ENGENDERING MENTAL HEALTH CARE SERVICES (MAKING THE HEALTH CARE DELIVERY SYSTEM GENDER-RESPONSIVE)[1]

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The purpose of this paper is to determine the gender responsiveness of the present mental health delivery system in the Philippines. According to the 1995 Census of the Population, 4.2 percent of the disabled population are mentally ill. In numerical terms, this is about 38,675 of 919,332 persons with disabilities. Of these, 52.64 percent are female while 47.36 percent are male. Most of those afflicted are in the 25-39 age group. The study is based on interviews with selected mental health care givers in an NGO clinic and in a government hospital and on observations of interactions between patients and care givers. At present, interest in mental illness among women is focused on domestic workers or *overseas Filipino workers* in foreign countries. While studies on psychiatric morbidity may be useful, these do not reflect the need to understand the social construction of gender in society. What is needed are studies that will contribute to changes in institutional treatment and policy development geared towards gender-responsive practices in mental health care settings.

Introduction

In the past two decades, substantial studies on emotional intelligence have shown the strong role of emotions in mental health well-being. Experiences indicate the effect of such emotions. The question of how we interact with others now, for instance, is often answered by looking into childhood experiences. The attachment theory that explains the interactive process posits the idea that failure to attach is failure to share feelings. Such explanations may not be visible to mental health care providers in the local setting. This explains why there is an absence of studies that deal with the interaction between

a mental health service provider (i.e., doctor-psychiatrist or psychotherapist) with the patient, particularly a female. Hence, this paper seeks to describe the interaction in clinical settings when a woman seeks professional help regarding mental health.

The World Health Organization (WHO) plans to integrate mental health care into primary health care. The plan calls for a general health worker to provide necessary mental health treatment even before the arrival of a specialist, e.g., psychologists/therapists, medical doctors. In adopting the plan, WHO anticipates a global phenomenon in the shift from institutionalized mental health care to non-institutionalized settings. This means that mentally ill people may stay in their respective communities, living with their families and relatives. The impact on economic savings both at the community and family level is expected to be tremendous with the adoption of the plan.

The other main objective of this paper is to have a better understanding of a conceptual framework for gender-based studies in relation to the mental health care delivery system in the Philippines. Such a framework may provide an interpretation of gender issues and problems of mental health care usually brought to the attention of counselors, therapists and medical doctors or psychiatrists. The said framework shall be a simple discourse as commonly raised by groups of people affected by mental health issues. In fact, a newspaper columnist in a popular daily paper (Alano, 1997) raised these related questions:

1. What does the community see as its mental health, psycho-social and emotional problems?
2. Which members of the community are considered to be emotionally vulnerable or at risk of psychosocial or other mental breakdowns?
3. What does the community believe are possible recourses to such problems, either through community intervention or by action of the health workers or other workers?

The second question above reveals a high clinical vulnerability among women.

Observations on Two Sites:
1. The Mental Health Association

The Philippine Mental Health Association (PMHA) began as an idea among Filipino medical specialists way back in 1932. It was 17 years later in 1949 that the idea was formally institutionalized by a group of Filipino specialists headed by Dr. Manuel V. Arguelles.

The PMHA envisions a peaceful Filipino nation governed by leaders who protect the basic human rights of its citizens, where families live in love and harmony and actively contribute to the economic, social, political and moral development of the country. That vision decrees that all individuals, especially those suffering mental illness, be provided with quality mental health services. The PMHA mission is to promote the sound mental health of the Filipino people to the highest level.

The PMHA developed its own programs and services to deal with mental illnesses which can be the result of a combination of biological, physical, psychological and socio-economic factors. Their primary program is the Education Information Services which promotes mental health outreach and training programs, student mental health clubs and public information drives. The second program is the Clinical and Diagnostic Service that provides out-patient services including psychiatric, psychological and social case work and services to children, youth and adults with disorders. Finally, its tertiary program is the Rehabilitation Services which provides day-care services, vocational training and work placement programs for the convalescing mentally ill through community-based, work-oriented activities.[2]

An ocular observation of the PMHA compound reveals that its building takes pride in a well-maintained structure, keeping in mind the principle that a healthy environment leads to well-being. Its office units are remarkably tidy and the processing of admission of patients

is orderly and systematic. The PMHA compound also maintains a well-trimmed garden for its patients. It is not PMHA's policy to keep patients in confinement. Patients who need constant monitoring are therefore sent to another mental hospital in Mandaluyong City. However, some patients who remain functional report to the center daily from 10:00 a.m. until 3:00 p.m.

Through interaction with some patients, it was observed that there are about 7 patients attended to in a day. PMHA patients normally ask visitors whether they belong to the hospital, thinking them to be mental patients too. On another observation period during the Christmas season, PMHA patients showed simple craftsmanship by working on Christmas decorations and candles and making *papier maché*. Their products were later sold to an exhibitor in an ongoing fair in one of the biggest malls in the city.

Throughout the period, the researcher observed the PMHA patients as "persons," making no distinctions to their womanhood or manhood. How the patients interacted with the visitors was viewed as an act of persons with individualities which was not gender-biased. *Gender was not an issue but their personhood.*

Part of the observation was a one-on-one interview with a psychiatrist. The following questions were asked:

- How long have you been working here?
- How many patients go to this hospital?
- How does the PMH cater to the needs of the clients?
- How many females are among the patients?
- Do you think your program is gender-responsive?
- Can you assess the status of mental health care delivery system in the Philippines?

The following details were abstracted from the respondents' replies[3]:

I have been working for the Philippine Mental Health Association for six years now. If you're talking before my coming to the PMHA, then it's already for ten years. Through the years, I have learned that my leaning is more of public service. That's why I chose to work here rather than in a private institution.

The number of patients who come to this hospital is quite difficult to determine. I do not have the records of the whole hospital. But in my office alone, per day, about twelve to fifteen patients visit me.

We give either clinical or diagnostic services. For example, a mentally disturbed person is first interviewed by a social worker. The consultation fee is P100 to 200 ($5-10). Then after the interview, he is categorized into A,B, or C cases.

The hospital also offers psychiatric tests to special children. It also offers rehabilitation. Those who really need to be confined are sent to Mandaluyong Hospital since PMHA has a day care center where the patients can stay for a day from ten in the morning to three in the afternoon. While in the center, they are monitored by some doctors. It is interesting to note that PMHA is a community-based center. It does not believe that the patients should be isolated since they are already isolated from society in the sense that people are normally afraid to approach them, be friends with them. If one sees a mongoloid, the initial reaction is to withdraw, to demonstrate the stigma and isolation. This program allows them to look at themselves with some sort of respect, "kahit konti man lang" (for a fleeting moment). The other service the hospital does is the educational information service. The hospital tries to educate society about mental health. We do

this through lectures, TV and the radio. This is important so that society becomes [sic] aware of these things (avoidance syndrome).

There is an equal number of patients who come to us: 50-50. The number of males who come here is the same as the number of females. We treat both females and males equally. But if we're talking about homosexuals, then that's a different story. For example, a person is diagnosed as a schizophrenic and we find out that he is homosexual, then that's a different story because it is generally more difficult to treat them. The same is true with homosexuals who are psychotic. We are dealing with two things here. We have to try to correct two things. Try to make him a man. We have to take into consideration a lot of things. Until now, people are debating whether homosexuality is caused by biological factors or caused by society.

The status of mental health in the Philippines needs improvement. We lack facilities to cater to the more disturbed. We are very much behind. Information is lacking. Believe it or not, the Philippines lacks psychiatrists who are not afraid of their own patients. Kasi kapag (but supposing...) severe psychotic for example, natatakot na 'yan (he fears). A doctor should know how to deal with these people. Sad thing is, a lot of these people are not treated because they do not have the money to bring themselves to hospitals. The Philippines only has two public hospitals that cater to mental health, the Philippine General Hospital and the National Center for Mental Health. Private hospitals are very expensive.

The author notes the absence of any significant changes in mental health approaches since her visit to a private mental hospital 17 years ago (1980).

2. The Sto. Tomas University Hospital

The Community Center of the Sto. Tomas University Hospital, a private psychiatric ward catering to the needs of psychiatric patients was also visited. At the time of visit, the Center's bed capacity was 52 units, with 24 beds for female patients, 24 beds for male patients and 4 private rooms. The ward is located on the second floor of the hospital's Clinical Division facing Dapitan Street. It is staffed by competent psychiatrists and nurses headed by a Neuro-Psychiatrist. Gender-sensitivity was not yet in fashion; classification in hospital treatment was done after separating male from female patients. Admission into the Psychiatric Ward was on a voluntary basis or upon the recommendation of appropriate government authorities. As a rule, all types of psychiatric patients are admitted into the Community Center. During the weeks of observation, the researcher took note of the reported problem behavior as initial concern. They were as follows:

- nervous, worried, irritable, anxious
- withdrawn
- deceptive, forgetful, slow
- strange thoughts, hallucinations, delusions
- assaultive and suicidal tendencies
- physical complaints without organic basis
- violations of code of decency

The researcher's initial interpretations of the indicated problem behavior based on the list above follows:

- nothing is really wrong with the patient
- mildly emotionally disturbed
- overworked and severely fatigued
- serious emotional or mental problems
- normal response to crisis
- physical problems

There was then as now no data disaggregation as to women and men's mental health problems. No records were kept that listed gender-based health concerns separately. The mental health problems of the patients were treated as human behavior problems and interpreted without gender bias. At that time, this was considered a good approach because the therapist did not have to worry about its implication for treatment provision.

During the course of that study (1980's), there were three relatively distinct patterns of successive redefinition of patient problems. One is characterized by a progressive intensification of the problem and is directed towards seeing the problem as mental illness. The second pattern views mental illness as an angry epithet of the sick individual. The third pattern revolves around an orientation outside the framework of problems of mental illness. In this case, successive redefinition denies that the patient is mentally sick. Again, note that the approach is not gender-sensitive. This was in the 80's when gender issues were not as prominent as they are today. What about the current researches on mental health? Do they recognize the issue of gender in mental health? What are the gender issues of mental health in the 90's?

The researcher assumes, based on the observations, that since most practitioners in the field are males, they bring forth into their practice the latent "ethos of the profession developed from a very patriarchal perspective."[4] Consequently, the gender of patients and clients is virtually ignored. Clinicians working (in the local setting) at the level of individual clinical intervention oftentimes do not have the necessary skills in addressing gender issues, particularly that of women. There might not be much interest in feminist psychology and in the psychology of women, unlike in western societies where the works of Lacan and Freud are familiar to the psychoanalysts and psychotherapists. Recall that Lacan Therapy "can facilitate the exposure of the illusions and sexual inequalities fostered within patriarchal ones, allowing women and men to develop in a way which acknowledges

the similarities and differences of our sexual and social being." (J. Usher, 1992). There is therefore a need to develop the contemporary knowledge base for feminist practice in mental health programs. One of the cornerstones for mental health is that it is influenced by social structure, culture and the environment. When the social structure does not recognize gender role differentiation, some of our individuality is lost.

With regard to community-level mental health intervention programs such as the Primary Health Care advocated by WHO, societal attitudes towards women need to be deconstructed. Gender needs to be considered in all cases.

The Philippine Mental Health Program

In our country today, about 16.3 percent of adults and 15 percent of children suffer a mental illness or disorder. To address a growing concern regarding mental health, the Philippine Mental Health Program (PMHP) was formulated and spearheaded by Dr. Alfredo Bengzon in 1986 during his term as Secretary of the Department of Health (DOH). The vision of the program is the full integration of mental health into the nation's health system and its mission is to make mental health care available, accessible, affordable and equitable to the whole Filipino population. The program functions as a policy-making body of the DOH on mental health issues. It also conducts training, research, supervision and monitoring of mental health resources, programs and services. In general, it acts as an umbrella program for all sectors concerning mental health strategies. At present, the program has 41 satellites all over the country.

Generally speaking, the PMHP does not concentrate only on patients with psycho-pathological illnesses. It also deals with psycho-social cases. The PMHP gives emphasis to moving psychiatric patients out of mental institutions since there are only 7,184 beds available to the 600,000 cases with severe mental illness. Presently, some

interventions for the mentally ill are counseling, psychotherapy and medicine. Counseling or psycho-social processing involves the patient's coping with the realization of his problems and probable solutions, with the aid of nurses and doctors. This form of counseling is often given to those individuals traumatized by disaster, torture and violence. Psychotherapy, on the other hand, is the more advanced stage of counseling rendered by professionals. An essential difference between the two is that in counseling, the patient is the one who decides for himself while in psychotherapy, the doctor is the one who decides for the patient. Medicines form an integral part of the patients' swift recovery and are utilized in both cases.

Rationale

Studies on mental health and gender issues are lacking in Philippine Sociology. The lack of a gender analysis in the area of mental health presupposes an absence of interest among scholars linking these two aspects; it could also be an indication of the absence of "culture reflections" on gender issues on mental health. It is a non-existing paradigm, giving rise to the perception that mental illness should be kept a secret. To be mentally ill is to be stigmatized.

Why do we need to make the necessary connection between mental health and gender issues? For one thing, more than half of overseas Filipino workers are women, many suffering from nervous breakdowns and traumas from the violence inflicted on them. Chances are that these women will not go to centers like the PMHA or to private hospitals like the Sto. Tomas University Hospital, St. Luke's Hospital or even Makati Medical Center. A model of mental health counseling for overseas Filipino workers which considers sex, sexuality and gender roles is a first step in giving aid to these women.

Putting Forward A Paradigm

In the clinical setting where the user (the distinction between female and male patient does not matter) and the therapist must be involved in the sharing of identities, the user and the therapist should

be able to "hear each other". There are nonverbal behaviors that may have different meanings for each and every user. These behaviors include personal space, body movements and touching.[6]

Differences between user and therapist in understanding nonverbal behavior may deter therapy because of misinterpretations and miscommunication. This may result in feelings of misunderstanding and rejection because the user feels that she has not been heard by the therapist. The patient should be listened to cautiously by the therapist who understands her vulnerabilities and helps her overcome feelings of inadequacy and helplessness. Sometimes, the therapist must learn to use metaphors to make the meeting less threatening to the user.[7]

Because of the stresses that a woman experiences, she could be at risk for mental health problems. Women in general tend to have greater fears and anxieties of the future. This may be because women are more sensitive than men to the rapid social changes going on. Her reaction to situations and events are different from men; while the difference may be obvious to the onlooker, therapist(s) often deny it. It is in the intimate, private world of clinical settings that the first step towards giving voice to the vulnerable must be initiated.

The first step toward engendering is based on how well the power of empathy and love as cornerstones of the mental health care delivery system are manifested. The therapist must be liberated from traditional practices that put a lower premium on gender. For instance, among women who have been raped, a full disclosure of their experience will be difficult especially within a system that allows oppression. An evaluation of the usefulness and attributes of the patient's support systems should be well considered by the therapist. The patient's self-esteem is bolstered by having a satisfying support system. Social support systems and mutual aid self-help groups enable the patient to experience a sense of security and belongingness.

The second step is to make the therapist recognize that "each person is an individual, and everyone has an experience worth telling."

There ought to be recognition of the frailty and vulnerability of the world and hence, a need to forge a partnership between the mental health care provider and user. This is the best of possible choices.

The researcher does not want to be involved in controversies in psychiatry surrounding the use of "technical terms as non psychiatrist, treatment and mentally disordered" (L. Krasner, 1978). Hopefully, by 1997, these issues shall have been resolved. However, the author seeks to make this contact between mental health, gender and treatment possible because responsiveness, or the lack of it, among treatment providers of women may pick open an old wound. Healing should then be forthcoming.

Kramer notes that "there is the symbiotic relationship between the therapist and the patient, the healer and the healed, the doctor and the patient. It may seem startling to say that both need each other. The therapist exists as a professional in his role only because of the existence of the individual needing help; the patient role exists because there is a therapist to give it meaning; neither would or could exist without the other." Yet the patient is not identified by Kramer. Would the same symbiotic relationship exist if the patient were a woman and the therapist a male? It is at this point that the more contemporary term, i.e., gender, comes into play. Gender is a social construction; society manipulates this concept toward some functional and/or dysfunctional framework (in the process of finding the meaning of our birth, our actions and interactions, our thoughts, our human gifts and flaws and the nuances that emanate from our individual and group mind).[8]

Gender, hence, is a socially constructed definition of what is masculine and feminine, laden with cultural prescriptions of what are acceptable male and female attributes. There is a whole set of literature on gender theories but like Gayatri Spivak, I will not join the scramble for legitimization in the house of theory.[9] Earlier in the

game, it was sufficient to ask, is sexual difference a relevant factor in the provision of treatment?

As early as 1976, Claudia V. Werlhof[10] in her article "Patriarchy, State and Class–Structure in Latin Amercia–Towards a General Theory of What to Ask About Women's Relation to Society" argues that a real understanding of society is impossible without including the position of women in the analysis. In her time, it was usual to exclude the woman question. This remains true today. Quoting Werlhof: "so we do not want to make the same mistake and look at 'women in society' exclusively, but at their relations with the rest of it. Now, which 'relations' have to be analyzed?" It is at this point that the author ventured into uncertain ground with respect to women's role in general. The consideration of a woman's role is dependent on the significance attached to her by others so that when a person reports to a mental health clinic, how is she perceived? Is she perceived as a woman with a stigmatized illness, as a person breaking down or as a man with severe work-related stress? The first perception may lead to her being demeaned, scorned or laughed at; the second may result in the person being helped and in the third, the man assisted to preserve his self-esteem. It is in the process of engendering that we can totally eliminate the first perception so that the woman can rebuild her self-esteem and consequently recover her sense of power and control over her life. Indeed, the survival of society is dependent on those responsible for the reproduction of life.

Conclusion

How do these observations impact on engendering mental health care delivery systems? What do we do in a setting where the subject is a woman and the therapist a male person? Engendering is according to Webster, "to cause to exist, to bring about into existence". In this case, it means to bring about a change in attitude and in ethics. What do we want to do with gender-related issues confronting the woman-patient in mental health care systems? The impact should be on:

- attitudinal change of health care providers
- institutional change, i.e., formulation of policies and mechanisms
- raising sensitivities
- raising awareness of their role in promoting their mental health and increasing empathy
- ethics (protecting the subject, not raising false hopes and confidentiality
- embracing the value of diversity; culturally acceptable beliefs based on gender

The following tasks must also be done to successfully engender the mental health care delivery system.

- Further research into the structure of research and training in mental health programs of academic institutions. A Researcher-Advocacy Model which has been used in resettlement countries around the globe with a special focus on survivors of torture and trauma is suggested. This model is from the Professor D. Silove and Company Reports (Sydney, Australia, 1997). According to Silove, the approach is being developed in an East Timorese community to apply to a traumatized minority group including women.
- For the improvement of the paper *per se,* there is a need to do intensive observation of what is actually happening inside centers and in mental health hospitals as well as the community's response to those considered mentally ill.
- A study of non-governmental organizations involved in serving women at risk is in order. There are existing NGO's whose main goals are to assist women victims of sexual assault and domestic violence and sufferers of psychological disorders such as depression or simply from "nervious" (nerves). These cases must be documented, including their approaches.

The Filipino Women of the 90's are on the threshold of discovering a collective voice. However, they have not begun to analyze the mental health implications of their social oppression.

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Endnotes

[1] This paper was first read during the World Congress of the World Federation for Mental Health, Lahti, Finland, 6-11 July 1997.

[2] From the field notes of students observing PMHA.

[3] *Unedited.*

[4] Jane M. Usher, et al., *Gender Issues in Clinical Psychology*, Introduction p. 1 (1992).

[5] The abstract is quite concise but does not include gender issues. The author, however, assumes that the model is worth looking into.

[6] Clinical Issues and Intervention With Ethnic Minority Women

[7] In Europe today, practitioners refer to patients as users. Consistently, they use this new terminology.

[8] Lecture notes, Prof. Rose Marie del Rosario, July 1996. Benitez Hall, College of Education, University of the Philippines.

[9] Cited in T. Brennan, The Story So Far, p. 8.

[10] Claudia Werlhof, Programme in Development Studies, Department of Sociology, University of Bielefeld (photocopy, Patriarchy, State and Class-Structure in Latin America-Towards a General Theory of What to Ask About Women's Relation to Society.)

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