NATIONS FOR MENTAL HEALTH

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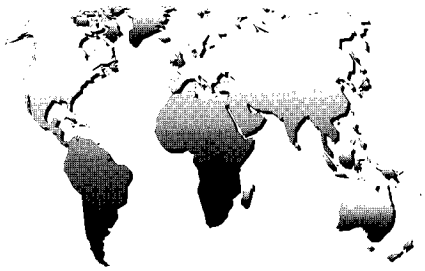

Gender differences in the epidemiology of affective disorders and schizophrenia

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NATIONS FOR MENTAL HEALTH : An Initiative for Mental Health in Underserved Populations

Objectives of Nations for Mental Health

- To enhance the attention of the people and governments of the world to the effects of mental health problems and substance abuse on the social well-being and physical health of the world's underserved populations. A first step is to increase awareness and concern of the importance of mental health through a series of key high profile regional and international events. Secondly, efforts will be devoted to building up the will of the key political authorities to participate. Thirdly, and finally, efforts are to be directed at securing political commitments by decision-makers.

- To establish a number of demonstration projects in each of the six WHO regions of the world. They are meant to illustrate the potential of collaborative efforts at country level, with the view of leading on to projects of a larger scale.

The implementation of the programme depends on voluntary contributions from governements, foundations, individuals and others. It receives financial support from the Eli Lilly and Company Foundation. In addition, financial and technical support is also being provided by the Government of the United Kingdom of Great Britain and Northern Ireland, the Institue of Psychiatry at the Maudsley Hospital of London (United Kingdom), the Free and Hanseatic City of Hamburg (Germany), the Villa Pini Foundation (Chieti, Italy), Columbia University (New York, USA), the Laboratoires Servier (Paris, France) and the International Foundation for Mental Health and Neurosciences (Geneva, Switzerland).

The World Health Organization's Division of Mental Health and Prevention of Substance Abuse has established an initiative called «Nations for Mental Health» to deal with the increasing burdens of mental health and substance abuse problems worldwide. The main goal of the programme is to improve the mental health and psychosocial well-being of the world's underserved populations (e.g. women, children and adolescents, refugees and indigenous populations and those who suffer from acute or chronic mental illness that is inadequately treated).

During the launching of the world mental health report prepared by the Department of Social Medicine, Harvard Medical School, the United Nations Secretary-General said of the UN Mission: «Our objective is to promote the mental health of and well-being of all inhabitants of the planet».The Nations for Mental Health programme embodies this mission.

Solutions to mental health and substance abuse problems entail a joint mobilization of social, economic and political forces as well as substantial changes in governmental policies related to education, health and economic development in each country. This demands an intense and sustained effort from the nations of the world, through joint cooperation between governments, non-governmental organizations and the organizations within the United Nations system. The programme is of utmost importance to the work of WHO and is willing to lead and coordinate this ambitious task. Several international meetings and launchings have been organized, in collaboration with other international organizations and academic institutions. A number of demonstration projects related to the programme have already been initiated in several countries. These projects are meant to illustrate and/or demonstrate the potential of collaborative efforts at country level, with the view of leading on to projects of a larger scale.

I am very pleased to present this document as part of the global process of raising awareness and concern for the effects of mental health problems. It is hoped that this important work will be useful in providing health planners and policy-makers with an integrated framework, linked both to specific needs and to epidemiological evidence, for addressing the broad spectrum of issues related to mental disorders and psychosocial problems.

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FOREWORD

by Michele Tansella

For a long time doctors and general practitioners have learned from clinical experience that women receive more services for mental disorder in primary care settings than men do. On the other hand psychiatrists and clinical psychologists are aware that this difference is less marked for specialist mental health services and particularly for hospital-based services. These impressions are confirmed by service research studies: there seems to be good evidence that men come to the attention of health services less often than women, but that men are more likely to be referred for specialist psychiatric care (Goldberg & Huxley, 1992; Jorm, 1995). These service utilization data may have important implications for health policy and service organization. However, they simply indicate the *extent* of treatment, not the *need* for treatment (Goldman & Ravid, 1980). The clinicians 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 demographic group within each sex, has the greater risk of experiencing psychological distress and mental illness.

From epidemiological surveys which have attempted to evaluate "true" prevalence by examining random samples of a population and by determining the mental status of the respondents to a questionnaire or interview, these does not appear to be much difference between males and females *in the overall prevalence of mental disorders*. But evidence does exist that *the pattern of the disorders, as well as of psychological symptoms*, differs between men and women.

The difference varies in different phases of life, from childhood to adolescence to adulthood. Males are more vulnerable to developing psychiatric disorders arising from insult to the central nervous system during ontogeny, probably because of a greater antigenicity to the pregnant mother. It has been suggested that this antigenicity may induce a state of maternal immunoreactivity which can lead, directly or indirectly, to fetal damage and thus to greater male susceptibility to environmental insults (Gualtieri & Hicks, 1995). Most studies show a higher prevalence of mental health problems in younger boys than in girls, the former experiencing more conduct disorders, with aggressive and antisocial behaviors. During adolescence the difference become smaller because girls experience more emotional problems, with fearful, anxious or overcontrolled behaviors. In adulthood men experience more alcohol and drug abuse and antisocial behavior, while women experience more anxiety, depression and eating disorders. Moreover, it is well known that males are much more likely to commit crimes (and more serious crimes) than women, as indicated by their higher arrest and imprisonment rates, and are more likely to commit suicide or to become homeless. Although there is no single cause of suicide, 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 severe mental disorder (Jorm, 1995).

The World Bank (1993) recently tabulated 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. Desjarlais et al. (1995) reviewed 15 studies focusing on psychiatric disorders as well as on psychological distress, carried out over the last decades in many parts of the world, including Africa, Asia, the Middle East and Latin America, and stated that "comparative analysis of empirical studies of mental disorders reveals 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 use disorders are more prevalent among men". In other words "men tend to externalize their suffering through substance abuse and aggressive behavior, resulting in an under reporting of psychological distress. Women, in turn, more often suffer distress in the form of depression, anxiety, 'nerves', and the like" (Desjarlais et al., 1995, p.180).

Four questions need to be addressed at this point. *First*, what is the present "state of the art" with regard to the difference between men and women in the frequency of well-defined psychiatric disorders, when the literature is critically examined, paying attention to the main methodological factors and biases that may affect the results; and what are the differences when incidence and prevalence studies, as well as overall rates and rates of specific disorders are analyzed separately? *Second*, is the difference between men and women consistent when we move from the level of psychiatric disorders (including those considered more severe) to that of psychological distress and to the level of individual symptoms or complaints relating to (less severe) disorders? These various expressions of suffering, from the most severe psychiatric disorders to the individual symptoms or complaints, differ in many ways and are likely to be determined by different causes or to be influenced and shaped by different combinations of causal factors. For instance, a gradient of biological factors with a decreasing causal role, from the first to the last level, has been postulated. A difference between males and females in the rate and/or in the phenomenology and/or in the outcome of the condition under study, only at one level or at all levels of the spectrum, would have important theoretical and practical implications. *Third*, is a gender difference more likely to emerge when we use a longitudinal rather than a cross-sectional approach? Gender, for instance, may influence incidence of depression (females are more likely to make transition from subsyndromal to definite episode of depression) rather than course of illness and transition to recovery, while the contrary may be true for other disorders such as schizophrenia. *Fourth*, where a true difference has been convincingly proven we need to go a step further and try to answer another question: what factors account for the differences, or, in other words, why do men and women express their suffering in different ways and experience some symptoms and psychiatric disorders with different frequency?

Furthermore, what are the implications of these differences?

The present Monograph by Dr Marco Piccinelli and his co-worker, Dr. Gomez Homen is a well balanced and meticulous piece of work that will be found extremely useful by those attempting to reply to the first and, in part, to the second question (with reference to affective disorders and schizophrenia). It is also a worthwhile and informative starting point for answering questions three and four. It was a very demanding task to sort out and critically analyze the vast literature related to gender differences in affective disorders and schizophrenia. Other authors will hopefully extend this kind of analysis to other conditions and disorders. The third and fourth questions will need more attention in the future, not only from those collating critical reviews of the literature but also from those planning and designing research studies.

I would like to comment briefly on some aspects of each of the four questions listed above.

The *first question* (the present "state of the art" of the difference between men and women in the true rates of well-defined psychiatric disorders) is extensively addressed by the authors of this Monograph, with reference to the full spectrum of affective disorders and to schizophrenia. We should, however, put the results of their review of the literature in the context of studies concerning other disorders that they have not analyzed.

It has traditionally been believed that mental disorders are more common in females than in males. More recent evidence has shown that the picture is not so simple and that the difference concerns, as already mentioned, the patterns of disorders and not the overall prevalence. There are therefore differences in results between earlier and more recent studies (mainly general population surveys), due to the fact that earlier surveys concentrated on disorders which mostly affect females.

We must be very selective and critical in analyzing the vast amount of descriptive studies on gender differences in rates of psychiatric disorders and we must discard those that do not meet