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Gender and Mental Health

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ABSTRACT:

It has been consistently observed and found in research that there are marked gender differences in the prevalence of many mental disorders. The paper will examine the most common mental health issues and their differential prevalence among men and women. The paper will also throw light on the various psychological models of gender development which might help in understanding the possible reasons of differential rate of different disorders among women and men. The paper will focus more on the psychosocial origin of gender differences in various mental health issues. It has implications to bring changes in socialization patterns, parenting practices, coping styles, reinforcement contingencies, shedding negative stereotypes to decrease the prevalence of some gender specific disorders.

Keywords: *Gender, mental health*

This paper first defines the concepts like gender, sex and mental health to have more clarity of these variables. Having defined the concepts, the paper will describe the theories of gender development and then the gender differences in the mental disorders/mental issues will be highlighted.

WHO defines mental health as a *state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*

Mental health is determined by host of biological, psychological and social factors. It is related to behavior and mental health can be enhanced by effective public health interventions.

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Sex refers to the biological categories of male and female, categories distinguished by genes, chromosomes, and hormones. Culture has no influence on one's sex. Sex is a relatively stable category that is not easily changed, although recent technology has allowed people to change their biological sex. Gender, by contrast, is a much more fluid category of male and female. These categories are distinguished from one another by a set of psychological features and role attributes that society has assigned to the biological category of sex.

Unger (1990) defines gender as "the cognitive and perceptual mechanisms by which biological differentiation is translated into social differentiation". A feature of the male sex category includes the Y chromosome; regardless of whether a male wears a baseball cap or barrettes, is competitive or empathetic, he is of the male sex because he possesses the Y chromosome. Personality and appearance are related to the gender category.

The first period focused on the differences between men and women and was marked by the publication of a book by Ellis (1894) titled *Man and Woman* which called for a scientific approach to the study of the similarities and differences between men and women.

In the past two decades, research on sex and gender has proliferated. There have been two recent trends. The first has been to view gender as a multifaceted or multidimensional construct, meaning that the two dimensional view of masculinity and femininity is not sufficient to capture. The development of the unmitigated agency and unmitigated communion scales was a first step in this direction. The second research direction has been to emphasize the social context in which gender occurs. The research on gender diagnosticity addresses this issue. Emphasis on the social context led to research on gender- role constraints, the difficulties people face sue to the limits a society places on gender- role appropriate behavior.

Biological theories of sex differences identify genes and hormones, as well as the structure and function of the brain, as the causes of observed differences in physical appearance, cognition, behavior, and even gender roles.

Psychological Theories of Gender Development

It is important to understand the various psychological theories of gender development. These theories help us understand the origin of possible gender differences. The implication of these theories lies in knowing the differential rate of various psychiatric conditions in men and women.

Social Learning theory

According to social learning theory, learning is produced by observation rather than by directly experiencing reinforcement or punishment (Mischel. 1993). Observation provides many opportunities for learning, including the learning of gender-related behaviors among children. The social environment provides children with examples of male and female models who

perform different behaviors, including gender-related ones. The models who influence children include mothers and fathers, but also many others, both real people and media images of boys, girls, men, women, and cartoon characters. In observing these many male and female models, children have abundant opportunities to learn. However, not all models have the same influence for all children, and not all behaviors are equally likely to be imitated.

The differential influence of models relates to their power or prestige as well as to the observer's attention and perception of the similarity between model and observer. Children tend to be more influenced by powerful models than by models with less power (Bussey & Bandura, I984), but children are also more influenced by models who are similar to them. This similarity extends lo gender, with children more likely to imitate same-sex models than other-sex models. Another important factor in performing a learned behavior is observing the consequences of that behavior. If people observe a behavior being rewarded, then they are more likely to perform that behavior than if they see the same behavior punished or unrewarded. Social learning theorists believe that reinforcement and punishment are not essential for learning, which occurs through observation. Instead, reinforcement and punishment are more important to performance, affecting the likelihood that a learned behavior will be performed in circumstances similar to those observed.

Children develop in an atmosphere in which they are exposed to models of gender-stereotypic behaviors "in the home, in schools, on playgrounds, in readers and storybooks, and in representations of society on the television screens of every household" (Bandura, 1986). These presentations do two things. First, all children are exposed to both female and male models, so all children learn the gender-related behaviors associated with both genders. Second, children learn which behaviors are gender-appropriate for them. Children learn that certain behaviors arc rewarded for girls but not for boys; for other behaviors, the rewards come to boys and not to girls.

Children experience many sources of modeling and reinforcement, and these sources influence the development of gender-related behaviors (Beal, 1994). When their children are infants, parents interact differently with their sons and daughters. For example, children accept and show equal enthusiasm for toys typically considered girls' and boys' toys (Idle, Wood, & Desmarais. 1993), but parents use some gender-typical preferences in selecting activities and toys for their children. Studies that observe parental interactions with children have confirmed gender differences in treatment.

Social learning theory hypothesizes that these forces affect gender-related thinking, and children come to develop gender knowledge and gender standards for their own behavior. In children age 2 to 4 years, behavior typical of the same sex was more common than behavior typical of the other sex for all ages of children (Bussey & Bandura, 1984). The younger children in the study reacted to their peers in gender-stereotypical ways but did not regulate their own behavior by these same standards, whereas the older children did both. These results indicate that these 4-

year-olds had begun to develop a coherent set of cognitive strategies for controlling their gender-related behaviors.

Sandra Bem (1985) criticized social learning theory, arguing that the theory portrays children as too passive. Bern pointed out that children's behavior shows signs of more active involvement than social learning theory hypothesize. Children do not exhibit a gradual increase in gender-related behaviors, hut rather seem to form cognitive categories for gender and then acquire gender-related knowledge around these categories. In addition, research evidence suggests that children may develop stronger gender stereotypes than their parents convey, which implies that children actively organize information about gender. Other social theories of gender development place a stronger emphasis on cognitive organization than doe's social learning theory.

Cognitive Developmental Theory

The cognitive developmental theory was propounded by Piaget. He was inspired by the work of Lawrence Kohlberg (1966) on moral development of children. He attempted to understand children's moral development through children's cognitions. Cognitive developmental theory views the acquisition of gender-related behaviors as part of children's general cognitive development. This development occurs as children mature and interact with the world, forming an increasingly complex and accurate understanding of their bodies and the world.

Cognitive developmental theorists see the development of gender-related behaviors as pan of the task of cognitive development. Very young children, lacking a concept of self, can have no concept of their gender. Most 2'/2-year-olds are unable to consistently apply the words *boy* or *girl* to self or others; thus they fail at gender labeling. Kohlberg (1966) hypothesized that children acquire some preliminary category information about gender during early childhood, but gender constancy, the belief that their genders will remain the same throughout life, is a cognitively more complex concept that may not appear until between ages 4 and 7 years.
Cognitive developmental theory views the acquisition of gender-related behaviors as a by-product of the cognitive development of gender identity. Children begin to adopt and exhibit gender-related behaviors because they adopt a gender identity and strive to be consistent with this identity. On the other hand, social learning theory hypothesizes that children come to have a gender identity because they model gender-related behaviors. Through the performance of these behaviors, children conform to either the masculine or feminine social roles of their culture. In summary, social learning theory sees gender identity as coming from performance of gender-related behaviors, whereas cognitive developmental theory sees gender-related behaviors as coming from the cognitive adoption of a gender identity.

Gender schema theory

Gender schema theory is an extension of the cognitive developmental theory. A schema is "a cognitive structure, a network of associations that organizes and guides an individual's

perceptions" Piaget used the term *schema* (plural, *schemata* or *schemas* to describe how cognitions are internalized around various topics; gender schema theory hypothesizes that children develop gender-related behaviors because they develop schemata that guide them to adopt such behaviors. In this view, gender-related behaviors appear not only as a result of general cognitive development, but also because children develop special schemata related to gender.

According to gender schema theory, the culture also plays a role in gender development, providing the reference for the formation of gender schemata. Not only are children ready to encode and organize information about gender, but they do so in a social environment that defines maleness and femaleness (Bem, 1985). As children develop, they acquire schemata that guide their cognitions related to gender. These schemata influence information processing and problem solving in memory and also regulate behavior (Martin &Halverson, 1981). Gender schema theorists posit that children use these schemata to develop a concept of self versus others, and each child's gender schema is included in that child's self-schema, or self-concept. In addition, gender schemata can provide a guide for concepts of personal masculinity and femininity; including personal judgments about how people personally fit, or fail to fit, these schemata. Thus, gender schema theory provides an explanation for the concepts of masculinity and femininity and how people apply these concepts to themselves.

Bem (1985) emphasized the process rather than the content of gender schemata. The information in (he schemata is not as important as the process of forming schemata and acting in ways that are consistent with them. Gender schema theory predicts that that cognitive changes that accompany schema formation lead to the ways that children process gender-related information, which changes the ways in which they behave.

In summary, gender schema theory extends the cognitive developmental theory by hypothesizing the existence of gender schemata, cognitive structures that internally represent gender-related information and guide perception and behavior. Children internalize their schemata for masculinity or femininity to form a self-concept, or self-schema, for gender-related behaviors. Research has indicated that gender schemata can affect the processing of gender-related information and can lead to gender stereotyping. Parents can attempt to circumvent gender-related messages by concentrating on the biological rather than the social correlates of gender, but all children come to understand their culture's messages about gender.

Gender Script Theory

Gender script theory is an extension of gender schema theory, proposing that the social knowledge that children acquire concerning gender is organized in sequential form. Schemata are representations of knowledge, whereas scripts depict an organized sequence of events.

Applied to gender role acquisition, gender scripts are "temporally organized event sequences. But in addition, gender scripts possess a gender role stereotype component which defines which sex stereotypically performs a given sequence of events" (Levy & Fivush, 1993). For scripts

such as eating lunch, the gender of the actor is not important, but the script for cooking lunch is likely to be gender specific.

Therefore, the sequencing component of gender script theory seems to broaden the concept of gender schemata. The research on gender script theory is less complete than the other theories of gender role development, but this theory is a promising addition to the other social theories of gender development.

Gender and Depression

Although gender differences exist in the diagnosis of depression, perhaps no differences occur in the frequency of negative mood (Nolen-Hoeksema, 1987; Tavris, 1992). That is, women and men experience the negative feelings that underlie depression at similar rates, but they express their feelings differently. Women tend to turn their negative feelings inward, whereas men tend to take action. In men, the feelings produce symptoms such as substance abuse, risk taking and violence.

Several explanations exist for this gender difference, including factors that make women vulnerable to depression, such as family role differences, personal control differences, and cognitive differences in coping with negative events. Another view holds that the gender differences in depression are a product of the ways in which women and men deal with distress. Women become passive, expressing symptoms of depression, and men become active, expressing symptoms of risk taking, violence, drug use, or some combination of these three behaviors. Other psychological models which explains why women have more depression then men are:

Rumination and depression

Research on the possible psychological explanation of sex differences in depression has focused on two specific kinds of coping strategies : rumination and distraction. Susan Nolen Hoeksema (1987) posits that women are more depressed than men because women ruminate about their feelings after negative events and men distract themselves. She argues that rumination increases depression in three ways. First, rumination interferes with instrumental behavior which might reduce depression. For example, if a student fails in an exam and keeps dwelling about it, it will distract him/her for future exam and increase stress and may ultimately lead to another failure experience and further depression. Second, ruminations about negative feelings makes other negative feelings and negative feelings more salient which will reinforce depression. Finally, ruminations lead people to make pessimistic explanation for negative events which will increase the chance of another episode of depression. In a number of studies, Nolen Hoeksema has shown that women are more likely than men to respond to depression by talking about and trying to figure out their negative feelings i.e. by ruminations. Men, however, try to respond to negative events by involving in sports and other activities. There is a vicious cycle of depression and

rumination. Women are more encouraged than men to ruminate and try to figure out the reason of their depression.

Private self-consciousness and depression

Private self-consciousness refers to attending to our inner feelings and thoughts. It has been found that private self-self consciousness is associated with depression. Some of the work in this area has shown that girls tend to focus more on their feelings and thoughts which explains why women have more depression than men (Sethi & Nolen Hoeksema, 1997).

Stereotypes and depression

Several theorists suggest that a gender stereotype contributes to sex differences in the expression of emotions like fear and sadness (Brody & Hall, 1993; Fischer, 1993b). The essence of the prevailing stereotypes is that women are more expressive than men of their stressful and sad feelings. This stereotype may give rise to two distinct effects. First the stereotype may function as a cognitive structure that leads to perceivers to focus on stereotype-consistent information. Thus, perceivers may be more likely to notice women's expression of fear and sadness, while similar expression by men may go unnoticed. Secondly,stereotypes provide the basis for socializing girls and boys about appropriate emotional behavior and thus early differences in reinforcement histories may lead to later differences in the sex-linked expression of emotions such as fear and sadness. Girls are socialized to expresse their emotions whereas boys are not (Brody & Hall,1993)

Stigmatization of women

Lutz (1990) argues that the emotional double-standard associated with the stereotypes serves a function of preserving the social hierarchy. According to the emotional double standard theory (Shields, 1987), women who express either fear or sadness are more likely than men to elicit an immediate positive response presumably because the expression of these emotions is consistent with the female sterotype. At the same, type, women's emotional emotional expressions may produce less immediate, more subtle and quite negative consequences. According to Lutz, women's emotional expressions help to preserve a social hierarchy in which are viewed as irrational, chaotic uncontrollable and therefore dangerous. In contrast, men are more associated with valued processes such as rational and controlled thought. According to Lutz'smodel, the belief that women are more emotional serves a larger social function of legitimizing women's subordinate rank in the power hierarchy. Expressions of fear and sadness connote weakness, lack of control and helplessness. As a result of emotional double standard, women who express fear and sadness may reap rewards in their immediate situation, but they may be stigmatized in the long run which in turn might increase the chance of depression in them.

Self-silencing model

Self-silencing model was propounded by Jack in 1991. The model posits that some women suppress their thoughts and opinions due to the perception that self-expression would lead to the loss of their intimate partner and relationship. Thus, self-silencing serves to maintain the relationship; however, this constant suppression of one's beliefs and opinions from the intimate partner theoretically results in depression, low self-esteem, and the loss of voice (Jack, 1991). Jack explicitly identify self-silencing as a 'specific, cognitive schema, derived from the culture,' and not as a personality trait. As such, the theory is based primarily on the phenomenological experience and social construction of reality within intimate relationships rather than a personality model of stable universal attributes.

Gender and substance-related disorders

Substance-related disorders involve the use of psychoactive substances, drugs that affect thoughts, emotions, and behavior. Examples include alcohol, amphetamines, marijuana (cannabis), cocaine, hallucinogens, opiates, sedatives, and hypnotics. In order to be diagnosed as having one of the types of substance-related disorders, the person must not only use the drug, but also must exhibit a strong desire to use the substance and experience problems in social or occupational functioning due to drug use.

Alcohol is the most frequently used and abused substance, and men drink more than women in all categories of drinking (USDHHS, 2000). That is, more men than women fall into the categories of light, moderate, and heavy drinking. Drinking and drunkenness are associated with the male, and not the female, gender role (Capraro, 2000).Sukhwal and Suman(2008) found in their study on the prevalence of alcohol use in college students in Bangalore City that out of 236 students 48.30% boys and 33.30% girls had initiated alcohol use. Kirmani (2008) also found in their study in Bangalore City that of the total sample studied (432), 190 students who reported having used alcohol, 150 (79%) were boys and 40 (21%) were girls. People expect men to drink beer and to get drunk, but the same expectation does not apply to women. Indeed, women are not expected to drink beer (but are expected to drink wine) and should not get drunk (Landrine, Bardwell, & Dean, 1988).

A variety of evidence suggests that drinking is related to depression, both in men and in women. Alcohol consumption shows a relationship to depression and mood (Berger & Adesso, 1991). Among depressed and nondepressed men and women who were not problem drinkers, men expected more positive effects from drinking, and drank more, than women did. The depressed men consumed more alcohol than any other group, and drinking decreased these men's perception of depression. This study demonstrated the relationship between negative mood and drinking, especially for men. Perhaps these men are at risk for developing problem drinking, but their strategy of drinking to manage depression showed some signs of being effective.

Research has confirmed the relationship between depression and problem drinking. Among men and women in treatment for their drinking problems, those problem drinkers with a history of depression reported that they drank to relieve their depressive symptoms (Hesselbrock, Hesselbrock, & Workman-Daniels, 1986). Another study tested the relationship between depression and problem alcohol use over a 3-year time span (Horowitz & White, 1991). A significant relationship existed between depression at age 21 years and alcohol problems at age 24 for men, but no such relationship appeared for women. Thus, men who use the strategy of drinking to manage negative emotions are at increased risk for problem drinking.

Illegal drug use is also higher among men than women, with men more likely than women to use and abuse drugs such as heroin, amphetamines, cocaine, and marijuana—a pattern that parallels their alcohol use (USDHHS, 2000). On the other hand, women are more likely to use prescription tranquilizers and sedatives. That is, women are more likely to describe symptoms to physicians that lead to their diagnoses of having mental disorders treatable by drugs. The higher rate of prescription drug use by women and the greater use of illegal drugs by men result in similar rates but different patterns of substance use.

In summary, the research indicates that a relationship exists between depression and drinking; depressed people drink more than the nondepressed and even attribute their drinking to depression. The tendency to drink more heavily when depressed is stronger among men but not exclusive to them. Perhaps men choose this strategy for dealing with negative feelings more often than women do, so this difference in dealing with negative feelings may account for some of the gender differences in depression and substance-abuse disorders. The overall pattern of drug use for men and women probably differs little, but women tend to use legal prescription drugs, whereas men's drug use is more likely to come in the form of alcohol and illegal drugs.

Gender and anxiety disorders

The group of disorders labeled anxiety disorders includes panic attack, phobias, obsessive-compulsive disorder, and posttraumatic stress disorder, all involving features of anxiety and avoidance of problem situations. A survey of over 18,000 people indicated that anxiety disorders affect more than 7% of adults in the United States (Regier, Narrow, & Rae, 1990). No gender differences exist for some types of anxiety disorders, but other types appear much more often in women than in men.

Panic attack is characterized by periods of intense fear that occur without any fear-provoking situation. These attacks are typically accompanied by physical symptoms of distress, such as sweating, dizziness, and shortness of breath. This disorder is about equally common in women and men, but panic disorder with agoraphobia is about twice as common in women. "The essential feature of agoraphobia is anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a panic attack or panic-like symptoms.

Agoraphobia can also occur without panic disorder, and women are also more likely to have this disorder (American Psychiatric Association, 1994; Cameron & Hill, 1989). Other phobias, unreasonable fears concerning some object or situation, constitute a second category of anxiety disorder. *Social phobias* appear as persistent fears of certain social situations, such as speaking in public, in which the person is judged by others or in which the person may do something embarrassing. The American Psychiatric Association (1994) stated that women in the general population are more likely to have social phobias, but in clinical populations, the gender ratio is either closer to equal, or men predominate. *Specific phobias,* fears of some object or situation other than anticipating a panic attack or being in a certain some social situation, are more common among women.

Obsessive-compulsive disorder is the combination of obsession, which refers to recurrent, intrusive thoughts about something the person would prefer to ignore, and compulsion, which refers to repetitive behaviors intended to prevent anxiety.

Posttraumatic stress disorder (PTSD) was originally applied to men who suffered lasting effects from their war experiences. Now the diagnosis is given to people experiencing the prolonged aftereffects of many different types of trauma, including natural disasters, accidents, and violent crime as well as military combat. It has been seen clinically and in epidemiological studies that women are more vulnerable than men to PTSD.

Research has shown a consistent pattern of the higher prevalence for agoraphobia (with and without panic disorder) and for specific phobias among women. The findings are not so clear for social phobia and obsessive-compulsive disorder. Overall, more women than men receive the diagnosis of some type of anxiety disorder, indicating that agoraphobia and specific phobias are sufficiently common to cause women to dominate this diagnosis.

Women with anxiety disorders experience more severe symptoms than men with anxiety disorders do, and in one study (Scheibe & Albus, 1992) stress within marriage was the most frequent event that preceded the development of the disorder. Anxiety and fear are more characteristic of the feminine stereotype than of the stereotypical male role. The match between gender role traits and mental disorders that appears in personality disorders (Landrine, 1989) may also apply to anxiety disorders and may constitute an explanation for the higher overall rate of anxiety disorders among women.

Gender and Schizophrenia

Several important classifications of mental disorders show few or no gender differences in prevalence, but men and women with these disorders may not exhibit identical symptoms or the same time course of the disorder. For example, schizophrenia—a serious and complex disorder involving thought disturbances, problems in personal relationships, and possibly hallucinations—has been diagnosed equally in women and men.

Other research (Lewis, 1992) showed similar patterns, but male schizophrenics tended to have poorer functioning before the onset of their disorders and were more likely than female schizophrenics to be involved in substance abuse. In addition, women were more likely to respond favorably to treatment. Despite these differences, male and female schizophrenics exhibited more similarities than differences.

Bipolar disorder is one of the mood disorders, along with major depression and dys-thymia. Bipolar disorder is characterized by periods of mania, high activity, and elevated mood alternating with periods of depression. These drastically different mood states change in a cyclic fashion such that the affected person experiences both mania and depression over a period of weeks or months, interspersed with periods of normal moods. Unlike the other two mood disorders, bipolar disorder shows no gender differences in prevalence (American Psychiatric Association, 1984).

The *somatoform disorders* show some gender differences. This classification of disorders includes problems with physical symptoms of disease, but no physical basis for those symptoms. As a group, women are more likely to receive the diagnosis of somatoform disorder, but some of the disorders within this classification show no gender differences. *Conversion disorder,* the loss of physical function without any physical basis for the disability, was originally called *hysteria.* In the late 1800s, this disorder was so strongly associated with women that the extension of the label to men was controversial. The *DSM-IV* (American Psychiatric Association, 1994) stated that this disorder occurs rarely in men, and another study (Tomasson, Kent, & Coryeli, 1991) found that the diagnosis of conversion disorder was three times more common in women than in men.

Another of the somatoforrn disorders is *somatization disorder,* the recurrence of physical complaints and the seeking of medical attention without receiving any diagnosis of a physical problem. These complaints are often dramatic or exaggerated, and the affected person seeks care from many medical professionals. Women account for 95% of somatization disorder patients (Tomasson et al., 1991).

Gender and sexual disorders

A Sexual disorders consist of two groups of disorders, *paraphilias* and *sexual dysfunctions.* Paraphilias are characterized by intense sexual feelings in response to objects or situations, such as nonhuman objects, children, non consenting persons, or even the suffering of self or others. The nonhuman objects include animals or items of clothing, and the situations include exposing one's genitals to strangers, fondling strangers in public places, observing sexual activities, or dressing in gender-inappropriate clothing. Sexual masochism—experiencing pleasure from receiving pain or humiliation—and sexual sadism—experiencing pleasure from inflicting pain or humiliation on one's sexual partner—are also among the paraphilias. About 20% of sexual

masochists are women, and this disorder is the most common paraphilia among women, which indicates that women are rarely diagnosed as having any of the paraphilias.

Sexual dysfunctions consist of abnormally low (or high) levels of sexual desire, or difficulty achieving arousal or orgasm. Women are more likely to receive diagnoses indicating abnormally low levels of sexual desire or inhibited orgasm, but men also experience these sexual problems.

CONCLUSION

Several mental disorders show patterns of gender differences, and some disorders that have no overall discrepancy in prevalence do show gender differences in onset or experience. The most dramatic gender differences occur for anxiety and somatoform disorders, diagnoses overwhelmingly given to women, and sexual paraphilias, diagnoses overwhelmingly given to men. Schizophrenia and bipolar disorder show no gender difference in prevalence, but male schizophrenics show some behavioral differences compared to female schizophrenics. The gender differences in bipolar disorder relate to age of onset, with women receiving more diagnoses in middle age than men, who tend to be diagnosed at younger ages.

Although psychopathology constitutes more than exaggerated gender role behavior, all gender differences in mental disorders lend themselves to interpretations relating to gender roles. People tend to exhibit pathology related to their gender roles; that is, women show signs of weakness and physical complaints, whereas men show violence and unusual sexuality. Male schizophrenics are more violent and socially withdrawn, whereas female schizophrenics are more talkative and silly; both behaviors are consistent with traditional gender roles.

The patterns in rates of mental disorders for men and women reflect the power of male and female gender roles. The most common patterns of disorder for both men and women show consistencies with what are considered to be appropriate gender-related behaviors. When violations of gender roles occur, clinicians are likely to perceive that these patients have more severe problems than patients who exhibit psychopathology consistent with their gender roles.

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