Gender differences in mental health

Michele Tansella

For many years, doctors have known from clinical experience that women receive more services for mental disorder in primary care settings than men. On the other hand, psychiatrists and clinical psychologists are aware that this difference is less apparent in specialist mental health services, and particularly in hospital-based services. Men come to the attention of health services less often than women, but are more likely to be referred for specialist psychiatric care.

However, such findings simply indicate the extent of treatment, not the need for treatment. The clinicians should therefore look beyond their clinical practice and acknowledge that they need help from epidemiologists, and from epidemiologically based research, if they are to understand which sex, or which demographic group within each sex, has the greater risk of experiencing psychological distress and mental illness.

Surveys conducted in the general population do not show much difference between males and females in the overall prevalence of mental disorders. But there is evidence that the pattern of the disorders, as well as that of psychological symptoms, differs between men and women.

The difference varies in different phases of life, from childhood to adolescence and adulthood. Males are more vulnerable to developing psychiatric disorders arising from insult to the central nervous system during their development. Most studies show a higher prevalence of mental health problems in young boys than in girls, the former experiencing more conduct disorders, with aggressive and antisocial behaviour.

During adolescence, the difference becomes smaller because girls experience more emotional problems, with fearful, anxious or over-controlled behaviour.

In adulthood, men have more problems related to alcohol, drug abuse and antisocial behaviour, while women suffer more from anxiety, depression and eating disorders. Moreover, men are much more likely to commit crimes (and more serious crimes) than women, as indicated by their higher rates of arrest and imprisonment, and are more likely to commit suicide and to become homeless. More than 90% of those who commit suicide have a mental disorder, and between a quarter and a half of single homeless men are suffering from a severe mental disorder.

Disability rates

The World Bank and WHO recently drew up tables of the burden associated with different diseases, in terms of disability-adjusted life years. Depressive disorders account for almost 30% of the disability from neuropsychiatric disorders among women, but for only 12.6% among men. On the other hand, alcohol and drug dependence accounts for 31% of neuropsychiatric disability among men, but for only 7% of the disability among women. In a recently published book called World mental health: problems and priorities in low-income countries (Oxford University Press 1995), Robert Desjarlais and others reviewed 15 studies on psychiatric disorders and psychological distress carried out over the last decades in many parts of the world, including Africa, Asia, the Middle East and Latin America. They found "a consistency across diverse societies and social contexts: symptoms of depression and anxiety as well as unspecified psychiatric disorder and psychological distress are more prevalent among women, whereas substance disorders are more prevalent among men."

It is difficult to use gender as a category to analyse the risk factors...
Gender issues

of mental disorders without knowing the relative weight of the various biological and psychosocial factors that make men and women differ from each other. On the one hand, there are clear-cut biological factors (for example the endocrine system) and, on the other hand, factors related to roles, stereotypes and social circumstances of people’s lives. What really matters?

It is more helpful to think of two main groups of causes of mental disorders: physical and biological on one side (such as genetic component, birth trauma, maternal infections at a particular point in a pregnancy); and social, situational and interactional on the other side (such as stressful factors but also buffers that serve to diminish the impact of unfavourable external events). Again, the relative contribution to mental disorder made by the biological/physical or by the social/cultural sets of factors is unclear.

Social stress

Desjarlais and his colleagues, after reviewing the proposed explanations of observed gender differences in psychiatric illness, conclude that “poverty, domestic isolation, powerlessness (resulting, for example, from economic dependence or low levels of education) and patriarchal oppression are all associated with a higher prevalence of psychiatric morbidity (exclusive of substance abuse) in women. In short, a considerable body of evidence points to the social origins of psychological distress for women.” They quote extensively a classical research study which found depression to be more prevalent among working-class than middle-class women living in London, and other studies which reported poor women experiencing more, and more severe, life events than does the general population. Still others reported that poor women are more likely to have to deal with chronic sources of social stress in the form of low-quality housing, dangerous neighbourhoods, higher risk of becoming victims of violence and of encountering problems in parenting and child care.

The incorporation of a gender-related perspective into psychiatric research may have important implications for theory, clinical practice and public health policy. Some of the implications for public health policy of higher rates of emotional distress, anxiety and depressive disorders in women were summarized in the recommendations from the 1991 Conference on Women’s Health organized by the National Council for International Health (NCH). They included the need to:
- establish standards for women’s health and well-being, and then measure progress towards those standards;
- develop ways to monitor the impact of structural adjustment programmes on women’s welfare and establish programmes to mitigate their adverse effects;
- enact or enforce legislation to improve women’s status;
- address women’s need for equitable employment and economic development;
- expand education for women and girls.

In addition to these measures, increased investment in research and service provision to improve psychological well-being and to reduce rates of alcohol abuse, violence and suicide in men is desirable, and will help indirectly to meet the needs of their wives and children.

As for the clinical implications, no doubt the clinician would benefit from an increased knowledge of gender-specific factors that may predict and influence the prevalence, course and outcome of mental disorders. We need more hard data before such knowledge can be provided.

Again, to quote Desjarlais’ report: “Women are often neither encouraged nor permitted to voice their feelings and complaints. When they do, they are likely to be discounted or dismissed.” The results of studies on gender differences in mental disorders may therefore have immediate implications for training. Health care professionals must be trained to empower women when they are interviewed in the clinic. Over the next decade, we should be able to see to what extent psychiatric medicine is able to increase our knowledge and to improve the prevention, care and treatment of psychological suffering and psychiatric disorders in both women and men.