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"She made me a dumping site":
A Preliminary Study on Social Exclusion amongst Women with Depression

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Abstract

This article aims to explore social exclusion experienced by women with psychiatric morbidity, particularly depression. Stigma is a major hurdle for personal mobility since it potentially degrades the status of victims' family and causes a great embarrassment especially in Eastern communities. Patients often are misunderstood and discriminated, restraining their true human potential. Similarly, the representational system of people with mental illness has been deeply influenced by a socio-historical product rather than pathological. Hence, such social exclusion is taken for granted in everyday life. This article is a preliminary study that employed a phenomenological approach to explore the significance of social exclusion experienced by the women. The gender lens was used to analyse the data. Four women who were service users of mental health care in Kedah and Penang were recruited and the data were analyzed through the gender point of view. The semi-structured in-depth interview and non-participant observation were the tools used for data collection. The data were then explicated with the aid of the qualitative data analysis tool, Atlas.ti, version 7.5. The findings revealed that the informants identified suffered systematic social exclusion including prejudices, oppression and discrimination, namely at individual, community and institutional levels. Also, the interplay between social exclusions and gender-based violence were evident in the data where this further pressed the patients down and worsen their condition. The results are supported by a number of past studies which highlighted that women usually had to endure the adverse effects of social exclusion more than men.

Keywords: *Women, Depression, Social Exclusion, Gender, Outpatient*

INTRODUCTION

Depression is a common disease in modern society. The World Health Organization (WHO) estimated that depression could be the second deadliest disease by 2030 (WHO, 2010). In Malaysia, a steady rise in cases of psychiatric morbidity can be observed in the statistics of the last 20 years. For example, in 2002, 2.9 percent of patients was registered as psychiatric sufferers while in 2011, the overall morbidity reached up to 9 percent from the overall population (Abdul Kadir et al., 2011). The statistics further stated that 29.2 percent or 4.2 million Malaysian adults were suffering from mental health problems, which three-fold more than those reported in 2011

(Institute for Public Health, 2015). In relation to social exclusion experienced by a person with psychiatric morbidity, Sayce (2000) argued that patients succumb to both material and non-material exclusions that systematically discriminate every aspect their life domains. The non-material factor usually originates from social environment that produces and potentially reproduces prejudice, discrimination and oppressing treatment, alongside resource deprivations such as job recruitment, education and housing opportunities (Morgan et al., 2007). Thus, the question of inclusion for access and participation from the mainstream economic, political, social and cultural activities are not by choice but by a forceful marginalization from the great systemic level that determines one’s future. This situation reveals that inclusion can be a bogus term that demolishes the agency, consistent with Morgan et al. (2007) term of “enforced lack of participation”.

The statistics in Malaysia showed a steady increment in the number of women experiencing psychiatric morbidity and often times the figure reported surpass those of men (Abdul Kadir et al., 2011; Institute of Public Health, 2015). In fact, it is well acknowledged that women suffer the detrimental effects of mental illness more than men (Garland-Thomson, 2002). Wetzel (2000) deliberately pointed out that the gender socialization in many societies turned their women into powerless, dependent and emotionally suppressed individuals who succumb to female inferiority. As a result, these women face twice as much the risk of vulnerability to mental illness and emotional trauma. With the above arguments, the current article explores the social exclusion experienced by four women who were diagnosed with depression from the gender lens.

LITERATURE REVIEW

Gender Perspective in Depression Studies

Depression is perceived as a gendered phenomenon in the most difficult situations (Conrad, 2005). Women often suffer vulnerabilities in twofold, from private and public discrimination as well as mental health issues and emotional labor risks. Feminists view women living in oppressive settings as being dominated by patriarchal power (Busfield, 1988; Wetzel, 2000). Simultaneously, mental health issues amongst women has always been given a misogynist label to keep the women’s status low in the social hierarchy, where the symptoms are often times perceived as a “myth” that should be resolved on its own (Ussher, 1991, 2011). This misogynist labeling does not only deny the right to acquire an access to better healthcare for these women but also repudiate the differences in the society of how they experience their everyday life.

However, Garland-Thomson (2002) highlighted that both genders were likely discriminated by the public because they bear the unwanted status in the society. Labels such as dangerous, unpredictable and violent were some of the behavioral prediction

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yardsticks that are imposed on psychiatric patients (Corrigan et al., 2011). The pressure placed by the society leads to disability, a social construction of everyday language about the docile body. Thus, the identified docile body is deemed to require the need of disciplining through the politics of medicalization (Foucault, 1991). On the other hand, such double-standard treatment in the society cultivates prejudices, discrimination and oppression that hampers the recovery process, often causing sufferers to feel hopeless (Corrigan & Shapiro, 2010). In a disability study of mental illness, Garland-Thomson (2002) contended that men who are diagnosed with mental illness are perceived by the mainstream society as having feminine quality and abject bodies that are equal with women, elderly and children. In this context, the men are deemed as individuals who failed to associate themselves with the hegemonic masculine quality and consequently this made them weak, dependent and powerless (Wong et al., 2012; Oliffe et al., 2013).

Women and Social Exclusion

The impact of social exclusion is unfavorable and demeaning to one's life. Morgan et al. (2007) posited that social exclusion in the community can confiscate social roles and networks that would limit an individual's opportunity in the future. The biases of the representational system based on history, culture, and tradition play a major role in shaping the public perception towards this vulnerable group. In this realm, men and women were both discriminated by the authority and public as a whole in every aspect of the life (Garland-Thomson, 2002). However, the degree of discrimination is somewhat different, where women endure the effects more. This situation is linked to women's position in the society and the treatment they often receive within the patriarchal structure. For example, reports on gender-based violence such as domestic violence state that more women than men are battered and this attests to the inequality in women's life.

Women were expected to carry the twice the burden or double shifts in a day compared to men. Most cultures do not associate men with household chores and caring for children or parents. These burdens are assigned to women where a softer touch is needed in handling each task. In the era of globalization and improvement in literacy, many women are forced to work outside the house to ease the cost of living but they are less likely to be free from the burdens in the private domain (Busfield, 1988). The ensuing stressful condition increases pain and heightens the tendency of developing mental illnesses amongst women.

Help-seeking behavior also favors men over women. Some Eastern cultures perceive mental health issues as a non-medical problem (Barn, 2008; Basu, 2012) simply because the status tarnishes the family image and ends marriage prospects for their women (Al-Krenawi et al., 2001). In a traditional family in India, Basu (2012) reported that women who have displayed symptoms of mental illness were forced to suppress their emotional unrest up to the point that they felt they were dysfunctional in everyday life. On the contrary, family members were more sensitive to the behavioral

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changes of their men. In this case, a sick man who showed depressive symptoms were expected to be sent to the hospital or shamans to receive treatments while sick women were often left untreated (Janardhana et al., 2011). This response proves that the social structure in most cultures favors men over women due to men's significant role as an economic provider for the family.

In a similar vein, psychiatric morbidity risks the denial of opportunities in many aspects of life such as employment, education, housing, social relations and others (Asia-Australia Mental Health, 2008). The stigma associated with the mental illness status spurs the bandwagon effect in other life domains and endanger one's citizenship rights (Crabtree & Chong, 1999). So rather than seeking for help, many psychiatric sufferers choose to avoid help seeking (Sunkel, 2011; Ito et al., 2012).

METHODOLOGY

This research conveys preliminary findings from a bigger project. For the purpose of answering the study's objective, a phenomenological approach was undertook to explore the significance of a phenomenon, in this case, the experience of social exclusion. The approach was chosen because the narratives from the informants are regarded as representing the first-hand accounts of the investigated phenomenon (Creswell, 2013). The recruitment of each informant was made at the government psychiatric outpatient clinic, namely in Kedah and Pulau Pinang. The recruitment process followed four main inclusive criteria, 1) woman, 2) aged 18 years old and above, 3) diagnosed with depression, and 4) has sought for care at the psychiatric outpatient clinic for at least 12 months.

Data were gathered through a semi-structured in-depth interview with four informants. Each of the interviews was audiotaped. All the interviews were conducted at the clinics as it was preferred by the informants. The data were transcribed and explicated with the aid of the qualitative software, Atlas.ti to identify the emerging themes. The study has obtained the ethical clearance from the Ministry of Health Malaysia (MOH) and the university's research board (IRB).

FINDINGS

Socio-Demographic Profile

The researcher interviewed four women who were the service users of the government mental health care in Kedah and Pulau Pinang. Each interview session took approximately 45 to 60 minutes and covered general questions on the feeling of depression they had experienced. The informants were aged between 23 to 63 years old.

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The employment status indicated that all the informants worked in both formal and informal sectors. Two informants were actively working in private and government sector, one was a government pensioner, and another was a homemaker. Simultaneously, one informant was single when the interview took place; while two were married, and one was a divorcee. All of them received tertiary education.

Social Exclusion at the Individual Level

All the informants associated themselves with adverse life events that lead them into the feeling of depression. During the interview, every informant described that depression had bred internal threats within them which were unnoticeable at the initial stage of the depressive episode. In this context, the informants felt dejected and marginalized without any valid reason. The internal threats they described are consistent with the symptoms outlined by the Diagnostic Statistical Manual produced by the American Psychiatric Association (APA). The unpleasant feeling was also often associated with the role of women in the household that affected their relationship with the person in control at home. They also reported that they did not receive adequate support from their family members and friends. Simultaneously, the data indicated complaints about feeling dysfunctional in everyday task or feeling of inadequacy in performing the task as a caretaker. Such dysfunctional state has triggered the differences in experiencing their day-to-day life. These feelings were expressed by a homemaker, Fatin, who gave up her work as a manager in one of the multinational companies in Kuala Lumpur. She decided to take care of her sick mother after she failed in her marriage. Three years before the decision were made and after her father's passing, Fatin had her first depressive episode. She lost her safety net in life. She stayed with her mother who was antagonistic towards her but simultaneously demanded her presence. Fatin then decided to marry her boyfriend, a Pakistani who wished to live freely in the country. The decision was made to restore her safety net that she had before even though Fatin had only known him for six months through a friend. Despite the objection from her mother, she pursued her decision to get married as an escape plan from her tense life in her mother's house. The three years of the marriage was destructive for her. Fatin suffered three miscarriages as well as emotional abuse from her husband who claimed she was not good enough for him. She further elaborated:

> *Depression is like hopelessness, useless, nobody loves you, appreciates you, nobody wants to be with you, feeling the loss, in my opinion, feeling of unworthiness…. When my dad died, I felt like a big chunk of me was taken out, that was my safety net. I didn't know at that point in time that I had developed depression…. Then, I decided to marry my boyfriend, whom now is my ex-husband, to fill in the male-figure in my life. Mom was against my decision, but I had to run away from mom because she made me a dumping site for all her negative emotions towards her sisters and her other kids. My marriage was hell! He was overly jealous, asking*

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> *me to quit my job, and not happy if I worked from home. He wanted to stay for free and had given away my expensive carpets and some other stuff to strangers like he was a rich man. We fought so much! He battered my soul by saying, "You are a bad wife and I must teach you a lesson", just because I was not willing to let him sell my house and share my earnings! He repeated them like chanting mantras. I cannot take these pressures! I threw him out of my house and filed for a divorce after three years in this brutal relationship.*
>
> *(Fatin, 43, Homemaker)*

Social Exclusion at the Community Level

Social exclusion in the community often exists due to the misunderstanding on the disease a person has. This fact is often voiced in relation to mental health issues. According to Goffmann (1963), such misunderstanding originates from stigma, a discernible symbol that weakens the qualities of an individual's status and his/her value in the society. Most often than not, psychiatric patients are usually tainted with a lifetime of stigma or moral career which they pursue upon receiving treatment at the psychiatric clinic. The moral career shapes a new identity, influenced by the societal belief system that portrays them as inferior, weak, unpredictable and violent (Pescosolido, 2013). In Malaysia, the government pays little attention to protecting their rights as citizens by proiding only lip service through its policies and programs (Crabtree & Chong, 1999). The situation renders most psychiatric patients in great helplessness due to the suffering resulting from social withdrawal and alienation at the community level. All the informants testified that they lost many friends due to their sickness, especially their good friends and relatives.

Among most of the informants interviewed, loneliness emerged as one of the prominent state that described their life. Although they believe it is necessary to express their ordeal explicitly to release their stress, paradoxically they did not have anyone to talk to about it. Trust was another issue they pointed out. Because of the severe effect of misunderstanding, they often reserved their feelings and opinions. This case was clearly depicted by Nicky, 24, who was a student at a local college and was working part-time at one of the sports centres in Pulau Pinang. Growing up with dyslexia took a significant toll on her mental well-being as people undermined her true ability and capacity, especially in education. Nicky came from an educated family, spoke fluent English and expressed her opinion clearly during the interview. Nicky realized the stigma and oppression that are suffered by people with mental health issue, and it led her to build a wall of secrecy as her strategy to curb the effects. The situation caused her to indirectly withdraw from her circle of friends by displaying vigilant behavior towards everything she engaged. She further explained:

> *No, I didn't mix with my friends or classmates anymore because I was scared that my secret of this illness will be known by others. I am scared*

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> *of the consequences of telling. So, it's better for me to keep it to myself so people don't know. I am a Dean List student, working hard to reach this stage so that I could get a good job. The field I studied is small in Malaysia. I had a standard to adhere. So, imagine if the rumor on my illness gets to the employer's ears? I opt to control this situation.*
>
> *(Nicky, 24, College student cum Sales Clerk)*

Social Exclusion at the Institutional Level

The social representation of mental illness is often taken for granted, spread and internalized into the social system of the society. Policies and programs, either from the public or private services in the country, are identified to have discriminating elements towards these patients. This paradox situation eventually are shaped and politicized by the people in power, such as the government (Pescosolido, 2013). The effort to normalize depression undertaken through the mass media changes the perceptions of public as a whole, where the issue is openly discussed by celebrities who claimed that they have experienced depression (Kangas, 2004). Interestingly, Angermeyer et al. (2014) identified that although the negative perceptions were alleviated in Germany, the attitude of the people there remain unchanged. Essentially, the changes affecting anti-stigma movement are minimal due to the low support they receive and hence, discrimination persists. In gender relation, women represent the minority as they have lesser power and limited agency to make changes. Hence, women are more open and prone to discrimination compared to men.

All of the informants professed that their health professionals had passed judgment on them and showed little empathy during treatments. One of the informants, Rokiah, a pensioner, discovered she had depression when the doctor confirmed she had a brain disease affecting her body balancing. In her marriage, Rokiah often had qualms about her ability to serve her husband sexually ever since she passed her menopausal phase. On top of that, she reported that had stopped performing household chores such as cooking, tidying the house and laundry. Meanwhile, in the hospital, the discrimination was often inflicted by the medical officers who attended many of the cases compared to the psychiatrists. She asserted that doctors often lacked interest in listening to the patient and showed no initiative to instil a sense of empowerment in the patients. Concomitantly, the unsystematic registration and waiting at the service counter added to the stress she was already facing. Rokiah expressed:

> *The doctors are pressing every time I come and see them. They often accuse me of not consuming my medication because my symptoms didn't improve as they had projected. Well, I did take the pills on time. I felt like a guinea pig. Some of the doctors didn't even bother to check the data before attending to the patient. Young doctors showed a lack of experience; they never used their psychology [skill] while conversing with us. It hurts me most of the time when they undermine me. Clearly,*

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> *this is not the way to talk to psychiatric patients, and it is very impolite especially for an elderly like me. The doctors straight away labeled me! They just wanted to get the job over and done with. I had to wait two to three hours for the treatment, but the meeting usually takes five to ten minutes only. It's not worthwhile with the long waiting. Everybody just wanted to get rid of the patients fast!*
>
> *(Rokiah, 63, Pensioner)*

DISCUSSION AND CONCLUSION

This study is a preliminary investigation to understand the type of social exclusion experienced by psychiatric patients, particularly from the gender standpoint. The data found supported the notion that patients are confronted with daily challenges to reach the stage of well-being. In fact, the study suggests that these patients found it impossible to recover because the stigma attached on them influenced their mobility in their everyday activities. In these cases, all the informants reported of having been involved in adverse life events that caused their depression. The data also suggest that the lack of agency for each of the patients intensified their stress, coupled with the shortfall of social support from family members and friends. This finding concurs with Alvarez-del Arco et al. (2013) which highlighted that family members and friends are the top perpetrators who inflicted abuse either emotionally, physically or sexually on patients with mental illness. The lack of agency is also manifested in the gender relation within the patriarchal family structure where women should obey the elderly and their husband. This cultural prescription molds the expected behavior of women and they are forced to work to ease the household financial burden in both private and public spheres. Women tend to be entrapped in double roles and this increases the probability of living stressful lives, hence ensnaring them in the hollow of depression. The paucity of agency caused many women could not promote change, where they were badly treated by their husband although they were financially independent. The findings served a definitive evidence of occurrences of domestic violence perpetrated by the husbands in their private domain. Most often, such abusive acts are legitimated as corrective actions on their women, and they are largely accepted and approved by the society. In other words, culture often normalizes these abusive acts, turning them as necessary actions (Heise et al., 2002). The situation unfortunately bred internal threats within the patients that pull them down in life. In this case, women are exposed to domestic violence although they are financially independent. However, the awareness that they have to stop the abusive relationship, empowered by their financial independence, helps them to escape the dreadful circumstances they are in.

Stigma is indeed apparent in patients' life. Labeling is the catalyst of the stigmatizing process that straightaway undermines the value of the labeled individuals.

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Patients tend to adopt secrecy of their illness as a strategy to control the labeling of the society. Simultaneously, the response of keeping the illness as a secret is a manifestation of their distrust of their social environment. In this context, the study noted the failure of the deinstitutionalization agenda for eliminating the social stigma imposed on psychiatric patients. In addition, the study also identified the gap in the doctor-patient relationship, namely that doctors do not strive to gain the mandate of trust of the patients through their insensitive gestures. According to Skirbekk et al. (2011), the limited mandate of trust inhibits openness to authorize the doctors to undertake their medical judgment on the patients. Through this limitation, the type of relationship established in the hospital in view of the gender lens proved that women with depression experience social exclusion at the individual, community, and institutional level. This is consistent with Garland-Thomson (2002) who posited that the social exclusion of women developed a state of disability, where disability in this context is culturally constructed by enveloping it into the everyday language of the body between the normal and abnormal. The presumption of the ideal body built upon the Western framework of commonness deepens the social exclusion in Eastern society, even more for psychiatric patients. Likewise, women with mental illness in this study were considered as somewhat disabled – to think, make a decision, or control their bodies. The issue of representation through the label to one extent influenced the patients to accept the derogatory label as the prescribed attributes that promote vulnerability in them (Corrigan et al., 2011). Hence, it high time that a review of deinstitutionalization agenda in the country is undertaken to evaluate and realign the theory with practice. Gender sensitizing is important because it is assesses not only women but also another group that is systematically marginalized by the current ruling.

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