**Mental health and gender differences: a review**

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### Article info

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### Summary

Gender difference affects the rule and control of men and women over socioeconomic determinants, their access to resources as well as their status, roles, options and treatment in society. The differences evidently exist in the society despite the lesser socioeconomic gradient. Gender has significant explanatory power regarding differential susceptibility and exposure to mental health risks and differences in mental health outcomes. Gender differences in rates of overall mental disorders are negligible. However, highly significant gender differences exist in depression, anxiety and somatic complaints that affect more than 20% of the population in established economies. There should be a standard practice to disaggregate all epidemiological data by sex and age for all diseases and health conditions. Besides documenting differences in prevalence rates of mental disorders and other diseases, it is crucial to examine how women's and men's differences such as their roles and responsibilities, their knowledge base, their position in society, their access and use of health resources influence the vulnerability to mental disorders. So a systemic gender approach to mental health provides guidance to the identification of appropriate responses from the mental healthcare system, as well as from public policy. This paper aims to amalgamate information from various sources as an effort to explain the relationship of gender and health-seeking behaviour as a powerful determinant of gender differences, to examine the gender differences in common mental health disorders.

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### Introduction

Mental illnesses of various types are very important parts of the chronic diseases. Discussions about issue of demographic and epidemiological transition elicit the attention of the health professional about mental health deterioration. Contrary to overall general perception, mental illness constitutes a serious threat to the national health and account for 13% of the global burden of disease.1 In the world more than 450 million people are suffering from neuro-psychiatric disorders where as in Bangladesh there are 15 million people are suffering from mental illnesses of various types.2 Mental health problems are among the most important contributors to the global burden of disease and disability. Mental and behavioural disorders are estimated to account for 12% of disability-adjusted life-years lost globally and 31% of all years lived with disability at all ages and in both sexes according to year 2000 estimates. Yet, more than 40% of countries have no mental health policy, over 90% have no mental health policy that includes adolescents and children, and over 30% have no mental health programmes.3 Mental illness or psychiatric disorder remains lower in the list of the agenda of policy makers, particularly in developing countries like Bangladesh. Moreover, gender influences, that is, how much control men and women have over key aspects of their lives can also affect mental health, such as economic position and social status. Research that takes gender into account is considered to lead to better treatments and outcomes.4 Gender-based differences may emanate from a biomedical (genetic, hormonal, anatomical, physiological), psychosocial (personality, coping, symptom reporting) and epidemiological (population-based risk factors) aspects. Large-scale cultural, social, economic, and political processes observed from more global perspective ultimately produce differential health risks for women and men.5,6

The relationship of gender and health-seeking behavior is a powerful determinant of gender differences. So it was worth discussing the matters that examine the gender differences in common mental health problems.

### Materials and methods

Possible literature search was done by library work as well as MEDLINE search with key words of gender differences, sex and mental disorders. The author of this review also searched through PubMed search within a single hour limit. Besides World
Health Organization (WHO) publications and online documents about gender and health and/or gender and mental health were also reviewed and added to the references list.

Results and discussion

Frequently in some biomedical literature and by some influential stakeholders using, “gender” as a misnomer for “sex”, a tendency which has created confusion. Sex denotes biologically determined characteristics, while gender indicates culturally and socially shaped variations between men and women. Inherited from generation to generation irrespective of race, color, regions, education we are perceived and expected to think and act as women and men because of the way society is organized, and not because of our biological differences. Not in all circumstances biology act alone to determine health inequities, there are the social determinants, including gender, interact with each other and exacerbate biological vulnerabilities.

Psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. A gender approach to mental health provides guidance to the identification of appropriate responses from the mental healthcare system, as well as, from public health policy. Gender differences clearly exist, even where the socioeconomic gradient may not be strong. Never married and separated/divorced men have higher overall admission rates to mental health facilities than women in the same marital status categories. In contrast, married women have higher admission rates than married men. Lack of privacy, confidentiality and availability of information about options and services are the complaints raised by the conscious women, which are usually seen in many developing countries. Underprivileged women feel inadequacy in accessing the basic healthcare sources more often than men from the same socio-economic group. Lacking of female health care providers and discrimination of meanings of identical symptoms according to male and female by some doctors, inappropriate medication are the attributes to the barriers for women. Some researchers identify emotional and cognitive capacities of women themselves may limit their access to healthcare. Amin and Bentley suggested that gender inequity manifested through fertility, marriage, post marital violence and poor psychological health. This resulted in rural Indian women accepting high thresholds of suffering and not seeking treatment for their symptoms.

Gender differences in prevalence of mental disorders vary across age groups. Conduct disorder is the commonest psychiatric disorder in childhood, with three times as many boys as girls being affected. During adolescence, girls have a higher prevalence of depression and eating disorders and engage more in suicidal ideation as well as suicide attempts than boys. In adulthood, women had a higher prevalence of most affective disorders and non-affective psychosis, and men had higher rates of substance use disorders and antisocial personality disorder. Men may develop alternative disorders in response to stress, such as antisocial behavior and alcohol abuse. They may be more likely to have been socialized to express anger or other forms of acting out, whereas women may be more likely to have been socialized to express dysphoria in response to stress. In support of this, studies have shown that expected gender differences in depressive disorders were balanced out by higher male rates of alcohol abuse and drug dependency.

Depression and anxiety are the most common co-morbid disorders, and a significant gender difference exists in the rate of co-morbidity. Their diagnosis is often associated with somatic complaints and is known to affect around one in five people in the general community and more than two in five primary care attendees in many countries.

In outpatient settings among adults, women presented slightly more often with milder types of depression than with severe depression. Yet adolescent girls have been found to be significantly more likely to experience low and moderate levels of depression and anxiety than adolescent boys. First episodes of depression are more frequent in women than men and are likely to result from a mixture of social, psychological and biological factors. Fluctuating hormone levels may partly explain the higher rates of depression in women. However, hormones are likely to affect other aspects of women’s lives such as their general health, relationships and living environment and with social factors, such as the position of women in society and the value placed on women’s roles rather than being the sole cause of depression. First episodes of depression in women have been linked to the onset of puberty and menstruation, childbirth, and the transition to menopause. Depression is more frequent in married than never-married women and in unsupported mothers also.

Gender differences in rates or correlates of depression exist but may differ for different countries. In Alexandria, Egypt the rate of having depressive symptoms in girls was almost double that in boys. In Oman, however, there was no significant difference. The prevalence of major or minor depression among pregnant women ranges from 7% to 26%. Depression during pregnancy is a strong predictor of postpartum depression and is associated with adverse fetal development. So the treatment of ante-partum depression is important. Anxiety is a disorder which is also more frequent in women than in men though this may partially reflect the relative unwillingness of men to seek help. Men are more likely to turn to drugs or alcohol (in particular) to cope with stress problems and are more likely to develop substance abuse problems than women. Anxiety problems, including panic, agoraphobia, obsessive–compulsive disorder
and PTSD, are reported up to twice as often by women as by men.31

Adolescents and young adult women are the major portion of the society has eating disorders in the United States. Not only has the various physical health issues but also eating disorders are associated with some common mental illnesses such as depression, substance abuse, anxiety, and especially OCD. Eating disorders, including anorexia and bulimia, are more common in women.32

Study source from Arab regions the prevalence of both anorexia nervosa and bulimia was similar for both males and females in an Omani study whereas a Moroccan study found the prevalence of bulimia was higher among female adolescents in comparison to their male counterparts.33 The finding of co-morbidity of anorexia or bulimia nervosa with obsessive-compulsive neurosis in the patients of some research could explain the absence of gender differences in eating disorders.32

Schizophrenia is the most chronic and disabling of mental disorders, with psychotic symptoms by which men and women alike are affected and the lifetime morbidity risk is around 1%.34 But the age of onset, pattern of symptoms, brain structure impairment, response to treatment and outcome may differ.34,35 Lifetime onset age differs significantly between men and women, where men get ill with schizophrenia, on average, 4–6 years earlier than women.36,37 However, Lewine in his research yielded that sex and not gender was a significant predictor of age at first hospitalization while the gender perspective may best serve other aspects such as neuropsychological functioning.38 Conversely, Naqvi et al. found that there was no significant gender difference in the age of onset of the disorder.39 The controversy could be explained through the findings of Salokangas et al. They found that women have a later onset of schizophrenia than men but only in its paranoid form.40

Different pattern of oppression and violence are practiced by the man to demonstrate his masculinity and very often victim is the women, his counterpart. Therefore many experts from different corners indicate domestic violence and gender-based violence is two sides of same coin. In Bangladesh, there are many different forms of gender-based violence including: domestic, dowry-related acid attacks, rape, forced abortion, and trafficking for prostitution. Victims of all such forms of torture or violence suffer from severe enduring psychological as well as psychosomatic illnesses like anxiety, PTSD, depression, sexual dysfunction, personality disorder, OCD and suicide. Researchers found that situation in case of a married woman are terrible who is subjected to be tortured by her husband and has unhelpful or unsupportive mother-in-law.41 Some reputed population-based studies suggested that 25% to 50% of women around the world reported being victims of physical abuse by men at some point in their lives.42

However, reliable data on the extent of domestic violence are sparse, particularly in developing Asian and African countries. An explanation could be that women are often extremely reluctant to report attacks for fear of not being believed or being re-victimized.43 The prevalence of self-reported violence among pregnant women is also common, being 21% in a relatively-recent study.44

In Bangladesh the level of awareness of and medical care sought for mental illness is very low. Besides there is significant social stigma attached to mental illness that has severe impact on the health seeking behavior of people suffering from psychosocial or mental illness. Social stigma, on the one hand, prevents them from seeking care and, on the other, makes them silently suffer from social isolation and discrimination. Consequently, morbidity from psychiatric illnesses remains high and a seldom understood and/or recognized public health problem in Bangladesh. About 60% of ever married women of reproductive age in Bangladesh reported having experienced sexual and/or physical violence that remains largely ignored by the government and the power elites. Moreover, very little is known about violence against unmarried female adolescents.45

A growing national concern, drug and substance abuse by women and children has increased over the years. The trend of drug consumption is high among the youth and teenagers, between the age of 15 and 30 years. In recent years, drug and substance abuse is fast increasing among young/adolescent females.46

Researchers found that a woman who is subjected to torture by her husband has the highest probability of suffering from depression followed by an unhelpful or unsupportive mother-in-law or spouse. In most cases it is the preference for a male child and the failure to produce one by the pregnant woman that makes the husband and/or the mother-in-law unhelpful and unsupportive.47

Conclusion
While dealing with effective strategies for reducing mental health related risk factors there was no distinctive way to develop a gender-neutral approach. Women's status and opportunities for an independent livelihood remain low worldwide and so the risks themselves are gender-specific. Low status is a potent mental health risk. Self-worth, competence, autonomy, adequate income and a sense of physical, sexual and psychological safety as well as security are the integral part of mental well-being or mental health. So denial those needs can produce grievous impact on a woman's psychology. The persistent violation of women's rights, including their reproductive rights, right to access
in main stream economy contributes directly to the growing burden of disability caused by poor mental health. The documentation of differences in prevalence rates of mental disorders and other diseases, in men and women—their roles and responsibilities, their knowledge base, their position in society, their access and use of health resources—are very important. Linking gender sensitivity to training as well as in performance appraisals will develop the confidence among women regarding their mental health caring. Besides, formal or informal attention should be given to identify factors that would facilitate the process of coping with stress or distress. Challenge must be adopted to design intervention programmes specifically for mental health of women in all the tiers of health care level.

References


40. Salokangas RK, Honkonen T, Saarinen S. Women have later onset than men in schizophrenia—but only in its paranoid form. Results of the DSP project. Eur Psychiatry 2003;18:274-81.


