social relationships. These embedded practices within the health-care system sustain inequities in treatment and poorer health outcomes for women with a mental health diagnosis.

It is critical that health-care providers listen to and explore with mental health clients the clients’ experiences of the health-care system. If nurses and other health-care professionals are to act with an emancipatory intent that supports the empowerment of clients, then it is important acknowledge and lobby for system changes so that the women’s experiences of silencing, marginalization, and powerlessness are eliminated for all mental health clients.

Overall, the research methodology used in this study provided an opportunity for the women and researchers to share power (Chinn 2004), with the intention of supporting insights and taking action towards change. In this
sense, the research process was political; the female participants’ stories were shared and heard, highlighting their intersubjective understandings, along with illuminating how their self-identity and their physical well-being were ignored. This transformative approach was the pivotal feature in supporting the intended project outcome—sociopolitical change (Fonow & Cook 2005; Henderson 1995; Hooks 1994; Olesen 2005).

To support ongoing sociopolitical change, as health-care professionals, we must continually ask: whose interests are being served by maintaining the status quo? Surely, a reconsideration of policy that focuses on the values of empowerment for women with a history of mental health challenges rather than endorsing health disparities (Giddings 2005b) would facilitate improved overall health for this vulnerable group. Health policy changes to current health-care delivery to provide a more holistic health approach increase attention to health promotion, and DOH that influence health (Health Canada 2006; Public Health Agency of Canada 2001), along with the facilitation of active involvement in one’s care (WHO 1978), will assist women living with a mental health diagnosis to be more successful in directing their health-care needs so that they are heard by the health-care system. This approach would turn the health-care system’s gaze away from stigmatization and medicalization toward the client and their interests being served, with clients being at the centre of care.

Through the united and raised voices of the female participants, to health-care student workers and other professionals, doors may open for change to occur in health-care services, thus their health-care needs may finally be addressed. Nursing students have begun their work with the female participants by supporting a meeting with the hospital emergency room manager so as to hear the women’s emergency room-related health-care experiences. The women offered suggestions to the manager to bring about changes to the emergency department that they felt were necessary for improved health-care services for themselves and others. The primary outcome was that their voices were heard and changes made accordingly.

Through activities such as these, the female participants and ourselves as researchers believe changes in attitudes and practices in all relevant health-care sectors can begin anew as ‘to truly understand how to deliver service one must first listen to the stories of those whose lives are affected’ (Currie 1997: p. 7). ‘We have a part to play in it (our health), like to be persistent . . . but it is so frustrating when the person you (are) talking to has no idea what you are talking about . . . and so education’ of health professionals would help (Pandora). ‘I wanted him to hear me . . . really hear what I am saying.’ (Mary 4)

REFERENCES


Colton, C. W. & Manderscheid, R. W. (2006). Congruencies in increased mortality rates, years of potential life lost, and


