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Comparing sex inequalities in common affective disorders across countries: Great Britain and Chile

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Abstract

Most studies throughout the world have found that women report more psychological symptoms than men. Much less is known about possible variation between countries in the magnitude of these sex differences or the factors contributing to the increase of risk among women in countries with different levels of development. This study aimed to compare sex differences for common affective disorders (CAD) between Great Britain and Chile based on two large urban cross-sectional psychiatric household surveys that used similar methodology. Women in both countries reported more CAD than men but Chilean women had an increased risk in comparison to their British counterparts, a difference that became larger as symptom severity increased. Of all the main explanatory variables included in the analysis—education, employment status, children at home, marital status, and social support—the only statistically significant interaction that could account for this increased risk was education, with an increasingly larger risk for women with lower levels of educational attainments in Chile compared to Britain. Education is a powerful socio-economic indicator that is difficult to revert later in life, especially in countries where opportunities for women are less forthcoming, and it might act as powerful reminder of social entrapment.
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Introduction

Sex differences in the prevalence of common affective disorders across countries

The commonest affective disorders (CAD), depression and anxiety, are frequent and disabling in rich as well as poor countries (Murray & Lopez, 1997). One of the most consistent findings in psychiatric epidemiology is that women, especially those living in urban settings, seem to be at an increased risk of suffering from CAD (Piccinelli & Wilkinson, 2002; Patel, Araya, Ludemir, Todd & Lima, 1999; Bebbington, 1998). However, less is known if the magnitude of these sex differences in the prevalence of CAD is comparable across countries or if the type of risk factors that might explain this increased risk among women are similar in countries with different levels of development. The use of different methodologies to ascertain the presence of psychological symptoms, the difficulties of comparing unadjusted or partially adjusted results, and the scarcity of large household surveys from developing countries have somehow hindered the making of valid comparisons across countries. This is an important issue that interferes with the possibility of gaining further

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insight into the aetiology of psychiatric disorders when examining similarities and differences between countries.

How to explain differences between countries in the prevalence of common affective disorders among women?

Although little is known of risk factors that could differentially increase the risk of CAD among women in some countries, it would seem unlikely that a biological factor would be able to explain much of these differences. There are no obvious discrepancies in the biological make-up of women living in different countries, other than those brought upon by living in different social, cultural, and economic realities. Thus if there were differences in the prevalence of CAD among women from countries with different levels of development, psychosocial factors are more likely to provide an explanation for these differences. Psychosocial factors that have been linked to an increased risk of psychological morbidity and show unequal distribution between countries are worth exploring, such as employment or unemployment, socio-economic differences, the number of dependent children, multiple roles, or low social support (Araya, Lewis, Rojas & Fritsch, 2003; Piccinelli & Wilkinson, 2002; Bebbington, 1998; Weich, Sloggett & Lewis, 1998).

Several single-country studies, mostly from developed countries, have investigated the effect of work on women's mental health. Most of these studies, but not all, have been carried out as part of research investigating the impact of multiple roles ('role strain hypothesis') on the mental health of women (Fokkema, 2002; Matthews, Power & Stansfeld, 2001; Weich, Sloggett & Lewis, 2001; Weich et al., 1998; Waldron, Weiss & Hughes, 1998). As a whole, this research has failed to provide good evidence in support of the 'role strain' hypothesis but, on the contrary, several of these studies have shown that work was likely to have a positive effect for the mental health of women, regardless of the number of roles held simultaneously. Studies carried out in the developing world (Iran, India, Brazil and Chile) have failed to find differences in the mental health of working and non-working women (Ahmad–Nia, 2002; Araya, Rojas, Fritsch, Acuna & Lewis, 2001; Patel et al., 1999). It is possible that the more unfavourable living situation of women in developing countries might have contributed to dilute any positive effects of employment on women's mental health. Other methodological issues, such as for instance the possibility that psychologically healthier women were more likely to take on employment, also interfere with reaching any firmer conclusions. So in spite of the evidence suggesting beneficial effects of employment it is not possible yet to assume that work is beneficial for all women and under all circumstances.

The evidence from developed countries suggesting that education might be an important risk factor for mental illness is scant and there is even less support for an educational effect that could account for the gender differences in the prevalence of CAD (Bebbington, 1996, 1998). Nonetheless, there are marked differences in educational attainments within and between countries, with women consistently achieving lower levels than men especially in developing countries (World Bank, 2001a, b). There is stronger evidence to show that socio-economic adversity is associated with the presence of CAD (Lorant et al., 2003; Araya et al., 2001, 2003; Weich, Lewis & Jenkins, 2001; Weich & Lewis, 1998; Lewis et al., 1998); and that people, especially women, in poorer countries are comparatively under more social disadvantage than individuals in richer countries (World Bank, 2001b; United Nations Population Fund, 2000; Desjarlais, Eisenberg, Byron & Kleinman, 1995). Thus it might be reasonable to expect that sex differences in CAD could be larger in poorer than in richer countries. British studies have also shown that the presence of two or more young children at home and the lack of a confiding partner were also associated with an increased prevalence of depression in women (Bebbington, 1996; Brown & Harris, 1978). Equally previous research had consistently shown an inverse association between social support and CAD, with less support associated with an increased prevalence of CAD, but sex differences in this association are less commonly reported (Berkman & Glass, 2000).

There are many difficulties, though, when trying to determine the relative importance of individual psychosocial factors to increase the risk of CAD across countries. Some authors have argued for the need to include into the analysis the socio-economic, cultural, and political context under which these factors operate (Janzen & Muhajarine, 2003). Contextual differences cannot be underestimated when comparing countries with different cultures and levels of socio-economic development. However, contextual variables are rarely incorporated into the analysis for this kind of research in mental health. Among possible reasons for this omission are (1) difficulties in obtaining reliable and comparable contextual data across countries, (2) variation in the relative importance of contextual factors across cultures and over time within countries, and (3) methodological difficulties in analysing this kind of data adequately. We are unaware of any study comparing mental health between countries that incorporates contextual as well as individual variables into the analysis. However, most studies usually consider contextual differences when interpreting results and reaching conclusions.

The social context under which sex differences in CAD present is complex in the developing world. For instance, many international agencies and governments

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