Mental Health: Ada Apa dengan Gender?

by **Vizla Kumaresan**

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In discussions about gender and mental health, it is easy to become focused on the differences of rates of psychological pathology between men and women — the "gender gap". Often cited are statistics indicating that women are more likely than men to be depressed, women have higher rates of anxiety disorders than men, and men are more likely to be diagnosed with Post Traumatic Stress Disorder than women. The very state of being a woman is a supposed risk factor for developing certain mental illnesses. However, gender and mental health have far bigger concerns than statistics and vulnerabilities alone. The very history of mental health and psychology is steeped in gender and stereotypes of gender differences.

In the late 19th century, the subject of hysteria came into the focus and attention of important social thinkers of the time. Hysteria, considered to be the "archetypal psychological disorder of women" (Herman, 1997:9), was one that was commonly understood but poorly defined. According to Herman (1997:10), one historian considered it a "strange disease with incoherent and incomprehensible symptoms … a disease proper to women and originating in the uterus (p. 10). Another historian termed hysteria "a dramatic medical metaphor for everything that men found mysterious or unmanageable in the opposite sex" (Herman, 1997: 10).

Jean-Martin Charcot, a French neurologist, was one of the early scientists dedicated to the study of hysteria. Prior to his studies, women suffering hysteria (termed hysterical women) were thought of as malingerers whose treatment was dependent on hypnotists and healers (Herman, 1997). Charcot's work, however, did not seek to discover the reasons for which women were hysterical. Though he discovered that their source was psychological, he reaffirmed the "known fact" that women suffered from this condition because they were more prone to high emotional states. The "emotional outbursts" were considered "… a lot of noise over nothing." (Herman, 1997: 11).

Charcot's work was later further developed by psychoanalysts Janet in France and Freud in Austria. Their work focused on discovering the reasons for which women were prone to hysterics; and discovered the role that early childhood trauma played in the development of these symptoms. Controversial at the time, it opened European society to the possibility that young girls and women were facing sexual dangers within their own homes from men that were respected and trusted members of society. This aspect of the work suffered a lot of backlash.

Just as important was the discovery that the key to alleviating the symptoms was putting words, or giving voice, to the trauma and its ensuing emotions. Thus was born the "talking cure" or psychotherapy.

The study of hysteria fell back into the shadows in the light of other psychological developments of the time, namely development psychology. However, the links made were clear: women were prone to hysterics because of their emotionality, and this made them weak.

It was not until World War I that symptoms of hysteria were noted again, this time amongst male soldiers who were fighting in Europe. Soldiers — men of valour — were found to be displaying similar, if not the same, symptoms which were thought to be only evident in hysterical women. This led early doctors and psychiatrists to question the masculinity of the men with these symptoms. These men were thought to have less control over their emotions. Termed shell shock, soldiers who were symptomatic were court martialled or discharged dishonourably. Men who were displaying these emotions, or negative reactions, because of their experiences at war were not "real men" and were, therefore, weak.

This practice continued well into World War II and also the Vietnam War. Soldiers returning from war with symptoms received little sympathy and even less medical attention. Through the work and advocacy of the anti-war movement — veterans, doctors and activists — there was sufficient attention to the symptoms that these soldiers were returning from the war front with. They faced tremendous difficulties settling into civilian life. Many veterans suffered depression as a result, and suicide was not uncommon. The term Post Traumatic Stress Disorder ("PTSD") was thus coined and it was considered a legitimate disorder faced by people who have endured trauma. Still, the definition of trauma was limited to the likes of war. It was assumed that only some members of society — mainly men — were exposed to these situations.

Then, through the work of feminist activists, the definition of trauma was widened to include "everyday" events such as violence and harassment. It was thus that domestic violence and rape — dangerous common experiences faced by women — were considered trauma.

This history of the development of what is now known as, and of, PTSD indicates that gender plays a large role in how symptoms are interpreted; and how expectations of gender roles intersect with how symptoms are manifested and understood. What became evident is that symptoms of psychological distress are not dependent on the sufferer's gender, but on more psychological aspects of the person.

Just one example of how gender impacts mental health is highlighted in studies linking conformity to gender stereotypes with mental illness. Studies have shown that there is a link between conformity to masculine norms and depression (Levant, Richmond, Majors, Inclan, Rosello, Heesacker, Rowan and Sellers, 2003; Magovcevic and Addis, 2008; and Chuick, Greenfeld, Greenberg, Shepard, Cochran and Haley, 2009). Studies have also shown that strong adherence to traditional masculine ideology is associated with significantly more negative attitudes toward psychological help-seeking amongst men and women (McCusker and Paz Galupo, 2011).

Masculine traits in women have also been shown to contribute to depression. It has been argued that the changes in social structures and gender roles, especially for females, in the last decades have led to women becoming more masculine while men have become more feminine (Udry, 2000 cited in Moller-Leimkuhler and Yucel, 2010). Yet, it cannot also be denied that there are social advantages of being masculine, as there is a (patriarchal) dividend to be gained (Connell, 2002). Thus, women who are socialised to incorporate aspects of masculinity in themselves seek to do so because of the social advantages it is supposed to provide. Masculinity, therefore, is internalised by men and women.

The issue, therefore, is not the sex or gender of the person presenting with symptoms of mental illness. What matters are the gendered stereotypes of the person, and also those held by the attending mental health professional. Gender ideologies of the attending mental health professional will also determine how symptoms presented by men and women are interpreted and diagnosed.

Just as important is the fact that the science and field of mental health is constantly growing. Knowledge about mental illness grows not only with discovery of new symptoms, disorders, and new forms of classification of these disorders, but also how society and its constituent members are understood.

This understanding is vital for the development of public health and education strategies, and policies. Considerations of mental health and gender would be important in devising strategies of dealing with depression. The World Health Organization ("WHO") predicts that by 2020, depression will be the second leading cause of disability in the world after ischaemic heart disease (WHO, 1996). As of April 2016, it is estimated that 350 million people worldwide suffer from depression (WHO, 2016). At worst, depression can lead to suicide. While more women are diagnosed with depression than men, men are more likely to commit suicide than women (Payne, Swami and Stanistreet, 2008). These gender differences are

important to consider when devising social policies to deal with such health issues. The differences, it has been argued, lies not in biological differences between men and women but on social constructions of masculinities (Swami, Stanistreet and Payne, 2008).

Globally, it is acknowledged that mental health is a serious issue. It is no different in Malaysia. It is one that warrants not just attention, but also nuanced and measured responses from the relevant sectors. The management of mental health issues amongst the public is not just a matter for mental health professionals. It requires a multi-sectoral and multi-disciplinary approach. Questions of gender cannot be relegated to that of differences between the sexes.

Yet, issues of gender are still ignored. The Ministry of Health Malaysia in 2011 published the Psychiatric and Mental Health Services Operational Policy. This is in light of the awareness of the rising problem of mental disorders in Malaysia. Statistics indicate that mental disorders contribute to 7.3% of the burden of disease in Malaysia, second after cardiovascular diseases (Ministry of Health Malaysia, 2011).

The operational policy is in line with the National Mental Health Policy (1988) which has a vision to "create a psychologically healthy and balanced society which emphasises promotion of mental health and prevention of psychological problems" (Ministry of Health, 2011). In the operational policy, the word "gender" appears just once, under the section for gender identity development amongst adolescence. The focus in Malaysia's management of mental disorders is that of provision of services and rehabilitation, especially community based approaches. The approach very much focused on welfare of the mentally ill, which is considered a disability in Malaysia (Deva, 2004). Prevention strategies identified include identifying risks factor that contribute to psychiatric disorders in the elderly; prevention of relapse; and promoting positive mental health and wellbeing by increasing emotional resilience, reduce vulnerability to mental illness and encouragement to seek help when needed (Ministry of Health, 2011).

While the policy acknowledges that a multi-sectoral approach is required to manage the national mental health issue, it is not taking into consideration social and environmental factors like gender. There are different stakeholders involved in the creation and promotion of damaging gender stereotypes that have been shown to contribute to mental health morbidity. It is imperative that gender stereotypes be questioned and challenged. This is more than just a question of equality. It is a matter that involves lives.

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