Multiple choice questions

1. Services for men are more accessible and acceptable if:
   a public education targets men and men's problems
   b primary care and mental health clinics are provided at times and places appropriate for families
   c media campaigns are aimed at family and friends as well as the patient at risk
   d criminal justice agencies raise awareness and know how to divert to psychiatric services
   e they offer the choice of a male clinician.

2. Mental disorders and problems more common in men include:
   a specific learning disabilities
   b deaths by suicide and homicide
   c gambling, self-harm and substance misuse
   d courtship and attachment disorders
   e rage attacks and chronic resentments.

3. Treatment and rehabilitation services for men should:
   a focus on addictions as primary or comorbid problems
   b recognise psychosexual difficulties as comorbid problems
   c allow patients to sort out bullying and pecking-order behaviour
   d address issues of violence and coercion in the family and workplace
   e recognise grief and attachment issues regarding loss of contact with children and others.

4. Service developments should:
   a ensure a balance between single-gender and mixed treatment settings
   b be based on local preferences and offer appropriate choice
   c be blind to race, culture, ethnicity and gender
   d raise awareness of less-common disorders that occur predominantly in men
   e emphasise the similarities between presentations of mental illness in men and women.

MCQ answers

1	2	3	4
a T	a F	a T	a T
b F	b T	b T	b T
c T	c T	c F	c F
d T	d T	d T	d T
e T	e F	e T	e F

Commentary

Jennie Williams

The papers by Ramsay *et al* and Kennedy in this issue take us on a journey over the bumpy terrain of gender differences in mental health and mental health service provision. My intention is not to comment on the finer points of their journeys, rather to suggest that they would have concluded more satisfactorily if greater reference had been made to the existence of social inequalities.

Social inequalities and mental health

There is ample evidence (e.g. Harris & Landis, 1997; Newnes *et al*, 1999; Milne & Williams, 2000) that

Jennie Williams is a clinical pyschologist with a background in social psychology. She is senior lecturer in mental health at the Tizard Centre (University of Kent at Canterbury, Canterbury, Kent CT2 7LZ; tel: 01227 824047; fax: 01227 763674; e-mail: J.A.Williams@tizard.ukc.ac.uk). Her main research interest is the effects of social inequalities on mental health and service provision.

https://doi.org/10.1192/apt.7.2.99 Published online by Cambridge University Press

social inequalities – including those based on gender, race and class – are a root cause of mental health difficulties: a causal relationship that helps explain differences between groups in the manifestations of distress. Some of the main findings from this body of work can usefully be borne in mind when considering the data presented by Ramsay *et al* and Kennedy.

First, inequality can control access to resources known to affect mental health (Williams, 1999). As Ramsey *et al* note, the obvious example is money, although social networks, status and power could also be included here. The existence of inequalities in our society means that substantial numbers of people, because of their gender, race, class or age, have restricted access to resources. Second, many of the processes that characterise and perpetuate inequitable relationships between social groups, are known to have mental health consequences. These include exploitation, discrimination and oppression. Particularly significant for mental health are processes that hide injustice and its effects on people's lives and experiences. This includes victim blaming and attempts to conceal oppression by labelling the oppressed as 'mad'. Finally, the existence of structural inequalities creates opportunities for very serious abuses of power. Physical and sexual violence and abuse, most typically perpetrated by men, are a common and sometimes covertly sanctioned means of expressing and maintaining dominance in family and community settings. The mental health implications of these power abuses are now well substantiated.

An obvious implication of these findings is that clinicians should be alert to the possibility that a client's distress or damaging behaviour are a response to his or her history of oppression(s). More contentious is the possibility that social inequalities should be a consideration when working with clients from privileged social groups, including men. These are some of the main points made by writers such as Miller & Bell (1996). First, it is argued that male dominance is founded on expectations of masculinity that can place injunctions upon emotional entitlement. Successful male socialisation requires men to be silent and strong, leaving individuals little scope to acknowledge and deal constructively with feelings of vulnerability or powerlessness. Instead, men are offered safety through dominance and control of the external world, and survival through the sanctioned means of violence. Such understandings help to contextualise Kennedy's keen observations about men's response to loss and fear. Second, it is important to remember that the rewards of male dominance are not evenly distributed throughout society. White middle-class heterosexual men may well gain some satisfaction from having fulfilled the male script, and from being one of the 'real men'. However, this is unlikely to be the case for men who are poor, unemployed, from Black and minority ethnic groups, or who are gay: men who need to reconcile the gap between the expectation of dominance and the reality of their lives and experiences. Finally, it is not only women who experience the abuse of male power. Many men, as children and adults, experience bullying, brutality and violence within the home and their communities – traumas that are consistently underreported because they "should not have happened", or should not matter to a "real man" (Miller & Bell, 1996; Freeman & Fallot, 1997).

In summary, the evidence suggests that the existence of social inequalities needs to be taken into account in our efforts to meet the mental health needs of both women and men. Indeed, the inclusion of men within this paradigm is crucial if we are to offer constructive service responses to the mental health needs of men identified by Kennedy and others (e.g. Miller & Bell, 1996).

Service responses

Now, let us return to the main service development issue identified by Ramsay *et al*, that of needs assessment. On the basis of the evidence summarised above, I would argue that knowledge and understanding of the mental health implications of social inequalities needs to inform our assessment work with *all* clients, men and women, with the full range of presenting problems. This means that practitioners need training and supervision to enable them to find out about: the client's experience of power and power abuses; how they have coped with powerlessness, discrimination and loss; their use of power in the context of social inequalities; and whether their distress or damaging behaviour is a response to their history of oppression(s). Practitioners also need the skills to build an appreciation of the processes that have silenced their client and made it difficult and unsafe to give open expression to emotions such as pain, grief, fear and rage. Only then will they be in the position to offer a 'needs assessment' and to identify the kind of help that the client needs to enable direct and safe expression of his or her distress.

The paper by Kennedy makes the case that 'men need special help', and I would agree. However, they need help that is informed by an understanding of the ways in which social inequalities can affect their lives and psychological functioning. This includes explicit consideration of the implications of race and ethnicity, which is very important at a time when it

https://doi.org/10.1192/apt.7.2.99 Published online by Cambridge University Press

is still easy – as Kennedy's paper illustrates – to marginalise such considerations. Kennedy suggests improving the accessibility of services to men through careful attention to public education, campaigns and advertising, and to the time and place of service provision. All these ideas seem sensible, and should be considerations in the provision of mental health care to any 'difficult-to-reach groups'. However, these solutions do not address the main problem, which is psychiatry's very tentative stance towards social inequalities. At this point, it is more important for psychiatry to give precedence to taking account of the extensive literature on social inequalities and mental health. The quality of service provision to all clients can significantly improve only when the existence of social inequality moves into the foreground of mainstream thinking, rather than being detectable only by inference or invisible altogether. This would lead to significant improvements in the efficacy and safety of services (Williams & Keating, 2000) and facilitate reflection and positive action about discrimination, abuse and re-victimisation within mental health services. I doubt whether some of Kennedy's assumptions relating to the value of mixed-gender therapeutic environments would stand up to this scrutiny.

Conclusion

I have tried to illustrate the value and power of considering gender-difference data from a social inequalities perspective. Although there continues to be resistance to this approach, it is possible to take encouragement from the fact that the current government is willing to name problems of inequality and exclusion as social problems that warrant serious attention. It is timely, therefore, for psychiatry to pick up this challenge.

References

Freeman, D. W. & Fallot, R. D. (1997) Trauma and trauma recovery for dually diagnosed male survivors. In *Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness* (eds M. Harris & C. L. Landis), pp. 357–372. London: Harwood Academic.

Harris, M. & Landis, L. L. (1997) *Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness*. London: Harwood Academic.

Kennedy, H. G. (2001) Do men need special services? *Advances in Psychiatric Treatment*, **7**, 93–101.

Miller, J. & Bell, C. (1996) Mapping men's mental health. *Journal of Community and Applied Social Psychology*, **6**, 317–327.

Milne, A. & Williams, J. (2000) Meeting the mental health needs of older women: taking social inequality into account. *Aging and Mental Health* (in press).

Newnes, C., Holmes, G. & Dunn, C. (eds) (1999) *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*. Ross-on-Wye: PCCS Books.

Ramsay, R., Welch, S. & Youard, E. (2001) Needs of women patients with mental illness. *Advances in Psychiatric Treatment*, **7**, 85–92.

Williams, J. (1999) Social inequalities, mental health and mental health services. In *Thinking about Psychiatry and the Future of the Mental Health System* (eds C. Newnes & G. Holmes). Ross-on-Wye: PCCS Books.

Williams, J. & Keating, F. (2000) Abuse in mental health services: some theoretical considerations. *Journal of Adult Protection*, **2**, 32–39.

Author's response

Harry Kennedy

I am glad that Dr Williams and I agreed on so many points. However, although we both concur that there is a place for public education, I advocated the need to target this very carefully by using market research techniques. Naturally, neither Dr Williams nor I knows the outcome of such research, but I would be very surprised indeed if Dr Williams' approach to fostering the victim role among young inner-city men would be effective. More likely than not, it would make services even more unacceptable and unappealing. In a more general sense, I have never found it helpful to encourage patients to think of themselves as victims.

https://doi.org/10.1192/apt.7.2.99 Published online by Cambridge University Press