

ENGENDERING PHILIPPINE MENTAL HEALTH*

Marita V.T. Reyes, MD**
Baltazar V. Reyes, Jr. MD**

ABSTRACT

This presentation evolved from Marita V. Reyes' involvement in gender sensitivity and mainstreaming workshops in the past six years and Baltazar V. Reyes' participation in the crafting of a National Mental Health Program in the late 1980's. It aims to bring about a better understanding of the relationship between gender and mental health and thence generate advocacy in gender sensitivity among mental health professionals and gender responsiveness in mental health institutions and programs. The ultimate goal is gender equality in mental health care through gender equitable policies and programs.

Male/Female Differences in Mental Disorder

Various studies have shown that there are male/female differences in the prevalence of mental illness particularly in the rates of the common mental disorders — depression, anxiety and somatic complaints:

Whereas no significant male/female differences has been observed in the more serious disorders like bipolar disorder, schizophrenia

* Keynote Speech delivered during the 20th Postgraduate Course and 15th Midyear Convention, Philippine Psychiatric Association, July 21, 2004, Isla Ballroom, Edsa Shangri La, Mandaluyong City.

** Marita V. T. Reyes is Chancellor of UP Manila while Baltazar V. Reyes, Jr. is retired professor of the UP College of Medicine.

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| Gender Differences in Depression and Suicide | Women | Men |
|--|----------------|-----------------------|
| Depression in a given year | 12%, 12.3M | 6.6%, 6.4M |
| Major depression per year | 6.5%, 6.7M | 3.3%, 3.2M |
| Those who commit suicide per year | | 4 times more |
| Those who attempt suicide per year | 2-3 times more | |
| Anxiety disorders | 2 times more | |
| Eating disorders | 85-95% | 5-15% |
| Alcohol report heavy use in past month | | 4 times more |
| Report as heavy drinker | | 2 times more |
| Diagnosis of antisocial personality disorder | | 3 times more |
| ADHD | | 2-3 times more (boys) |
| Autism | | 4 times more (boys) |

obsessive-compulsive disorder and social phobia, male/female differences have also been reported in the age of onset of symptoms, frequency of psychotic symptoms, course of the disorders, social adjustment and long term outcome. It is important to point out that the disability associated with mental illness falls most heavily on those who experience three or more comorbid disorders which predominate among women.

Many research reports attempt to explain the male/female difference in the prevalence of common mental disorders as due to physiological or hormonal differences between the sexes. Much emphasis has been given to women's reproductive function, e.g., the onset of menses, pregnancy, labor and nursing, and perimenopausal experiences as correlated with the high prevalence of anxiety disorders among women. On the other hand, the contribution of men's reproductive phases to their mental health has received very limited attention. It is as if men should not be psychologically affected by infertility, loss of the fetus by miscarriage, stillbirth or prematurity.

Let us now introduce some gender concepts.

Gender Concepts

Gender refers to feminine and masculine designations which are determined and defined by society and culture. It is how

individuals are perceived and expected to think and to act as women and men because of the way the society is organized and not because of biological differences. The process of learning and internalizing culturally approved ways of thinking, feeling, and behaving according to one's gender is termed as *gender role socialization*. Individuals react and are informed by societies expectations. Gender role socialization is a pervasive process and permeate our development even before birth and dictates our realities that our identities as persons, as men and women, are so developed.

Our prevalent social structure is hierarchical in nature and is operationalized by power relations. This hierarchy assigns gender roles, i.e., (1) positions within the social structure indicating where women and men belong or are expected to belong, (2) rules of behavior and interaction for men and women and (3) relationships between men's and women's roles. Thus, gender relations are power relations, i.e., one's power over the other: the power of men over women.

In this gender framework, men are assigned productive roles which are usually performed sequentially while women usually have a triple role, i.e., domestic responsibilities (child care, meal preparation, clothing arrangement, family secretary, health caregiver), productive work (executive secretary, nursing, teaching) and community activities (family representative, barangay health volunteer, census volunteer) all of which often have to be carried out simultaneously. Gender roles do limit the psychological and social potentials of individuals because, once internalized, gender roles are further reinforced, maintained and sanctioned by a pervasive mechanism of social control, by family, church school, media, and workplace.

How internalized gender roles can be was surmised in one study supported by ReproCen that aimed to determine the

extent of understanding of women consulting in charity hospitals about human rights, their rights. In response to the question, *Ano po ang nalalaman ninyo tungkol sa inyong mga karapatan?* (What do you understand about human rights?), several of the women replied, *Karapatan po naming paligayahin ang aming asawa.* (It is our right to give pleasure to our husbands.) Indeed, traditional gender roles deny women access to the public world of work, achievement, independence and power, while it denies men access to the nurturant, emotive, other-oriented world of domestic life.

The principal effect of gender role socialization is gender bias. Gender bias is pervasive in many societies and is generally at the expense of women. Gender bias is manifested as gender stereotyping (fixed, unquestioned beliefs or images we carry in the back of our minds about men and women, transmitted from generation to generation, about women and child-rearing, religion, occupations, education, language, behavior and popularized as the Mars/Venus divide), as women's subordination, marginalization, and multiple burdens, as violence against women. These all ultimately impact on personhood and lead to lack of self-esteem and the feeling of no control over one's body.

Gender and Mental Health

Thus, Lesley Doyal (Draft Framework in the UN Womenwatch website) proposes that gender should become an analytical tool in explaining the differences between men's and women's susceptibility and exposure to specific mental health risks. This is because gender influences the differential power men and women have in controlling their lives, in coping with risks that influence the process of mental health development. She emphasizes that without the concept of gender, it is not

possible to begin to ask questions about how the different social categories occupied by women and men differentially affect how they see, experience and understand the world, their mental health.

The concept of mental health is continually evolving out of new experience and new research. Four perspectives of normality have been formulated by Daniel Offer and Melvin Sabshin (in Sadock and Sadock, 2000 : 677-678).

- (a) Normality as health, such that behavior is assumed to be within normal limits when no manifest psychopathology is present.
- (b) Normality as utopia, such that the blend of the diverse elements of the mental apparatus culminates in optimal functioning (equated with ideal functioning or what humanistic theorists have called "self actualization").
- (c) Normality as average, such that normality is the level of functioning enjoyed by the majority of people and is mathematically represented through a bell-shaped curve where the middle range is the normal and the extremes as deviant.
- (d) Normality as a process such that normal behavior is perceived as the result of interacting systems and that it changes over time (according to the age of the person and the developmental goals appropriate to that age).

Other notions of normality include the capacity to flexibly adjust or adapt to the external world, form emotionally satisfying relationships, master developmental tasks, learn from experience, take responsibility for one's actions and deal with conflicting emotions.

It is, however, WHO's definition of mental health (1981) that allows us to see the relationship between gender and mental health as it identifies all salient dimensions of mental function-

ing and the levels at which the determinations of mental health will operate. It says that —

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

Although gender is not mentioned — it can be argued that gender can and does impact very markedly on the capacity of the individual, the group and the environment to attain subjective well-being, justice and equality (Asbury, 1999). As emphasized earlier, gender determines the differential power and control men and women have over the social determinants of their mental health and lives, their social position, status and treatment in society and, therefore, their susceptibility and exposure to specific mental health risks.

For example, Lesley Doyal in the previously cited work pointed out that economic inequalities mean that in many countries women have difficulty in acquiring the basic necessities for a healthy life. Of course the degree of their deprivation will vary depending on the community in which they live but the 'feminisation' of poverty remains a constant theme. 'Cultural devaluation' is also important although difficult to measure or even to define. Because they belong to a group that is seen by society to be less worthwhile, many women find it difficult to develop positive mental health. This process begins in childhood with girls in many cultures being less valued than boys.

The nature of female labor itself may affect women's health. Household work can be exhausting and debilitating especially when it is done with inadequate resources and combined (as it is with many women) with pregnancy and subsistence agriculture.

It can also damage mental health when this work is given little recognition and is carried out in isolation. For some women, domestic life and labour may also carry the threat of violence since the home is the arena in which they are most likely to be abused. Even in the context of paid work, 'female' jobs often pose particular hazards that receive little attention.

Certain disadvantages have also been identified for men as male breadwinner—they are compelled to take on the most dangerous jobs, and, thus, among men, the incidence of industrial accidents and diseases are higher, deaths from occupational causes are more common. Men are also more likely to adopt a variety of unhealthy habits like smoking and heavy drinking, as well as to indulge in dangerous sports. Some cultures have strong ideas of masculinity that encourages risk taking behavior and increased incidence of male violence. Some also note that male stereotyping narrows the range of emotions they are allowed to express.

One may, in fact, classify health problems into general health problems (diseases any person can have regardless of sex, e.g., lung disease, hypertension), special health problems (diseases particular to women/men because of physiological attributes, e.g., ovarian cysts, prostate carcinoma) and gender health problems: those associated with low status of women, e.g., spouse abuse, rape; those associated with men's and women's traditional roles e.g., vulnerability to contagious diseases, stress and those associated with gender stereotypes (anorexia nervosa, complications of surgical reconstruction).

Depression, anxiety, somatic symptoms and high rates of comorbidity are significantly related to interconnected risk factors such as the gender based role, stressors and negative experience and events.

In summary, gender-specific risk factors for common mental disorders that disproportionately affect women include gen-

der based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank, and unremitting responsibility for the care of others. The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post-Traumatic Stress Disorder (PTSD) following such violence, render women the largest single group of people affected by this disorder. Nevertheless, the mental health impact of long term, cumulative psychosocial adversity has not been adequately investigated.

In her presentation on *Gender and Mental Health*, Marta Elliott (in Asbury, 1999) offered the following explanations for the gender differences in the prevalence of depression and suicide. She avers that there is not enough evidence to link hormonal changes, but that hormonal changes may indeed provoke mental illness. However, she gave much weight to differences in the following characteristics:

- (1) Attribution style: The characteristic manner of explaining the causes of events. One is more depressed when she/he perceives causes to be internal, or as permanent rather than isolated, or as applicable to all aspects of life rather than just the aspect in question.
- (2) Coping Style: She observes that problem-based coping is more masculine (action-oriented, aggressive) while emotion-based coping is more feminine (sensitive, quiet).
- (3) Exposure to disturbing life events: She points out that women are more likely to become widowed, to be raped, to witness the horrors of war. (An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters and displacement are women and children.) (Gender and Women's Health, WHO website)

- (4) **Role Conflict:** She says that role conflict between work and family is more pervasive for women as they still bear the lion's share of the burden for housework and child rearing when they are not "at work". However, men feel more conflict when they have problems at work, whereas women feel more conflict when they have problems at home.
- (5) **Role Strain** occurs for women on the job when they are expected to carry out their duties, yet be feminine and nurturing at the same time.
- (6) **Role Configurations:** There is an observation that employed women tend to suffer fewer mental health problems than unemployed women. But unemployed men are likely to abuse alcohol and suffer from reduced self-esteem than unemployed women.
- (7) **Differential Exposure:** Men have more stressors at work, women have more stressors at home.
- (8) **Differential Vulnerability:** Lifetime prevalence rate of violence against women ranges from 16% to 50%. (Gender and Women's Health, WHO website).
- (9) **Response biases:** Women are more likely than men to speak openly about their emotions, inviting a diagnosis of depression or anxiety.

Three factors have been cited as highly protective against the development of mental problems especially depression. These are: (1) having sufficient autonomy to exercise some control in response to severe events; (2) access to some material resources that allow the possibility of making choices in the face of severe events; and (3) psychological support from family, friends or health providers. (Gender and Women's Health, WHO website). Note that the first two are lacking among women in general.

Following the above exposition, we can now understand that *gender blindness* is the failure to recognize that gender is an essential determinant of social outcomes including health. *Gender awareness* means an understanding that there are socially determined differences between men and women based on learned behavior which affect their ability to access and control resources. *Gender sensitivity* is the ability to perceive existing gender differences, issues and inequalities and incorporate these into strategies and actions. Gender responsiveness applies to policies and programs that address needs and bring about gender equality.

The National Mental Health Program

Since the late 1980's, many developing countries have initiated efforts to improve their health systems. These were prompted by the failure of state-controlled economies, insufficient funding for health in times of financial crisis, the lack of basic health services for many citizens and the poor quality, low accountability, and inefficiency of existing health services. Many governments then launched health sector reforms which are intensive long-term efforts to strengthen and improve health systems with the following goals (WHO, 2000):

1. Efficiency — health improvements should be achieved at the lowest possible cost.
2. Quality — appropriate and safe clinical services, adequate amenities, skilled staff, and essential drugs, supplies, and equipment should be available.
3. Equity — health resources should be distributed fairly so that nobody is denied access to essential care.
4. Client responsiveness — the system should meet people's expectations and protect their rights, including their rights to individual dignity, privacy, autonomy in decision making, and choice of health provider.

5. Sustainability — the health system can continue to achieve its goals using available resources.

Most reform measures can be grouped into three broad categories: financing mechanism changes, organizational changes and policy changes. A cross-cutting objective of these measures is to empower consumers by educating them and giving them more choices.

The proposed National Mental Health Program prepared by the Department of Health must have been drafted in the light of our own health sector reform. The document consists of the vision, mission, functions, areas of concern, strategies, guiding policies, and projects. It is through this document that we shall attempt to do a gender analysis of the program.

Doing a gender analysis means to determine whether gender concepts have been integrated in the program framework and whether gender concerns and issues have been addressed in the strategic plan. In other words, is gender mainstreamed in Philippine Mental Health?

Gender mainstreaming (Pietila, 2002) involves ensuring that attention to gender equality is a central part of all interventions — in data analyses, in policy development, in advocacy, legislation, in research and in the planning, implementation, monitoring and evaluation of projects and programs. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.

Gender analysis was established as a basic requirement for the mainstreaming strategy. The current situation of women and men in relation to different issues and problems and the impact

of planned policies, legislation, and projects and programs on women and men respectively — and on the relations between them should be analyzed before any decisions are made. Gender analysis should go beyond cataloguing differences. Gender analysis must proceed to identify inequalities and to assess relationships between women and men. Within organizations, gender analysis is also required to assess the extent to which values, cultures, structures and procedures support promotion of gender equality.

The stated mission of the National Mental Health Program is “to make available, accessible, affordable and equitable, quality mental health care services to the Filipinos especially to the poor, the underserved and the high-risk populations”. Even if we assume that women are included among the “high-risk populations, there has to be an explicit statement on the thrust of seeing to it that mental health services are “gender fair and equitable”.

The list of present concerns regarding national mental health (DOH document, 1990s) includes the psychosocial aspects in the care of overseas contract workers, disaster victims, victims of violence, mental illness, children in especially difficult circumstances, violence against women and children. It is good that there is mention of women's risk factors re violence, nevertheless these gender issues must hopefully be addressed using a gender framework.

Further on in the document, the cited guiding policies (*Ibid.*) repeatedly include the importance and integration of psychosocial aspects of mental health albeit without specific mention of addressing gender differences. Unless gender is specifically mentioned, the impact of gender bias may not be recognized and addressed.

We noted that our data on the State of Mental Health in the Philippines (Tolentino, 2003) are not sex-disaggregated and, therefore, can not help in identifying gender-specific problems that can lead toward the development of gender equitable programs and services.

Nevertheless, it is with some degree of comfort that we noted that in the list of challenges to hurdle, “. . . coping with the effects of social factors negatively affecting mental health, e.g., poverty and minority status (children, women, ethnic groups) . . .” was included.

In general, our mental health program is gender blind but there are certainly opportunities to make it gender responsive. There has to be a commitment to reduce inequalities and to develop a comprehensive health service around the needs of individuals and different populations. Women are one such population.

Recommendations

1. All levels of scientific inquiry from the formulation of research questions to design, methodology and interpretation of results need to explicitly articulate the contribution of gender. The fact of gendered experience must be acknowledged in the construction of test instruments and questionnaires, if times are to have gender salience and accuracy.
2. More attention must be given to gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity. Gather evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors.

3. Promote the formulation and implementation of health policies that address women's needs and concerns from childhood to old age (WHO).
4. Enhance the competence of primary health care providers to recognize and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women (WHO).
5. All health care providers must undergo gender sensitive training.

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