The Medicalization of Female Deviance & Criminality

Introduction:

In a correctional system geared towards male offenders, women face many difficulties when they become criminalized. From a lack of programming to somewhat dismissive government policies, it is undeniable that women within the criminal justice system are often overlooked due to their relatively small numbers. We have seen the correctional system ebb and flow with regards to women, with some governments trying to address women's issues and others attempting to dismiss them almost entirely. However, the treatment of women within the correctional system is also a medical issue in addition to being a political issue. Ultimately, women are subdued and manipulated medically by the correctional system in Canada, mirroring the centuries of medicalizing and controlling women to fit the ideals of a society that continues to be patriarchal. I will explain in my paper that the continuous medicalization of women for exhibiting deviance masks the underlying structural issues which lead women to commit crimes, and that this approach is not helpful in the rehabilitation process.

Medicalization:

What is medicalization? The term refers to the treatment of social conditions or mental states, or collections of symptoms which are considered undesirable as if they were a medical problem (Kilty, 2014, p. 236). This can include more controversial conditions such as alcoholism, substance abuse, menopause, and even sexuality has been medicalized at various points in history (p. 236-237). However, the process of medicalization includes conditions which most people would agree are legitimately medical, such as epilepsy (p. 236). What may have been considered a medical issue a century ago may no longer be considered as such nowadays. The reverse is also true, in that some conditions were not considered medical in nature but now are conceived of in this manner. Identifying these undesirable conditions to be medicalized is hence defined by social and historical context.

This process is also used to conceive of criminality as a type of illness which must be cured or treated using medical intervention (Kilty, 2012, p. 163). According to Jennifer Kilty, medicine acts as a form of social control (Kilty, 2012, p. 163). It follows, then, that deciding which conditions and which people must receive medical attention and which do not is a form of power. Medicalization notably becomes even more of an issue of power when it is applied to deviance. There is already a lot of contention when dealing with deviance in society, as it often involves rehabilitation, treatment, and punitive measures. However, when deviance is medicalized, it becomes a mechanism of rather intensive social control, as I will demonstrate throughout this paper.

All too often, prisoners and psychiatric patients with mental health concerns are deinstitutionalized and left in the hands of other treatment services in the private sector, becoming a “repackaging of misery” (Maidment, 2006, p. 19). This means that rather than dealing with the issues that medicalized deviance brings, the affected individuals are shuffled around between institutions and subjected to various treatment options without addressing the underlying circumstances which led to the criminality or deviance in the first place. The reasons for decarceration and deinstitutionalization are largely economic, meaning that these economic motivations masquerade as compassion (p. 19). People are sent back into the community without having received adequate attention from professionals, and often receiving treatment that is not well-suited for their needs. The end result is that the real medical issues which may be present are not addressed as well as they could be, and they are rarely dealt with sufficiently to achieve the goal of rehabilitation.

Outside the Prison Walls:

Women and women's needs have been medicalized for centuries. Kilty describes how women's bodies have been made medical through processes of childbirth, pregnancy, menopause, and also through the growing fields of psychology and psycho-pharmacology (Kilty, 2014, p. 237). Outside the prison walls, many women's criminogenic needs and risk factors have been treated as medical problems. An example of this is how some women in the past were considered to have a condition called "hysteria" which, in reality, was just the healthy expression of female sexuality (Tasca et. al., 2012, p.110). As we know, medicalizing seemingly normal aspects of life is a way of controlling certain populations. Women were often considered to be weak and vulnerable to mental disorders when female hysteria was treated as a legitimate medical condition (p. 110). Since women who experienced what we would now consider normative sexual feelings were considered deviant, it follows that being a woman was a form of deviance in itself.

Female hysteria has a long history, with its origins and early mentions being traced back even as far as the time of Ancient Egypt (p. 110). Descriptions of female hysteria were present in Ancient Greece, Rome, the Renaissance, and even in the early 20th century (p. 110-115). It was known as a disease of women, inhibiting their ability to procreate, presenting unfulfillable sexual desires, and allowing women to manipulate their environments to serve their needs (p. 115). Reading this description of the "illness" in the 21st century, it seems almost obvious that this was a mechanism of control devised by men. The erring woman, subject to her earthly desires, capable of thinking beyond that which was expected of the loyal and doting housewife, has long been a threat to the patriarchal order of society. It follows logically that there have been mechanisms put into place to "heal" or treat the erring woman in a medical milieu to serve the needs of the patriarchal order of society.

As we have seen illustrated in the case of female hysteria, women are often construed as the victims of their own biology and as entities that require control and male discipline. The construction of women as irrational and overly emotional is a form of patriarchal dominance (Snider, p. 273). Snider so eloquently states that women "always bore the blame, the shame, and the baby" (Snider, p. 273). This expresses the deviant nature of the simple act of being a woman in a male-dominated society. Criminalized women were for a long time seen as worse than men convicted of similar crimes and thus, they were in need of treatment (Snider, p. 274). Problematizing and medicalizing women's needs and concerns is a process which is especially heightened in their interactions with the correctional system. This is particularly relevant for women already facing a nexus of poverty and discrimination prior to their involvement with the criminal justice system. We can consequently assume that having needs is considered inherently un-feminine and requires intervention.

On the other hand, the normative woman is constructed as subservient and nurturing (Menzies & Chunn, 2014, p. 179). When women are victims, there is also a prescription for how they can be victims, the reasons for victimhood, and so forth (p. 179-180). Breaking these norms is thus construed as a sign of moral depravity (p. 180). Even women who are not violating the Criminal Code can be considered as breaking the norms of what it means to be a good and normal woman. Traditionally, women have been located within the home and with the family, relegated to the private sphere of life (p. 181). It thus follows that any woman who breaks this mold and locates herself within the public sphere – working, not marrying, remaining childless, potentially being promiscuous – will be identified as deviant (p. 181). As we have seen time and time again, deviance is often medicalized. Transgressing norms of femininity is frequently discussed in medical terms, whether it is in a formal medical condition such as female hysteria, or informally in the sense that something must surely be wrong with a woman when she does not fulfill her prescribed feminine duties.

This moral ineptitude can be dealt with in a myriad of ways. As Kilty describes, there is a growing reliance on pharmaceuticals to provide a quick fix for a variety of symptoms (2014, p. 237). When deviant women are medicalized, this opens the possibilities for intervention – medications can help to obscure the larger picture of poverty and structural disadvantage with individual pathology (p. 237). This masks the root of the deviant behaviours or characteristics and places the blame on the individual women and their "damaged minds and flawed cognitive processes" (p. 237). The focus that powerful institutions in society have had on rendering women as deviant actors is a way to shift the responsibility for women's disenfranchisement from themselves and onto those women whom they have distinguished as problematic.

Inside the Prison Walls:

Within correctional institutions, women continue to be thought of as deviant and their needs are often constructed as medical in nature. Rather than thoroughly examining the social and cultural needs of criminalized women and developing adequate programming to suit these needs, the correctional system medicalizes these needs. In increasing numbers, criminalized women are diagnosed with psychological disorders (Kilty, 2012, p. 163). We are seeing a trend of women being treated as if they were inside a concrete womb when they are imprisoned, a term used by Watterson in the subtitle of her book (1996/1973). The criminal (in)justice system, as Maidment refers to it, is in conflict with women because it criminalizes experiences such as poverty, mental illness, past traumas, and the like (Maidment, 2006, p. 16). The medicalization of women inside the prison environment is thus a form of infantilization and control because it exacerbates past medical and health-related issues in a very oppressive manner.

This trend of relying on biomedical knowledge to quell prisoner unrest is not a recent phenomenon. Thuma describes how a Massachusetts women's prison came under fire in the 1970s when the public became aware of the extent of the erosion of human rights for prisoners (Thuma, 2014, p. 31-32). This period in the 1970s was riddled with rebellions unrelated to the prisons, notably the Puerto Rican Independence movement and anti-war movements, and activists began to enter prisons for charges related to their activities within these movements (p. 32). Their activism did not stop when they entered the prison and these "rebellious" prisoners would often be targeted for segregation and labelled as "mentally ill" due to their participation in activism (p. 33). In this fashion, women who were first criminalized and then labelled deviant within the prison also became medicalized.

Thuma further describes that prison administrators sought out ways to control the restless and rebellious prison population, and turned to techniques of behaviour modification, which included the use of "psychochemical" technologies (p. 32). These new approaches including a variety of methods Thuma refers to as verging on torture eclipsed the psychoanalytic and education-centric approaches earlier decades had seen (p. 32). Thuma refers to this evolution as the "biologization of violence" in correctional institutions (p. 32). Eschewing the past approaches for a more medical approach has, in turn, created a perception that violence and crime must be linked to biological defects, locating the problem or defect within the individual rather than the structure of society. This can also be described in terms of biological reductionism, wherein the prisoner is viewed not as a human being with a medical condition, but simply as a body to be fixed or cured. Even though Thuma's is an American example, it illustrates the fact that medicalizing deviant women is not new, nor is it an exclusively Canadian issue. Unfortunately, due to the nature of prisons, incarcerated women are subject to whichever method of "help" is fashionable at the time.

In the present day, the fashionable method of "help" is through pharmaceutical interventions. Of the women incarcerated in federal institutions, 87% of them have medication orders and they are prescribed on average 4.4 medications, 42% of which are psychotropic medications (Kilty, 2012, p. 163). These high numbers of criminalized women taking psychotropic medication can best be described as alarming. The rate at which psychotropic medication is prescribed within women's prisons is much higher than for women outside prison (Kilty, 2014, p. 237). Potent anti-psychotic medications are also used as sleep aids (p. 238-239). This is problematic for a variety of reasons, but the most damaging of these reasons is that this misuse of strong medications could be a contributing factor in drug dependence and further problematic substance use (p. 239). Given that substance use is already a factor in many marginalized women's lives, this form of treatment is grossly ignorant of the supposedly rehabilitative functions of prison and has the potential to worsen the situations of many of the women subjected to these medications.

Why are prisoners so heavily and problematically medicated? The answer lies in the chronic lack of adequate programming inside institutions. These therapeutic initiatives are enacted with the goal of reforming "the criminal mind" and "remak[ing] women into respectable ladies" (p. 239). The assumption behind this goal is that crime results from criminal individuals, rather than from social circumstances (p. 239). Correctional programs have a tendency to deny the structural factors which lead women into crime because when these are acknowledged, they are thought of as denials of responsibility (p. 240). Thus, in fear of seeming soft on crime, correctional services focus on attempts to responsibilize the women and reprogram their brains using psychiatric interventions and misused psychotropic medications. This practice furthers the medicalization of expressions of deviance from the social norm, including poverty, criminality, and womanhood itself.

The lives of women inside prisons are characterized by stress and confinement, so the fact that medical issues and anxieties may arise as a result of these less than ideal conditions is unsurprising. Some of the notable stresses imprisoned women face are upcoming court dates, dealing with lawyers and the justice system, worrying about their families and loved ones, and so forth (Watterson, 1996/1973, p. 255). These types of pressures are part of prison life and pursuing medical treatment in the face of this pressure will not fix the underlying issues, nor will this approach teach the women to cope with and overcome their circumstances. The reality of life behind bars needs to be addressed rather than masked with over-medicalization and the alarmingly high rate of use of psychotropic medication.

The psy-carceral complex, as Kilty refers to it, can have fatal consequences (Kilty, 2014, p. 236). Treating mental illness in the punitive prison environment often causes more harm than it heals (p. 236). Briefly looking at the case of Ashley Smith, a young woman who committed suicide while in administrative segregation, we can see the extent to which the current system of overly-medicalizing women offenders is in dire need of change. Ashley Smith had been difficult for prison staff to deal with, as her mental illness (which she had only been broadly diagnosed with inside prison) often manifested itself in resistance to authority (p. 242). A long list of failures of the system and of individuals involved was released after her death, one of which included the absence of a proper assessment of her condition, followed by a comprehensive plan to treat her condition (p. 243). A lack of understanding of Smith’s needs could have been avoided if mental health issues were not treated as a site of control and punishment for incarcerated women.

Indigenous Approaches to Healing:

Indigenous women are overrepresented in Canadian prisons, so there is an increasing focus on issues they specifically face in the correctional system. One such issue is that of decolonization with respect to healing trauma (Comack, 2018, p. 226). There remains a tendency to over-rely on psychiatrists and psychologists to provide the healing mechanisms and strategies, but the unfortunate reality is that these medical professionals pathologize individuals (p. 226). This is not conducive to the wholistic approach used in Indigenous communities, as these medicalized, Western approaches focus on “illness” rather than “wellness” as is done in Indigenous communities (p. 226). When we view trauma as an illness, we view it as something to be treated in terms of dysfunction. A wellness approach focuses on resiliency, which allows women to overcome their trauma rather than medicate it.

Comack raises an extremely valuable point – healing trauma must happen in a context that reflects the individual’s worldview, experiences, and knowledge (p. 226). For Indigenous women, this means relying on Indigenous methods of healing. As a society, we cannot impose a healing strategy on people for whom the strategy does not work – we must be mindful of the impact that culture has on healing trauma and overcoming psychological struggles. Imagine if a doctor prescribed allergy medication to combat a sprained ankle – this medical intervention would surely not work. We need to be cognisant of mental health and wellness in the same way as physical health, being aware of the issue and the type of treatment best suited for the person and their condition. Decolonization must be understood as the key to countering and overcoming the generations of trauma which have characterized the lives of Indigenous women in Canada (p. 227). It thus follows that implementing these culturally-sensitive and relevant approaches can have truly positive and healing effects.

Medicalizing experiences of trauma, victimization, and mental health concerns to the extent which is done inside Canadian women's prisons is unnecessary and hides the real structural issues present both inside and outside prisons. Creating a system where almost half of the women are on psychotropic medication constantly is similar to putting a band-aid on a bullet wound – it only masks the problem but does nothing to address the underlying problems and pain. Seeing as women are often victims before they become offenders, there are trauma trails which need to be addressed as part of the healing process.

"Crazy" Women & Dealing with the Criminally Insane:

A woman deemed "criminally insane" by the institutions which have the authority to impose this label has even more to deal with than the average offender when she enters the correctional system. These criminally insane women must navigate the complex maze of psychiatry and law as these institutions respond to their individual situations (Menzies & Chunn, 2014, p. 177). The crime here is not simply a violation of the Criminal Code of Canada, it is also a crime against womanhood and what it means to a normative female in Western culture (p. 177). In these instances, crime and gender intersect to create conflict with the system and to pathologize women who create that conflict (p. 177-178). Criminally insane women challenge the norms of what it means to be a woman and which types of people commit crimes.

Mental health systems have long been associated with treatment forms that mimic the normative gender expectations (p. 178). Menzies and Chunn compare mental health institutions to the psychiatric experiences of inmates, as both groups are subjected to similarly gendered forms of treatment and control (p. 178). However, criminally insane offenders must also deal with their status as criminals in addition to the stigma associated with their mental illnesses. This double transgression of womanhood, in the eyes of authorities, requires substantial domestication (p. 178). Seeing as “regular” criminalized women are already subjected to psychiatric and medical control, the extent of the control over women who already have significant mental health needs is even more imposing.

The famous case of Charlotte Ross in the 1940s is a good example of how deviously these women are painted in society. Charlotte Ross murdered her sleeping husband and then attempted to take her own life using the same knife (p. 177). She was constructed as a “black widow,” a woman who murdered her own husband and was thus the emblem of danger (p. 179). While these women do not generally pose any danger to other men or to society as a whole, they are treated as if they are extraordinarily dangerous (p. 179). The criminally insane black widow thus occupies a liminal space on the fringes of society, as someone whose crime is considered to toe the line between male and female and hovering between being both blameless and guilty (p. 179). This marginal status of having both violated the norms of acceptable behaviour and acceptable womanhood which is conferred onto all criminalized women becomes intensified in the cases of criminally insane women.

Regarding a woman as criminally insane goes against the very fabric of the structure of our society. Documents such as Creating Choices and its successor, Roadmaps, stress the responsibilization and the individuality of crime (Montford, 2015, p. 292) Diagnosing someone as irresponsible and incompetent consequently means that this individual is transgressing the norms of what it means to be a person in our neoliberal climate. Being “doubly deviant” as a woman who is also a forensic patient incites an intense level of scrutiny, which Menzies and Chunn say surpasses what her male counterparts must face (Menzies & Chun, 2014, p. 184). As such, it becomes evident that the criminally insane woman, in a neoliberal context, is even more of an anomaly and requires even closer scrutiny than any other category of offender in the system. Being unable to take responsibility and understand one’s criminal offences essentially means that one is incapable of rehabilitation with regards to addressing needs and risks, and thus must be subject to what could be considered medicalized warehousing, in which the woman is endlessly subject to psychiatric interventions while locked up.

The Unrelenting Neoliberal Influence:

Prisons are a site of resocialization – they aim to teach offenders that their past actions were wrong and to give them a new structure and code for how to act in the future. However, as evidenced by the documents which have shaped women’s corrections over the past thirty years, prisons are also very neoliberal in their approach to this resocialization. Creating Choices, released by the Task Force on Federally Sentenced Women, emphasized women’s needs, but it also emphasized neoliberal values of individualism in its recommendations. Medicalizing women and their deviance, criminogenic needs and risk factors shifts the blame onto the individual rather than the structure which has guided them into the correctional system.

Creating Choices was dubbed as a “feminist document” (Montford, 2015, p. 285). Its orientations were feminist, but they were also staunchly neoliberal. While it focuses on the needs of women and establishes the need for a women-centric approach to corrections, it also emphasizes that the responsibility for committing the crime is to be placed on the offender. Creating Choices outlines five principles for a women-centered approach to corrections: empowerment, meaningful and responsible choices, respect and dignity, supportive environment, and shared responsibility (p. 287). The notion of choice itself is flawed in this instance since the pathways which lead women to crime are often void of the ability to make choices. Structure often triumphs over agency for the individuals whose lives would be affected by Creating Choices. When a woman becomes medicalized in addition to already being criminalized, her capacity to make meaningful and responsible choices is additionally weakened, as she is subjected to various psychiatric controls.

Shifting responsibility onto the offender to take care of their own process of rehabilitation also requires the offender to take responsibility for their own health outcomes. This includes the process of medicalization which occurs inside the prison as well as any medicalization the woman might have experienced prior to entering prison. It is no secret that systemic inequalities are criminalized and medicalizing criminality and criminalizing medical conditions are just another example of this (Maidment, 2006, p. 16). Income and social status are one of the main social determinants of health, alongside employment, education, childhood experiences, gender, and others (Government of Canada, 2018). Since these factors denote that poorer and underprivileged individuals are most likely to experience poor health, this suggests that this population overlaps with those who are most likely to come into contact with the criminal justice system.

The neoliberal approach to crime is more punitive and tends to pathologize women much more than previous eras and approaches to crime (Maidment, 2006, p. 14). Those who are the most disenfranchised in society are those most oppressed by the systems they become involved with, especially the criminal justice system, mental health supports, social welfare, and the like (p. 15). Neoliberal views of crime attempt to locate the defect within the individual for committing a crime, while ignoring the social structure which led them to commit that crime. "This is a sick society," claims one of the imprisoned women featured in Watterson's book (1996/1973, p. 5). She makes a strong claim, but upon examining the neoliberal structure of society in relation to criminalized women, we can understand why this statement is true.

Crime, something which makes many people angry, is often a result of powerlessness and helplessness (p. 19-20). The women whose pathways in life have led them to commit crimes and eventually prison often lacked access to and knowledge of the health care system and resources to take care of their health prior to being incarcerated (p. 253). When these women become imprisoned, they must suddenly take individual responsibility for the crimes they have committed and face the repercussions of the lifestyles of powerlessness they have lived outside the prison walls. People who are powerless before prison are suddenly treated as if they have the power to heal themselves and to take control of their own health.

Conclusion:

Ultimately, we have seen that constructing women's needs and issues in a medical fashion serves as a mechanism of control and shifts attention away from the real structural issues in society which lead women to commit crimes or be construed as deviant. From the existence of female hysteria as a legitimate medical condition throughout the course of history to the over-reliance on psychotropic medication to subdue imprisoned women, the extent of the medical control exerted over imprisoned women is intense and unwavering. The medical condition of female hysteria was a way of medicalizing healthy expressions of women's sexuality and their inability or unwillingness to conceive. Its existence as a legitimate medical condition for a large portion of history demonstrates that the medical control of women is not a new phenomenon.

Transgressing the norms of femininity is often deemed as something to be treated and as a reason for intervention, by psychiatrists, psychologists, the criminal justice system, and so forth. The more a woman deviates from normative femininity, the more she is subjected to the wrath of the systems which seek to control and domesticate her. While the women locked up in prison are serving time for committing crimes, it is entirely unnecessary to subdue them with too much or excessive medication. As I have examined, there are better and more suitable approaches that can be taken to ensure the wellness of offenders, rather than focusing on illness. One of these methods is that of using Indigenous healing approaches, which work for Indigenous women because they are in line with their worldviews and cultural identities.

The neoliberal influence in women's corrections is glaringly unavoidable. Putting the onus on the female offender to take responsibility for her actions in situations which often present them with little-to-no choice is not working. The powerlessness and helplessness of these women's lives are not being dealt with when the crime is located solely within the individual. It needs to be addressed in correctional policies and programs that there are a whole host of circumstances which are responsible for the crime, not just the woman herself. In the future, those in charge of creating programming to deal with mental health concerns must look to wholistic wellness approaches to address past traumas, experiences of victimization, and other issues. If this trend of medicalizing deviance and criminality does not change, then women's corrections in Canada will remain in a state of inertia.

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