

EXCERPTED FROM

Adding Insult to Injury:
(Mis)treating Homeless
Women in Our Mental
Health System

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1

Homeless Women and Mental Health

Laura meets Nikki while interviewing her friend, Kesha. Laura and Kesha have been sitting in a small counseling room in one of the shelters that dot San Pedro Street in Los Angeles's Skid Row District. Laura is asking Kesha, a victim of childhood abuse, a series of questions about her experiences of trauma and the coping strategies she uses to deal with the effects of what she has been through when they hear a knock at the door. Opening it, Laura finds Nikki, an African American woman in her late thirties, standing on the other side, politely letting her know that she is waiting to be interviewed next. Hearing her friend's voice, Kesha speaks up and asks if Nikki could join the discussion.

Both women have become homeless for financial reasons and are desperate to move out of the shelter and out of Skid Row. Nikki has just started a job and begins to describe what getting up in the morning and leaving Skid Row for her new job are like.

NIKKI: I have to be at work at six o'clock in the morning. I get up at four o'clock in the morning, so I'm up when the action starts on the streets. So I see people knocking on people's tents for heroin. I'm standing at the bus stop, you see so much. You hear women prostituting their daughters out. Are you serious? This is like real? It's like a bad movie.

LAURA: How does it feel to be the odd person out?

KESHA: [laughing] It's weird!

NIKKI: It's crazy! Because what's normal here is not normal anywhere else. . . . It's like a bizarre world. Like on Seinfeld. Everything that was normal, the rules don't apply here!

Both found life at the shelter stressful, and each was coping with the fights, the drama, and the strange rules in different ways. Kesha, who had been diagnosed as borderline obsessive compulsive disorder (OCD), acknowledged that her recently developed daily cleaning rituals served a dual purpose: they kept her area free of scabies, lice, and bedbugs, and they permitted her a measure of control within a space in which she had none. Leaning in slightly, she explained, “You can’t control the situation you’re in, but you can keep your locker clean, [and] you can keep your bed straight.” Nikki was struggling with feelings of depression and anxiety over her situation: “My crazy is me being a single parent and having my daughter down here. She’s twenty-three. It’s a control issue of . . . my eating’s out of control. I can’t control nothing around me, but I can control if I put some chips and some cheesecake in me.” When the discussion turned to other methods of coping, the subject of antidepressants came up, and Nikki said that “especially here” (indicating the shelter) pharmacological solutions for any problems were commonly recommended by staff and the shelter’s doctor. Whereas Kesha had already seen a psychiatrist at a local clinic and been prescribed the antidepressant sertraline to deal with her anxiety issues,¹ Nikki’s case manager at the shelter recommended she take antidepressants, going so far as to refer Nikki to the shelter’s doctor in order to secure a prescription.

NIKKI: They wanted to give me some Zoloft.

KESHA: That’s what they tried to give me!

NIKKI: And something else.

LAURA: Who did you go see? Your doctor?

NIKKI: My case manager. She was referring me to the doctor here.

LAURA: To then get on the . . .

NIKKI: Zoloft.

LAURA: What was your response?

NIKKI: I was like that’s not what I was coming here for. My whole thing was to make sense of all of this. I’m gonna be honest with you. I’m thirty-eight years old. My intention in life was never *ever* to live on Skid Row. [Everyone starts laughing.] I’m just keeping it real. I just need to make it make sense. It didn’t make sense.

LAURA: Have you had an opportunity to do any one-on-one counseling?

NIKKI: Actually, I have with [names a counselor]. She’s good. She really helps me put a perspective . . . she really helps me see the other side. That’s what I needed. I didn’t need a pill. I just needed some therapy.

Nikki’s story is not unusual. Over the years we have come to realize there are thousands and thousands of Nikkis, homeless or otherwise impoverished women who are struggling to make sense of, and to hopefully overcome, events in their lives that sometimes defy ready explanation. When they seek

help, they are frequently directed to a mental health system that, arguably, all too often opts for pharmaceutical over therapeutic interventions. It tells them the solution is pills that neurochemically alter the brain instead of also addressing cognitive needs as a potential solution. As in the case of Nikki, such views not only predominate within the healthcare system itself but are shared by those who work within the institutions that frequently structure the lives of homeless citizens: shelters, public social work offices, courts, and jails.

As we will show in the subsequent chapters, lacking few alternate resources, if any, and variously persuaded, compelled, bribed, and coerced into accepting this form of treatment as the solution to their problems, untold numbers of women find themselves dealing with the effects of trauma and chronic stressors by chemically burying them. Although relying on placebo effects and sedation is presumably cheaper in the short term than providing expensive therapeutic sessions like psychotherapy and secure housing, the reality is simple: for many women, the underlying issues remain, and thus the lives of too few women ever improve.

The Argument

Despite the definition of the World Health Organization (WHO) of health as a “state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity” (Armstrong and Armstrong 2010, p. 4), over the past several decades a notable shift has occurred in how societies think about individuals’ well-being, a shift away from ensuring the physical, social, and mental health of citizens. This shift is attributable to a combination of factors, including the reliance on the medicine model (e.g., a variation of the allopathic model), the medicalization of common conditions, and the associated stigma, as well as the resulting ascendancy of a model of human cognition, emotions, and behavior that purports to answer all questions about why humans are the way they are: biopsychiatry.² The US healthcare system is based in the for-profit sector and utilizes predominantly an allopathic approach to healthcare, which is focused on penetrating the body physically (surgery) or chemically (drugs) as a means for curing what professionals in this area see as illness and ill health (Armstrong and Armstrong 2010). The system has become jaded due to the motivations of private institutions (e.g., pharmaceutical companies) that add to the for-profit model as they dominate and control the progression of medicine in a quest for monetary gain. Together these factors dictate the way in which healthcare is delivered and its impact on individual experiences and views of healthcare as an institution, again as a means of promoting the continuation of the allopathic approach to healthcare.

The allopathic medical model emerged in the nineteenth century as the primary medical model in the Western world. *Allopathy*, a combination of *allos*, meaning “opposite,” and *pathos*, meaning “suffering,” was coined by the German physician C. F. S. Hahnemann (1755–1843) in reference to the seemingly barbaric medical practices common to the eighteenth century, such as bloodletting, purging, and toxic drugs.³ The idea behind such practices was tied to the notion of treating conditions based on their “opposite,” a reality common even now in Western medicine where, for example, constipation is treated with a laxative or a headache with a drug designed to eliminate the headache, such that “cuts and chemicals” remain predominant treatment options for illness (Jarvis 1996; Kaufman 1988). As Stephen Lyng explains,

[the] medical perception focuses on the problem of discovering the objective conditions that give rise to the subjective sensations that we know as patient complaints (defined as symptoms in this system). In other words, the problem is to objectify the subjective sensations of the patient. This task is accomplished by translating all illness (i.e., the patient’s subjective sense of abnormality) into disease. (1990, pp. 102–103)

Not surprisingly, in general, the medical model discounts alternative approaches to healthcare, such as chiropractic and homeopathic medicine, which are rarely seen as actual medicine or cures for illness or poor health. Indeed, Western society over the years has ingrained assumptions regarding health and healthcare, limiting alternative medical practices. These assumptions are simply viewed as societal truths. For example, one so-called truth is that illness is biological, a truth that in turn disregards the social determinants of health that focus on the impact that environment, socioeconomic status, or standards of living can have on physical and mental health (Armstrong and Armstrong 2010). Indeed, these social determinants cannot be disregarded in their role in shaping the psychological health and well-being of homeless women.

Unquestionably, however, the allopathic medical model has saved many lives, and the resulting advancements in medicine have increased life expectancy in North America (Armstrong and Armstrong 2010). However, rather than trying to take preventive measures, the focus on science, biology, medical advancement, and cures highlights the political economy and consumerism underlying the current healthcare system, essentially, orienting it toward the pursuit of profit (Armstrong and Armstrong 2010). In the United States, this system is shaped by private institutions (e.g., doctors, pharmaceutical companies) that add to the for-profit sector. Institutions dominate and control the progression of medicine; therefore, many scholars argue, developments and innovations (new medications, new healthcare practices,

and new medical devices) are no longer a means of responding to the needs of society but instead represent the quest for monetary gain, power, and resources (Armstrong and Armstrong 2010). Political ideologies that have shaped governance provide a fertile breeding ground for the progression of individual health advocacy wherein patients who can afford to do so pursue their own health needs. They act as consumers of healthcare and advocate on behalf of their own needs and desires. The question then becomes, what is a healthcare need?

In 1992, Peter Conrad and Joseph Schneider drew attention to a new trend: the transformation of what some saw as deviance and other social problems into medical problems. In essence, they argue that, within this new paradigm, “deviance” is relabeled as “illness,” and the individual comes to be viewed as someone who can be helped, even cured, by medical authorities and their technical knowledge. Through this process, termed *medicalization*, the patient becomes largely disempowered, falling under the authority of medical professionals. Although we do not take this position, some scholars go so far as to argue that mental illness does not exist but is instead a label that has been successfully applied to particular body processes and social problems (see Bowden 2014; Conrad and Barker, 2010; Fried et al. 2015; Hesslow 1993; Launer 2014; Pickersgill 2013). As such, all medical facts are argued to be socially created products, arguably constructed and developed by interested parties and claims makers with much to gain, that allow medicine to reign as an institution of social control (Conrad and Barker 2010).

Medicalization occurs at three levels: the conceptual level, where medical vocabulary is used to define the problem; the institutional level, where medical personnel supervise treatment or act as gatekeepers to treatment; and the interactional level, which is the point at which doctors treat what they see as the medical problems of their patients (Armstrong and Armstrong 2010). At each level, relationships of power situate what is labeled as the treatment of the patients, whose agency is by and large dictated by their adherence to the medical directives put forth by the medical professionals from whom they are receiving care. Thus, with medicalization, not only do increasingly common problems become redefined as manifestations of psychopathology requiring intervention, but individuals grappling with an issue are left to seek out and then adhere to a prescribed course of care if they want to be viewed as helping themselves and their situation. Conrad and Schneider (1992) explained that by being reclassified as patients, rather than just seen as homeless women, individuals become entitled to help, but they are first put into the submissive position of adherence if they are to get help or to “rectify their situation” under the medical profession.

Within the medical model is where biopsychiatry falls. At its root, biopsychiatry is a worldview predicated on the belief that human suffering can be grouped into discrete categories based on symptomology, labeled as clinical disorders, and then linked to dysfunctional biological processes within the nervous system. This perspective continues despite the fact, again evidenced in more recent criticisms of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), that little evidence can be given for specific biological markers of mental illness (see Pickersgill 2013). An individual's problems, as suggested by biopsychiatry, are not caused by environmental factors (e.g., social determinants of health); rather, the root of problems and thus the potential solutions lie in the functioning of neurons and synapses, as dictated by genes. According to this paradigm, these processes can be beneficially altered through expert administration of neurochemical compounds that inhibit or reverse the effects of malfunctioning neurons and synapses—the so-called chemical imbalances of the brain—through selective or nondiscriminate chemical actions. Said another way, a reliance on drugs by medical professionals, specifically prescription medications designed to alter the functioning of the brain, underlies biopsychiatry. The administration of these drugs is the province of a growing number of practitioners within the so-called helping professions in the United States—psychiatrists, primary care doctors, nurse practitioners, and pharmacists—who not only are sanctioned to diagnose conditions but have been granted prescriptive authority and thus the privilege to treat patients using psychoactive substances.⁴ However, we are not suggesting all prescribing is unnecessary, erroneous, or inappropriate; instead, here we point to where prescriptions replace rather than accompany therapeutic interventions or serve as ineffective or lazy Band-Aid approaches targeting overrepresented populations, like homeless women.⁵

Much has already been written about the growing biopsychiatrization of everyday life and the accompanying neurochemicals biopsychiatric practitioners deploy (Bentall 2009; Frances 2013; Greenberg 2013; Rimke and Brock 2012). Indeed, a veritable cottage industry has sprung up to warn citizens of the risks found in converting everyday behaviors into mental health problems, giving our children drugs for behavior problems,⁶ or relying too heavily on antidepressants to make us, if not happy, then at least momentarily content. Although much has already been said about this medicalization, and more specifically biopsychiatrization, in relation to the general public, one area of social life can be examined in which biopsychiatry wields an enormous power that is seldom scrutinized and generally accepted as both right and necessary, that is, in the lives of homeless citizens.

Long considered a repository of any and all social ills, homelessness has been transformed from a social space within which individuals appear as morally corrupt degenerates to one holding an ever-increasing assortment of individuals deemed mentally ill. This change is easily explained. Psychiatry, as embedded in the medical sector of society, has long been associated with homelessness as providing both an explanation and potential cure for this state. With respect to the former, a significant body of commentary attributes the character of contemporary homelessness to the move away from asylums and other psychiatric residential treatment facilities toward community-based forms of treatment (see, for example, Dear and Wolch 1987). Thus, the ranks of homeless citizens today are said to be largely drawn from those who were previously institutionalized, or who would have been institutionalized today if such facilities were still routinely used in this way.⁷

Having redefined this social problem as psychiatric in origin within a larger social framework that increasingly views the biopsychiatric worldview as providing the solution to most, if not all, of society's complex and mundane problems, one can see how biopsychiatry has been touted as the solution to homelessness and how unstintingly faith is to be placed in the chemical regimens often prescribed. This unwavering faith has had important consequences for how homeless citizens are treated. It has spawned new ways of thinking about, and responding to, their problems, which, on the surface, appear similar to how society views the problems of other segments of the population. Invoking a disease metaphor to explain the causes of their distress, homeless citizens learn their only hope is to participate in the treatment of their "chemical imbalances." Within this framework, responsabilized self-care is portrayed as an individually empowering act; however, as we shall discuss, it is ultimately one that does little more than maintain social and structural inequities that disempower individuals who are suffering.

Thus far we have focused on the history of the medical model in the United States and, more specifically, on the way in which biopsychiatric power manifests at a macro level, a theme to which we return in the following chapter. Our primary interest, however, is in analyzing its effects on individuals, a task that reveals three principal forms of biopsychiatric power, that we use to refer to—the power of professionals to diagnose, prescribe, and garner compliance with drug treatment regimes, and the way this power manifests in the lives of people who are homeless. The first power is that of the authority to diagnose individual suffering, giving it a name and an ascribed cause as well as redefining the individual through the application of a diagnostic label. No longer simply Jane or

Joe, the individual is endowed with a new institutional and sometimes personal identity as a “bipolar” patient or as a “schizophrenic.” The second form of power we discuss here is the power to prescribe a course of treatment based on a diagnosed condition. To the extent that the underlying problem is deemed biochemical in nature, this prescriptive power is enacted through instructing patients to routinely ingest one or more psychiatric drugs that are deemed necessary to right their perceived chemical imbalance. The third power we analyze here is the ability to garner individual compliance with psychiatric drug prescriptions through a variety of persuasive and coercive techniques. These techniques, as will be made evident, work both directly through community-based programs, institutional confinement, and forced outpatient treatment and also indirectly through networks of alliances with other institutions.

Further tying these three principal forms of power together is how they are easily forced upon people in psychological distress or living in a state of homelessness—people who are stigmatized (Goffman 1963). Erving Goffman defines stigma as “an attribute that is deeply discrediting . . . a relation[ship] between stereotype and attribute” (1963, p. 4). Stereotypes, per Goffman, originate and are established in society, whereas attributes are characteristics possessed by a person. Stereotypes and attributes are related in that when an attribute is stigmatized, the stigma suggests the bearer possesses an othering quality that qualifies that person for social rejection, exclusion, or isolation. Stigma defines the bearer’s master status and as such structures that person’s self-perceptions, interactions, and the social order (Goffman 1963). It creates divisions among community members across societies.

The stigma experienced by the homeless women in our study is multifaceted and complex. They are stigmatized by their cognitive state (mental illness), their homelessness, and even their ethnicity or race, sexuality, or criminal past. The relationships between such attributes and the associated stereotypes shape their lived experiences, including opportunities available, treatment by others, and even self-perceptions (Kondrat and Early 2011). In consequence, bearing a stigma and the associated label ensures that their esteem is low, that they live with the knowledge that they will be judged simply by the fact that they reside on Skid Row and they will be rejected by others (Kondrat and Early 2011). Stigma, always a dynamic process and never a static reality, places these women in an inferior position by focusing on their virtual social identity rather than on their actual social identity (Goffman 1963), consequently leaving them subordinate and disempowered. In this same context, the stigma and associated prejudice, even discrimination, these

women face leave them even more vulnerable to those with biopsychiatric power, or any position endowed with power due to having the resources these women need given their desperate need (see Chapter 2).

We stress here that the problems of homeless citizens are not trivial or unworthy of assistance. Indeed, as discussed in Chapter 3, the vast majority of homeless individuals live under the weight of the emotional and mental scars they carry as a result of living trauma-infused lives. As a consequence of their histories of abandonment, neglect, violence, and deprivation, among a host of other tragedies, a significant number of homeless persons develop trauma-induced responses that are recoded as symptoms of psychiatric conditions. With few, if any, resources available to them, individuals are placed within a system that is often completely ineffective at recognizing and responding appropriately to the effects of trauma. Indeed, typical treatment responses to issues of trauma often entail little more than outmoded forms of talk therapy (Huey, Fthenos, and Hryniewicz 2012), prescriptions for psychoactive drugs, or both. When individuals do not respond to what the system defines as treatment, as is often the case, such failures are easily attributed to the individuals—their so-called disease being treatment resistant—and not to ineffective treatment or relationships with the treatment provider that may bar treatment effectiveness. Homeless citizens will then cycle in and out of the various institutions that make up the circuits of control in which homeless citizens are routinely plugged: shelters, hospitals, jails, and prisons. Of course, these spaces too carry a stigma of their own, which further burdens the women who must somehow navigate these realities and the associated meanings their experiences suggest to members of society. Not surprisingly, as these women increasingly fail to improve in their ability to function in ways society sees as normal, the role of psychiatric drugs becomes even more crucial to their management, both within the community and behind institutional walls. This book, in response, is about society's failure to provide adequate mental health care for homeless citizens, the majority of whom are deeply traumatized and stigmatized and experience chronic distress as a consequence. This failure, we argue, can be traced to the rise of the discourse of biopsychiatry, which has become the dominant lens through which homelessness and its attendant ills have come to be viewed (Rose 1998). Reliance on this lens has led professionals to turn away from the healing of trauma in favor of an overreliance on psychiatric drugs to suppress the purported dysfunctions of those least able to resist biopsychiatric power. In essence, then, what we describe here is not healing but the expedient management of problems, from the problems of individuals to the supposed social plight of so-called problem populations.

The Focus

Little doubt can be found that biopsychiatric power is a set of processes, embedded in the allopathic medical model, with the potential to affect all homeless citizens who come into contact with the institutions that make up or support the mental health complex (i.e., shelters, courts, hospitals, jails, and prisons). Indeed, these institutions bear a stigma of their own—the prison, the asylum, the court—that in itself is indicative of the empowerment of those with authority in such facilities. The doctor holds authority over the patient, the prison officer over the prisoner, and the judge over the defendant. The patient, prisoner, defendant, and so on, are known by their master status (Goffman 1963): the label they hold evinces their disempowerment and leaves them susceptible to what is put forth by those in positions of authority as “for her own good” (Ehrenreich and English 2005). With this situation in mind, we made the focus of this book women who are homeless and the way their responses to trauma come to be redefined as forms of psychopathology to be treated principally, if not solely, through the administration of psychoactive drugs—chemicals—without the accompaniment of any counseling, treatment, or trauma-informed care. We have chosen to narrow the scope of this book in this fashion because of the unique vulnerabilities experienced by homeless women as a group (see Chapter 3).

To illustrate why women might be more likely to be subject to biopsychiatric powers, we begin by examining the link between gender and trauma. Without intending to diminish men’s experiences of trauma, we note that studies have consistently found significant gender-based differences in exposure to forms of trauma and the responses they generate. Although men may typically be exposed to a greater number of potentially traumatizing events, in the form of accidents, combat, and physical assaults (Norris, Foster, and Weisshaar 2002), women are more likely to experience interpersonal violence, particularly involving someone they trust (child abuse, sexual assault, and domestic violence being three notable examples) (Ghafoori, Barragan, and Palinkas 2013; Tolin and Foa 2006). Women have also been found to experience greater levels of posttraumatic distress. For example, in a meta-analysis of studies of gender, trauma, and posttraumatic stress disorder (PTSD) symptomology, David Tolin and Edna Foa (2006) found that women exposed to trauma were more likely than men to report symptoms of mental distress by a ratio of approximately two to one. Women also reported higher levels of traumatic flashbacks, avoidance behaviors, and stress arousal (Ditlevsen and Elklit 2010), which last for a longer duration than found among traumatized males (Breslau et al. 1999). Women also appear to be at increased risk of postevent depression (Ghafoori, Barragan,

and Palinkas 2013; Tolin and Foa 2006). One theory put forward to explain these differences suggests that women's exposure to interpersonal violence by those they trust—caregivers, intimate partners—is more emotionally and psychologically devastating because of the element of betrayal involved in such actions (Freyd 1994; Hetzel-Riggin and Roby 2013), and that such betrayals threaten their sense of safety and security in profound ways (Janoff-Bulman 1992). Others point to the fact that of the various forms of traumatic experience analyzed by researchers, sexual assault, which is reported with greater frequency by women, is also associated with the highest reported rates of PTSD (Tang and Freyd 2012).

Regardless of the underlying dynamics, one thing remains clear: women exposed to traumatizing events, overall, are at an increased risk of developing symptoms of mental and emotional distress. The fact remains that women make up only a small percentage of the homeless population yet suffer from many vulnerabilities, particularly in ways unique to women. Thus, if women are generally more vulnerable in this regard, then the expectation is to see homeless women, who experience high rates of violence and significant life stressors and often live in highly adverse conditions, as being at substantial risk of developing or experiencing worsening mental health conditions (Davies-Netzley, Hurlburt, and Hough 1996; D'Ercole and Streuning 1990; Huey, Fthenos, and Hryniewicz 2012; Jasinski et al. 2010; Lam and Rosenheck 1998; Larney et al. 2009). And, of course, that is exactly what researchers have consistently noted. In a meta-analysis of research conducted in the 1990s, Marjorie Robertson and Marilyn Winkleby found that homeless women report higher levels of distress than that found in the general population, and they also consistently report higher levels of mental health problems:

The lifetime rates of schizophrenia in homeless women ranged from 2.5 to 17.1%, compared to 1.7% for women in the general population. Rates of major depression ranged from 15.8 to 32% compared to 10.2% for women in the general population. Bipolar disorders ranged from 3.3 to 12% compared to less than 1% in the general population. (1996, p. 317)

More recently, Angela Hudson and her colleagues reviewed the literature on victimization among homeless citizens, observing that childhood sexual abuse and physical violence are generally associated “with poor general health and psychiatric co-morbidities, including post-traumatic stress disorder, depression, and suicidal ideation” (2010, p. 1215). In their study of experiences of adult assault among homeless women, the authors found links between physical abuse and depressive symptoms, including loneli-

ness, low self-esteem, and social withdrawal (Hudson et al, 2010; see also Ambrosio et al. 1992). One longitudinal study found that “childhood sexual abuse, living in a shelter, physical violence, childhood physical abuse, and death or injury of a friend or relative predicted avoidant coping and symptoms of depression” among homeless women (Rayburn et al. 2005, p. 667). Perhaps it is not entirely surprising to find that to deal with the distressing psychological and emotional effects of trauma, many impoverished women turn to forms of avoidant coping, including drugs and alcohol (Rayburn et al. 2005; Robertson and Winkleby 1996; Yeater et al. 2010).

In general, not only do women report higher levels of mental distress following a traumatizing event (Koopmans and Lamers 2007), but they also appear more willing to use mental health services (Andrews, Issakidis, and Carter 2001; Rhodes et al. 2002; Sorenson and Siegel 1992; Wang et al. 2005). This finding appears to apply equally to homeless women: despite the fact that impoverished women face barriers to accessing healthcare services, researchers suggest a number of women do seek treatment for mental health issues (Huey, Fthenos, and Hryniewicz 2012; Tam, Zlotnick, and Bradley 2008). In one study, almost a quarter of the sample of 663 impoverished female participants had sought mental health treatment after a traumatic experience (Rayburn et al. 2005). By way of contrast, in a study of mental service use among homeless men, researchers found that “men are often reluctant to ask for help,” and those surveyed were “not likely to seek help for their physical and psychological struggles” (Amato and Macdonald 2011, p. 227).

Their increased use of healthcare services provides women a greater number of opportunities to be diagnosed with a psychiatric condition and offered drugs as treatment. With respect to the general population, this supposition is borne out by studies of prescription drug use that reveal higher rates of psychiatric drug use among women (Hausken et al. 2010; Hausken, Skurtveit, and Tverdal, 2007; Medco 2011; Roe, McNamara, and Motheral 2002). Data from one of the major pharmacy benefit managers in the United States shows a similar pattern: “Women are far more likely to take a drug to treat a mental health condition than men, with more than a quarter of the adult female population on these drugs in 2010 as compared to 15 percent of men” (Medco 2011, p. 2). According to the Medco (2011) study, women were more likely than men to use antidepressants (men’s usage in this category is almost half that of women), antianxiety drugs (again, women’s rate of use is nearly twice that of men), and to be prescribed antipsychotics. The only category where males exceed females in drug use is with respect to stimulants prescribed for attention deficit hyperactivity disorder (ADHD). Even here, girls are catching up,

with rates of prescriptions for girls described as increasing by almost 40 percent over ten years. These findings are mirrored elsewhere. In relation to antianxiety drugs, one set of Norwegian studies found that “being a woman” was a significant predictor of antianxiety drug use (Hausken et al. 2010, p. 472), with women being twice as likely to use these drugs as men (Hausken, Skurtveit, and Tverdal 2007).

In relation to psychiatric drug prescription and usage among homeless women, researchers know almost nothing. Despite high rates of reported psychiatric diagnoses within homeless communities (Austin, Anderson, and Gelberg 2008; Bassuk et al. 1998; Larney et al. 2009), treatment issues generally and the use of psychiatric drug treatment in particular have failed to generate broader attention from researchers beyond issues of drug efficacy and treatment compliance. Thus, one cannot say with any degree of certainty whether homeless women are more likely to be prescribed and consume psychiatric drugs than their male counterparts. However, theorizing their greater use in the population is not unreasonable given everything currently known about the gendered nature of mental health issues in both homeless communities and larger society.

To summarize our reasons for having narrowed the focus of this book to examining the range of homeless women’s experiences with mental illness: to the extent that homeless women experience relatively high rates of trauma, are significantly more likely to be emotionally and psychologically affected by trauma, and are more likely to visit a healthcare provider in search of treatment, they represent a group that is more likely to be recast as exhibiting any number of forms of mental illness. Further, this mental illness is then seen as amenable to treatment with drugs, especially psychoactive drugs. Thus, although this tendency cannot be seen as solely a gendered phenomenon, it *is* highly gendered. Further support for this contention comes from a review of the history of the “psy sciences,” a term we borrow from Nikolas Rose (1998), a domain notoriously littered with examples of how women’s suffering has been pathologized and their bodies subjected to harrowing treatments (Tasca et al. 2012).

Sources

The inspiration for our desire to explore the lives of homeless women came from a series of interactions we had while conducting research on trauma and coping mechanisms. The impetus for the current study can be traced back to Detroit and Chicago, where the research team, led by Laura Huey, conducted in-depth qualitative interviews with almost 100 women. A further fifty-five

interviews were then conducted with female participants in Liverpool and Manchester in the hope of teasing out a comparative approach to services. In the early days of the research, the focus was specifically on trauma, access to mental health services, and service usage. Although many of the women interviewed had participated in various forms of counseling, few spoke directly of experiences with psychiatry or of being prescribed psychiatric drugs. However, various women were encountered who, if they did not speak directly about their encounters with psychiatry, manifested physical signs of such encounters in the form of visible side effects of psychiatric drug use.

In 2012 the decision was made to relocate the fieldwork to Los Angeles, a city with a sizable homeless population that would afford greater opportunities to locate female participants. In shifting research sites, we also opted to expand the scope of the research to include a more broadly defined set of coping strategies that women use to deal with the effects of trauma. The current study is based on these interviews, which yielded significant insights into the use of psychiatric drugs to treat women's problems and, in particular, the way prescription drugs were being used in some cases as a means of modifying women's behaviors. During the first round of research in Los Angeles, the research team collected 107 interviews that were subsequently transcribed and analyzed. The initial results highlighted something that had been brewing in the back of our minds since starting this work: the great extent to which psychiatric drugs were being used routinely and often exclusively for the treatment of symptoms of trauma-based distress. Whereas the women in Detroit and Chicago seldom spoke of using psychiatric drugs, perhaps from fears of being stigmatized or because few had the opportunity to see a psychiatrist or general practitioner, women in Los Angeles were much more forthcoming about their experiences with both medical professionals and their psychoactive solutions. As a result, when we returned for two more rounds of interviews, the focus continued to remain on broader issues of trauma and coping, but more time was now spent listening to women's experiences of their encounters with such professionals. Within this phase of the interviews, women had much to tell us about the mental health diagnoses they had received, their feelings about the various forms of therapy they had tried, the treatments they had been prescribed, treatment compliance issues, and so on. In total, the team conducted 201 ($n = 201$)⁸ interviews in Los Angeles.⁹

The Shape of Things to Come

We have organized the chapters of this book to follow the lines of our argument. Thus, Chapter 2 provides a conceptual framework by introducing

some of the relevant literature on structural violence, the medicalization of social conditions, and stigma. Specifically we explore these phenomena in relation to how biopsychiatry as a worldview has come to dominate cultural discussions of human functioning and human suffering. We then investigate how homelessness has become medicalized, and we look at, in further detail, the role of biopsychiatry in the social response to homelessness, from the psychiatrization of the problem of homelessness in the 1980s to the use of psychoactive drugs to treat symptoms and regulate behaviors. We conclude the chapter with a critique of the medicalized and biopsych account of homelessness, providing an alternative, trauma-based explanation for the signs of emotional and psychological distress seen in homeless populations.

In support of our contention that trauma is a significant factor in the lives of homeless women, the nature of the suffering experienced by study participants is the focus of Chapter 3. Drawing on the women's own words, we break the first half of this chapter into three parts, which detail, in turn, the traumatic experiences women have faced in childhood and adulthood, as well as the struggles associated with becoming and being homeless. The discussion then turns to the damaging psychological effects of these experiences and how women attempt to cope with few available resources.

The purpose of Chapter 4 is to detail the first of the three forms of biopsychiatric power previously enumerated: the defining of women's problems through the act of diagnosis. We begin by exploring how women came to receive psychiatric treatment and the means by which psychiatrists, general practitioners, and other medical professionals translate women's suffering into a mental health diagnosis. Then, continuing to draw on participant experiences, we examine some of the diagnoses women had received, contextualizing these diagnoses by situating them in relation to the types of suffering women had experienced. We also consider individual thoughts and feelings about diagnoses, including the extent to which individuals self-identified with the labels affixed to their suffering.

Chapter 5 examines the second form of biopsychiatric power detailed here: the ability of medical professionals to prescribe psychoactive drug treatment for their patients, drugs that can null or suppress effects in terms of their emotional, cognitive, and behavioral functioning. First, we look at the types of psychiatric drugs that women in the Los Angeles study were prescribed, before turning to an examination of how women viewed the effects of these drugs. As our analysis reveals, for some, psychiatric drugs are seen as vehicles for self-improvement: that is, as solutions to the physical, mental, spiritual, social, existential, and other problems they face. One of these solutions, and perhaps the most obvious, is through symptom abatement. However, emphasis is also placed by some on the use of psychoactive

drugs as part of their reform-oriented work: that is, as a means of altering one's feelings and cognitions in the hope of effecting permanent life changes. We also consider the views of those who have alternative perspectives on the use of psychiatric drugs, views shaped either through beliefs in alternative healing systems or as a result of observing or experiencing null or negative effects from these drugs.

The focus of Chapter 6 is the third manifestation of biopsychiatric power in homeless communities: the range of persuasive (soft) and coercive (hard) techniques employed within and across institutions to garner treatment compliance. In particular, we explore the institutional environments within which psychiatric drug treatment decisions are made, supported, and enforced. Forms of persuasion include, for example, community-based programs that reinforce what is seen as patient responsibility in pill taking. When persuasion fails, various coercive mechanisms also can be deployed in order to enforce treatment compliance. These range from soft coercion in community treatment centers to health codes that permit involuntary detention and forced treatment to laws that allow for court-ordered treatment in the community. Although the laws, regulations, and policies described are specific to California, to the extent that such mechanisms exist in many other states and countries, we hope to furnish insights into how such euphemistically named concepts as assisted outpatient treatment function.

In Chapter 7, we begin by considering the effects of biopsychiatric power on individuals and in relation to the problem of homelessness. These considerations bring into sharp relief the extent to which the present system of mental health treatment is not only failing homeless citizens but increasing the potential for women to suffer further. In the second half of this chapter, we explore what an alternative mental health care system could look like and the benefits it could provide to individuals, families, communities, and the larger society.

Social Problems: A Final Consideration

As we previously stated, our primary interest in this book is in how biopsychiatric power manifests at the level of the individual and what the effects are for that individual. In placing the focus here, we are mindful of the fact that the problems of the people represented—homelessness, interpersonal violence, addiction, and mental health issues, among others—have social causes, meanings, and consequences. Although biopsychiatric power may be felt by particular individuals, it manifests through the institutions within

which they are embedded. Thus, any attempt at hiving one off from other is inevitably doomed to fail at providing a fuller picture of the social phenomenon we are attempting to analyze.

Focusing exclusively on the micro level is an analytical strategy that carries with it other risks. As other commentators have noted (Lovell 1992; McKenzie-Mohr, Coates, and McLeod 2012), the medicalization and psychiatrization of homelessness has permitted a means for the social problems referenced above, principally homelessness, to be redefined, thus shifting the burden of responsibility away from policymakers and institutions onto the backs of those least able to defend themselves from misattribution and blame. Rendering social problems into forms of individual pathology also allows for maintenance of an unacceptable status quo, a point well captured by Ann Lovell:

Using psychiatric status as an indicator of need presents a further danger. It promotes a circularity by which the supply defines the demand. That is, by defining the needs of homeless persons in terms of psychiatric dimensions and symptoms, the service itself—hospitalization or treatment—becomes the social goal. This circularity in turn legitimates and reinforces the existing system (or nonsystem) of services while preempting the possibility of other types of responses. It also removes from the universe of discourse (social policy) any indication of the macro-level changes that create and affect the day-to-day situation of homeless persons. It also removes from the universe of discourse (social policy) any indication of the macro-level changes that create and affect the day-to-day situation of homeless persons. (1992, p. 256)

A goal in this book is to use the same analytical strategy to invert the logic underlying the politics of biopsychiatry and to do so by using women's stories to reveal how the act of pathologizing individuals, and then inadequately treating their ascribed pathology, does little to solve the problems biopsychiatry purports to address. Indeed, more often than not, the acts of defining, treating, and enforcing compliance simply perpetuate or exacerbate these problems. That said, we return to our earlier contention that providing a fuller account of a given phenomenon, or a solution to a particular social problem, is impossible when individuals are treated as discrete entities that function separately from institutions, social structures, and processes. Thus, where appropriate, we will shift from a focus on the individual to the institutional, from the institutional to the social, and vice versa. Despite such attempts at providing what we hope to be simultaneously a broader and more detailed account, we are deeply cognizant of the fact that there is always so much more to be said.

Notes

1. Throughout this book the nonproprietary (generic) name is used in reference to or when discussing a particular psychiatric drug. However, when quoting a participant or another author or trying to clarify something for the reader, the appropriate brand name is left or added where referenced.

2. We employ the term *biopsychiatry* here to refer specifically to this branch of the general field of psychiatry. Although it is the predominant worldview found within contemporary psychiatry, as well as an influence on the work of practitioners in allied fields, it is not the only form of psychiatry presently in existence. Others include social psychiatry and cross-cultural psychiatry. Thus, we use *psychiatry* to refer to the field as a whole and *biopsychiatry* when discussing that body of research and clinical practice predicated on the belief that manifestations of human suffering are forms of mental illness largely, if not wholly, with biomedical causes.

3. Such medical practices were rooted in the ancient Greek humoral theory that tied disease to a variety of diverse imbalances, including those of the four humors (blood, phlegm, black bile, and yellow bile), four bodily conditions (hot, cold, wet, and dry), and the four corresponding elements (earth, air, fire, and water). Physicians were to balance these humors through treatments that were “opposite” to the symptoms. For example, bloodletting was a treatment to remove what was believed to be excess blood when a patient was flush due to being fevered (i.e., hot) (Kaufman 1988). This notion of allopathy has, although with contention, been applied to Western medicine to refer to a reliance on pharmaceutical and surgical treatments.

4. Prescription privileges vary by state. In California, registered nurses and pharmacists are permitted to prescribe drugs.

5. Again, our focus in this book—what we take issue with—is when such drugs are prescribed without being accompanied by any counseling, treatment, or trauma-informed care.

6. For example, dire outcomes, including suicidal ideations and feelings, were tied to the use of Paxil, especially among youths (Campbell 2010; Sexton 2003).

7. Ben-Moshe, Chapman, and Carey (2014) draw attention to falsities in historical understandings in explaining how the belief that the deinstitutionalization of people in treatment centers resulted in increased prison populations is not supported by demographic information. Instead they show how the prison boom accompanying deinstitutionalization was male and nonwhite rather than paralleling the demographic composition of the deinstitutionalized population. In this context, many of the victims of deinstitutionalization likely ended up on the streets.

8. Seventy-seven ($n = 77$) of those interviews were personally conducted by Laura Huey, and at least half a dozen of the remaining number were conducted under her direct supervision. An important point: although many of the participants in this study had been diagnosed with a mental illness, usually depression or an anxiety disorder, a principal requirement of study participation was the ability to give informed consent. Thus, if any woman appeared to be incapable of giving that consent (i.e., seemed intoxicated or exhibited signs to suggest that she was actively delusional at that time), we skipped the interview, and she was given a gift card and thanked for her time.

9. Although we do not make use of those earlier interviews in Detroit, Chicago, Liverpool, and Manchester in this book, we may include Huey’s experiences in these sites when illustrating a salient point.