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Rethinking gender and mental health: A critical analysis of three propositions

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ABSTRACT

In this paper, we critically examine three propositions that are widely (but not universally) accepted in the gender and mental health literature. First, women and men have similar or equal rates of overall psychopathology. Second, affective disorders like anxiety and depression, which are more common among women, and behavioral disorders like substance abuse and antisocial personality, which are more common among men, are functionally equivalent indicators of misery. Finally, women are more likely to respond to stressful conditions with affective disorders while men are more likely to respond to stressful conditions with behavioral disorders. Our review of previous research shows little to no consistent empirical support for any of these propositions. Results from national studies of overall psychopathology or "any disorder" are, at best, mixed and limited to a narrow range of mental health conditions. A comprehensive test of gender differences in overall psychopathology would require a systematic and exhaustive examination of gender differences across the known universe of mental health conditions, but this may be impossible to achieve due to a lack of consensus on the universe, the proliferation of diagnostic categories, and the tendency to pathologize the mental health of women. There is no empirical evidence to suggest that women substitute affective disorders for behavioral disorders or that men substitute behavioral disorders for affective disorders. There is no theory to suggest that affective and behavioral disorders should be treated as comparable indicators of misery. Some studies support the idea that women and men respond to stress in different ways, but most do not. Numerous studies show that women *and* men respond to stressors with higher levels of emotional distress, substance abuse, and antisocial behavior. We conclude with seven recommendations to advance theory and research and several general reflections on the sociological study of gender and mental health.

Introduction

Studies of gender and mental health consistently show that women exhibit higher rates of affective disorders like anxiety and depression, while men exhibit higher rates of behavioral disorders like substance abuse and antisocial personality (Aneshensel, Rutter, & Lachenbruch, 1991; Kessler et al., 1994; Kessler, Berglund, et al., 2005; Needham & Hill, 2010; Regier et al., 1988; Robins et al., 1984; Seedat et al., 2009). Building on these basic patterns, researchers developed three rather influential propositions. *Proposition #1*: *Women and men have similar or equal rates of overall psychopathology* (Bird & Rieker, 2008; Rieker, Bird, & Lang, 2010; Rosenfield & Smith, 2010; Umberson & Williams, 1999). *Proposition #2*: *The affective disorders that women experience and the behavioral disorders that men experience are functionally equivalent indicators of misery* (Dohrenwend & Dohrenwend, 1976; Horwitz & White, 1987; Rosenfield & Smith, 2010; Simon, 2002). *Proposition #3*: Women and men respond to stressful conditions in different ways, with affective disorders and behavioral disorders, respectively (Aneshensel et al., 1991; Horwitz, White, & Howell-White, 1996; Simon, 2002; Slopen, Williams, Fitzmaurice, & Gilman, 2011).

Although these propositions are now widely referenced in the gender and mental health literature, they are not universally accepted. Following previous work (Gove & Tudor, 1973; Mirowsky & Ross, 1995, 2003; Slopen et al., 2011), we present a critical analysis of all three propositions. In the interest of scientific scrutiny, we review old and new arguments concerning rate equality, functional equivalence, and gendered responsivity. After outlining several

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recommendations to advance theory and research, we conclude with some general reflections on the sociological study of gender and mental health.

Before we begin, we would like to note that the propositions examined in this paper are based on the premise that women and men do, in fact, experience different types of mental health conditions. Since mental health disorders, such as depression and antisocial personality disorder, are not directly observable, it is possible that women and men express symptoms of the same underlying problem in different ways. This could lead to biased estimates of gender differences in mental health in population-based studies if the full range of symptoms is not captured by the instrument(s) used to assess the disorders of interest or if the instrument(s) suffer from item-level bias by gender (Cole, Kawachi, Maller, & Berkman, 2000). Furthermore, estimates of gender differences in mental health from studies of clinical populations may be biased by gender differences in help-seeking behavior or by the gendered nature of the medical encounter (Hall & Roter, 2002; McKinlay et al. 2006; Sandhu, Adams, Singleton, Clark-Carter, & Kidd, 2009).

Do women and men have similar rates of overall psychopathology?

> "*In summary, women are generally not necessarily more distressed than men.*"
>
> Umberson and Williams (1999: 226)

> "*…it is now well established that the overall rates of mental health disorders in the United States are similar for men and women.*"
>
> Bird and Rieker (2008: 31)

> "*It is therefore clear that neither gender is worse off than the other in mental health overall.*"
>
> Rosenfield and Smith (2010: 259)

Gender differences in mental health have been noted for over 400 years. In the Western world, prior to the Industrial Revolution (before the mid-1800s), men were depicted as having poorer mental health than women (Porter, 1987). For example, Porter's (1987) social history of mental illness comments that there are no images of women in Robert Burton's *Anatomy of Melancholy*, which was originally published in 1621. Porter also reminds us that two *male* statues of "Raving and Melancholy Madness" were displayed at the entrance of Bethlem Royal Hospital, one of the oldest mental institutions in the world, from 1676 to 1815.

After the Industrial Revolution (between 1850 and the early 1990s), dominant conceptions of mental illness were feminized, and women were thought to have poorer mental health than men (Ehrenreich & English, 1978; Porter, 1987). During the nineteenth century, an epidemic of female invalidism led medical professionals to conclude that women are mentally and physically inferior to men. "Neurasthenia" and "hysteria" are examples of diagnostic labels that were applied to upper- and middle-class women who complained of symptoms like fatigue, irritability, and anxiousness. Disorders such as these were attributed to the female reproductive system, and sickness was considered the natural state of women. By the late nineteenth century, hysteria was defined as a mental disorder and treated by mental health professionals rather than gynecologists (Ehrenreich & English, 1978).

The belief that women have poorer mental health than men persisted throughout most of the twentieth century. This understanding was primarily supported by studies showing that women tend to exhibit higher levels of anxiety and depression than men (Rieker & Bird, 2000). However, in the early 1990s, results from the *Epidemiological Catchment Area Study* (1991) and the *National Comorbidity Survey* (1992) challenged the idea that women have poorer mental health than men by assessing the incidence and prevalence of a broader range of mental health conditions, including, for example, substance abuse and antisocial behavior. Because some of these studies show no gender differences in overall psychopathology or "any disorder" (Bourdon, Rae, Locke, Narrow, & Regier, 1992; Kessler et al., 1994; Kessler, Berglund, et al., 2005; Kessler & Zhao, 1999; Robins et al., 1984), it is now widely reported that women and men have unique mental health profiles, but similar or equal rates of overall psychopathology.

Women and men clearly experience different types of mental health conditions, but do they really exhibit comparable rates of overall psychopathology? This question is important because mental health professionals and researchers have noted gender inequalities in mental health for at least four centuries. The evidence concerning gender differences in "any disorder" is actually mixed. While it is true that some studies report no gender differences in overall mental health status (referenced above), there is also evidence to suggest that women have higher rates of psychiatric comorbidity and overall psychopathology (Bourdon et al., 1992; Kessler et al., 1994; Kessler & Zhao, 1999; Regier et al., 1988; Seedat et al., 2009) and lower rates of no psychopathology (Kessler, Chu, Demler, & Walters, 2005).

With this evidence mixture in mind, there are several reasons why studies of overall psychopathology should be interpreted with caution. Nearly three decades ago, Robins et al. (1984: 953) warned that such studies "cannot be taken as a measure of total psychiatric morbidity in the population" because interviews are limited to a narrow range of mental health conditions. To the best of our knowledge, the most comprehensive national study of community mental health – Kessler, Berglund, et al.'s (2005) analysis of data from the *National Comorbidity Survey-Replication* – includes only 19 disorders or, for context, approximately 6% of the 297 disorders listed in the *DSM-IV*. How can we base claims of gender equality on studies that exclude over 90% of known *DSM* mental health conditions?

A direct test of gender differences in overall psychopathology would require a systematic and exhaustive examination of gender differences across the known universe of mental health conditions. To this point, no such study has been published. We are assuming, of course, that such a study is feasible, but this may not be the case. Simply agreeing on the universe of mental health conditions is one major obstacle in executing such an analysis. Medicalization and the proliferation of diagnostic categories (Horwitz, 2002) is another. We must also consider the social construction of mental illness and the tendency to pathologize the mental health of women (Kupers, 1998). How can we meaningfully assess gender differences in overall psychopathology when the universe of known mental health conditions is constantly changing and seemingly stacked against women?

Are affective disorders among women and behavioral disorders among men functionally equivalent indicators of misery?

> "*…male alcohol and drug problems may be functionally equivalent to depression among females…*"
>
> Horwitz and White (1987: 167)

> "*…women's symptoms of depression and men's alcohol problems are functional equivalents…*"
>
> Simon (2002: 1088)