Gender differences in mental illness experiences

ASSIGN
BUSTER

Title: In what ways does gender shape the experience of mental illness?

Introduction

Women and mental health is a vast topic and we do not presume to cover all aspects of it within the confines of this essay. We will, however, explore a number of relevant themes in some detail by particular reference to peer reviewed literature on the subject. In doing so, we recognise the fact that it is vital to make a critical assessment of the literature as, in any branch of medically related work, it is vital to acquire a firm evidence base. (Berwick D 2005).

Much of the literature that we have assessed for consideration amounts to little more than simple opinion on a subject, and as such, is only of use as an opinion rather than a fact that has been subject to proper scientific scrutiny. (Green & Britten 1998). In this essay we take note of opinions but aim to present verifiable facts.

We do know that mental illness in the UK is associated with a significant burden of both disability and morbidity in general, and this will vary with both the severity of the illness at any given time and also the nature of the illness itself. (Annandale, E1998). A number of studies have shown that, as a lifetime experience, nearly half of the population will suffer some kind of quantifiable psychological or psychiatric disorder. (Bayer, 1987)

The actual incidence of morbidity is hard to assess accurately. Firstly because doctors tend to under-diagnose positive psychiatric morbidity and secondly because there is a general reluctance to seek medical help with

this type of complaint. It has been suggested that only 40% of people with a significant mood, anxiety or substance misuse problem will actually seek help in the first year of the problem becoming apparent. (Boswell G & Poland F 2004)

In the context of this essay we should note that, in broad terms, the overall rates of psychiatric disorder are approximately equal in both men and women, but the significant differences between the sexes are found in the patterns of how the disorders manifest themselves. (Castle DJ et al 2001)

It is also fair to comment that an examination of the literature seems to suggest that the morbidity which appears to be associated with mental disorders has been the subject of more attention and research than the actual determinants and mechanisms that appear to be significant in both the promotion of mental health, and protection against mental illness, together with those factors which appear to give a degree of resilience against stress and other adversities which are gender specific. (Rogers & Pilgrim 2002)

Gender differences

We do know that a number of psychiatric illnesses have different rates of presentation. Some, such as schizophrenia have gender differential modes of presentation and illness trajectory (Kornstein S & Clayton A 2002).

Just why should this be? A number of authors point to various features of gender difference that may account for this difference. Castle (et al 2001) spend a large proportion of their book differentiating the male and female

brain in terms of the effect of testosterone on neurodevelopment. While this is undeniably a source of difference, it would appear that their argument rather falls apart when other authors point to the fact that the differences that we are considering here are actually better correlated with both gender and culture than actual biological sex. (Pattison 2001)

Gender has much deeper socio-economic and cultural implications than simply a sexual consideration. It is gender that is one of the prime determinants of the differential power and status factors that influence the degree of control that both men and women have over their socio-economic situation and social position in their own cultural hierarchy. This, in turn, determines both their susceptibility, and indeed their exposure, to significant mental health risks. (Busfield J 1996)

We have already alluded, in passing, to the differential incidence of various illnesses. We know that depression and anxiety related patterns of illness, together with those that have a significant element of somatosisation of their symptomatology, are more likely to occur in women than men with a ratio of about 3: 1. Illnesses such as reactive (unipolar) depression is found to occur with double the frequency in women, when compared to men. This particular disease process is statistically the most common mental health problem that affects women, but it also tends to be more persistent in women both in terms of longevity of the episode and in frequency of relapse. (APA 1994)

Gender differences are also apparent when it comes to a consideration of substance abuse, however it is usual to find the reverse ratio in most studies on the subject. Alcohol abuse and dependence will occur 2. 5 times more

frequently in men than women. It is not certain whether these changes are primarily cultural or biological, as they do vary to a degree between different cultures, but the sex difference is generally found. (Kraemer S 2000)

Unlike the unipolar depressive disorder, bipolar disorder, like schizophrenia, has no differential rate of presentation although there are defined differences in the disease trajectory in terms of age at presentation, the frequency and nature of the first rank psychotic symptoms. This may have a bearing on the longer term sequelae such as social readjustment and long term disease process outcome. (Kaplan HI et al 1991)

It is also a demonstrable fact that the degree of morbidity rises exponentially with multiple degrees of comorbidity. In studies on the subject, women outnumber men in this area as well.

This consideration then begs the question, “ just what are the gender specific different factors that determine mental health or the susceptibility to mental illness?”

We have already suggested that many factors are not purely biological, and a number of different papers point to the fact that many of the triggers and stressor factors which can be associated with mental illness, are also gender specific. The gender based role in a particular society (certainly in the UK), will produce different exposure to different stressors and negative life experiences. Equally it will give different exposure to the protective effect of a positive life experience. (Moynihan C 1998)

We can cite specific examples in this regard. Women are frequently the domestic target of male-based violence. This factor is probably important in the fact that women have the highest incidence of post traumatic stress disorder (PTSD).(Jewkes R 2002)

There is still a gender gap in the earnings tables, both in total lifetime earnings and also in average earning levels. This implies that women tend to be less financially independent and more socio-economically deprived (on average) that males. In many societies this is also translated into lower social status that the male and this is often also associated with fewer social freedoms – all of which may be associated with an increasing psychological co-morbidity. (Gordon G et al 2001)

There is also the consideration that in the majority of cultures, it is the woman who typically bears the major impact of care in the family, not only of the children, but also of the elderly relatives, and this frequently produces constant and unremitting levels of stress, which again, is recognised as a major trigger for psychological morbidity. (Davies TW 1994)

All of these factors, when considered collectively, appear to exert a significant influence on the overall patterns of gender specific distribution of psychiatric morbidity in the community at large. These factors are generally exacerbated (and the gender differences accentuated), when there are sudden and unpredicted fluctuations in the general income level or the stability of the social strata.(Murray M 1995).

We have already alluded to the fact that the rates of diagnosis by the healthcare professionals tend to underestimate the true incidence of

psychiatric morbidity in the community. It is likely that the healthcare professional can also skew the results in a different way. We know, from a number of studies, that gender bias occurs in both the diagnosis and treatment of mental conditions. Doctors have been shown to be more likely to make a diagnosis of depression in women than in men even when the cohorts have been previously matched in terms of symptom severity and when the present with matched symptoms. Doctors are also statistically more likely to prescribe psychotropic medication for women than for men. (Bhui K et al 1995),

Why should this be? Part of the reason is that women have demonstrably different patterns of presentation of psychological morbidity than men. Women are more likely to be open and to disclose their problems to a healthcare professional than a man. Women tend to disclose problems to a primary healthcare team professional (and therefore be treated in the community), whereas a man is statistically more likely to present to a secondary care specialist (which is possibly why men have a disproportionately high representation of inpatient care) (Boswell G & Poland F 2004)

This may be due to the general perception of the gender stereotype. It is more “ socially acceptable” for a man to have an alcohol problem. Some would argue that Dean Martin made a career out of his drinking. Women are “ expected” to be more emotionally labile than men, and the typical male stereotype is to be stoical and unflinching in the face of adversity. These patterns of behaviour in both the general public, as well as in the perceptions of healthcare professionals, go a long way towards perpetuating

many of the gender inequalities that we have examined thus far. It is certainly possible that they may be responsible, at least in part, for the apparent varying susceptibility of the sexes to different illness patterns. (Bandarage A 1997)

Conclusions

In this essay we have considered some of the evidence that related to the gender differences in the presentation and trajectory of mental illness. We note that the WHO recognises many of these factors on a global scale and has put forward three factors that it considers to be protective in the development of mental morbidity (especially depression).

In the light of our discussion above, it can be seen that, although the WHO addresses the points generally to the whole population, they, arguably, have a greater relevance for women than men, certainly in our current culture in the UK.

1. Having sufficient autonomy to exercise some control in response to severe events.
2. Access to some material resources that allow the possibility of making choices in the face of severe events.
3. Psychological support from family, friends, or health providers is powerfully protective.

(WHO1998)

We have established that women represent the greatest element of morbidity in the overall consideration of both psychiatric and psychological

pathology. This may a real finding, but we note that there is a considerable element of bias in the figures, both from the differential rates of presentation and also relative gender bias that appears to exist in the healthcare professionals in general.

There is also additional bias in the fact that women have a longer life expectancy than men and therefore have more “ life chances” to present with psychiatric morbidity, quite apart from the fact that the morbidity rates increase with advancing age, primarily associated with the dementias and various organic brain syndromes (Russell D 1995).

On a world wide basis, women are more susceptible to the destabilising effect of war, economic instability and natural disasters which add to the burden of negative life experiences that are a prime risk factor for the development of mental illness. (Brown GW 1978).

We have also identified the fact that the woman’s position in her particular culture or society is also a very significant factor in generating gender differences. There are gender differences in society and therefore it clearly comes as no surprise that these differences are reflected in the gender differences in health generally. The woman, in the majority of cultures is expected to assume a number of different roles (sometimes simultaneously), each with their own pressures. The unremitting role of the carer is common and clearly a cause of chronic stress. This can be both combined with, and exacerbated by, situations of comparative poverty which again magnifies the effect of all of the negative stressors which can mitigate towards mental ill-

health. Other factors such as sexual abuse can also play a gender specific role in the aetiology of mental illness.

In the words of Masson, (J. M. 1986) in his historical overview of the field of psychological disability:

There is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women. Severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict depression.

Some authors point to the difficulty of communication of the patient with the healthcare professional. In areas where there are cultural or perceived socio-economic differences, it is accepted that this may be a significant factor (Platt, FW & Gordon GH 1999).

If difficulty of communication is a problem, the conscientious healthcare professional should endeavour to be aware of it and minimise it's potential impact with strategies such as a translator or perhaps a more empathetic or understanding approach. One could hope that this would go some way to reducing the burden of disclosure from a patient who may already have a significant burden of psychological illness themselves.

All in all, we can conclude that the whole area of gender, in relation to mental health problems, is both difficult, multifactorial and complex. A significant amount of work has been done in this field, but there is clearly scope for a great deal more.

References

Annandale, Ellen (1998)

The Sociology of Health Medicine A Critical Introduction.

Cambridge: Polity 1998

APA 1994

American Psychiatric Association. DSM-IV. Diagnostic and statistical manual of mental disorders. 4th ed.

Washington, DC: APA, 1994

Bandarage A 1997

Women, population and a global crisis

London : Zed books 1997

Bayer, Ronald (1987)

Homosexuality and American Psychiatry The Politics of Diagnosis.

Princeton, New Jersey: Princeton University Press. 1987

Berwick D 2005 Broadening the view of evidence-based medicine Qual. Saf. Health Care, Oct 2005; 14: 315 – 316.

Boswell G & Poland F 2004

Women's minds, Women's bodies

London: Routledge ISBN 0333919696

Brown, George W.& Tiril Harris (1978)

The Social Origins of Depression A Study of Psychiatric Disorder in Women.

New York: The Free Press. 1978

Brown, G. W., S. Davidson & T. Harris (1977)

Psychiatric Disorder in London and North Uist

Social Science and Medicine 11: 367-377

Bhui K, Christie Y, Bhugra D. 1995

Essential elements in culturally sensitive psychiatric services.

Int J Soc Psychiatry 1995; 41: 242-56

Busfield, Joan (1996)

Men, Women and Madness Understanding Gender and Mental Disorder.

London: Macmillan. 1996

Castle DJ, John McGrath, Jayashri Kulkarni (eds) 2001

Women and Schizophrenia

Cambridge University Press, ISBN 0 521 78617 7 : 2001

Davies TW. 1994

Psychosocial factors and relapse of schizophrenia.

BMJ 1994; 309: 353-4.

Gordon G, Welbourn A. 2001

Stepping stones and men.

Washington, DC: InterAgency Gender Working Group, 2001.

Green J, Britten N. 1998

Qualitative research and evidence based medicine.

BMJ 1998; 316: 1230-1233

Jewkes R 2002 Preventing domestic violence BMJ, Feb 2002; 324: 253 – 254 ;

Kaplan HI, Sadcock BJ 1991

Synposis of Psychiatry,& behavioural Sceinces

Baltimore: Maryland Wilkins & Wilkins 1991

Kornstein S & Clayton A (eds) 2002

Women's Mental Health: A Comprehensive Textbook 2002

The Guilford Press, ISBN 1 57230 699 8

Kraemer S 2000 The fragile male BMJ, Dec 2000; 321: 1609 – 1612 ;

Masson, J. M. (1986)

A Dark Science. Women, Sexuality and Psychiatry in the Nineteenth Century.

New York: Farrar, Strauss and Giroux. 1986

Moynihan C 1998 Theories in health care and research: Theories of masculinity BMJ, Oct 1998; 317: 1072 – 1075

Murray M. 1995

Prevention of anxiety and depression in vulnerable groups.

London: Royal College of Psychiatrists, 1995

Pattison H 2001 Women and Schizophrenia • Women and Mental Health BMJ, Jul 2001; 323: 114 ;

Penfold, P. Susan & Gillian A. Walker (1984)

Women and the Psychiatric Paradox.

Milton Keynes: Open University. 1984

Platt, FW & Gordon GH 1999

Field Guide to the Difficult Patient Interview 1999

Lippincott Williams and Wilkins, pp 250 ISBN 0 7817 2044 3

London: Macmillian Press 1999

Rogers A and David Pilgrim 2002

Mental Health and inequality

London: Macmillan, ISBN 0333786572 : 2002

Russell, Denise (1995)

Women, Madness and Medicine.

Cambridge: Polity. 1995

Showalter, Elaine (1987)

The Female Malady. Women, Madness and English Culture 1830-1980.

London: Virago. 1987

Skultans, Vieda (1987)

The Management of Mental Illness among Maharashtrian Families: A Case Study of a Mahanubhav Healing Temple".

Man: Journal of the Royal Anthropological Institute 22(4): 661-679

Szasz, Thomas S.(1971)

The Manufacture of Madness. A Comparative Study of the Inquisition and the Mental Health Movement.

London: Routledge. 1971

WHO 1998

World Health organisation 1998

The World Health Report

Executive Summary

Geneva: World Health organisation 1998

##

##############

17. 1. 06 PDG Word count 2, 813