Drawing the line: Boundaries, Women's Mental Health and the Politics of Care

Introduction

Psychiatry is a discipline of boundaries. It distinguishes belief from delusion, distress from disorder, whilst aiming to derive meaning from pathology. These thresholds may be clinical necessities, yet they can be historically contingent, culturally embedded, and ethically charged. Nowhere is this more apparent than in women's mental health, where experiences of emotional excess or poverty and relational suffering have long occupied psychiatry's most contested borderlands. With The World Health Organisation (2025) reporting that depressive and anxiety disorders account for most cases of mental disorder overall of which over 60% of each is shouldered by women or females, acknowledging gender and sex differences is critical to delivering equitable psychiatric care whilst ensuring that diagnostic boundaries safeguard patients without diminishing the significance of their experiences.

Psychiatry does not operate in a medical vacuum but within social and cultural frameworks that influence which experiences are recognised as requiring medical attention (Kleinman, 1988). Long before society sought to classify certain experiences as overtly medical in nature, women's experiences were already being regulated through myth and narrative. The works of Euripides, dating back to the fifth century BC, showcase ancient narratives that have established an enduring attitude that women who transgress emotional or social norms are difficult or dangerous. In his *Bacchae*, the Maenads' ecstatic devotion represents a form of female intensity that is tolerated only insofar as it can be contained, while in *Medea* female suffering is rendered intelligible only through the binary lenses of irrational excess or hyper rational monstrosity. This tension persisted into Victorian literature, where Wilkie Collins's *The Woman in White* depicts female mental distress as something spoken about rather than listened to meanwhile Charlotte Perkins Gilman's *The Yellow Wallpaper* offers an enduring literary critiques of medical normalisation, exposing how women's suffering can be simultaneously dismissed as trivial or managed through oppressive care. Contemporary feminist writing continues this lineage. In *All in Her Head*, Misty Pratt argues that gender bias in medicine sustains a diagnostic predicament in which women are either over pathologised or denied legitimacy altogether.

Whilst literature may allow us to putatively examine how societal attitudes track and change across time, offering psychiatry a mirror to illuminate how its boundaries are drawn and whom they often constrain, this essay seeks to explore scientific research and articles to evaluate these boundaries and their impact on women's mental health. Indeed, boundaries in healthcare exist in order to recognise when appropriate diagnoses, management, and treatment may be required. However, if these boundaries are drawn too tightly, symptoms and experiences risk being categorised prematurely, but if they are drawn too loosely, they risk being rendered invisible.

Gender blindness

While ancient tragedy and modern fiction may seem distant from current psychiatric practice, to assess whether psychiatry has meaningfully moved beyond these inherited frameworks, it is necessary to examine empirical evidence not only in terms of diagnostic trends, but also through patient accounts of care.

Gender blindness in clinical practice continues to shape how women's mental health is understood and treated. Although distinctions between different genders are becoming more fluid as society's understanding of gender evolves, certain illnesses remain strongly associated particular genders or sexes. Hartnett et al. (2025) highlight that the basis of our clinical understanding about mental illness is derived from male biased research designs despite women bearing a greater burden of disability from common mental disorders. Agmon et al. (2022) reveal that relative to female prevalence of conditions being investigated that females remain underrepresented in clinical trials reducing opportunities to detect gender or sex specific symptoms or treatments. Hartnett et al. (2025) also provide an overview of common mental disorders where there are significant sex/ gender disparities including but not limited to; mood disorders, autism, ADHD, anxiety disorders, OCD, trauma and PTSD, and eating disorders. To address each of these individually with appropriate care and consideration would require a far more generous word count allowance and so only a select few shall be discussed further.

With the publishing of such articles, gender is becoming increasingly visible as a clinical variable, however, many diagnostic and treatment practices continue to be informed by research paradigms built upon male norms of cognition, behaviour, and illness expression. What changes over time is not necessarily the structure of this dynamic, but its vocabulary from divine frenzy, to hysteria, to diagnostic categories that claim neutrality yet remain shaped by gendered assumptions. The persistence of gendered blind spots in psychiatric research and practice reinforces the need for gender aware clinical frameworks grounded in lived patient experience.

Representation

Key determinants of health include sex and gender, and this is particularly evident in mental illness which manifests unequally across men and women. Data from 2023-2024 reveals that 24% of women contrasted with 15% of men in England had a common mental health condition (NHS Digital, 2025). Indeed, despite women having a higher likelihood of receiving more mental health diagnoses and experiencing physical health problems, Barr et al. (2023) demonstrate that the organisation of mental and physical healthcare, shaped by policy, funding and research practices often perpetuates gender disparities instead of alleviating them, limiting improvements in health outcomes for women. Barr et al. (2023) also state that women are disproportionately represented within some of the most stigmatised psychiatric diagnoses; they are approximately three times more likely than men to receive a diagnosis of emotionally unstable personality disorder (EUPD), more commonly termed borderline personality disorder (BPD) in research literature. Despite the high prevalence of trauma and sexual violence among individuals diagnosed with BPD/EUPD, women frequently report negative attitudes, stigma, and invalidation within mental health services following diagnosis (O'Dwyer et al., 2019). At the same time, reliance on narrow diagnostic formulae may cause clinicians to hesitate to diagnose BPD/EUPD in the absence of an overt trauma history, highlighting inconsistencies in how diagnostic boundaries are applied.

Conversely, autism has historically been conceptualised as a predominantly "male" condition, with Baron-Cohen's (2002) "extreme male brain" theory continuing to frame neurodevelopmental difference through a male lens. Whilst O'Nions et al. (2023) suggest that up to 489,900 people aged 20-49 years, and that up to 591,600 people over the age of 50 may have undiagnosed autism, the female autism phenotype remains under recognised, and existing diagnostic tools, largely developed and validated using male cohorts, lack sensitivity to gendered differences in symptom expression (Cruz et al., 2025). As a result, autistic women and girls are at increased risk of delayed, missed, or alternative diagnoses, underscoring the need for assessment instruments that better capture gender specific presentations.

Diagnostic boundaries

To extrapolate further, an increasingly scrutinised diagnostic boundary lies in the overlap between autism and BPD/EUPD. A growing body of evidence suggests that autistic women are disproportionately likely to receive an initial diagnosis of BPD/EUPD, reflecting longstanding gendered assumptions about emotional intensity or instability and interpersonal difficulty (May et al., 2021). Autism and BPD/EUPD can present with overlapping features, including differences in emotional regulation, social interaction, and sensory processing, making differentiation clinically challenging. However, clinician bias can result in misdiagnosis or missed diagnosis, particularly when neurodevelopmental differences are interpreted through a personality disorder framework. High rates of psychiatric comorbidity further complicate this picture, with up to 70% of autistic individuals reported to have at least one additional diagnosis, including personality disorders (Mosner et al., 2019).

Tamilson et al.'s (2024) phenomenological study of autistic adults previously diagnosed with BPD/EUPD illustrates how participants, particularly women, experienced this process. Many described feelings of invalidation, stigma, and self-blame following the misdiagnosis. Gender was repeatedly identified as central to these missed diagnoses, with one participant in the study reflecting that "i*f I was a boy … it probably would have been picked up while I was still in school*". Such misdiagnoses highlight the ethical tension at the heart of psychiatric practice that diagnostic boundaries are essential for accessing care, yet when drawn without gender aware understanding, they may delay or deny appropriate support. Tamilson et al. (2024) therefore advocate for improved autism training for psychiatrists and consideration of routine autism screening when adults, especially women, are diagnosed with BPD/EUPD.

Misdiagnosis

Misdiagnosis is not unique to psychiatric conditions, it also profoundly affects women's physical health with cascading mental health consequences. Endometriosis is often described as *"the missed disease"*. Despite severe, chronic pain frequently characterised as *"overwhelming"*, the average time from symptom onset to diagnosis is approximately eight years (Engemise et al., 2010). An All-Party Parliamentary Group inquiry into endometriosis reports the common experience of normalising symptoms with various studies noting that symptoms are frequently dismissed as being '*imaginary'* or exaggerated by medical professionals (Ballweg, 1997). The Inquiry showed that 58% of respondents attended ten or more GP appointments before receiving a diagnosis and as one participant described, *"Living with endo is an invisible disease… because it's unseen and not many people are aware of what it is, it feels as though you're attention-seeking or lying."* (APPG, 2020). Accordingly, Culley et al. (2013) conclude that women living with endometriosis are more likely to experience depression or anxiety while Karavadra et al. (2025) highlight the significant negative impact on psychological health is exacerbated by medical dismissal or neglect leading to diagnosis and treatment delay in this context.

Such narratives echo those of women under predominantly psychiatric care whose distress is either prematurely categorised or prematurely normalised. In both cases, the ethical failure lies in the refusal to view women's symptoms holistically and, most importantly, to take them seriously. To normalise and dismiss women's experiences is not only an epistemic injustice and clinically dangerous but also ricochets further implications affecting identity, relationships, employment, and bodily autonomy.

Intersectionality

While much of the discussion around women's mental health focuses on gender alone, Crenshaw's (1989) seminal work on intersectionality highlights the compounding effects of race, class, and other social identities on how women's distress is perceived and treated. Crenshaw argued that anti-discrimination laws and social institutions often fail to account for individuals whose marginalisation is simultaneously shaped by multiple axes of identity, leaving their experiences invisible or misinterpreted. Applied to psychiatry, this framework demonstrates why women from certain ethnicities or socioeconomically disadvantaged backgrounds may face even greater barriers to care, diagnostic "credibility", and meaningful engagement (Kapedia et al., 2022). Intersectionality emphasises that healthcare systems still reproduce inequality, particularly when structural biases intersect with gendered expectations. Integrating intersectional awareness into clinical practice and research is therefore essential to ensure that care is applied equitably across all women.

Conclusion

Psychiatry's task has never been simply to categorise distress, nor to dilute all experiences into the realm of "normal," but to navigate the boundary between the two. As this essay has traced from ancient tragedy through to modern literature and ultimately contemporary clinical practice, women's experiences have repeatedly been distorted by extremes. Progress has undeniably been made with the advent of gender aware frameworks, qualitative research promoting women's voices, and structural shifts within the profession itself. The General Medical Council (2025) report that women now outnumber men on the UK medical register with 164,440 female doctors compared with 164,195 male doctors. The opportunity that this structural change within the medical profession offers should be used to address inequalities. Such reorientation can further move psychiatry beyond its historical inheritance, but demographic change alone cannot guarantee systemic change. The challenge ahead lies in cultivating psychiatric care that neither rushes to diagnose nor retreats into dismissal, and recognises when classification is protective rather than reductive. To draw the lines appropriately in women's mental health is not an act of restriction, but of responsibility, one that encompasses scientific rigour while remaining attuned to women's lived realities. Psychiatry's future depends not on abandoning boundaries, but on learning how to draw them with awareness of the key determinants in healthcare inequalities. Indeed, this paradigm shift should be harnessed and extrapolated to implement necessary changes to meet the needs of people of *all* genders, enabling practitioners to deliver gender aware mental healthcare that is pertinent to all patients, respectively.

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