



Health
and
Gender



Gender and Mental Health

in the Eastern Mediterranean Region

Mental health problems are among the most important contributors to the global burden of disease and disability. Mental and neurological conditions account for 12.3% of disability-adjusted life years (DALYs) lost globally, and for 31% of all years lived with disability at all ages in both sexes, according to estimates for 2000. Research shows that socially constructed differences between men and women in relation to roles, responsibilities, status and power, interact with biological differences between the sexes to contribute to differences in the nature of mental health problems suffered, the health-seeking behaviour of those affected and responses of the health sector and society as a whole.

What we know

Sex differences in prevalence, onset and course of disorders

Although there do not appear to be sex differences in the overall prevalence of mental and behavioural disorders, there are significant differences in the patterns and symptoms of the disorders. These differences vary across age groups. In childhood, most studies report a higher prevalence of conduct disorders among boys than among girls, with boys displaying more aggressive and anti-social behaviour. During adolescence, girls have a much higher prevalence of depression and eating disorders, and engage in more suicidal ideation and suicide attempts than boys. Boys experience greater problems with anger, engage in high-risk behaviour and commit suicide more frequently than girls. In general, adolescent girls are more prone to behaviour that is directed inwardly, while adolescent boys are more prone to act out this behaviour.

In adulthood, the prevalence of depression and anxiety is much higher in women. In the Islamic Republic of Iran, one fifth of the population surveyed had mental disorders; the figure for women was 1.7 times higher than for men: 29% versus 15% [1]. Similarly a population-based study in a poor urban area in Rawalpindi, Pakistan, estimated that 24% of women and 10% of men suffered from depressive

disorders, with levels of distress increasing with age in both women and men [2].

Substance abuse disorders and anti-social behaviours are higher in men. In the case of severe mental disorders, such as schizophrenia and bipolar depression, there are no consistent sex differences in prevalence, but men typically have an earlier onset of schizophrenia, while women are more likely to exhibit serious forms of bipolar depression. In a study completed in Saudi Arabia on psychiatric admissions to a general hospital, males were more frequently admitted for schizophrenia and females for mood and anxiety disorders [3].

Suicide rates are higher for men than women in almost all parts of the world by an aggregate ratio of 3.5:1. Although men die by suicide more frequently than women do, suicide attempts are reported to be consistently more common among women than men

Reproductive health factors

Genetic and biological factors play some role in the higher prevalence of depressive and anxiety disorders among women. Mood swings related to hormonal changes as a part of the menstrual cycle are documented by some studies. In the case of antenatal and postnatal depression, the interaction of psychosocial factors with hormonal fac-



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appears to result in an elevated risk. For example, marital disharmony, inadequate social support and a poor financial situation are associated with an increased risk of postnatal depression. Women may also experience considerable psychological distress and disorders associated with reproductive health conditions and problems.

Infertility and hysterectomy have been found by some studies to increase women's risk of affective/neurotic syndromes, especially given the high value placed on children in the Region, and the way in which children define women's role and purpose in life. Of 370 women sampled at an infertility health clinic in the Islamic Republic of Iran, 40.8% had depression and 86.6% had anxiety. Depression was most commonly found after 4–6 years of infertility [4]. The mental health ramifications of female genital mutilation and its reproductive repercussions warrant further research. In contrast to the literature on women's reproductive biology and mental health, there is little research on the contribution of men's reproductive functioning to their mental health.

Predictive mental illness variables

Studies in the Region have found that predictors of mental health problems include: physical abuse by spouse, illiteracy, financial insecurity, lack of family planning, lack of autonomy and no controllable source of income. These predictors are confirmed in a study of depressive disorders in women in a fishing community in Pakistan, where reasons included: increasing age, being married, more than four children in the family, illiteracy and financial difficulties at home [5]. The feeling of a lack of autonomy and control over one's life is known to be associated with depression. In a poor urban area of Rawalpindi, women in joint households suffered more distress than those in nuclear households, where there was a greater degree of autonomy for women [3].

Poverty

The frequent exposure of impoverished populations to uncontrollable life events, such as illness and death of family members, job insecurity, unsafe environments and hazardous workplaces puts them at a significantly higher risk of depression. A study of 260 women in a squatter settlement in Karachi found around 1 in 4 women suffered from mental illness. Factors contributing towards mental illness included arguments with the husband or in-laws, husband's unemployment, women's lack of income and a lack of autonomy in decision-making [6].

Conditions of poverty may also be associated with an increased risk of alcohol and drug abuse, as well as violence in men. Education may have a role in reducing the incidence of men abusing their wives or having multiple marriages. In addition, women's education was found to be a protective factor against mental distress. The likelihood of experiencing mental distress among Syrian women who had finished 12 years of schooling was found to be one third of that of illiterate women [7].

Male vulnerabilities

The social expectations placed on men not to express their emotions and to be dependent on women for many aspects of their domestic life may contribute to high levels of distress among men when faced with situations such as bereavement. The social and religious expectation on men to bear the sole responsibility for providing financially for their families may also add to stress levels for males.

Gender-based violence

Data, although fragmentary, indicate strong associations between gender-based violence and mental health. Depression, anxiety and stress-related syndromes, dependence on psychotropic medications and substance abuse and suicide are mental health problems associated with violence in men and women's lives. A study in an upper Egyptian village found that 61% of women were physically abused [8].

In a sample of young, physically healthy women from primary health care centres in the Syrian Arab Republic, researchers found that the strongest predictors of mental health problems were illiteracy, involvement in a polygamous marriage and experience of physical abuse. One quarter of married women admitted to physical abuse, mostly by husbands [7]. Interviews with 150 women attending health facilities in Pakistan found that 34% reported having been physically abused, and 15% reported being physically abused while pregnant [9]. Seventy-two per cent (72%) of physically abused women were found to be anxious and depressed [9].

Mental health in areas of complex emergency/conflict
Victims of complex emergencies are at special risk of being affected by mental health problems, although males and females may respond in different ways. Women, for example, have been found to experience severe mental health problems in conflict situations. Recent studies in post-conflict Afghanistan found that women had significantly poorer mental health than men and higher levels of post-traumatic stress disorder (PTSD), depression and anxiety [10]. In a population-based study of survivors of the Bam earthquake, those suffering from the most severe psychological distress were found to be the elderly, the less educated, the divorced or widowed, the unemployed and women [11].

Stigma

Stigma prevents many mentally ill people from seeking help and receiving adequate treatment. People may refuse to seek help from mental health professionals for fear of social reaction and may try to hide the illness, which in itself can add to stress, shame and isolation [12]. Even after diagnosis, there may be anxiety about disclosing the illness to others or continuing treatment. Among women with depression in a fishing community in Pakistan, only 13% reported treatment from a government facility and only 14% reported a previous consultation with a psychiatrist. A larger proportion (27%) reported seeking relief from traditional alternative treatments [5].

Women may suffer from the stigma of mental illness in regard to reduced marital opportunities and increased risk of divorce in an existing marriage, should the condition become public. The higher number of men receiving hospital treatment for schizophrenia in Morocco suggests the stigma is greater for women, as few women come forward for treatment [13].

In other situations the stigma of mental illness may cause greater negative implications for men. A study conducted in Egypt found that a female with severe depression was more likely to be accepted by family members than males with the same disease (14).

The greater stigmatization of male depression was explained by the perception that men would have greater difficulties than women in fulfilling their prescribed social and family roles.

What research is needed?

There is a need to examine how gender differences influence women's and men's risk and vulnerability, their access to health services, and the social and economic consequences of mental illness, in different settings and social groups and at different points in the life-cycle.

A greater focus is needed on operational research to identify factors that help people to deal with distress, and the results should inform intervention programmes, especially at the community and primary health care level. Greater research is also needed on how gender differences interact with

differences in women's and men's reproductive biology to influence mental disorders, and also how these modify the effects of different pharmacological and psychosocial treatments.

The implications of women's changing work status on the mental health of both women and their spouses should be investigated. The mental health implications for home caregivers of the mentally ill should be studied, and the general mental health of elderly men and women in the Region needs to be researched in greater detail.

What are the implications for mental health policies and programmes?

Mental health services for both males and females should be fully mainstreamed into primary health care. Mental health policies and programmes should incorporate understanding of gender issues in a given context, and be developed in consultation with women and men from communities and families and from among service-users. Gender-based barriers to accessing mental health care needs to be addressed in programme planning. A public health care approach to improve primary prevention and address risk factors, many of which are gender-specific, is needed, as is the provision of community-based care for chronic and mental disorders. This provision of community-based care needs to be organized to ensure that facilities meet the specific needs of women and men, and that the burden of caring does not fall disproportionately on women.

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