



ISSN: 2456-0057

IJPNPE 2020; 5(2): 226-228

© 2020 IJPNPE

www.journalofsports.com

Received: 29-06-2020

Accepted: 12-08-2020

Pratibha KumariResearch Scholar, Department of
Psychology, LNMU, Darbhanga,
Bihar, India

Study of gender differences in mental health

Pratibha Kumari

Abstract

This paper aims to discuss why gender matters in mental health, 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, namely, depressive and anxiety disorders, eating disorders, schizophrenia, and domestic violence, and finally, to raise some recommendations stemming from this review.

Keywords: gender differences and mental health

Introduction

In 2002, World Health Organisation (WHO) passed its first Gender Policy, acknowledging the gender issue as important on its own. At about the same time, WHO began using the UN's Millennium Development Goals (MDGs), which go beyond the Health for All framework's focus on equity in general, specifying more particularly that gender equality and the empowerment of women are vital goals; MDG, Goal three. Unfortunately, "gender" is increasingly used inappropriately as a substitute for "sex", particularly in biomedical literature, a tendency which has created confusion. Sex denotes biologically determined characteristics, while gender indicates culturally- and socially-shaped variations between men and women. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, and not because of our biological differences. Absence of discrimination on the basis of a person's sex in opportunities, and the allocation of resources or benefits, or access to services, is gender equality. Therefore, gender equality refers to the fairness and justice in the distribution of benefits and responsibilities between women and men [1-4].

Gender-based differences may emanate from a biomedical (genetic, hormonal, anatomical, physiological); psychosocial (personality, coping, symptom reporting); epidemiological (population-based risk factors); or even a more global perspective. The latter analyses large-scale cultural, social, economic, and political processes that ultimately produce differential health risks for women and men. Rarely does biology act alone to determine health inequities. Social determinants, including gender, interact with each other and exacerbate biological vulnerabilities. For example, women's lower social autonomy exacerbates their biological susceptibility to the human immunodeficiency virus (HIV) [5]. Also, a more than two-fold increase in risk has typically been found for those in the lowest social class compared to the highest, for psychological as well as physical morbidity. Psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. Mental health problems are among the most important contributors to the global burden of disease and disability.

Mental and behavioral 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 include adolescents and children, and over 30% have no mental health programmes [6]. For a long time, general practitioners have learnt from clinical experience that women receive more services for mental disorder in primary care settings than do men. On the other hand, psychiatrists and clinical psychologists are aware that the difference is less marked for specialist mental health services, and particularly hospital-

Corresponding Author:**Pratibha Kumari**Research Scholar, Department of
Psychology, LNMU, Darbhanga,
Bihar, India

based services. Service utilisation data may have important implications for health policy and services organisation. However, they simply indicate the extent of treatment, not the need for treatment. The clinician should therefore go beyond their clinical practice and acknowledge that they need help from epidemiologists and from epidemiologically-based research to be able to understand which sex, or which demographical group within each sex, has the greater risk of experiencing psychological distress and mental illness [7]. The aim of this work is to discuss why gender matters in mental health, 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 problems, and to raise some recommendations stemming from this review to conclude the paper.

A similar PubMed search strategy to a study previously published by the author was followed to collect papers reviewed in the current study [8]. In a PubMed search within a single hour limit (on April 13, 2006), the Medical Subject Heading (MeSH) database of the MEDLINE for articles under the psychiatry and psychology category (mental disorders, behaviour and behaviour mechanism, psychological phenomena and process, and behavioural disciplines and activities) was explored, limited to the last 15 years. The search was then combined using the Boolean "AND" with the key words "gender difference" OR "sex difference". The abstracts of psychiatry and mental health publications with "gender difference" or "sex difference" in its title or text over the last 15 years were then reviewed. From the aforementioned rapid review, selected full papers were downloaded or requested, and thoroughly reviewed and comprised the current study references. Added to that, WHO publications and online documents about gender and health and/or gender and mental health were also reviewed and added to the references list.

Gender matter in mental health and health-seeking behaviour

A gender approach to health means to distinguish biological and social factors while exploring their interactions, and to be sensitive to how gender inequality affects health outcomes. A gender approach to mental health provides guidance to the identification of appropriate responses from the mental healthcare system, as well as from public 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. Gender, like other stratifiers, does not operate in isolation. It interacts in an additive or multiplicative way with other social markers like class and race.

Gender analysis improves understanding of the epidemiology of mental health problems, decisions and treatment of these problems in under-reported groups, and also increases potential for greater public participation in health. Overlooking gender-based differences or gender bias could have drastic consequences. Doctors are more likely to diagnose depression in women compared to men, even when they have similar scores on standardised measures of depression or present with identical symptoms. Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men, appear to reinforce social stigma and constrain help-seeking along stereotypical lines. They are a barrier to the accurate identification and

treatment of psychological disorders. Women's mental health affects others in society. Their increasing presence in the workforce means that their mental health affects national productivity. Their social role as caregivers means that their mental health affects the mental health of their children and elderly parents. Moreover, understanding the needs of adolescent girls for services is important for many mental disorders, especially those that affect large numbers of young women, such as mood, anxiety and eating disorders. Finally, all that would be translated into better interventions and services for females and their community [9].

To reduce gender disparities in health, the provision of medical services alone is clearly inadequate. Viewing health through a gender lens necessitates steps to improve women's access, affordability and appropriateness to the health services. Health services for women tend to focus on their reproductive functions, neglecting the needs of women outside the reproductive ages. A lack of female medical personnel is sometimes a barrier for women to utilise healthcare services. Poor women find themselves without access to healthcare more often than men from the same social group, even in rich countries like the United States [10]. In many developing countries, women complain about lack of privacy, confidentiality and information about options and services available [11].

Another barrier is that medical doctors either attribute different meanings to identical symptoms for presenting male and female patients, or attribute women's illnesses to psychiatric disorders and prescribe inappropriate medication. Women's higher mental and physical morbidity have also been hypothesised as being caused by their gender sensitivity to physical cues and to the social acceptability of sick roles for women. On the other hand, emotional and cognitive capacities of women themselves may limit their access to healthcare.

Amin and Bentley concluded that gender inequalities, manifested through fertility, marriage, and work norms, violence in marital relationships, and poor psychological health, have resulted in rural Indian women accepting high thresholds of suffering and not seeking treatment for their symptoms [12].

Gender differences in mental health disorders

Astbury found that gender differences in mental disorders extend beyond differences in the rates of various disorders or their differential time of onset or course and include a number of factors that can affect risk or susceptibility, diagnosis, treatment and adjustment to mental disorder. 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 and suicide attempts than boys, who are more prone to engage in high risk behaviours and commit suicide more frequently. 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 behaviour and alcohol abuse. They may be more likely to have been socialised to express anger or other forms of acting out, whereas women may be more likely to have been socialised 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.

Conclusion and Recommendations

Effective strategies for risk factors' reduction in relation to mental health cannot be gender-neutral, while the risks themselves are gender-specific, and women's status and life opportunities remain low worldwide. Low status is a potent mental health risk. For too many women, experiences of self-worth, competence, autonomy, adequate income and a sense of physical, sexual and psychological safety and security, so essential to good mental health, are systematically denied. The pervasive violation of women's rights, including their reproductive rights, contributes directly to the growing burden of disability caused by poor mental health. Therefore, an inter-disciplinary action to set policies which protect and promote women's autonomy and women mental health is crucial. Ministries of health should take steps to develop and integrate gender-relevant indicators in the existing national health information systems, and to find mechanisms to monitor gender sensitivity in the health system.

References

1. World Health Organization. Health for all in the twenty-first century. Geneva: World Health Organization 1998.
2. Vlassoff C, Garcia Moreno C. Placing gender at the centre of health programming: challenges and limitations. *Soc Sci Med* 2002;54:1713-23.
3. World Health Organization. Gender and health: Technical paper. Geneva: World Health Organization 1998.
4. World Health Organization. WHO gender policy. Integrating gender perspectives in the work of WHO. Geneva: World Health Organization 2002.
5. Zierler S, Krieger N. Reframing women's risk: Social inequalities and HIV infection. *Annu Rev Public Health* 1997;18:401-36.
6. World Health Organization. The World Health Report. Mental health: New understanding, new hope. Geneva: World Health Organization 2001.
7. Tansella Foreword M, Piccinelli M, Homen FG. Gender Differences in the Epidemiology of Affective Disorders and Schizophrenia. Geneva: World Health Organization 1997.
8. Afifi M. Mental health publications from the Arab world cited in PubMed. *East Mediterr Health J* 2005;11:319-28.
9. Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. Women, mental health and mental illness, and addiction in Canada: an overview 2006.
10. Krieger N, Zierler S. Accounting for the health of women. *Curr Issues Public Health* 1995;11:251-6.
11. Vlassoff C. Gender inequalities in health in the Third World: Uncharted ground. *Soc Sci Med* 1994;39:1249-59.
12. Amin A, Bentley ME. The influence of gender on rural women's illness experiences and health-seeking strategies for gynecological symptoms. *J Health Manag* 2002;4:229-49.