

**GENDER DIFFERENCES IN MOOD AND ANXIETY DISORDERS:
PATTERNS OF DIAGNOSIS AMONGST PATIENTS
ADMITTED TO WESTERN CAPE PSYCHIATRIC HOSPITALS**



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ABSTRACT

Research studies have consistently shown that gender impacts on psychiatric diagnosis. Different prevalence rates and patterns of mental illness have been shown to exist amongst men and women. Research based on both psychiatric hospital admissions and community surveys has consistently indicated that mood and anxiety disorders are more common amongst women. Various explanations have been given for this discrepancy; however, there is much evidence to support the explanation that higher rates of depression and anxiety amongst women are related to social factors associated with women's roles and life experiences. The present study analysed records at the Western Cape's three public psychiatric hospitals to determine gender differences in the diagnosis of psychiatric disorders, in general, and in mood and anxiety disorders, in particular. Sociodemographic data, such as race, marital status, employment status, and age were also obtained from hospital records and correlations between gender and demographic factors were explored. Results showed the female to male ratio for depressive and anxiety-related disorders to be as high, or higher than those reported in other countries. Women showed higher rates of those disorders compared to men regardless of race. Reasons for the high prevalence of depressive and anxiety-related disorders amongst female psychiatric inpatients in the Western Cape were hypothesised.

DECLARATION

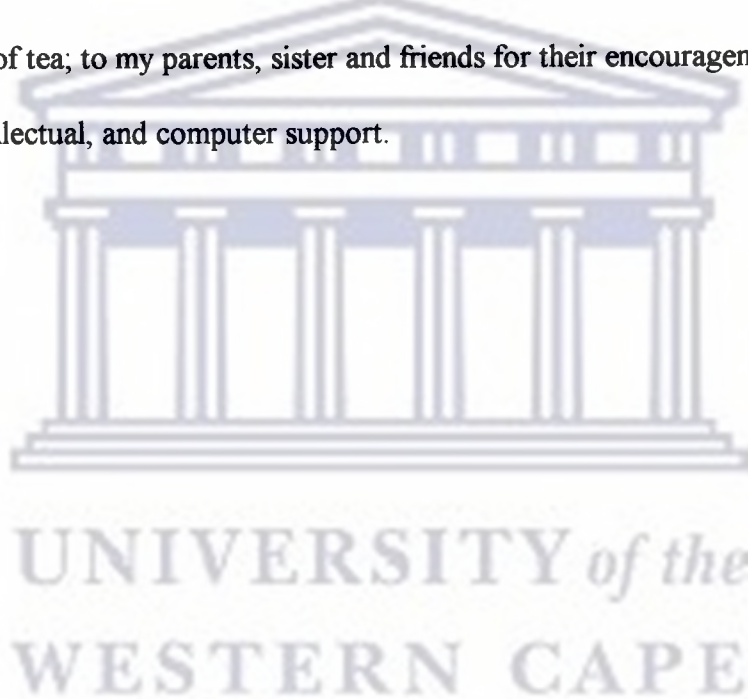
The author hereby declares that this whole dissertation, unless specifically indicated to the contrary in the text, is her own original work.



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CHAPTER ONE

INTRODUCTION

Psychiatric epidemiological research has an important role to play at this stage in South Africa's history, when the country is undergoing a process of political and social change. The new political dispensation has precipitated a process of re-examination of South Africa's institutions with a view to restructuring, including those institutions involved in the delivery of health services.

Historically, mental health has been one of the most neglected and underdeveloped sectors of health care in South Africa (Allwood, 1990). Planners of psychiatric services for the new South Africa face many challenges, including a shortage of facilities and adequately-trained personnel at both a community and an institutional level, as well as an historical legacy of racial and regional inequities (Freeman, 1990).

Policy development and implementation are hampered by a lack of knowledge of the mental health status of the population with regard to distribution of disorders and risk factors. In the case of psychiatric hospitals, while extensive archival material exists, records have yet to be analysed to reveal trends in diagnosis. Epidemiological research into mental illness has implications for the planning of mental health services and appropriate training for mental health care workers, as well as for the developing of targeted strategies for promoting mental health and preventing mental illness (Parry & Swartz, 1997). Information regarding variations in the prevalence or clinical features of mental disorders across populations or between subgroups of populations makes a vital contribution to our understanding of the contextual aspects of mental health. The need for clarity regarding the health status of the South African population has been recognised by national government, who have recently commissioned a national 'health census' of the population. Several

authors, both in South Africa and abroad (Dohrenwend, 1994; Miller & Swartz, 1992), have motivated for psychologists to get involved in psychiatric epidemiological research due to the unique perspective which they can bring to the enterprise.

Despite a proposed shift towards community primary mental health care (Freeman, 1990), the psychiatric hospital remains an important node in the mental health care delivery system. However, South African psychiatric hospitals are currently in a state of crisis, and some will inevitably be closed (Vongai & Van Zilla, 1997). Notwithstanding Allwood's (1990) argument that the number of psychiatric hospital beds is presently inadequate to meet the need for inpatient care, and that psychiatric hospitals require substantial expansion and upgrading in the context of a comprehensive psychiatric health care system, the reality is that deinstitutionalisation is a fiscal imperative. Unfortunately, despite the national government's commitment to accessible health care at community level, support structures for psychiatric patients are woefully inadequate in most areas (Cape Times, 1997).

Whereas the issues relating to gender¹ and mental illness have been the subject of extensive research internationally, little work has been done in this area in South Africa. Due to the racial inequities in the delivery of health services under apartheid, not to mention the adverse psychological consequences of apartheid (Klugman & Weiner, 1992), issues of race have

¹ The terms 'gender' and 'sex' have distinct meanings. While sex refers to physical, biological differences between women and men, gender refers to the implications of those differences with regard to social expectations and roles. 'The main sex difference between women and men is that men can impregnate and women can bear children. The main gender difference between women and men is that women as a group have a lower status than men' (Mackenzie, 1992, p. 16).

appropriately been prioritised in debates around a new system of mental health care (Allwood, 1990; Freeman, 1990). Although gender equity is enshrined in South Africa's new constitution, many South African women, particularly poor women, continue to be exposed to pervasive and persistent gender-specific stressors which potentially undermine their mental well-being (Haffajee, 1997; Klugman & Weiner, 1992).

Research in both developed and developing countries has generally suggested a higher prevalence of mental illness amongst women than amongst men (Rieker & Jankowski, 1995; Smyke, 1991). In addition, different patterns of mental illness have consistently been found to exist amongst men and women (Dohrenwend & Dohrenwend, 1974; Regier *et al.*, 1993; Vasquez-Barquero *et al.*, 1992). Research based on various sources of data, including hospital admissions statistics, data gathered from general practices, and community surveys, and conducted in different countries, has repeatedly demonstrated that women have higher rates of depressive disorders, anxiety disorders, and somatisation disorders, while men have higher rates of alcohol abuse or dependence, drug abuse or dependence and antisocial personality.

The high prevalence of depressive and anxiety-related conditions amongst women is a source of concern both as a women's health issue and as a general mental health issue. In the case of depression, on average, women are diagnosed with depression twice as often as men (Nolen-Hoeksema, 1990). Indeed, Russo (1995) asserts that it is likely that the overall gender difference in rates of mental illness is accounted for by the gender differences in rates of depression.

Most authors have agreed that no single factor can be identified as being responsible for the high rates at which certain mental disorders are diagnosed in women. Various explanations have been

forwarded, including those which have argued that apparent gender differences are a diagnostic artefact, as well as those which maintain that the gender differences are real. Amongst the latter, there is strong empirical evidence in favour of social causation (Russo, 1995). One of the findings which seems to justify social explanations is that the female excess of depression, although widespread, is not universal, and does not occur in certain circumscribed populations (Nolen-Hoeksema, 1990). Thus, gender differences show variations across different social and cultural contexts in ways which other theoretical models, such as biomedical and intrapsychic models, cannot adequately explain.

Sociodemographic factors such as marital status, presence of dependants, employment status, income and educational level have been found to interact differentially with sex in influencing vulnerability to mental illness (Regier *et al.*, 1993; Romans-Clarkson, Walton, Herbison & Mullen, 1988; Vasquez-Barquero *et al.*, 1992). However, much epidemiological research has focused exclusively on discrete and relatively proximal risk factors, and has neglected the underlying social conditions which provide the context for the risk factors, and can arguably be considered 'fundamental causes' of disease (Link & Phelan, 1995). It is therefore necessary to ground an analysis of those factors which render women at risk for developing depression and anxiety in an appreciation of the context of oppressive social structures which result in women experiencing a lack of personal control.

Although there is a dearth of studies relating to gender variations in symptomatology and diagnosis in Africa, Kisekka (1990) reports that, amongst the few which have been conducted, the majority of studies seem to have found a higher incidence of depression and psychosomatic disorders amongst women than men. Research into gender differences in mental illness is required

in Africa generally, and in South Africa specifically, in order to establish whether the predominantly British and North American findings on the subject are replicated here.

Sociodemographic characteristics of women's psychiatric illness and the relationship between gender-specific stressors and mental illness also need to be investigated.

Psychiatric epidemiological research into the gender distribution of mental illness in South Africa is necessary not only because it contributes towards a growing body of knowledge of the health status of the South African population, but also because it helps to answer the question as to whether gender differences in mental illness persist across all cultures and subcultures. If the gender ratio here is lower than the international average of 2:1, then we can examine which social factors protect women against depression and anxiety. If it is higher, then specific aspects of the South African sociocultural context which seem to predispose women to those problems need to be elucidated. As sexism and oppression of women still persist in South Africa in various forms and in many settings, it is hypothesised that gender differences in rates of mood² and anxiety disorders will be the same, if not higher than the international average ratio of 2:1.

In the next chapter, some of the relevant literature around gender and mental illness will be reviewed. Firstly, some of the broad patterns of gender differences in mental illness will be sketched, and in particular, the widely held assumption that women suffer from mental illness more than men will be unpacked. The focus will then fall on gender differences in depression and

² The terms 'mood disorder' and 'affective disorder' will be used interchangeably in the paper, as both appear in the literature, denoting roughly the same group of disorders. However, the term currently used in the DSM-IV (APA, 1994) is 'mood disorders'.

anxiety-related disorders, which are, in almost all sociocultural settings, diagnosed more frequently in women than in men. Studies from North America and Europe, where most of the literature originates, as well as those studies available from Africa, and South Africa in particular, will be examined. Various explanations for the preponderance of neurotic³ disorders amongst women have been proposed ranging from orthodox biomedical models, to radical arguments which take issue with the fundamental concepts on which psychiatry is based, such as the concepts of 'mental illness', 'diagnosis' and 'the patient', and more particularly with the way psychiatry conceptualises and relates to women (Heather, 1976; Kaplan, 1983), to models which, perhaps with reservations, accept the current classification system as valid, and argue that explanations for the gender discrepancies in the prevalence of certain disorders lie in women's lack of personal and social power (Russo, 1995).

In the third chapter, the focus shifts to the current research project, which aims to provide a gendered analysis of admissions to the Western Cape's three state psychiatric hospitals, based on data obtained from the patients' case records. In this section, some relevant background information to the study will be outlined, including a brief history of the three psychiatric hospitals from which the sample was drawn, as well as a brief description and critique of the system for classifying mental disorders currently in use in South Africa: the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) (APA, 1994). The research method will then be detailed, including the sampling and data-gathering procedures, as well as the analysis of data.

³ Although the term 'neurosis', more specifically 'psychoneurosis', has its roots in psychoanalytic thought, and in the strict sense, connotes a condition which is the product of unconscious conflicts, here the term is used to denote a cluster of relatively mild disorders whose main feature is a sense of subjective distress, but with which reality testing remains intact (Reber, 1985).

Next, the results of the study will be documented. A comparison between male and female patients at the three hospitals will be effected, in relation to the demographic variables of race, age, marital and employment status. Gender differences in psychiatric diagnoses given to the patients in the sample during the time period in question will then be reported. Diagnoses on both Axis I and Axis II of the DSM-IV's system of multi-axial assessment and classification will be considered. Thereafter, the subgroup of patients diagnosed specifically with mood and anxiety disorders will be highlighted. Male and female patients in the subgroup will, as with the overall group, be compared to establish whether demographic factors show any variation between men and women with mood and anxiety disorders.

In the fifth and final chapter, the implications of the results will be discussed. The results of the present study will be compared with the results of studies performed in other countries, with regard to differences and similarities in the prevalence and distribution of certain disorders, particularly mood and anxiety disorders, across the different settings. Associations between gender and the other demographic variables included in the study will then be explored. Although the scope and nature of the study is not such that causes of gender differences in mental illness can be established with certainty, possible explanations for observed differences will be speculated upon, in the light of the relevant literature. The concluding section of the chapter will reflect upon some critical mental health issues which have been raised by the current project, as well as some of the implications of the results for future research, the development of health policy and the planning of health services. In addition, some of the limitations and shortcomings of the research in terms of both focus and methods will be considered.

CHAPTER TWO

LITERATURE REVIEW

Over the past few decades, the issue of gender differences in health generally, and in mental health in particular, has been recognised as an important area of research, with implications for the planning and provision of health care. In this section, some of those research trends will be reviewed. Firstly, the gender differences in overall rates of psychiatric conditions will be critically examined, and variations across different historical and geographical settings will be noted. Gender differences in anxiety and depression-related disorders will then be explored, with specific reference to findings from South Africa and other African countries. Various theoretical models which have provided frameworks for understanding the reported differences will be discussed and briefly evaluated. These explanatory models can be classified into those which would argue that gender differences in mental illness are artefactual, and those which conclude that the statistics represent actual differences in morbidity. Amongst the latter, various explanations have been posited, including those which would focus respectively on biological, intrapsychic and psychosocial factors. Empirically, psychosocial factors have been strongly linked to gender differences in depression and anxiety-related disorders; for the remainder of the chapter, therefore, the relationship between those factors and the incidence of mental illness will be explored.

2.1 GENDER DIFFERENCES IN PREVALENCE OF MENTAL ILLNESS

Research into the relationship between gender and mental illness has often shown that overall, more women are *diagnosed* as being mentally ill than men (Kaplan, 1983; Miles, 1991; Pilgrim & Rogers, 1993; Smyke, 1991; Vasquez-Barquero *et al.*, 1992; Weissman & Klerman, 1977). This

finding has been drawn from two main categories of data: firstly, statistics of people who have either been admitted to psychiatric hospitals or received some form of psychiatric intervention, including consultations by psychiatrists and general practitioners, and secondly, community surveys (Pilgrim & Rogers, 1993). While the former encompasses treated cases of mental disorder only, the latter elicits both treated cases and those which might otherwise go undetected and untreated.

An excess of mental illness in women does not occur consistently across time and space, however. Research into the cultural history of psychiatry (Chesler, 1972; Ehrenreich & English, 1978; Showalter, 1987) has been inclined to highlight the overlap between cultural representations of women and those of madness. The claim has also been made that, historically, the psychiatric system oppressed women by regulating their minds and enforcing patriarchal versions of reality. However, Busfield (1994) argues that there is little empirical support for such assertions. In particular, Busfield takes issue with Showalter's contention that, for several centuries, women have been statistically overrepresented amongst the mentally ill. Showalter's claim has assumed the status of core fact in a growing body of research into women and madness, but as Busfield argues, is a misrepresentation of the data, based on only a cursory overview of statistics from nineteenth-century asylums. Busfield (1994, p. 275) concludes that 'there was no clear female monopolisation of madness either in terms of cultural representations or in terms of patient populations'. Similarly, Tomes (1992) cites empirical data from the nineteenth century through to the 1980's demonstrating that men and women have been admitted to mental hospitals at similar rates. Tomes also states that women are diagnosed with serious mental illness at similar rates to men.

In the contemporary era, as far as different geographical and cultural settings are concerned, higher rates of overall psychiatric morbidity for women than men would seem to be the norm in most developed countries, although exceptions have been reported in countries such as New Zealand, where equal levels of psychiatric morbidity in men and women were found in a community study (Thornley, Walton, Romans-Clarkson, Herbison & Mullen, 1991). However, where available, findings from developing countries appear to differ. Kisekka (1990) reports that throughout Africa, the trend is for there to be higher rates of psychiatric admissions for men than for women. In South Africa, Gillis, Lewis and Slabbert (1968) found higher rates of psychiatric disturbance in men than women in a Cape Town community survey.

Further unpacking of the apparent excess of psychiatric morbidity amongst women indicates that treated rates of mental illness often differ according to the sector of the mental health system from which data are drawn. For example, Rieker and Jankowski (1995) found that, in outpatient clinics, men and women were equally represented. On the other hand, men were more likely than women to be treated in public psychiatric hospitals (where men represented 57% of new psychiatric inpatients, while women accounted for 43%), but women were more likely than men to be admitted to private psychiatric clinics. Women are also more likely than men to consult general practitioners for psychological problems than men (Miles, 1991). Similarly, Miles asserts that the greatest preponderance of women over men is associated with those conditions which are usually dealt with by general practitioners without referral to psychiatrists. These results would seem to imply that when a female excess of psychopathology does exist, it is more likely to be apparent towards the mild to moderate end of the spectrum. It follows therefore, that, with regard to specific categories of mental disorder, the greatest excess of women over men would be evident in anxiety and depression-related disorders, otherwise referred to as psychoneuroses or neurotic disorders.

2.2 PATTERNS OF PSYCHIATRIC MORBIDITY

If the results of studies aiming to determine whether women suffer from mental illness more frequently than men have been inconsistent, then research into *patterns* of mental illness for each gender has been more unequivocal. Research has repeatedly shown similar trends in the gender distribution of received diagnoses within the general population (Abbey, Hood, Young & Malcolmson, 1993; Dohrenwend & Dohrenwend, 1974; Leibenluft, 1996; Regier *et al.*, 1993; Vasquez-Barquero *et al.*, 1992). Schizophrenia is usually found to be equally distributed between men and women, as is bipolar affective disorder, while women generally experience higher rates of depressive disorders, as well as somatisation disorders, and most anxiety disorders. In contrast, men exhibit higher rates of substance abuse and dependence, severe cognitive impairment and antisocial personality. Some studies have shown that men have higher overall rates of personality disorders (Dohrenwend & Dohrenwend, 1974; Vasquez-Barquero *et al.*, 1992), while others have shown that a male excess is limited to certain specific personality disorders. Typically, antisocial, paranoid and obsessive-compulsive personality disorders are diagnosed more frequently in men, while histrionic, borderline and dependent personality disorders are diagnosed more frequently in women (Kaplan, 1983; Nuckolls, 1992).

Significantly, statistics from different countries indicate that although the gap in overall diagnosis rates between men and women had narrowed gradually since the 1950's, in general, the pattern of diagnoses has remained the same (Pilgrim & Rogers, 1993; Rosenfield, 1989).

2.3 GENDER DIFFERENCES IN MOOD AND ANXIETY DISORDERS

The most frequent diagnosis given to women is that of depression (Russo, 1985; Weissman & Klerman, 1977). In fact, as was mentioned earlier, it has been argued that any excess of mental illness in women is accounted for by the comparatively high rates of depression amongst women (Russo, 1995). In addition, the excess of mood disorders amongst female admissions accounts for the high overall rate of female psychiatric admissions (Cochrane, 1993). The category of mood disorders is by far the largest single cause of mental hospital admissions in industrialised countries (Cochrane, 1993; Rieker & Jankowski, 1995). Sashidharan, Surtees, Kreitman, Ingham and Miller (1988) report that, for women, two types of affective disorder, affective psychosis and neurotic disorder together account for 45% of the total treated psychiatric morbidity. Leibenluft (1996) reports that, although the gender ratio among patients with bipolar affective disorder is equal, in women the disorder tends to show a different course to that of men, with women being more likely to develop rapid-cycling form of the illness, as well as being more likely to experience more depressive and dysphoric manic episodes compared with men.

2.3.1 International studies

Desjarlais, Eisenberg, Good and Kleinman (1995) confirm that the greater prevalence of neurotic disorders amongst women represents a world-wide trend. These findings appear to be consistent across diverse societies, social contexts and ethnic groups (Abbey *et al.*, 1993; Carr, Gilroy & Sherman, 1996; Desjarlais *et al.*, 1995; Russo, 1995). As far as race is concerned, it has been demonstrated that, when all other demographic factors are controlled for, black women and white

women exhibit the same rates of psychiatric morbidity (Gibbs & Fuery, 1994). It is generally agreed that in industrialised countries, women's lifetime prevalence rate of depression exceeds that of men at a ratio of two to one (Pilgrim & Rogers, 1993; Russo, 1985; Smyke, 1991). In the USA, the vast Epidemiological Catchment Area (ECA) survey (Regier *et al.*, 1993) found a one-month prevalence rate for affective disorders of 5.1% for both sexes, 6.6% of the female population and 3.5% of the male population, a female to male ratio of 1.9:1. The survey also found that anxiety disorders were the most prevalent group of disorders in the general population, with a rate of 7.3%, and with those disorders being twice as prevalent in women as in men. The DSM-IV (APA, 1994) reports higher rates for women than men for the majority of mood and anxiety disorders (see Table 1).

Although less data are available from developing countries, Smyke (1991, p. 123) asserts that 'it appears that there are few fundamental differences in the nature or prevalence of mental illness in developing countries as compared with the industrialised world'. High rates of depression amongst women relative to men have been noted in countries such as Puerto Rico (Canino, Rubro-Stipek, Shrout, Bravo, Stolberg & Bird, 1987) and India (Doyal, 1995). In contrast, however, Weissman and Klerman (1977), reviewing a wide range of international studies, conclude that while higher rates of mood disorders amongst women than men are usually found in developed countries, exceptions have been reported in some developing countries such as India, Iraq, New Guinea, and Zimbabwe, where rates are either equal between men and women, or higher amongst men. In yet another more recent, comprehensive review of all methodologically sound research studies of depression in countries other than the USA, including studies involving treated cases and community samples, Nolen-Hoeksema (1990) concludes that the average female to male ratio for depression in those countries is, as in industrialised countries, 2:1.

Table 1 DSM-IV statistics regarding sex differences in mood and anxiety disorders (APA, 1994).

DSM -IV Category	Prevalence
Mood Disorders	
Major Depressive Disorder	2x as common in adolescent and adult women
Dysthymia	occurs equally in both sexes in children 2-3x as common in women than men
Bipolar I Disorder	equal
Bipolar II Disorder	more common in women
Cyclothymia	equal distribution
Anxiety Disorders	
Panic Disorder without Agoraphobia	2x as often in women as in men
with Agoraphobia	3x as often in women
Specific Phobia	animal and natural environment, and situational type: 75-90% women blood-injection-injury type: 55-70% women
Obsessive-Compulsive Disorder	equal distribution
Generalised Anxiety Disorder	clinical settings: 55-60% women epidemiological studies: 2/3 women

In Nolen-Hoeksema's review (1990), no studies into gender differences in *treated* cases of depression using standardised diagnostic criteria had been performed in Africa. However, in a community study performed in two Ugandan villages, Orley and Wing (1979) found no significant gender differences in overall psychiatric morbidity or in syndrome profiles (with the exception of pathological guilt, which was significantly more common amongst women). Similarly, Dhadphale, Ellison and Griffin (1983) screened patients attending general outpatients departments in Kenya for psychiatric morbidity, and found a high prevalence rate of 29%, but again, discerned no

significant gender differences. In both studies cited above, neurotic disorders dominated the syndrome profiles for both sexes. In fact, for both sexes, rates of neurotic disorders were high relative to those recorded in developed countries. Orley and Wing (1979) found that depressive disorders in the Ugandan women sampled were twice as prevalent, and also more severe than they were in a sample of women from London.

2.3.2 South African studies

There have been few studies concerning demographic patterns of mental illness in South Africa specifically, but it is worth examining existing studies in some depth, and extrapolating where appropriate. Seedat (1984) cites official figures for patients discharged from all South African state psychiatric hospitals in 1975. He reports that for white⁴ patients, neuroses constituted 21% of first admissions, while representing only 2% of first admissions for other groups. Seedat cautions that these figures do not imply that neuroses are uncommon amongst blacks, but rather that facilities for treating black patients with neuroses were severely limited. Seedat does not report any gender differences in diagnoses for hospital patients. It is worth noting that, under the

⁴ As racial categories will be referred to extensively in this project, it is important to explain the terms which will be used. The terms, white, African, coloured and Asian, used to describe racial groups in this project derive from the (now repealed) South African Population Registration Act (1950), which in the past, differentially determined access to resources. It is acknowledged that these racial categories, and indeed the concept of race, are the subjects of continuing controversy and debate. The terms are used here because of the demonstrable social and economic imbalances between racial groups which still exist as a result of past legislation. In addition, the term 'black' is used occasionally in the sense that it refers to 'those who are politically, socially and economically discriminated against, and identify themselves as such' (Biko, in Ramphela, 1995, p. 59).

apartheid government, conditions in mental institutions for black patients were typically appalling, and that diagnoses were often inaccurate and treatment therefore inappropriate (Allwood, 1990; Seedat, 1984).

As far as community studies are concerned, the overall prevalence rate for psychiatric morbidity in the Western Cape was cited by Gillis, Lewis and Slabbert (1968) as 23%, and in a more recent study by Rumble, Swartz, Parry and Zwarenstein (1996) as 27.1%, both high rates compared to international norms. Rumble *et al.* found that depression and anxiety disorders account for 58% and 24% of all psychiatric disorders respectively, while Gillis *et al.* reported that 43% of the population sampled showed psychophysiological disorder, 15% exhibited anxiety states, 12% clinical depression, while 2.4% were frankly psychotic, 3.7% had personality disorders and 1.4% organically-based disorders. The high rates of depressive and anxiety-related symptomatology found in both studies stand in stark contrast to the perception in some quarters that depression, anxiety and guilt are uncommon in African populations, or are alien to the 'African character' (Carothers, 1953, cited in Orley & Wing, 1979).

Regarding the gender distribution of neurotic conditions in the general population, Gillis *et al.* (1968) found that women had more neurotic and psycho-physiological symptoms patterns and were more prone to depression and neurasthenic symptoms. Although men had higher overall rates of mental illness, this was accounted for by the widespread prevalence amongst the men of chronic alcohol abuse and dependence. A study conducted in a rural village in the Western Cape (Hoffman, Pick, Joubert, Yach, Thomas & Klopper, 1988) reported a higher prevalence of 'nerves' (a colloquial term for stress-related mild to moderate mental disorders distinct from more serious psychiatric conditions, which would include features of mood, anxiety and somatoform

disorders) amongst females than males, although, in the same community, Rumble *et al.* (1996) did not find a statistically significant association between gender and psychiatric morbidity. On the surface, this finding would appear to be consistent with the assertion, made above, that women are more likely than men to experience milder psychiatric problems.

Pulling together the findings reported above, it appears that the tentative conclusion can be drawn that women in South Africa, as in the rest of Africa, experience higher rates of both psychological distress and mental disorder, and in particular, a high level of symptoms of anxiety and depressive disorders. As far as admissions to psychiatric hospitals are concerned, however, the trend in Africa is for there to be higher rates of admissions for men than for women (Kisekka, 1990). That this is the case in South Africa is to a certain extent confirmed by Gillis, Sandler, Jakoet and Elk (1986), who report that, while more or less equal numbers of white men and women are admitted to one of the hospitals involved in the current study, 68% of coloured admissions and 72% of African admissions were male. The differences between the white patient population and the coloured and African patient populations must be understood against the backdrop of South Africa's apartheid history, which led to stark differences between the social and economic circumstances of blacks and whites. Thus, while figures for whites are consistent with European and North American findings, figures for blacks are more in line with those for the rest of Africa.

Kisekka (1990) speculates that reasons for the preponderance of male admissions to psychiatric hospitals in Africa may include men's greater involvement in the formal employment sector, which gives them greater access to medical benefits, as well as the fact that men tend to be more physically aggressive and predominate amongst city marginals, making them more likely to come into contact with the police. She cites a study of Ugandan psychiatric hospital admissions by Orley

(1972), in which the author found that the difference in admission figures between males and females was most obvious in cases brought in by the police.

2.4 EXPLANATORY MODELS

Reasons for the gender discrepancies in the prevalence of psychiatric illness, and in the prevalence of neurotic disorders in particular, have been debated in the literature at length. Empirical studies in the field began by investigating associations between different variables, and much of the research still remains at the associative level. However, the need to gather together the various research findings and to develop comprehensive, coherent theoretical models has been identified (Ross & Mirowsky, 1989; Weissman, 1987). At present, the range of explanations for the gender differences in depression and anxiety derive from a variety of paradigms. These explanations can be classified into those which assert that the gender differences in depressive and anxiety-related disorders are artefactual, and those which suggest that the differences are real. The second group of explanations fall into three broad categories: biological, intrapsychic and psychosocial.

2.4.1 Diagnostic artefact

According to the artefact perspective, ostensible gender differences in mental illness result from methodological and/or conceptual shortcomings in research and in the classification of mental disorders, or alternatively from bias on the part of diagnosing clinicians. In addition, some authors have argued that the diagnosis of depression and anxiety involves a process of collusion between patient and clinician, in which common, everyday unhappiness is given a psychiatric label.

2.4.1.1 Research and classification problems

Some authors have argued that research and classification problems have contributed to the erroneous perception that women suffer from mental health problems more than men. This set of arguments ranges from those which would challenge the fundamental principles of the diagnostic system, to those which have criticised relatively superficial aspects of the research process. Thus, some authors (Kaplan, 1983; Rosser, 1992) have argued that the DSM system of classification of psychiatric disorders is a document generated by a male-dominated team of researchers, which contains certain implicit *biased* assumptions about normal and abnormal female behaviour. This is a contentious argument which has been strongly disputed elsewhere (Williams & Spitzer, 1983). On the other hand, problems have arisen due to the fact that different researchers have employed different definitions of mental illness, setting different parameters which would include some and exclude other disorders, thereby producing apparently different results (Pilgrim & Rogers, 1993).

Another set of studies would explain the female excess of certain mental disorders in terms of gender differences in attitudes towards illness, and in help-seeking behaviour (Jenkins & Clare, 1989; Kaplan, 1983; Pilgrim & Rogers, 1993). Following this argument, women are said to be more likely than men to express symptomatology, visit health professionals and generally adopt the sick role. While there is some evidence that this is the case (Pilgrim & Rogers, 1993), other studies have reached the opposite conclusion, that women do not seek help more often than men, that higher rates of mental illness in women are not due to an increased tendency of women to express feeling states and demoralisation, but rather do indeed represent clearly defined psychopathological entities (Clancy & Gove, 1974; Landrine, 1989; Vasquez-Barquero *et al.*, 1992).

2.4.1.2 Diagnostic bias

According to this set of arguments, sexism amongst diagnosticians, and negative stereotypes of the 'neurotic', 'hysterical', complaining woman, are factors leading to an overdiagnosis of anxiety and depressive disorders in women (Miles, 1991). It has been suggested that stereotypes held by clinicians lead them to underdiagnose or overdiagnose certain conditions on the basis of demographic features of the patient, including gender (Rosser, 1992). Redman, Webb, Hennrikus, Gordon and Sanson-Fisher (1991) found that doctors were more inclined to diagnose mental illness in women than in men, and that they also overestimated the level of severity of psychopathology amongst female outpatients, despite the fact that the women in that sample reported similar levels of symptomatology on self-report to the men in the sample. Loring and Powell (1988) found that the sex and race of the patient influenced the diagnosis given by psychiatrists, even when symptomatology was the same.

The concepts of 'neurosis', 'depression' and 'anxiety', and indeed 'madness' or more benignly 'mental illness', are socially constructed, denoting deviance from the dominant social norms and sex-role prescriptions. These are terms which, when applied, invariably have negative consequences for the individual. Feminist writers have argued that women have to walk a much narrower path of conformity to social norms than men (Kaplan, 1983). Dramatic evidence supporting this assertion appeared in a landmark study which showed that clinician's criteria for psychological healthiness in men and in adults were the same, whereas their criteria for healthiness in women were different (Broverman, Broverman, Clarkson, Rosenkranz & Vogel, 1970). The implication of this finding is that when women conform to the female sex-role stereotype, they are

considered to be unhealthy adults, but if they do not conform to the female sex-role stereotype, they are considered unhealthy women.

In contrast to the studies mentioned above, however, a review of the literature on sex bias in diagnosis and psychotherapy indicated that the majority of studies have failed to demonstrate the existence of bias against women, including women in non-stereotypical roles (Smith, 1980).

Lopez (1989) also reviewed the literature around patient variable biases in clinical judgement and found that of the three variables surveyed (gender, race and social class), the evidence for gender bias was the least consistent. Thus, Jenkins and Clare (1993) maintain that while evidence for the discrimination against women in the field of psychiatry exists, the conditions for its occurrence are rather circumscribed and may be declining. Indeed, Lopez has proposed a reconceptualisation of the biased clinician. He suggests that where diagnostic bias occurs, it is much less likely to be due to a prejudiced clinician who makes judgements based on a single defining characteristic of the patient, than due to selective information processing on the part of a clinician who must synthesise complex information when diagnosing and treating patients, and who, in the process, draws on his or her fund of clinical knowledge about group differences in patterns of psychopathology.

2.4.1.3 The medicalisation of unhappiness

According to Miles (1988, 1991), women experience high levels of psychological distress as a result of various social stressors. She argues that changes in social structure that have occurred in the 20th century have resulted in a breakdown of community cohesiveness, so that previous systems of support and advice-giving no longer exist. In addition, people are constantly encouraged, through advertising and other forms of social pressure which bombard people with

utopian images, to strive for levels of happiness, fulfilment and achievement which are difficult to attain. As a result, people are increasingly turning to the medical and para-medical professions in an attempt to find solutions for psychosocial and sociobehavioural problems, or even for everyday unhappiness. Miles contends that at the level of doctor-patient interaction, the two participants collude in medicalising the patient's problem. For patients, a psychiatric diagnosis legitimates unhappiness, easing guilt about 'not coping', while for doctors, a psychiatric diagnosis (usually one which falls into the neurosis category) and the consequent prescription of medication enables them to feel that they have done something positive for the patient, thus reducing feelings of professional inadequacy.

However, with regard to the scope of the current study, it is thought that if a collusion between doctor and patient does occur, as Miles suggests, it is probably more likely to happen in general practice, and less so with patients referred for specialised psychiatric treatment. It is also unlikely that many of the patients so labelled would make it through the 'gateways' to public psychiatric hospitals. Thus Miles' position, while interesting, is not really relevant to the present study.

2.4.2 Gender differences reflect actual differences

Another set of arguments, including the biomedical, intrapsychic and psychosocial perspectives, would assert that differences in the rates at which men and women experience or are diagnosed with certain disorders represent, at least for the most part, real differences, and are not due to any diagnostic artefact.

2.4.2.1 The biomedical perspective

Biological explanations would focus on the incidence of depression associated with the female reproductive cycle (such as post-partum depression, menopausal depression and pre-menstrual dysphoric disorder), and would relate these to the role of either sex-linked genes or gonadal hormones. At present, however, there is no conclusive evidence that non-psychotic affective disorders are transmitted genetically. Similarly, there is insufficient evidence to conclude that non-psychotic mood disorders are caused by imbalances in gonadal hormones, even so far as disorders associated with the female reproductive system are concerned (Cochrane, 1993; Jenkins & Clare, 1989). Therefore, it appears unlikely that biological factors play a significant role in the aetiology of gender differences in depressive disorders. As an exception, however, there is abundant evidence that biogenetic factors play a significant role in the aetiology of bipolar mood disorder (Carson, Butcher & Coleman, 1988). However, as has been mentioned, that disorder differs from non-psychotic affective disorders in that it usually shows an equal sex distribution.

2.4.2.2 The intrapsychic perspective

Although, in general, this set of explanations acknowledge the social conditions which impact on women's mental health, their emphasis is on the intrapsychic processes which increase women's vulnerability to depression and anxiety. Included here are a group of theories which outline women's psychological development, such as the Self-in-Relation Model (Chodorow, 1990; Gilligan, 1990; Miller, 1990) as well as the Silencing the Self Model (Jack, 1991). The Self-in-Relation theorists assert that for women, separation, individuation and autonomy are not the core aspects of identity formation that they are for men. These authors would argue that the major

psychodynamic theories of development have failed to integrate an explanation of the gender differences inherent in the development of a sense of self. The crucial difference, according to the Self-in-Relation Model, is that women's psychological development first and foremost locates them in a connecting matrix of relationships. However, women's primary need for reciprocity and affiliation runs counter to the values of the prevailing (male-defined and dominated) culture, so that women's needs are often frustrated, thus rendering women vulnerable to feelings of failure, emptiness and hopelessness.

According to Jack's (1991) Silencing the Self Model, women who become depressed have been socialised into equating adequacy and fulfilment with success in intimate relationships. Within their relationships, women strive to fulfil the role of 'good wife' or 'good mother', roles which invariably involve a process of self-sacrifice, self-denial and a suppression of authentic opinions and feelings (including anger), to the extent that women experience a 'loss of self', which in turn leads to feelings of hopelessness, helplessness and ultimately, depression.

From a somewhat different theoretical perspective, studies have also been performed on gender differences in cognitive styles which might increase women's vulnerability to depression and anxiety. For example, Nolen-Hoeksema (1990) found that women were more likely than men to adopt a ruminative cognitive style in response to stress, which both increased the likelihood of depression developing and increased the duration and severity of the episode.

2.4.2.3 The psychosocial perspective

There is a substantial body of research which would argue that gender differences in mental illness are real, and are related to aspects of the social structure which disadvantage and disempower women, thereby rendering them more susceptible than men to certain mental disorders (Cochrane, 1993; Nolen-Hoeksema, 1990; Rieker & Jankowski, 1995; Russo, 1985). From this perspective, excessive rates of mental illness, particularly neurotic disorders, amongst women, are viewed as being rooted in women's life experiences and social roles; furthermore, many of the risk factors associated with depression and anxiety, such as sexual abuse for example, are experienced more commonly by women than by men.

Rieker and Jankowski (1995) assert that, despite variable and evolving patterns of gender role socialisation, the unchanging cross-cultural commonality is for women to be socialised into a subordinate status with attendant low levels of personal control. There is an growing body of research which conclusively demonstrates that social factors are implicated in the aetiology of psychopathology, especially with regard to depression and anxiety (Brown & Harris, 1978; Miles, 1991). Perhaps the most convincing argument in favour of this position is the finding that when some demographic factors, for example, employment, are controlled for, rates of depression are often strikingly similar for men and women (Jenkins & Clare, 1989; Nolen-Hoeksema, 1990). Furthermore, patterns of mental illness vary with the sociocultural context in ways which cannot be explained by the traditional biological and intrapsychic theories (Russo, 1995). Nolen-Hoeksema (1990) found that the female excess of depression does not occur in certain circumscribed populations, such as US college students, members of the Old Amish and the newly widowed elderly, all of whom show an equal sex distribution. In addition, prevalence rates and

patterns of mental illness can show variations over time within the same community (Murphy, Sobol, Neff, Olivier & Leighton, 1984).

Some of the potential risk factors which have been investigated are demographic factors such as employment status, marital status, number and age of children, socio-economic status and age, as well as life events such as sexual or physical abuse, physical illness and losses. Some of these factors will be discussed here in greater depth. However, it is worth noting the importance of locating risk factors in their proper social, cultural and economic context. Link and Phelan (1995, p. 80) argue that 'an exclusive focus on proximate risk factors, potentially controllable at the individual level, resonates with the value and belief systems of Western culture that emphasise both the ability of the individual to control his or her personal fate and the importance of doing so'. Attempts to address individual risk factors will be ineffective if not embedded in an understanding of the background of basic social conditions, processes and relationships against which the risk factors occur. With the above cautions in mind, the following section will examine some of the psychosocial factors that have been linked with high rates of depression and anxiety amongst women.

2.5 PSYCHOSOCIAL FACTORS ASSOCIATED WITH GENDER DIFFERENCES IN MOOD AND ANXIETY DISORDERS

2.5.1 Employment

The interaction between gender, employment and mental health appears to be a complex one. Cochrane (1993) argues that employment status is by far the best predictor of psychological well-

being. Several authors have found that unemployment is detrimental to the mental health of both men and women (Cochrane, 1993). However, unemployment is especially stressful when it is coupled with responsibility for the care of others (Rieker & Jankowski, 1995). In Brown and Harris' landmark study (1978), the authors identified several risk factors which render women vulnerable to depression, amongst which were the combination of having several young children to care for and not having paid employment outside the home. Gove (1984) found that less structured roles and nurturant roles (which combined describe the role of housewife) were associated with poor mental health and higher rates of morbidity. However, in contrast, Vasquez-Barquero *et al.* (1992) found that in a rural Spanish community, unemployment was related to the incidence of mental illness in men, but not in women. The same study also found that child-care responsibilities served a protective function for women, presumably due to the fact that child-care is a relatively highly valued role in that society.

Although employment provides opportunities for affiliation and recognition, as well as greater power, prestige and material resources, it has alternatively been suggested that full-time employment, combined with family and domestic obligations create excessive demands on women's lives, or 'role overload', which has adverse effects on mental health (Cleary & Mechanic, 1983). However, Rosenfield (1989) found that women have greater symptoms of depression and anxiety both when they are overloaded by work and family responsibilities, or when they experience low power, low self-esteem, lack of independence, isolation and boredom as a result of being out of the job market, and that the combination of part-time work and household responsibilities was most predictive of psychological well-being for women. The underlying mechanism which explains the high rates of neurotic symptoms in both the unemployed housewife

and the overloaded working woman, it is suggested by Rosenfield, is that of a decreased sense of personal control.

2.5.2 Marital Status

Higher rates of psychiatric morbidity, particularly depression and anxiety, have been recorded amongst married women, as compared with married men (Vasquez-Barquero *et al.*, 1992). In fact, Rosenfield (1989) reports that the greatest gender differences in anxiety and depression are to be found between married women and married men. Russo (1995) indicates that married women have higher admission rates to mental hospitals than married men, whereas in contrast, never married and separated or divorced men had higher admission rates than women in the same categories. The preponderance of married women amongst mental hospital admissions in the USA was found to be particularly marked amongst minority women (Russo, 1985). Marital conflict has also been found to be the most common precipitating problem amongst depressed women presenting for outpatient treatment (Russo, 1985). Findings such as these have led to the conclusion that while marriage is beneficial to men's mental health, it is deleterious to women's mental health (Auerbach & Figert, 1995). The USA's ECA survey refined the observation by demonstrating that rates of major depression are lowest for both men and women who are married and getting along with their spouse (although happily married women are still more likely to get depressed than happily married men), while depression rates were highest in married women with unhappy marriages (Weissman, 1987). In contrast, however, studies conducted in New Zealand found that married and widowed women, and mothers showed lower rates of psychiatric disorder than never married and childless women, while, for men, the relationship between marital status and psychiatric

morbidity was the same as that reported elsewhere (Romans-Clarkson *et al.*, 1988; Thornley *et al.*, 1991).

Thus, it appears that rates and risk factors often differ from country to country and even within countries, between communities which differ culturally, socially or geographically. Marriage on its own may not be detrimental to women's mental health, but problems in the marital relationship seem to undermine women's sense of psychological health to a greater extent than they do men's. It seems likely, therefore, that what is significant in terms of risk for mental illness is not the demographic factor *per se*, in this case marital status, but the meaning and status ascribed to that factor in a particular community. In addition, it is likely that marital status interacts with other social factors such as presence of children, social isolation, poverty, and level of education (Jenkins & Clare, 1989), so that its effects on mental health are uneven and complex. For example, Russo (1985) reports that, in the USA, the demographic group most at risk for depression is low-income, *single* mothers, who, although protected from the 'stressor' of marriage, are exposed to other, more powerful risk factors.

2.5.3 Age

Many studies of gender differences in psychopathology have neglected to examine the role of age. Nolen-Hoeksema (1990) asserts that the higher prevalence of mental disorders in women only occurs after adolescence, and that studies which lump all age groups together when reporting findings tend to obscure and minimise the extent of the differences in adult women. In South Africa, Hoffman *et al.* (1988) also found that the female to male ratio for 'nerves' rises sharply after age 14. Different peaks in rates of depression have been reported, with most authors showing

higher rates of morbidity amongst middle aged women (Bebbington, Hurry, Tennant, Sturt & Wing; 1981; Regier *et al.*, 1993; Vasquez-Barquero *et al.*, 1992), while others have found the highest rates in younger women (Thornley *et al.*, 1991). In fact, Sashidharan *et al.* (1988) have suggested that mood disorders in women display two peaks, with 'neurotic depression' peaking in early adulthood, and 'psychotic depression' peaking during middle age. Women in the 45-64 age group also had lower chances of experiencing remission of psychiatric illness than women in other age groups (Romans, Walton, McNoe, Herbison & Mullen; 1993).

2.5.4 Poverty

Community studies have repeatedly found that people with lower levels of income and education have higher levels of depression (Belle, 1990; Romans *et al.*, 1993; Ross & Mirowsky, 1989), although a minority of researchers have found that level of income does not effect psychiatric morbidity (Weissman, 1987).

It has been argued (Rieker & Jankowski, 1995) that world-wide, poverty is increasingly taking on a female face: a phenomenon referred to as 'the feminisation of poverty'. In Africa, the widespread social and economic subordination of women has, as one of its consequences, a situation in which women have limited opportunities to gain recognition and independence through productive work (Turshen, 1991). Furthermore, over the past few decades, the socio-economic positions of both rural and urban African women have deteriorated (Kisekka, 1990).

In South Africa, social and economic hardship amongst women is extensive. Govender, Budlender and Madlala (1995) report that 35,2% of South African women are unemployed, compared to

25,7% of men. In the Western Cape the situation is somewhat better overall, but still sees women in a less advantaged position, with 21.5% of women unemployed, compared to 14.3% of men (Central Statistical Services (CSS), 1996). Amongst South African working women, 37% earn less than R500 per month, 38% earn between R500 and R1500, and only 25% earn above R1500. Both in South Africa and in other countries, women have a lower average income than men, both because traditionally they tend to be clustered in lower paid jobs, and also because in some cases they get paid less than men for doing the same work (Govender *et al.*, 1995; Romans *et al.*, 1993).

In addition, in South Africa, 32% of households are headed by women (Govender *et al.*, 1995), in line with an international trend towards an increase in families headed by women (Rieker & Jankowski, 1995). In figures for 1993, the mean monthly income per capita in female-headed households in South Africa was R243, compared to an average of R468 for all households. Even when women are married, they tend to have less financial control and security than their partners (Romans *et al.*, 1993). It is important to note that although all South African women have been exposed to sexism in some form or another, the experiences of black and white South African women differ vastly, in that it is black women who bear the brunt of poverty and its attendant social ills.

2.5.5 Violence against women

South Africa has emerged from a traumatic era of state-orchestrated violence. The structural violence and oppression of the past has arguably created a culture of violence which permeates all social institutions, including the family, school and peer group (Vogelman, 1990). Today, South Africa has the second highest crime rate in the world (Govender *et al.*, 1995). Reasons for the

prevalence of violence in South Africa are manifold, and include unemployment, poverty, substance abuse, racial and class conflict, and a widespread acceptance of the notion that violence is an appropriate, and indeed often the only means by which to attain personal and societal goals (Vogelman, 1990).

It can be argued that women are more likely to become victims of certain types of violent crime than men, as they are more likely than men to experience rape, indecent assault, as well as assault and murder by their sexual partners. Rape rates in South Africa are amongst the highest in the world, with South Africa having been described as a rape-supportive society (Russell & Hansson, 1994). It is estimated that one out of every two South African women will be raped during her lifetime (Badat, 1994). In one year, 1993, an estimated 966 000 rapes were committed in South Africa (Govender *et al.*, 1995). Black women are most at risk, with a rate three times higher than that of white women (Mackenzie, 1992).

In addition, many women are subject to violence by their sexual partners. It is estimated that one in six, or a total of 1 291 694 South African women are battered regularly by their male partners (Motsei, 1993). Furthermore, marital rape and murder of women by their spouses are reported to be high in South Africa relative to other countries. Over half the men who admit to having committed murder have killed their female partners (Hansson, 1991).

The incidence of childhood sexual abuse is also alarmingly high, and one in every four girls under the age of 16 will have been abused, most often by a family member (Badat, 1994). In South Africa at the moment, reports of sexual abuse are on the increase: the first quarter of 1997 showed a 40% increase compared to reported rates during the same period the previous year (Thiel, 1997).

It is unclear, however, whether, this increase in reported rates reflects an increase in the incidence of sexual abuse of children, or an increase in reporting, related to changes in public attitudes towards the police and/or sexual abuse.

Sexual and physical abuse have profound implications for the mental health of both men and women, but particularly for women, who are more likely to experience such violence (Russo, 1985). Strong evidence now exists which indicates that childhood sexual abuse has long-term, adverse psychological consequences. Victims of childhood sexual abuse are at least twice as likely to suffer from clinical depression in adulthood as non-victims (Cochrane, 1993). Sexual abuse has also been linked to disorders such as posttraumatic stress disorder, dissociative disorders, somatic disorders and borderline personality disorder (Weaver & Clum, 1993).

Despite the high rates of sexual and physical abuse in South Africa, Strebel and Leon (1996) found that the incidence of rape, childhood sexual abuse and battering recorded in the clinical histories of psychiatric inpatients was relatively low. At the same hospitals involved in the present study, a documented rate of sexual and physical abuse experiences of only 10% for female patients and 1% for men was found in the patients' case notes. However, at one of the hospitals, detailed and specific questionnaires administered to patients admitted to an acute female admissions ward regarding the cumulative incidence and severity of childhood and adult sexual and physical abuse elicited a rate of 85%. Although the populations sampled differed somewhat (the latter sample was obtained from an acute ward where the main diagnoses were schizophrenia and bipolar mood disorder), it seems reasonable to conclude that in many cases, sexual abuse experiences will not be picked up during the initial intake interview unless the experience is directly and immediately related to the presenting problem. Strebel and Leon's findings mirror those reported by Dill, Chu,

Grob and Eisen (1991) regarding the over-representation of physical and sexual abuse in psychiatric patients. The authors report that 75% of female psychiatric patients have a lifetime history of abuse, and that initial denials of abuse histories during the standard intake interview are fairly common. Reasons for non-disclosure include perceived lack of confidentiality, lack of knowledge about what constitutes 'abuse', mistrust on the part of the patient, and questions which are not sufficiently specific or direct on the part of the interviewer (Dill *et al.*, 1991). With regard to the South African situation, due to a variety of factors, including clinician-patient power differentials, as well as the more banal problem of understaffed wards and overworked clinicians, history-taking can be an expedient and superficial process. Once admitted, the main form of treatment for almost all patients is psychotropic medication, with few whites and even fewer blacks receiving any intervention with regard to psychosocial and/or socio-economic problems (Msomi, 1997; Gillis *et al.*, 1986). Indeed, in one study, clinicians felt that, when it came to social and economic stressors, these problems had been adequately addressed in only one third of cases (Gillis *et al.*, 1986).

2.6 CONCLUSIONS

In summary, a variety of demographic factors, including marital status, employment status, age, and socio-economic status, as well as traumatic life events, such as sexual and physical abuse, have been found to be correlated with the high prevalence of mood and anxiety disorders in women relative to men. A search for a link between the various risk factors would seem to suggest as a common denominator, a lack or loss of personal control. Thus, Tomes (1992, p. 151) proposes, that for women, psychiatric symptoms function metaphorically as a 'desperate communication of the powerless'. She shows that although the specifics of gender role socialisation have changed

throughout history, women's lack of personal control has not. Following this argument, it is not gender *per se* (i.e. 'innate' vulnerabilities) but the demonstrable, objective lack of power and resources and the consequences that follow from those social conditions which contribute strongly towards higher rates of neurotic disorders in women.

The association between powerlessness and depression date back to Seligman's experiments in the 1960's which led to his developing the Learned Helplessness Theory (1975). This theory states that repeated, uncontrollable, negative events lead to passivity, hopelessness and the suppression of learning. However, theoretical models which specifically explain how social conditions interact with gender in the aetiology of mental illness, are still in their infancy. In general, psychiatric epidemiological studies have not proceeded beyond demonstrating a range of demographic variables associated with mental illness; few studies have attempted to elucidate the mechanisms by which the risk factors operate (Parry & Swartz, 1997). Weissman (1987) remarks that the blame lies partly with our limited understanding of the mechanisms and aetiologies of psychiatric disorder: our current classification system is based on *manifest* criteria. As far as the majority of psychiatric disorders are concerned, it is not yet known whether or not a common process is at work in producing the cluster of symptoms which constitute the classifiable disorder. Some further shortcomings of the current system of conceptualising and classifying psychiatric disorders will be discussed in the following chapter.

Although the significance of social factors in the aetiology of mood and anxiety disorders has been demonstrated conclusively, there is a growing body of evidence indicating that depression and anxiety are causally complex, and that while some depressive and anxiety conditions have their roots in psychosocial or personality factors, others are primarily biogenetic in origin, while perhaps

the majority involve multiple interactive causes (Murphy *et al.*, 1984). In addition, current research strongly suggests the individual's appraisal and interpretation of life events and social circumstances is one of the more important factors in determining whether those events or situations will be pathogenic (Parry & Swartz, 1997).



CHAPTER THREE

METHODS

3.1 AIMS

The aim of this research project is to provide a gendered analysis of admissions to the Western Cape's public psychiatric hospitals, in order to establish whether findings about gender differences in mental illness drawn from studies conducted elsewhere are applicable locally. One of the primary goals of the project is to ascertain whether the female excess of mood and anxiety disorders, or so-called neurotic disorders, which has been found in many other countries, and across different ethnic, cultural and socio-economic groups, is also evident in South Africa. In addition, the study aims to explore associations between gender, psychiatric disorders and other variables, such as demographic features and stressful life events, which in other studies, have been linked, sometimes aetiologically, to women's increased vulnerability to certain disorders. The method selected for achieving the research goals outlined above is an archival study entailing an examination of patient records at the three state psychiatric hospitals in Cape Town.

3.2 BACKGROUND

The current project's approach can be described as both epidemiological and archival. Epidemiology can be defined as 'the study of the distribution of illness in populations over time and space' (Kreitman, 1985, p. 19). As has been noted earlier, epidemiological research has an important role to play in identifying the mental health needs of the South African population, thereby informing the development of appropriate, efficient and user-friendly health services.

Archival studies involve the analysis of documented information, in this case the records of patients admitted to Cape Town's public psychiatric hospitals. Archival research methods hold both advantages and disadvantages. While such studies offer an efficient means of gathering large amounts of data, the information is always mediated by the perceptions and judgement of the clinician responsible for the records (Mouton & Marais, 1990). While the subjectivity of the recording clinician is an appropriate subject for analysis in qualitative studies, it cannot be explored in detail in a quantitative study like this one.

Archival studies differ from other types of psychiatric epidemiological studies, such as community surveys, in both their aims and outcomes (Pilgrim & Rogers, 1993). While studies which look at both treated and untreated cases of mental illness play an important role with regard to, for example, informing mental health policy decisions and planning appropriate mental health interventions, studies of treated cases are by nature, more focused and more limited in their scope. Archival studies elicit information about the kind of population served by psychiatric hospitals, and thus give an indication of who has access to such institutions. However, the composition of the inpatient population is also determined and limited by the types of interventions which a hospital offers. On the other hand, studies of untreated cases of mental disorder elicit incidence and prevalence rates of psychopathology in a community and are more likely to capture different degrees of severity of symptomatology (Nolen-Hoeksema, 1990). Studies of treated cases, especially cases treated in a public psychiatric hospital, tend to involve samples exhibiting relatively severe psychopathology, including the major psychiatric disorders, such as schizophrenia and bipolar disorder. Furthermore, this type of cross-sectional, descriptive study is not able to link variables causally; at most, it is able to point to correlations between different variables. Thus, comments regarding aetiology can only be speculative in nature, based on observed associations.

The three psychiatric hospitals from which samples were drawn in the present study are Valkenberg, Stikland and Lentegeur Hospitals. All three hospitals have specific, discrete catchment areas within the province, which include both metropolitan and rural districts. Valkenberg Hospital, located in 'pleasant farmlike surroundings' (Swartz, 1995b) in Cape Town's predominantly white southern suburbs, was opened in 1891. At its inception, the hospital was conceptualised as a more humane and modern alternative to the asylums at the time, which were located on Robben Island and at the Old Somerset Hospital (Swartz, 1995a). Originally, Valkenberg admitted whites only, but began to admit patients of colour in a separate section of the hospital in 1916. The hospital remained racially segregated until the early 1990's. (Swartz, 1995b). During the first decades of the 20th century, both the Old Somerset Hospital and Robben Island ceased to function as asylums. Their closure inevitably put pressure on Valkenberg, and consequently, a new hospital, Stikland, located in Cape Town's northern suburbs, was opened in 1962 to meet an increasing need for psychiatric hospital beds. The third hospital, Lentegeur, opened in 1987, and is located northeast of Cape Town. Its catchment area covers the relatively new coloured and African townships of Mitchell's Plain and Khayelitsha. Lentegeur Hospital was hastily conceived and planned by the government in 1977, largely as a consequence of the so-called Smith-Mitchell scandal, during which the appalling conditions and human rights abuses in privately-run mental institutions for black psychiatric patients were exposed by the media (Seedat, 1984). From its inception, Lentegeur admitted patients of all races. At present, financial constraints, combined with the new government's emphasis on primary health care, appropriate to South Africa's status as a developing country, mean that psychiatric inpatient facilities are to be reduced (Strategic Management Team (SMT), 1995). As a result, Valkenberg Hospital is currently under threat of closure (Vongai & van Zilla, 1997).

The Western Cape, a province with an estimated population of 3,721,000 (CSS, 1996), was, in the past, for various political and historical reasons, endowed with greater financial resources than other regions in the country (SMT, 1995). One of the consequences of this imbalance is a high number of psychiatric hospitals compared to other historically neglected regions, such as the Northern Province. In the Western Cape, in 1992, there was a total of 4,025 psychiatric beds (most of which were located in the three psychiatric hospitals involved in this project), a ratio of 1.0 bed per 1000 of the population, which, although low when compared with the World Health Organisation's recommended 1.5 beds per 1000, is high when compared to the bed to population ratios in some of the other provinces (SMT, 1995). With the restructuring of the provinces and, consequently, of the provincial health systems, the Western Cape's position of privilege is in the process of changing, in line with the need for greater equity in health care delivery between the different provinces.

At the three psychiatric hospital in question, diagnosis is usually performed by psychiatrists and psychiatric registrars, psychologists and intern psychologists, social workers, and less commonly, occupational therapists and psychiatric registered nurses. In the past, psychiatrists, who occupy the position at the top of the professional hierarchy in psychiatric hospitals, were predominantly white men, while women predominantly occupied the positions of social workers, occupational therapists and psychiatric nurses. The situation has changed substantially over the past decade, and now there are more women than men in all professions, mirroring an international trend in the gender complement of mental health delivery systems (Pilgrim & Rogers, 1993). Racial equity has lagged behind gender equity, but staff at the various hospitals are gradually becoming more representative of the South African population as a whole.

The typical procedure on admission is for a new patient to be assigned a case manager who will conduct an interview to elicit the patient's psychiatric history and mental status. Often, the case will later be discussed in a multi-disciplinary ward round and consensus achieved about the patient's diagnosis. Nevertheless, in many wards in the three hospitals, for various reasons, satisfactory and comprehensive assessment, diagnosis and treatment does not occur (Gillis *et al.*, 1986).

3.3 SAMPLE

The study was conducted on a random, stratified sample of all patients admitted to Valkenberg, Lentegeur and Stikland Hospitals for the period of one year, from January 1 to December 31, 1994. The strata were the three hospitals, and gender. Thus, out of a total of 7938 patients admitted to the three hospitals in 1994, the sample drawn for the purposes of the study comprised 700 patients per hospital (350 women and 350 men), giving a total of 2100 patients (1050 women and 1050 men). The sample was computer-generated from hospital records listed according to date of admission.

3.4 PROCEDURE

All information was obtained from hospital records only, and no patients were interviewed. A team of post-graduate psychology students (honours and masters students) were employed as fieldworkers to peruse the folders and encode the data. A data capture form was designed for use by the fieldworkers, and all the potential categories of data were given codes (see Appendix 1). In the event that unanticipated categories were found in the course of the research, the system of

codes was adjusted accordingly. The data capture form comprised the following categories of information which were obtained from each patient's folder:

3.4.1 Demographic variables

The demographic variables of sex, race, marital status, employment status and age were encoded. The last four factors were selected as they have been shown to interact differently with the incidence of mental illness amongst men and women. Parity was originally included in this study as a demographic variable, as number of children has been reported to be a significant predictor of psychiatric morbidity, and in particular, of depression in women (Brown & Harris, 1978). However, it was observed that the number of children frequently went unreported for male patients, and it was thus concluded that interpretations made regarding the relationship between parity and psychiatric morbidity would be invalid; consequently, parity was encoded but excluded from the analysis.

3.4.2 Admission-related variables

Admission-related variables were referral source and type of admission. Sources of referral to psychiatric hospitals included the patient him or herself, family, police, other hospitals and clinics, social services and employers. Type of admission was determined according to the section of the Mental Health Act, no. 18 of 1973, under which the patient was admitted. These categories include voluntary admission (Section 3), admission by consent (Section 4), certification (Section 9), urgency applications (Section 12), and forensic cases (Sections 79 and 28) (Allan, 1997).

3.4.3 Diagnostic variables

Psychiatric diagnoses were recorded according to the Diagnostic and Statistical Manual: 4th edition (DSM-IV) system of classifying psychiatric disorders (APA, 1994). The DSM-IV, developed by the American Psychiatric Association, is the system of nomenclature and classification which is used most widely in South Africa, and is the system into which trainee health and particularly mental health professionals, including psychologists, psychiatrists and social workers, are inducted. At the time that this research was conducted, however, the DSM-IV had only just been published and was not yet widely in use. Thus, most clinicians would still have been employing the DSM-III-R.

The DSM was first published in 1952 in an attempt to increase the reliability and validity of diagnosis amongst mental health professionals (Loring & Powell, 1988). The first edition of the DSM was a brief, vague document which did little to enhance reliability (Loring & Powell, 1988). However, the manual has undergone considerable changes in the course of successive editions (Von Talge, 1995), with subsequent editions being based on extensive field trials, and containing detailed, explicit, operational definitions of conditions and their symptoms (Loring & Powell). Nevertheless, although the importance of an empirical basis for the diagnostic categories, as well as specific symptoms included in the nomenclature, was emphasised by the DSM-IV Task Force, the manual's authors acknowledged that the final document was arrived at by consensus (Von Talge, 1995).

From the outset, the DSM system of classification has evoked controversy amongst both academics and mental health professionals. Criticism has been levelled at the DSM on several

fronts. Although the DSM purports to adopt an atheoretical and non-causal stance in relation to mental disorders (Von Talge, 1995), it clearly embraces the medical model as a paradigm for understanding and treating mental health problems. Non-medical mental health workers such as psychologists and social workers have criticised the way in which the document represents and perpetuates the dominance of both the psychiatric profession and the biomedical model in the field of mental health (Loring & Powell, 1988).

The DSM-IV has been also been criticised for continuing to employ a categorical system of classification, i.e. a system which divides disorders into different types based on the manifestation of specific symptoms, as opposed to, for example, a dimensional format, which evaluates functioning across different dimensions (Widiger & Shea, 1991). While a categorical system may be appropriate in organising and describing medical conditions, which, to a great extent, consist in discrete and mutually exclusive 'disease entities', the realm of psychiatric disturbance, it is argued, is not analogous (Brammer & Shostrom, 1977; Heather, 1976). Indeed, Heather challenges the basic philosophical principles underlying such a system of classification. He maintains (1976, p. 63) that the main motive underpinning the development and continued use of a diagnostic system such as the DSM is the perpetuation of the myth that psychiatry is equivalent to other medical specialities, when it is in fact 'a quasi-medical illusion', falsely employing and applying medical concepts such as 'illness' and 'patient', and quixotically chasing after exclusively biological aetiologies for mental problems.

Despite the fact that the DSM-IV is a less than perfect document, it continues to be used widely in a variety of settings, and most users would concur that, for both clinical and research purposes, the current, categorical classification system is the most acceptable system available at the present

time, in so far as it facilitates the summarisation and communication of clinical information (Von Talge, 1995) .

In its current manifestation, the DSM-IV employs a system of multiaxial assessment, which covers different domains of functioning, and, according to its authors, facilitates a comprehensive, holistic, systematic and nuanced approach towards diagnosis (APA, 1994). The multiaxial system comprises five axes. For the purpose of this study, diagnoses on Axes I and II were examined.

Axis I includes all clinical disorders and conditions, except for personality disorders and mental retardation. These disorders are organised under broad categories (such as schizophrenia and other psychotic disorders, mood disorders, anxiety disorders and substance-related disorders), which usually consist of several specific disorders. In addition, other conditions that may be a focus of clinical attention are recorded on Axis I. These conditions are usually related to either sexual and physical abuse, relational problems, sociocultural problems, or medication-induced problems. With the exception of the medication-induced disorders, these conditions are often referred to as V-codes.

Axis II comprises enduring and pervasive conditions such as personality disorders, prominent maladaptive personality traits and mental retardation.

For the most part, the relevant data were taken from the patient's discharge summary. Each hospital has its own standard clinical summary form (See Appendix 2) which is completed on discharge by the patient's case manager. The information recorded in the discharge summary typically includes identifying data, reasons for admission, course of illness during hospitalisation,

condition on discharge, diagnosis and recommendations. With regard to the present study, it was observed by the researchers that the information on the discharge summary was often incomplete or inadequate, in which case, the relevant information was obtained from the clinician's case notes in the same folder, where both the patient's history and process notes were recorded. Infrequently, the required information could not be found at all and had to be omitted. When an obsolete diagnostic category from one of the previous editions of the DSM had been used by the clinician, the disorder's new title or its nearest equivalent or in the DSM-IV was substituted (For example, organic disorders were changed to cognitive disorders, and brief reactive psychosis was changed to brief psychotic disorder).

3.5 IMPRESSIONS REGARDING ASPECTS OF PATIENT RECORDS

The researcher's impressions were that data relating to demographic features and to the patient's background history were particularly scanty with regard to certain categories of patients. These included patients admitted to acute wards, patients who had been re-admitted, and African patients, especially those who did not speak English or Afrikaans.

Regarding language, it is worth noting briefly that the majority of professional staff responsible for diagnosis and treatment in the hospitals do not speak an African language, and translation is often performed by nurses or non-professional staff members such as cleaners (Drennan, 1993).

Communication problems posed by language differences between patient and healer have been recognised as posing a barrier to effective, efficient and equitable health service delivery in the South African health services in general (Petros, 1997), and in mental health services in particular,

where, probably more than in any other discipline, 'illness' is infused with sociocultural values and language is the primary means of communicating symptoms (Drennan, 1993).

Returning to the researcher's impressions, patient's records appeared more comprehensive when the patients had been admitted to neuroclinics or forensic wards, had been diagnosed with non-psychotic disorders, or were white. The observation that the patient's race influenced the amount of detail obtained about the patient's background is noteworthy from a historical point of view, in the respect that it echoes Swartz' (1995b) findings about the frequent use of the term 'unknown' (and by implication 'unknowable') with regard to black patients' identifying data and social circumstances in the case notes of black patients admitted to South African asylums in the early part of this century.

With regard to the current project, it was further observed that the quality and quantity of reporting also differed according to the profession and position of the reporter. Notes tended to become more concise and in many cases less thorough, the more senior the clinician.

Despite the informal observations made by the researchers regarding the adequacy of patient records which have been noted here, it is not within the scope of this project to evaluate the accuracy or reliability of diagnoses given to patients. However, some general comments regarding diagnostic validity and reliability will be made later in this paper.

3.6 ANALYSIS OF DATA

After the data-gathering process was complete, the data were captured at the Medical Research Council and statistical analysis performed. Analysis of variance (ANOVA) for both sexes for the entire sample was computed. Associations between sex and four demographic variables: marital status, employment status, race and age were then examined. Chi-square tests was computed in order to determine levels of statistical significance between sexes on all variables except age. For the variable of age, a Kolmogorov-Smirnov two-sample test was performed to establish whether the distribution of ages were significantly different between male and female subjects. The overall pattern of diagnoses on both Axis I and Axis II for each sex was also investigated. Thereafter, a sub-sample was extracted comprising mood disorders, anxiety disorders and adjustment disorders, as classified using the DSM-IV diagnostic criteria. Adjustment disorders were included in the sub-sample due to the frequent prominence of depressive and anxiety-related symptoms in those disorders. Analysis of variance for both sexes was again calculated to elicit associations between sex and marital status, employment status, race and age, and the same statistical tests of significance as outlined above, were performed.

3.7 ETHICAL CONSIDERATIONS

This project forms part of a broader research project into the relationship between demographic, diagnostic and management variables with regard to patients admitted to the Western Cape's three public psychiatric hospitals. Permission for this component of the project was obtained from the Medical Superintendents of the three hospitals. The anonymity of the patients sampled was

maintained, as no data identifying specific patients was gathered. The research findings will be reported back to interested staff members of the hospitals concerned.



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CHAPTER FOUR

RESULTS

Analysis of data covered several broad areas. Firstly, gender differences in overall admission rates were examined, followed by gender differences in the variables of marital status, employment status, race and age. Chi square tests to establish levels of significance indicated that the gender differences in the distribution of the demographic variables of marital status, employment status and race were indeed significant. However, with regard to the variable of age, the Kolmogorov-Smirnov two-sample test showed that the distribution of ages between male and female inpatients was not significantly different. Next, gender differences in diagnostic profiles on both Axis I and II received attention, with results indicating significant differences in the distribution of certain disorders across both genders. Gender differences in the distribution of mood and anxiety disorders were particularly stark, although consistent with predictions. Lastly, variation between males and females diagnosed with neurotic disorders with regard to marital and employment status, race and age was assessed. While the differences between men and women in relation to marital status and employment status were statistically significant, the differences in race and age between genders were not.

4.1 GENDER AND DEMOGRAPHIC VARIABLES: ALL ADMISSIONS

As far as total admissions for 1994 were concerned, 7938 patients were admitted to all three hospitals in that year. Of those admissions, 3222 patients (40.6%) were women and 4716 (59.4%) were men. Thus 1.46 times as many men as women were admitted. Since the gender ratio in the

Western Cape is 1:1 (CSS, 1996), it therefore appears that men in the Western Cape are nearly 50% more likely to be admitted to a psychiatric hospital than women.

With regard to marital status, single people made up the majority of patients, both male and female. However, a significantly greater percentage of male patients were single (64.6%) compared to female patients (45.1%). In contrast, a greater percentage of female patients were married (31.9%) compared to male patients (23.8%) (See Table 2).

Table 2 Gender, marital status and employment status: all admissions.

	Female		Male	
	n	%	n	%
Marital Status *				
Single	474	45.1	681	64.6
Married	335	31.9	251	23.8
Divorced/widowed	241	23	122	11.6
Employment **				
Employed	198	18.8	247	23.4
Unemployed	573	54.6	529	50.2
Disability Grant/Pension	216	20.6	245	23.2
Student	62	6.0	31	2.9

* DF = 3; chi square = 38.824; $p = < 0.05$

** DF = 5; chi square = 61.137; $p = < 0.05$

With regard to employment status, the rates for females and males were similar for each category. However, significantly more women were unemployed than men (54.6% of the female patients compared to 50.2% of the men). Given that housewives were included in the 'unemployed' category, the rates for both sexes are probably even more similar than the above figures suggest. In addition, more male patients than female patients were employed (23.4% compared to 18.8%). The difference between men and women in receipt of a disability grant or pension was slight, but still significant (23.2% of men compared to 20.6% of women), while more female patients were students (6% compared to 2.9% for male patients) (See Table 2).

The breakdown of figures for race are similar to the population from which the patients are drawn, which is 18.2% African, 58% coloured and Indian, and 23.8% white (CSS, 1996). However, there were more African, coloured and Indian men than women from the same ethnic groups. There were also considerably more white women than white men (25.2% compared to 15.2%) (See Table 3).

The age distribution between male and female patients was not found to be significantly different. The majority of patients of both sexes were concentrated in the adult (19-60) age group, a result attributable to the scarcity of inpatient facilities for children and adolescents at the time of the study. More specifically, both sexes seemed to be clustered around middle adulthood, with 72.1% of the females and 70% of the males falling in the combined 25-40 and 41-60 age groups (See Table 3). The mean age for male patients was somewhat younger than that of female patients (34 years 5 months compared to 38 years 6 months).

Table 3 Gender, race and age: all admissions.

	Female		Male	
	n	%	n	%
Race *				
African	170	16.2	226	21.3
Coloured/Indian	616	58.6	672	63.4
White	265	25.2	161	15.2
Age **				
0-12	3	0.3	11	1.1
13-18	50	4.8	35	3.3
19-25	145	13.9	225	21.5
26-40	459	43.9	519	49.5
41-60	295	28.2	215	20.5
61+	93	8.9	43	4.1

* DF = 2 ; chi square = 16.684 ; p = < 0.05

** DN = 0.333 ; p = 0.893

4.2 ADMISSION-RELATED VARIABLES

Regarding types of admission under the Mental Health Act, no. 18 of 1973, some 27.2% of the male admissions were admitted certified as opposed to 17.2% of the female admissions. 3.8% of the male patients were forensic patients (defined here as patients who were either referred by the courts for psychiatric observation or patients who had been found unfit to stand trial or not responsible due to mental illness), compared to only 0.4% of the female patients. The majority of patients of both sexes consented to be admitted (63.4% of the female patients and 51.6% of the

male admissions), while 18.9% of the female and 17.3% of the male patients were admitted voluntarily (See Table 4).

Significantly more men than women were brought into hospital by the police, their families, or were referred by their employers. Women were more likely than men to be referred by general practitioners, private psychiatrists or psychologists, or via day hospitals or clinics (See Table 4).

Table 4 Gender differences in admission-related variables.

	Female		Male	
	n	%	n	%
Type of admission*				
Voluntary	197	18.7	184	17.3
Consent	663	63.1	547	51.6
Certified	186	17.7	289	27.3
Forensic	5	0.5	40	3.8
Referral source **				
Self	61	5.8	65	6.1
Family	251	24.0	285	26.9
Police	95	9.1	213	20.1
General practitioner	121	11.5	79	7.5
Social services	108	10.3	121	11.4
Clinic/day hospital	371	35.4	255	24.1
Employer	10	1.0	28	2.6
Psychologist/ psychiatrist	31	3.0	13	1.2

* DF = 4; chi square = 32.707; $p < 0.0$

** DF = 7; chi square = 36.230; $p < 0.05$

4.3 GENDER DIFFERENCES IN AXIS I AND II DIAGNOSES

Significant gender variations in diagnoses on both Axis I and II were found. Gender differences in both the broad diagnostic categories and in specific disorders were examined. Amongst the patients sampled, 91.2% of the female and 90.2% of the male admissions received an Axis I diagnosis. As far as the broad diagnostic categories were concerned, for men, psychotic disorders was the main category (47.4%), followed by substance-related disorders (23.1%) and mood disorders (14.2%). On the other hand, for women, mood disorders was the most frequently received group of diagnoses (41% of all female admissions), followed by psychotic disorders (29%), with comparatively low rates of substance-related disorders (9.5%). The other significant category for both sexes was cognitive disorders, although men were diagnosed more frequently with these disorders than women (11.5% for men, compared to 7.3% for women). Adjustment disorders were also diagnosed fairly frequently in female patients (7.7%), but infrequently in male patients (1.4%). The rates of admission for anxiety disorders were low for both sexes; however, women received a diagnosis in that group of disorders more frequently than men (3.8% for women as opposed to 1.0% for men). The combined totals of mood, anxiety and adjustment disorder amounted to 503 female patients (52.5% of all female admissions), and 159 male patients (16.6% of all male admissions). Other diagnostic categories, such as somatoform, dissociative, eating, sexual and gender identity disorders were diagnosed rarely in both men and women (See Table 5). The most frequently given specific diagnosis for all patients was schizophrenia with 24.8% (n=474), followed by bipolar mood disorder with 15.7% (n=301). The main individual diagnosis for female patients was bipolar mood disorder (20.5%), followed closely by schizophrenia (19.3%), and major depressive episode (17%). Schizophrenia was by far the leading diagnostic category for males, accounting for 30.2% of all disorders amongst male inpatients.

Table 5 Gender differences in Axis I diagnoses.

Axis I Disorder*	Female		Male	
	n	%	n	%
Mood Disorders	393	41.0	136	14.2
Major Depressive Episode	162	17.0	24	2.5
Dysthymia	35	3.7	7	0.7
Bipolar Mood Disorder	196	20.5	105	11.0
Anxiety Disorders	36	3.8	10	1.0
Generalised Anxiety Disorder	6	0.6	1	0.1
Panic Disorder	4	0.4	3	0.3
Posttraumatic Stress Disorder	22	2.3	5	0.5
Obsessive-Compulsive Disorder	4	0.4	1	0.1
Psychotic Disorders	277	29.0	453	47.4
Schizophrenia	185	19.3	289	30.2
Other Psychotic Disorders ^a	50	7.3	83	8.7
Substance-induced Psychosis	22	2.3	81	8.5
Substance-related Disorders	91	9.5	221	23.1
Alcohol Abuse	60	6.3	144	15.1
Other Substance Abuse	31	3.3	77	8.0
Adjustment Disorders	74	7.7	13	1.4
Somatoform Disorders	5	0.5	0	0
Dissociative Disorders	5	0.5	0	0
Cognitive Disorders^b	70	7.3	111	11.6
Other Disorders^c	7	0.7	12	1.2

* DF = 9; chi square = 302.166; p < 0.05

^a 'Other Psychotic Disorders' include schizophreniform disorder, schizo-affective disorder, brief psychotic disorder and delusional disorder; ^b 'Cognitive Disorders' include delirium, dementia, organic mood disorders and organic brain syndrome; ^c 'Other Disorders' include sexual dysfunction, paraphilias, gender identity disorder and miscellaneous other disorders.

This was followed by alcohol abuse (15.1%), bipolar mood disorder (11%) and substance-induced psychotic disorder (8.5%). Amongst men, major depressive episode accounted for just 2.5% of all cases. In contrast to the men, alcohol abuse and substance-induced psychotic disorder were diagnosed relatively infrequently in women (6.3% and 2.3% respectively) (See Table 5).

Within the broad category of mood disorders, the most common diagnosis for women was bipolar mood disorder, followed by major depressive episode, and then dysthymia. Women received a diagnosis of bipolar mood disorder 1.87 times as often as men did. Women also received a diagnosis of major depressive episode 6.75 times as often as men, and a diagnosis of dysthymia 5 times as often as men. In addition, women were 5.69 times as likely to be diagnosed with an adjustment disorder (a diagnosis of which the predominant subtype was 'with depressed mood').

Within the broad category of anxiety disorders, the most common diagnosis for both men and women was posttraumatic stress disorder; however, women received this diagnosis 4.4 times as often as men.

Regarding Axis II diagnoses, 33.8% of the female patients and 32.4% of the male patients were given an Axis II diagnosis. The predominant diagnosis on Axis II for both sexes was Mental Handicap (33.8% of female and 43.8% of male patients with an Axis II diagnosis). Amongst the personality disorders, the diagnoses most frequently given to women were dependent (20%), borderline (17.2%) and histrionic personality disorder (12.7%). By far the most frequent Axis II diagnosis for male patients in this sample was antisocial personality disorder (30.3% compared to 4.2% for women) (See Table 6).

Table 6 Gender differences in Axis II diagnoses.

Axis II Diagnosis*	Female		Male	
	n	%	n	%
Deferred	696	66.2	717	67.6
Mental Handicap	120	33.8	150	43.8
Antisocial	15	4.2	104	30.3
Borderline	61	17.2	16	4.7
Histrionic	45	12.7	2	0.6
Narcissistic	7	2.0	12	3.5
Dependent	71	20.0	17	5.0
Other ^a	36	10.2	42	12.3

* DF = 5; chi square = 179.545; p = < 0.05

^a 'Other' Axis II disorders include schizoid, schizotypal, paranoid, obsessive-compulsive, avoidant, passive-aggressive and mixed personality disorders.

4.4 GENDER AND DEMOGRAPHIC VARIABLES: MOOD AND ANXIETY DISORDERS

Many of the trends which manifested in the larger sample persisted in the sub-sample of patients diagnosed with mood and anxiety disorders. Again, with regard to marital status, a significantly greater proportion of single men were diagnosed with those disorders relative to single women, and again, a significantly greater proportion of married, divorced and widowed women were diagnosed with those disorders relative to men in the same categories (See Table 7).

Table 7 Gender, marital status and employment status: mood and anxiety disorders.

	Female		Male	
	n	%	n	%
Marital Status*				
Single	205	40.8	87	55.4
Married	177	35.2	42	26.8
Divorced/widowed	121	24.1	28	17.8
Employment**				
Employed	119	23.7	5	32.3
Unemployed	267	53.1	65	41.1
Disability grant/pension	79	15.7	34	21.5
Student	38	7.6	8	5.1

* DF = 2; chi square = 10.429; $p < 0.05$

** DF = 3; chi square = 27.877; $p < 0.001$

The pattern of sex distribution for employment status also showed the same trend for both samples. As with the overall sample, significantly more men than women were employed or were on disability grants, while more women than men were unemployed or students. The subsample differed from the overall sample in that a greater percentage of both men and women were employed or students than in the overall patient population, while a slightly smaller proportion of men and women were unemployed or on disability grants (See Table 7). This result would seem to suggest that the patients with mood and anxiety disorders represent a somewhat higher functioning

group compared to the total patient population, although rates of unemployment are still high compared to the general population.

With regard to race, the differences between male and female patients diagnosed with mood and anxiety disorders was not statistically significant. There was a slightly lower proportion of both African and coloured men and women and a greater proportion of white men and women in the subsample relative to the entire patient population (See Table 8).

Table 8 Gender, race and age: mood and anxiety disorders.

	Female		Male	
	n	%	n	%
Race*				
African	77	15.0	24	15.1
Coloured/Indian	292	56.9	92	57.9
White	144	28.1	43	27.0
Age **				
0-12	0	0	0	0
13-18	24	4.7	7	4.5
19-25	76	14.8	26	16.6
26-40	232	45.2	94	59.9
41-60	145	28.3	23	14.6
61+	36	7.0	7	4.5

* DF = 2; chi square = 0.0653; p = 0.968

** DN = 0.5; p = 0.441

As with the entire sample, the difference in the distribution ages between men and women was not statistically significant. However, the female patient group in the subsample displayed an age distribution very similar to that of the larger sample, although the male patient group tended to be more concentrated in the 26-40 age group than the overall patient population, with 59.9% of males in that age group in the subsample compared with 49.5% in the larger sample (See Table 8). Nevertheless, the mean age for males in both samples was similar: 34 years 3 months in the subsample and 34 years 5 months in the overall sample. Female patients showed a greater difference between mean ages for the subsample and the overall sample (37 years 9 months in the subsample, 38 years 6 months in the overall sample).



CHAPTER FIVE

DISCUSSION

In this chapter, the broad diagnostic patterns on both Axes I and II will first be sketched and discussed. Thereafter, the focus will be on gender differences in mood and anxiety disorders in particular, and on examining possible reasons for these differences. Associations with demographic variables and specific psychosocial stressors will be explored.

5.1 GENDER DIFFERENCES IN TOTAL ADMISSIONS

Men in the Western Cape are nearly 50% more likely to be admitted to a psychiatric hospital than women. The proportion of female and male patients in this study (40.6% women; 59.4% men) is almost identical to that reported by US authors (Rieker & Jankowski, 1995; Sanguineti, Samuel, Schwartz & Robeson, 1996) for admissions to public psychiatric hospitals in that country. This finding is also consistent with other studies from Africa, which have also reported that more men than women are hospitalised for psychiatric problems, although elsewhere in Africa, the ratio of men to women tends to be even higher (Kisekka, 1990). There are several possible reasons for this excess of male admissions.

Various factors (socio-economic status, geographical setting, support systems, age) determine whether someone will seek or be brought for psychiatric treatment. Usually, only the most severe cases, or those who are disruptive, will be treated (Nolen-Hoeksema, 1990). This situation is especially pertinent in the Western Cape today as reduced government funding puts pressure on public psychiatric hospitals to rationalise their services (SMT, 1995). As Kisekka (1990) suggests,

men are more likely than women to become physically aggressive and disruptive when they are psychiatrically ill, which would either bring them into contact with the police or prompt their families to bring them in as a matter of urgency. Similarly, Parker, Georgaca, Harper, McLaughlin and Stowell-Smith (1995) note that men are more likely than women to be admitted to hospital involuntarily, either by being certified, or as forensic patients.

In line with the above research findings, this study found that male patients were more likely than female patients to be brought in by the police or their families, while female patients were more often referred via another point in the health system, suggesting a lesser degree of immediacy surrounding the admission. Furthermore, a higher proportion of men than women were admitted as certified (27.2% compared to 17.2%) as opposed to being admitted voluntarily or consenting to admission, indicating that a higher proportion of men are admitted due to behaviour which is problematic to others.

The increased tendency for men to display violent or criminal behaviour when mentally ill is further illustrated by the fact that 3.8% of the male patients were forensic patients, compared to only 0.4% of the female patients (a ratio of 9.5:1). Presumably to meet this need, between the three hospitals there are 5 male forensic wards, with 275 beds, while there is only one, 15-bed female ward.

Therefore, given the fact that men tend to express mental illness in more disruptive, 'extrapunitive' ways, it is possible that, while men are more likely to be treated at psychiatric hospitals, women are more likely to receive psychiatric treatment at other points in the health delivery system, for

example day hospitals or general practitioners, as is the case in other countries in the world (Miles, 1991; Smyke, 1991).

Finally, the excess of male inpatients may be reflective of an actual excess of psychopathology amongst males in the community. This would tie in with Gillis *et al.*'s findings (1968) that, in the Western Cape, more men showed signs of definite psychiatric disturbance than women, but differs from the findings of Rumble *et al.* (1996) who reported that gender was not a predictor of overall psychiatric morbidity in a Western Cape community.

5.2 GENDER DIFFERENCES IN DIAGNOSTIC PROFILES

The findings regarding gender variation in diagnostic profiles on the whole followed international trends. As anticipated, mood and anxiety disorders were diagnosed more frequently in women than in men, but the extent of the difference was somewhat startling. Findings regarding two major disorders, schizophrenia and bipolar mood disorder, ran contrary to most international findings concerning their gender distribution.

5.2.1 Axis I diagnosis

Contrary to other studies which found an equal sex distribution for schizophrenia (e.g. Regier *et al.*, 1993), in this study more men than women were diagnosed schizophrenic. Many of the comments made above about the excess of male admissions generally, may also be pertinent here. It is possible that the excess of schizophrenia amongst male admissions is not reflective of prevalence rates in the community, but rather relates to differences in the expression of

symptomatology, such that when men become psychotic, they may tend to exhibit behaviour that is more disruptive than women. However, when the variable of race is added to the analysis, it also becomes apparent that, in this sample, a disproportionate number of black men, and African men in particular, were diagnosed schizophrenic, compared with white men (Msomi, 1997); thus, an additional dimension is created due to potential racial diagnostic bias.

The high rates of psychiatric disorders involving substance abuse, such as alcohol abuse and substance-induced psychotic disorder, amongst male patients, is consistent with findings regarding the excessively high rates of substance use, specifically alcohol consumption, amongst South African males (Seedat, 1984), and in particular the high prevalence of problems related to substance-use in the Western Cape (Gillis *et al.*, 1968). It is also consistent with the apparently robust finding that substance-use disorders are more common in men than in women (Regier *et al.*, 1993). However, the possibility that substance-related problems are underdiagnosed in women, as they are less congruent with the feminine stereotype (Russo, 1985), also needs to be considered.

Cognitive disorders, in particular delirium and organic brain syndrome, were also diagnosed more commonly in men, a finding consistent with that of Regier *et al.* (1993). The higher rates of cognitive disorders are potentially an indication of men's greater propensity to engage in high-risk behaviour. Delirium commonly occurs secondary to substance intoxication or withdrawal; the high rates of substance use and abuse amongst South African men have already been noted. In addition, both delirium and organic brain syndrome can occur as a result of head trauma. Head trauma is often associated with such high-risk behaviours as reckless driving (including driving under the influence of alcohol), crime, violence and gangsterism, all of which are endemic to the Western Cape (Aranes & Friedman, 1994; Seaman 1994).

The present study indicates that, for both sexes, treated rates of disorders involving symptoms of depression and anxiety are as high as, if not higher than rates reported elsewhere, representing one of the major causes of admission to psychiatric hospitals. The excess of mood and anxiety disorders in female psychiatric inpatients compared with males, is in line with nearly all findings reported from developed and some of the findings from developing countries (Jenkins & Clare, 1989; Nolen-Hoeksema, 1990; Russo, 1985; Weissman & Klerman, 1977). For women, the combined rates of mood, anxiety and adjustment disorders account for 52.5% of all female admissions, higher than the rate of 45% recorded in Britain (Sashidharan *et al.*, 1988). The female to male ratio is also for the most part in excess of those reported in studies from other countries. The difference is particularly stark in the case of major depressive episode, which was diagnosed 6.75 times as often in women as in men, as opposed to the average of 2:1 reported by the APA (1994). Also noteworthy is the extent to which gender differences in prevalence rates in psychoneuroses differ from those reported elsewhere in Africa, where an equal sex distribution was found for those disorders (Dhadphale *et al.*, 1983; Orley & Wing, 1979). As mood and anxiety disorders are the focus of this project, explanations for the sex differences observed in the categories as a whole will be considered in more depth in the second part of this chapter.

Surprisingly, in contrast to the widespread finding that bipolar affective disorder is equally distributed in women and men (Leibenluft, 1996), this study found that almost double the number of female patients were diagnosed with bipolar disorder compared to men (a ratio of 1.87:1). The prominent contribution of biological factors, including genetic factors, in the aetiology of the disorder (Leibenluft, 1996) distinguishes it from other non-psychotic mood disorders, in which biological factors are thought to play a relatively minor role aetiologically (Cochrane, 1993).

Bipolar disorder's substantial biogenetic component has been cited as an explanation for the disorder's equal sex distribution (Carson, Butcher & Coleman, 1988).

It does, however, appear that an equal sex distribution for bipolar affective disorder may not obtain in all societies and cultures, with a minority of studies, such as Abbey *et al.*'s (1993) survey of an Inuit community, reporting higher rates of bipolar disorder amongst women. When the gender distribution of a disorder shows variation across different sociocultural contexts, it would seem to suggest that the biomedical model provides an incomplete framework for explaining the aetiology of that disorder. Perhaps then, the role of psychosocial factors in the development of bipolar disorder, as well as the ways in which those factors interact with acknowledged biogenetic agents, needs to be explored further.

As an alternative explanation, the higher rates of female inpatients with bipolar affective disorder in this study may in some cases be attributable to misdiagnosis. According to the DSM-IV, differential diagnoses for bipolar mood disorder include major depressive disorder, substance-induced mood disorder and psychotic disorders such as schizophrenia or schizo-affective disorder (APA, 1994). Since the depressive phase of bipolar disorder is indistinguishable from a major depressive episode, the misdiagnosis of a single manic episode would lead to an erroneous label of bipolar disorder. Amongst patients with bipolar disorder, women are more likely than men to exhibit more depressive and dysphoric manic episodes (Leibenluft, 1996). Thus, it is possible that, in women, there is a degree of blurring at the borders between the symptom profiles of bipolar disorder and major depressive disorder, especially if the presenting depressive episode has mood-congruent psychotic features. Since there is insufficient consensus as to what constitutes 'mood-congruency', zealous clinicians may be inclined to overdiagnose bipolar disorder. If this were the

case here, then it is possible that an even greater number of women suffer from non-psychotic mood disorders than are reflected in these results.

5.2.2 Axis II diagnosis

As far as Axis II diagnoses are concerned, an excess of histrionic, dependent and borderline personality disorders were found in women, while an excess of antisocial personality disorder (PD) was noted amongst male patients. This corresponds with the literature on personality disorders where the same trend has been observed (Kaplan, 1983; Nuckolls, 1992). Reasons for this pattern of diagnosis of Axis II disorders have been debated in the literature. Authors, such as Kaplan (1983) and Landrine (1989) have argued that there are conceptual problems with the current classification of personality disorders, in that the categories seem to encapsulate sex-role stereotypes of the group that tends to receive that label most often. There is considerable overlap between personality disorders on the one hand, and sex-role stereotypes and gender roles on the other: both are socially constructed, and both emerge in adolescence and represent an enduring constellation of traits. From the point of view of gender bias, it has been argued, personality disorders seem to be more susceptible to subjectivity in diagnosis than Axis I disorders.

Other authors, such as Nuckolls (1992), maintain that the gender differences in personality disorders are real, not artefactual, and that the roots of these differences are to be found in the process of gender socialisation, and in our current gender roles, whose origins can be traced back to the 18th century and the rise of capitalism and the Protestant work ethic. Thus, personality disorders represent socially constructed, gender-specific channels for the expression of deviance. With regard to the current research, it is thought that both the above positions are cogent.

However, further research into the validity and reliability of personality disorders in the South African context is required.

Antisocial PD was diagnosed almost seven times as frequently in men as in women. This ratio is consistent with international studies, in which men have been found to be diagnosed with antisocial PD between five and ten times as often as women (Nuckolls, 1992). Amongst men, the rates of antisocial PD relative to other personality disorders in the male cohort are high (Antisocial PD accounts for 30.3% of all Axis II diagnoses in men), but are consistent with the urban setting and the low socio-economic status of the population (APA, 1994). The excess of men in this sample with antisocial PD is partly attributable to the preponderance of male forensic wards relative to those for females, as has already been noted. Nevertheless, the necessity for such a high number of male forensic wards is remarkable in itself, and will be discussed later in this chapter.

5.3 POSSIBLE EXPLANATIONS FOR GENDER DIFFERENCES IN MOOD AND ANXIETY DISORDERS

As the scope of this study is limited to the *description* of patterns of morbidity amongst psychiatric hospital patients, informed conclusions about the reasons for the gender differences in mental illness which are evident cannot be drawn. However, possible reasons for the morbidity patterns can be explored against the background of current discourse around gender and mental illness.

Firstly, the option that the excess of neurotic conditions in women may be a diagnostic artefact needs to be considered. As has been noted previously, the hypothesis that apparent gender differences in the incidence of depression and anxiety are attributable to differences in help-

seeking behaviour has received ambivalent empirical support. In any case, there is some evidence that gender differences in help-seeking behaviour, if they do exist, tend to be more apparent with regard to milder emotional problems, and that at the level of severe psychological distress, men and women's propensity to seek help is almost identical (Pilgrim & Rogers, 1993). It is suggested that gender differences in illness behaviour might therefore be more evident in settings such as private practices, outpatient clinics and counselling services. Since only the more severe cases of depression and anxiety-related disorders (often involving suicidal ideation or intent) tend to be admitted to public psychiatric hospitals (especially in South Africa, where the demand for hospital beds exceeds their availability), it is thought that, even if women showed a greater tendency to seek help for psychological problems, such a tendency is unlikely to have had a significant impact on the inpatient population sampled here.

Another diagnostic artefact which might have played a role in elevating the numbers of cases of depression and anxiety disorders amongst female patients, is misdiagnosis due to gender bias amongst clinicians, although, as has been noted, empirical evidence for a gender bias in diagnosis is limited (Lopez, 1989). Misdiagnosis might have occurred as a result of the clinician, influenced either by gender stereotypes or by research findings about group differences, labelling certain symptoms as more or less severe than the patient's experience of them, or making a diagnosis on the basis of incomplete or inadequate information, or failing to detect signs or symptoms characteristic of non-neurotic disorders. Whatever the case, the validity of diagnoses given to patients in this sample has not been assessed, and thus cannot be commented upon with any authority. Although there is evidence that in some South African psychiatric hospitals (at least in the past) the misdiagnosis of psychiatric conditions in black patients as a result of a failure to conduct proper interviews and to acquire sufficient information to make an accurate diagnosis was

not uncommon (Seedat, 1984), there is no indication that gender has led to any such problems in the diagnostic process. Furthermore, as far as the disorders which are the subject of this study are concerned, in most cases, the differential diagnosis of a particular neurotic disorder would be another neurotic disorder. For example, according to the DSM-IV, the differential diagnoses of major depressive episode include adjustment disorder with depressed mood or a manic episode with irritable mood or a mixed episode; thus, an incorrect diagnosis would not have altered the results in terms of broad categories to any significant extent.

In summary, it is suggested that artefactual explanations cannot fully account for the large discrepancy between female and male rates of anxiety and mood disorders found here. The conclusion must therefore be drawn that the discrepancies in rates are an accurate reflection of the gender distribution of those disorders in the hospital population.

5.3.1 Variables associated with gender differences in mood and anxiety disorders

As has already been noted, a growing body of international research demonstrates that psychosocial factors contribute significantly towards the development of mood and anxiety disorders. It is proposed that the excess of neurotic disorders necessitating admission to psychiatric hospitals amongst women that was found here, is strongly linked to women's social circumstances, as well as the status of gender relations in South Africa. In the case of the current project, associations and interactions between gender, the disorders in question, other demographic variables, as well as psychosocial stressors need to be explored.

5.3.1.1 Gender and race

The excess of anxiety-related and depressive disorders amongst women differs from the findings of other studies performed in rural or semi-urban African settings, where there appears to be no clear pattern of sex differences for those disorders (Dhadphale *et al.*, 1983; Orley & Wing, 1979).

Although this sample constitutes a more racially heterogeneous group than those surveyed by other authors working in Africa, that heterogeneity does not explain the discrepancy between the two sets of results. Significantly, these findings indicate that gender differences in mood and anxiety disorders persist across all racial groups. The female to male ratio for all of those disorders in all three groups fell into a narrow range between 3.17 and 3.35. Thus, female inpatients are over three times more likely than male inpatients to receive such a diagnosis, whatever their ethnic group.

A possible explanation for the discrepancy between results from other African countries and those of the present study, is the existence, in those mainly rural settings, of protective factors for women not found in the urban environment from which this sample was drawn. Evolving social conditions for both women and men have been linked to changes in the epidemiology of depression and anxiety over time (Murphy *et al.*, 1984; Pilgrim & Rogers, 1993). Dhadphale *et al.* (1983) point out that, although none of the women in their Kenyan sample were formally employed, unemployment did not hold the same threat of boredom, frustration and low self-worth that it holds for women in industrialised countries. The same observation has been made by Vasquez-Barquero *et al.* (1992) with regard to attitudes towards female unemployment in a rural Spanish population.

The social transformation which occurred in Africa as a result of changes in historical material conditions in the wake of European colonisation in some ways mirror those which occurred in Western Europe following the Industrial Revolution. In pre-industrial Western societies women's roles, although circumscribed, were also respected and valued (Ehrenreich & English, 1978; Nuckolls, 1992). Industrialisation resulted in dramatic changes in social roles, with male and female roles becoming divergent and dichotomous, and the concomitant emergence of gender stereotypes which still prevail today. Thus, men came to be viewed as stoic, assertive and rational, while women were seen as delicate, timid and emotional (Ehrenreich & English, 1978). Intrinsic to these changes in gender relations is the perception of the female role and status as being inferior to that of men, and a concomitant lack of social, political and economic power for women.

Although, in this study, the female excess of neurotic disorders prevailed across all racial groups, it was observed that a slightly lower proportion of both African and coloured men and women and a greater proportion of white men and women were diagnosed with mood and anxiety disorders relative to the entire patient sample. Thus, the disorders in question are slightly over-represented amongst white patients and under-represented in coloured and African patients. It therefore appears that, although the diagnosis of psychoneuroses is far from uncommon in black patients, those disorders are nevertheless diagnosed less often in black patients than in white patients, relative to other psychiatric disorders. In a parallel study to this one, involving the same sample, Msomi (1997) found that the most frequent diagnosis amongst African patients (sexes combined) was schizophrenia (42.7%), with mood disorders representing 22.9% of all diagnoses. Schizophrenia was also the most common diagnosis amongst coloured patients (29.9%), again followed by mood disorders (23.7%). However, amongst white patients, mood disorders predominated with 38.6% of all white admissions, followed by substance-related disorders

(19.9%), with schizophrenia only the third most frequent category, representing 17.5% of admissions. Although a detailed discussion of the issue of race and diagnosis does not fall within the scope of this project, three possible reasons for the apparently lower prevalence of neurotic disorders amongst black psychiatric inpatients will be examined briefly.

Firstly, the infrequency may reflect actual morbidity patterns within the community, i.e. that mood disorders are less common amongst blacks than whites. This is unlikely, however, as research in black populations in both in South Africa (Gillis *et al.*, 1968) and other African countries (Dhadphale *et al.*, 1983; Orley & Wing, 1979) has found prevalence rates for psychoneuroses that are as high, if not higher than those in Western countries. Secondly, the patterns cited above may be an indication of thresholds of tolerance in the different communities. For various reasons, black people with mood or anxiety disorders may be less likely than whites to present for, or be brought for psychiatric treatment, possibly because, in general, patients with those disorders are less disruptive and more passive than patients with psychotic disorders. Thirdly, clinicians may be consistently overdiagnosing schizophrenic conditions and underdiagnosing mood disorders amongst black psychiatric patients. There is considerable research support for this assertion (Flaskerud & Hu, 1992; Fabrega *et al.*, 1994; Mukherjee, Shukla, Woodle, Rosen & Olarte, 1983). It has been suggested that, in South Africa, black patients in general, and African patients in particular, receive a less detailed and less nuanced assessment (Seedat, 1984; Swartz, 1995b), which could often lead to inaccurate diagnoses.

5.3.1.2 Gender and Marital Status

In both the overall sample and the sample of patients with mood and anxiety disorders, there were more married, divorced and widowed women than men of the same marital status, and also more single men than single women. This is to a certain extent consistent with findings reported in the literature, although divorced men have often been found to have higher rates of mental illness than women (Russo, 1995). Thus, in the Western Cape, being divorced may be more stressful for women than it is for men. Divorced women here also appear to be more vulnerable to serious mental illness than divorced women in other countries. Perhaps this finding relates to the financial burden borne by divorced women who often have children in their care, and often have to rely on maintenance payments which are either non-existent or erratic (Wilson & Ramphele, 1989). Perhaps also, South African women are more liable than South African men to experience negative feelings of, for example, loss, failure, loneliness, inadequacy, anger or resentment as a result of divorce.

Marital status does not distinguish the neurotic patients from patients with other disorders. As no statistics are available regarding marital status in the community, no comparison can be drawn to show whether specific marital categories are under or over-represented in this hospital population relative to the general population. Nevertheless, the tentative conclusion can be made that, as elsewhere, from a mental health perspective, marriage is good for men and bad for women.

5.3.1.3 Gender and Age

Nolen-Hoeksema's (1990) finding that a female excess of depression only occurs after puberty cannot be confirmed here, due to the fact that pre-adolescent children are rarely admitted to psychiatric hospitals, and are more likely to be seen in specialised child and family clinics. The 26-40 age group appears to be the most stressful period for both men and women, both in the group comprising all admissions and for those patients diagnosed with neurotic disorders. This may indicate that the developmental period roughly corresponding with Erikson's (1959) generativity versus stagnation stage holds particular challenges for both men and women, which increase their vulnerability to depression and anxiety.

5.3.1.4 Gender, Unemployment and Poverty

Amongst inpatients with neuroses, 68.8% of female patients were unemployed (a category which, for the purpose of this study, includes people who are able and want to work, but cannot find work, those receiving disability grants, and housewives, since the distinction between the three categories was not always clear from the patients' records), while a significantly lower proportion of 62.6% of men were unemployed. The figures compare with unemployment rates in the Western Cape community which stand at 21.5% for women and 14.3% for men (CSS, 1996). Thus, high rates of unemployment are found amongst both male and female psychiatric inpatients relative to the general population. The direction of the relationship between unemployment and psychopathology is not clear, however. The high rates of unemployment would seem to suggest one of two things: either people who are admitted to mental hospitals are less likely to find work,

or unemployment predisposes people to mental illness. Certainly, in the case of depression, the latter explanation has received substantial empirical support (Newton, 1988).

It should be noted that patients in the subsample comprising mood and anxiety disorders had lower rates of unemployment for both sexes relative to the sample comprising all admissions. This is possibly because neurotic disorders generally tend to be less disabling than some other categories of psychiatric illness, such as psychotic and cognitive disorders. For example, although psychiatric disorders were found to account for a quarter of all severe disability in a Western Cape village, the main disorders in this category were not neurotic disorders but mental retardation, psychotic illness and epilepsy (Hoffman *et al.*, 1988).

Despite the fact that socio-economic status was not formally assessed in this study (due to the fact that it involves a calculation based on factors which were not easily obtainable from patients' records), it can be asserted that people admitted to public psychiatric hospitals are usually those who cannot afford private psychiatric care, or who are not members of medical aid schemes, and thus represent a poorer section of the community than those treated in private settings (Freeman, 1990). Overall, only half of health care expenditure occurs in the public sector, which serves 80% of the South African population (SMT, 1995). Although unemployment is obviously not the only precursor of poverty, the two frequently occur concurrently (particularly in South Africa, where state-administered unemployment benefits are limited). Therefore, the high rates of unemployment recorded here can be used as a rough indication of the extent of financial insecurity amongst patients admitted to psychiatric hospitals.

5.3.1.5 Violence against women

As has already been noted, levels of violence against women, are, by international standards, very high in South Africa. In general, there tends to be a higher incidence of sexual and physical abuse histories amongst psychiatric hospital populations relative to the general population (Dill *et al.*, 1991), with sexual and physical abuse having been associated with the development of several psychiatric disorders, in particular those classified as neurotic. Although the incidence of abuse histories amongst female inpatients in this sample, as recorded in female patients' case notes was 10%, more detailed interviews with female patients in an acute admissions ward revealed a rate of 85% (Strebel & Leon, 1996). Thus, it is probable that sexual abuse is a common predisposing or provoking agent amongst the female patients in this sample.

Disorders indicating a direct reaction to a traumatic or stressful event or situation, like posttraumatic stress disorder and adjustment disorders, were more common in women, with the two disorders combined representing 10% of all cases for women compared to 1.9% of all male admissions. This discrepancy may indicate that women are more frequently exposed to such situations experienced as traumatic or stressful. Alternatively, men and women may experience similar levels of trauma, but have different modes of appraising and responding to such situations, as has been argued by some authors (Cochrane, 1993; Nolen-Hoeksema, 1990). Whatever the case, the impressions of staff from the Western Cape's public psychiatric hospitals, on the basis of their clinical experience, are that the most common precipitant for both the above disorders is either sexual or physical abuse (J. Verster, personal communication, December, 1996).

Besides those disorders which explicitly result from traumatic events, sexual abuse has been linked to other psychiatric conditions such as depression, dysthymia, somatic disorders, dissociative disorders and personality disorders, either as a predisposing or a precipitating agent (Weaver & Clum, 1993). Of all the personality disorders, borderline personality disorder has been most reliably linked with childhood sexual abuse, and moreover, with the type of childhood emotional environment which facilitates and tolerates abuse (Weaver & Clum, 1993). Borderline personality disorder was the second most frequently diagnosed personality disorder amongst women in this sample (17.2%), being diagnosed 4.7 times as often in women as in men, again suggesting the possibility of high rates of abuse experiences amongst female inpatients.

It is therefore proposed that the high incidence of violence against women and children in South Africa is a significant contributing factor towards the excess of neurotic disorders found amongst women admitted to psychiatric hospitals. It is probable that, as with those women admitted to psychiatric hospitals, the incidence of sexual and physical abuse is also high amongst women suffering from mood or anxiety disorders in the community, who are either being treated at outpatient or other community health facilities, or else go undiagnosed and untreated.

5.4 COMMENTS, REFLECTIONS AND RECOMMENDATIONS

Having discussed the possible reasons for the observed gender differences in depression and anxiety-related disorders, and having explored possible relationships between gender and specific demographic features and life events, it is now necessary to draw together the different strands of the argument, and to consider the implications of the research, both for future studies, and for the

planning of policy and services. This section will begin with a general critique of the research with regard to both the process and the results.

5.4.1 General comments

5.4.1.1 The issue of men and mental illness

Although this project has examined the prevalence and demographic features of mental illness in both men and women, it has nevertheless inevitably emphasised issues surrounding *female* psychopathology, in so far as it is women who experience higher morbidity rates than men with regard to the group of disorders which have been the focus of the study. It is therefore, perhaps, necessary to comment briefly on the subject of men and psychiatric illness.

A focus on women's mental health by feminist researchers developed partly in response to the perception that psychiatry was an historically patriarchal profession which served to enforce female conformity by marginalising and silencing women who defied gender stereotypes (Chesler, 1972; Ehrenreich & English, 1978; Showalter, 1987). While in one sense work such as Showalter's and other work in the 'hidden from history' genre has been important in challenging versions of history dominated by male accomplishments, it has perhaps paradoxically retarded our understanding of gender and madness by presenting a one-sided and even distorted representation of the facts (Busfield, 1994). One of the consequences of the influential nature of such work is that issues pertaining to the experience and expression of mental illness in men have been somewhat neglected by researchers (Pilgrim & Rogers, 1993).

By now, it is a common observation that men and women respond to emotional and social stress in different ways. While 'deviance' in women tends to take the form of private, self-damaging behaviour, men, on the other hand, tend to display more public, antisocial behaviour (Pilgrim & Rogers, 1983). It has already been noted that men manifest higher rates of antisocial personality and substance abuse and dependence, a fact confirmed by the results of the present study. In addition, men are more likely than women to present at the interface between the mental health and the criminal justice systems (Pilgrim & Rogers, 1983). Thus, Vasquez-Barquero *et al.* (1993) have postulated that men and women exhibit different, but socially equivalent disorders.

In order to achieve a fuller understanding of the relationship between gender and psychopathology, a consideration of the complex interaction of factors which results in mental illness in *both* men and women is required. In the present study, the results pertaining to gender differences in the distribution of disorders can be summarised as follows: men are significantly more likely to suffer from psychotic disorders, including substance-induced psychotic disorder, substance-related disorders, cognitive disorders and antisocial personality disorder, while women are more likely to suffer from mood, anxiety and adjustment disorders. From this scenario, it is difficult to avoid making deductions regarding which gender group is the source and which the target of the aggression and violence which is so prevalent in South African society. The unavoidable, albeit clichéd, conclusion is that the two groups of disorders, those experienced mainly by men and those predominantly experienced by women, represent two sides of the same coin. As Parker *et al.* (1995) point out, normal and abnormal experience are conditioned by available social meanings at a particular historical juncture. The sharp dichotomy between male and female expressions of deviance in this sample surely reveals a great deal about the state of gender relations in South Africa. It is also important to consider, in so far as gender politics

intersect with racial politics, that black men's violence towards black women can be understood as a displacement of aggression by men who have been humiliated and emasculated by a racist system, and who are struggling to reassert their masculinity and sense of personal control (Klugman & Weiner, 1992).

5.4.1.2 Validity of psychiatric diagnoses

On a methodological level, the accuracy of the diagnoses given to patients in this sample was not tested, although some of the researcher's informal observations regarding inadequacies and inconsistencies in the diagnostic process have already been discussed. Future studies need to investigate issues of validity and reliability in psychiatric diagnosis in South Africa, particularly with regard to potential sources of bias, such as gender and race. Qualitative research into the practice of psychiatric diagnosis in state hospitals, including an exploration of the both the organisational structure and ethos, as well as interpersonal dynamics between clinician and patient, including the role of power differentials, might also be fruitful.

On a more conceptual level, although some of the critical issues around psychiatric classification and diagnosis have already been raised, the issue of cross-cultural validity in psychiatric diagnosis has not yet been addressed, and must briefly be mentioned. The appropriateness of dominant 'Eurocentric' notions about health, illness and healing, and the practice of Western psychiatry, in the South African context, have been questioned by several authors (e.g. Gillis, Ben-Arie, Elk & Teggin, 1982; Parry & Swartz, 1997). Knowledge and sensitivity about African belief systems and practices are required in order for clinicians to be able to distinguish between culturally distinctive behaviour and manifestations of psychopathology. Despite progress in recent years with regard to

the training and appointment of black professionals, the majority of diagnosticians in South Africa, and at the three hospitals in particular, are still white. As a rule, South Africans of different racial groups have had little exposure to each others' worldviews and lifestyles, largely due to the apartheid system which enforced racial separation. Focusing on gender, as has been done in this study, in some ways implies a false homogeneity, as significant differences still exist between the circumstances and experiences of South African women of different racial groups. However, as this study has shown, there are also significant similarities, such as the finding that women of all racial groups experience higher rates of depression and anxiety than men.

5.4.1.3 Limitations of the research methodology and focus

In attempting to correlate prevalence of psychopathology with psychosocial factors such as demographic variables and single life events, the aetiology of mental illness may appear to have been over-simplified. Firstly, psychosocial factors in themselves always occur in a complex social milieu: specific events, changes or situations often involve risk factors for some people and protective factors for others (Murphy *et al.*, 1984). Although theories focusing on social causation have established that aspects of the social environment are important determinants of gender differences in mental health and illness, other theoretical models have been found useful for understanding why only some women or men become depressed or anxious when confronted with the same stressors. For example, intrapsychic models can help explain women's individual vulnerabilities and resiliencies to social stressors from the perspective of gender socialisation and personality development (Gilligan, 1990).

Therefore, although the identification of demographic factors and stressful life events associated with the incidence of depression and anxiety is a useful step towards beginning to understand the importance of psychosocial factors in the aetiology those conditions, many authors have argued that the future challenge for epidemiology in the field of mental health undoubtedly lies in the development of integrated models to explain the *mechanisms* whereby various social factors interact with other aetiological factors, both biological and intrapsychic, to impact on mental health (Parry & Swartz, 1997; Weissman, 1987). As all noninfectious disorders are generally multifactorially determined (Freedman, 1984), a multipronged approach, drawing variously on epidemiology, genetic and clinical research, is necessary to construct explanatory models.

5.4.2 Implications of the project for further research

Parry and Swartz (1997) report that most of the psychiatric epidemiological studies performed in Africa to date have been descriptive and not analytical in nature, providing a cross-sectional 'snapshot' of the mental health status of communities. Internationally, research into gender differences in mental illness has already begun to move beyond correlational studies into the realm of new theoretical models (e.g. Ross & Mirowsky, 1989). The current study is predominantly 'cross-sectional descriptive' in nature, mainly because it was thought that a baseline of epidemiological data regarding gender differences in psychopathology needs to be established as a prerequisite for more analytical research. However, the results of this study point the way to avenues for further research.

As has been noted, an archival survey taps only a fraction of the mentally ill community, weighted at the more severe end of the spectrum. Certain mental disorders, such as schizophrenia, are more

likely to be referred for treatment at a psychiatric hospital while other disorders, such as affective disorders, tend to be under-represented in treatment settings compared to their prevalence in the community (Sashidharan *et al.*, 1988). Many cases of mood and anxiety disorders go untreated. Sashidharan *et al.* (1988) report that, in the UK, while only 3% of women with any mental illness were in treatment, an even smaller 1% of those with affective disorders were receiving treatment. In South Africa, it is possible that treatment rates for neurotic disorders are lower than those in Western countries, due to limitations in psychiatric services. Although the Western Cape is relatively well serviced with three major public psychiatric hospitals, several psychiatric wards in general hospitals, private psychiatric clinics and a network of community health centres and satellite clinics (SMT, 1995), counselling services directed at the mild to moderate end of the spectrum are limited. Three decades ago, Gillis *et al.* (1968) found a 11.8% prevalence rate of definite psychiatric disturbance in their survey of the coloured population of the Cape Peninsula, but found that only 1% of the population utilised psychiatric services. Furthermore, although many psychiatric patients experience concurrent physical symptoms, and therefore will tend to seek medical instead of psychiatric treatment, there is a low level of awareness of psychiatric symptomatology amongst general practitioners and doctors working in primary health clinics, and also a low rate of referral to specialised psychiatric services (Freeman, 1990; Rumble *et al.*, 1996).

In sum, many fundamental aspects of the mental health status of the South African population remain unknown. Community surveys are therefore necessary to determine whether the patterns reported here are replicated in the broader community. Ultimately, what is required is a 'mental health audit' of the South African population, similar to the ECA study performed in the USA, which would not only ascertain the prevalence of psychiatric illness in the population, but could also attempt to establish correlations with demographic features. Such a study would enable risk

factors associated with the incidence of psychiatric illness in South Africa, which in this project can only be speculated upon, to be identified with greater confidence. Hopefully, the intended national health census will go some way towards achieving the above goals.

Parry & Swartz (1997) have suggested that an important direction for future research in South Africa is the understanding of social factors which either optimise or hinder the successful management of psychiatric problems. Research which investigates potentially salutogenic factors, such as religious motivation (Strümpfer, 1997) or a supportive intimate relationship (Pretorius, 1997), is important because it emphasises factors which enhance resilience to stressors like the ones which have been identified by this study.

Following on from the present study, it would also be important to establish whether and how demographic factors such as gender impact on the treatment received in psychiatric hospitals and other settings. For example, Strebel and Stacey's (1997) observation that women stay in hospital for longer periods than men, and are more likely to be treated with both medication and electroconvulsive therapy (ECT) than men, warrants further investigation.

5.4.3 Implications of the project for policy and services

As in other countries in the world, South African women's increased vulnerability to mood and anxiety disorders seems to be associated with their social and economic subordination. On the political front, many progressive steps have been taken by the new government: South Africa has one of the most gender-sensitive constitutions in the world, as well as a special Commission on Gender Equality; many laws which discriminate against women have been abolished, and women

are relatively well represented in parliament and other government structures. Nevertheless, many South African women continue to experience gender oppression in their personal lives (Haffajee, 1997). An ongoing attempt needs to be made to ameliorate adverse social conditions which affect women in particular, such as poverty, unemployment, lack of reproductive choice, multiple roles and sexual and physical abuse (Russo, 1995). Significant improvement in women's mental health status is unlikely to occur in the absence of such social changes.

In so far as violence against women has been identified as a significant contributing factor in the high rates of neurotic disorders amongst women in South Africa in general, and amongst female psychiatric inpatients in particular, it is suggested that a reduction in the incidence of physical and sexual abuse would greatly assist in reducing the incidence of those disorders amongst women. Many of these issues, such as child abuse, for example, are already receiving the attention of intersectorial teams comprising both government departments (such as Health, Social Services, Justice, Safety and Security and Education) and non-governmental and community-based organisations, who have developed detailed management protocols (September, 1997). These efforts need to be sustained, and management plans need to be operationalised urgently and effectively. Psychologists have an important role to play in both the prevention of violence against women and child abuse, through psycho-education, as well as by providing counselling and psychotherapy for survivors. In addition, psychologists can help promote an increased understanding of the personality attributes of abusers and rapists, and can also address those elements in the sociocultural milieu, such as the gender socialisation of men, or corporal punishment in homes and schools, which might have helped to produce such large numbers of aggressive, abusive men in our society (Vogelman, 1990).

Finally, if the hypothesis is correct that women's mental health needs are best met not by public psychiatric hospitals, but by outpatient and community clinics and counselling centres, then those facilities need to be further developed. As Klugman and Weiner (1992, p.16) remark, 'were counselling services easily available in a context which did not identify consumers of such services as socially deviant, many mental health problems could be identified and treated'. Thus, adequate diagnosis and treatment at community level would reduce the need for institutional care in many categories of psychiatric patients, because the availability and accessibility of such services would doubtless prevent many mental health problems from escalating to the extent that they require admission to inpatient facilities. In the absence of psychiatrically trained staff in community settings, general health workers need to be trained in basic diagnosis and counselling, and also need to be sensitised to the social context of women's depression and anxiety.

5.5 CONCLUSION

The broad aim of this research project was to address the need for research into gender issues in mental illness, as there is a paucity of such studies from developing countries generally, and from South Africa particularly. Although the author cast the net wide in order to capture broad diagnostic trends, one specific goal was to determine whether disorders whose primary symptoms are depression and/or anxiety were more common in women than in men, as many international studies have reported. It was anticipated that female to male ratios for mood and anxiety disorders would be as high, if not higher than the international average of 2:1. The author was also interested in relationships between gender differences in mental illness and psychosocial factors.

The research method was archival in nature, involving a survey of the hospital records of a random sample of the patients who had been admitted to one of Cape Town's three public psychiatric hospitals during a one-year period. Information pertaining to demographic variables, admission-related variables, and the patients' diagnoses on Axis I and II was recorded by the fieldworkers. Analysis of the data primarily entailed a gendered description of broad demographic and diagnostic patterns. Although the nature of the methodology did not allow for any conclusions to be drawn regarding the causes of gender differences in depression and anxiety-related disorders, the author was able to speculate about possible connections between different variables by drawing on available literature on gender differences in mental illness, as well as literature dealing with mental health in South Africa, and more general psychological and sociohistorical observations about the South African setting, which may be pertinent to the results of the current study.

The study elicited several findings which are potentially of value to South African mental health workers, particularly those with an interest in gender issues in mental health and/or health management. Similar to the situation in Africa and in some Western countries, more men than women tend to be admitted to psychiatric hospitals. There is also a greater likelihood that men will be admitted involuntarily, either due to certification or as forensic patients.

An analysis of gender differences in diagnostic profiles reveals some results which are at odds with those widely reported in the literature. For example, the study found that more men than women were diagnosed with schizophrenia, while more women than men were diagnosed with bipolar affective disorder. Both results run contrary to the prevailing wisdom that both schizophrenia and bipolar affective disorder typically show an equal sex distribution. There are various possible explanations for these findings, including misdiagnosis on the part of clinicians, gender differences

in the expression of symptoms, or, of course, the possibility that the gender differences in this inpatient population are reflective of actual differences in the distribution of the two disorders.

In so far as most of the other diagnostic categories on Axis I, as well as personality disorders on Axis II were concerned, the findings regarding the direction of gender differences were consistent with those reported elsewhere. However, with all the mood, anxiety disorders, not only was a female excess observed, but the female to male ratios were also much steeper than in other studies. The most striking example of this is the case of major depressive episode, which was diagnosed at a female to male ratio of 6.75:1, compared to the international average of 2:1. While minor variations in rates occurred across racial groups, which would benefit from further investigation, the female excess of the disorders which formed the focus of the study was apparent in all three racial groups.

Also noteworthy is the high incidence amongst women of disorders which tend to occur as a result of exposure to a severe stressor, such as posttraumatic stress disorder and adjustment disorder. In the light of other research findings, the results of this study suggest that there may be a high incidence of sexual abuse histories amongst the females of the sample, and that such abuse may have contributed to the high incidence of certain disorders amongst the female inpatients.

Various reasons for the high prevalence of mood and anxiety disorders amongst female patients compared to male patients were considered. It is thought that artefactual factors such as gender differences in help-seeking behaviour, or diagnostic bias are unlikely to have played more than a minor role in producing these results. Having noted earlier that biomedical explanations have not adequately been able to account for gender differences in non-psychotic mood disorders, it

therefore seems feasible that the female excess of depression and anxiety-related disorders found here might be related to South African women's social position, social roles and life experiences. These results sound alarm bells for mental health workers and policy-makers in that they suggest that the conditions under which many South African women live have a demonstrably negative effect on their mental health, increasing their vulnerability to certain mental disorders which have been shown to be influenced by oppressive or stressful social conditions.

It is therefore essential that attempts to address the mental health needs of the South African population, and in particular any programmes which aim to reduce the high rates of depression, integrate an understanding of those predisposing and precipitating factors which are predominantly experienced by women, and which render women particularly vulnerable to disorders in which depression and anxiety are the prominent symptoms. Strategies which empower South African women will inevitably lead to an improvement in their mental health status.



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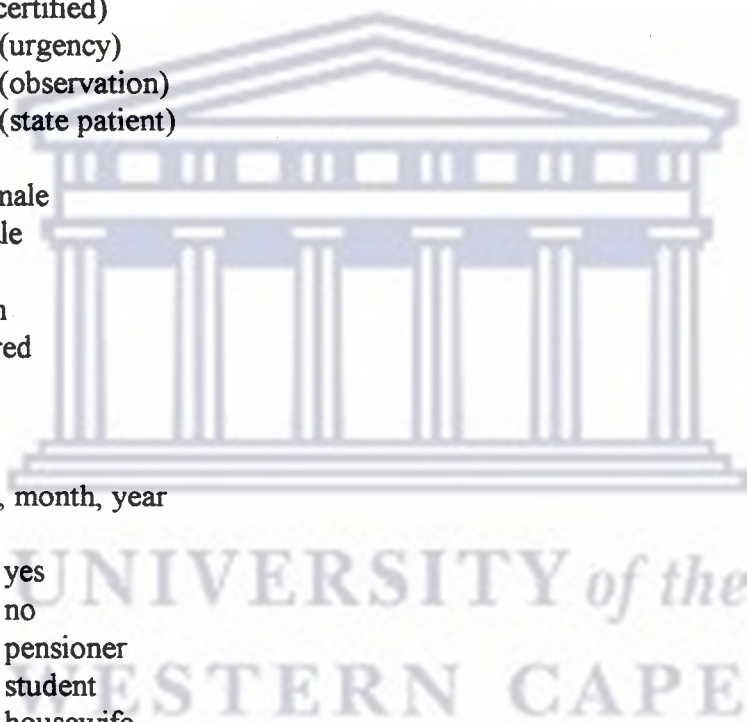
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APPENDIX 1

Data capturing form

1. Case number: 0001-8000
2. Hospital: 1-Lentegeur
2-Valkenberg
3-Stikland
3. Section: 1- 3 (voluntary)
2 - 4 (with consent)
3 - 9 (certified)
4 - 12 (urgency)
5 - 79 (observation)
6 - 28 (state patient)
3. Sex: 1 - Female
2 - Male
4. Race: 1 - African
2 - Coloured
3 - Indian
4 - White
5. Date of birth: day, month, year
6. Employment: 1 - yes
2 - no
3 - pensioner
4 - student
5 - housewife
6 - disability grant
7. Marital status: 1- single
2 - married
3 - divorced/separated
4 - widowed
8. Ward: 1 - Neuroclinic
2 - Admission
3 - Long-term
4 - Geriatric
5 - Forensic



9. Referral source: 1 - Self
 2 - Family
 3 - Medical Practitioner
 5 - Hospital/ clinic
 6 - Social Services
 7 - Police
 8 - Employer
 9 - Psychologist/ psychiatrist

10. Children: 1-99

11. Diagnosis on discharge:

Axis I

- 100 - deferred
 101 generalised anxiety disorder
 103 phobia
 105 obsessive-compulsive disorder
 107 dissociative
 109 major depression
 111 dysthymia
 113 organic mood disorder
 114 schizophrenia
 115 undifferentiated
 117 paranoid
 119 schizophreniform
 121 brief psychotic disorder
 122 substance-induced psychotic disorder
 123 alcohol abuse
 125 other drug abuse
 127 sexual dysfunction
 129 gender identity disorder
 131 dementia
 133 organic brain syndrome
 134 other
 135 no differential diagnosis
- 102 panic disorder
 104 posttraumatic stress disorder
 106 somatoform
 108 adjustment
 110 bipolar disorder
 112 cyclothymia
 116 catatonic
 118 disorganised
 120 schizo-affective
 124 polydrug abuse
 128 paraphilias
 130 eating disorder
 132 delirium

Axis II

- 200 deferred
 201 histrionic
 203 dependent
 205 schizoid
 207 borderline
 202 avoidant
 204 obsessive-compulsive
 206 schizotypal
 208 narcissistic

209 anti-social
211 mental handicap

210 paranoid

V Code

135 physical abuse
137 child sexual abuse
139 family relations
141 other

136 adult sexual abuse
138 bereavement
140 partner relations
142 none



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APPENDIX 2

Copy of clinical summary (Valkenberg Hospital)

5/21

CLINICAL SUMMARY
(Form to be completed on discharge)
(Please mark relevant box with "X")

CONFIDENTIAL

SURNAME: (Please Print) OCCUPATION: ADDRESS: TELEPHONE: ADMITTED: REFERRED BY: MAIN COMPLAINT + HISTORY OF MAIN COMPLAINT:

FIRST NAMES: IN-PATIENT NO.: OUT-PATIENT NO.: GENDER: M F

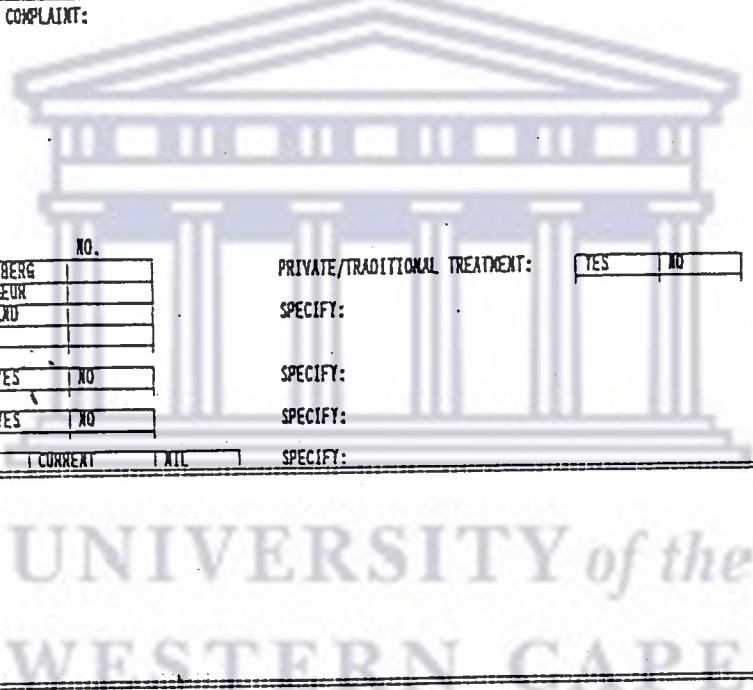
WARD: SECTION: 3 4 9 12 19 28 LANGUAGE: E A X OTHER DATE OF BIRTH: D M Y

SINGLE MARRIED DIVORCED WIDOW/ER AGE: DISCHARGED: L.O.A.: ADDRESS:

BACKGROUND HISTORY:

PREVIOUS ADMISSIONS: VALKENBERG NO. PRIVATE/TRADITIONAL TREATMENT: YES NO
LENGEBUR
STALAND
OTHER

HISTORY OF AGGRESSION: YES NO SPECIFY:
FAMILY HISTORY: YES NO SPECIFY:
SUBSTANCE ABUSE: PREVIOUS CURRENT NIL SPECIFY:



UNIVERSITY of the WESTERN CAPE

COURSE IN HOSPITAL:

TREATMENT RECEIVED: BIOLOGICAL: (Highest DAILY dose in Brackets)

FAMILY INTERVIEW: YES NO EMPLOYER CONTACTED: YES NO
PSYCHOTHERAPY/COUNSELLING: INDIV. GROUP COUPLE I.O.T. I.T. WORK ASSESSMENT

MEDICATION ON DISCHARGE: NEXT INJECTION DUE:

DIAGNOSIS: AXIS I. (NO ABBREVIATIONS): II. III. PROGNOSIS: GOOD FAIR GUARDED POOR

SPECIAL INVESTIGATIONS:

RECOMMENDATIONS:

DISABILITY GRANT: RECEIVING APPLIED FOR NOT APPLICABLE

COPIES SENT TO:

SIGNATURE: CASE MANAGER RAUX: VALKENBERG HOSPITAL OBSERVATORY/CAPE. 7935

NAME: DATE: