

Gender differences in mental health in the Middle East

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We are now seeing in clinical practice a generation of young women who are referred for psychiatric treatment by their parents because they are rebelling against society's cultural norms but it is often apparent that women fear their families finding out that they are seeking psychiatric help. Despite improvements in the cultural understanding of women's right to equality, there remain deeply rooted practices and cultural norms that continue to adversely affect women's mental health and well-being. Physical abuse, for instance, is rarely reported, for fear of shaming the family, or of retaliation with further abuse. Mental health services in many countries in the Middle East are undergoing reform, but little research has been done into gender differences in service delivery or needs.

The term 'Middle East' is often used to denote a broad geographical area. However, within the Middle East there are differences in culture, language and societal compositions and norms that have different impacts on mental health. Taking just the Gulf region as an example, which itself includes Qatar, Kuwait, Saudi Arabia, Bahrain, Oman and the United Arab Emirates, the population is widely multi-ethnic. In some countries, the number of expatriates may exceed the number of nationals. Most of the expatriates are single male labourers, on contractual work, with distinct mental health needs. Political and social rights vary widely between different countries in the region, as does the average level of education.

Mental health services in many countries in the Middle East are undergoing reform. Yet little research has been done into gender differences in service delivery or needs. Worldwide, a gender bias in the diagnosis of mental illness is well reported. In the Middle Eastern culture, it is important to consider the impact of gender-based discrimination and violence on mental health service delivery (World Health Organization Department of Mental Health and Substance Dependence, undated).

Changing cultural norms

With access to the internet, young people in the Middle East are more exposed to international influences. The website Go-Gulf.com (2013) published the following data: 88% of the region's online population uses social networking sites daily, in English and Arabic languages; these are primarily people aged 18–34. Saudi Arabia and the United Arab Emirates make up 80% of users

from member states of the Gulf Cooperation Council. These are traditionally reserved societies, very adherent to centuries of cultural rules and restrictions. The world has seen how the social media shaped the political agenda in this region with the 'Arab Spring'. This rapid change in youth culture is producing a generation that is confused, with often contradictory ideologies, between what it wants to believe and practise, Western influences, and their extended families' beliefs and expectations of them. Traditionally, men are allowed more freedom than women, including freedom of expression. We are now seeing in clinical practice a generation of young women who are referred for psychiatric treatment by their parents because they are rebelling against society's cultural norms.

Women are achieving higher levels of education than men in the Middle East. More women are now working and combining a professional career with family responsibilities. More women are expressing their sexuality openly. In several countries, this change has been too rapid for society to adapt to. Men continue to be seen to be 'in charge' of work and household; the male role is to provide financial support to the family while the woman does the housework. A study in Lebanon reported that a husband's involvement with housework was negatively associated with a woman's unhappiness and psychosocial distress (Khawaja & Habib, 2007). The increases in the women's literacy and employment rates have not been accompanied by a change in the attitude of men (Regional Consultation, 2004).

Despite vast and evident improvements in the cultural understanding of women's right to equality, there remain deeply rooted practices and cultural norms that continue to adversely affect women's mental health and well-being. The practice of female circumcision continues in rural areas, regardless of public appeals and even legislation banning it. This is prominent in East Africa and Egypt, where a study showed that circumcised women had more symptoms of depression, somatisation, anxiety and phobia than non-circumcised women (Ibrahim *et al*, 2012).

Physical abuse is seen in many parts of the region as the right of a male member of the family to 'teach' a female appropriate behaviour and rectify any perceived misconduct. Studies in Egypt, Palestine, Israel and Tunisia reveal that one in three women is subject to beating by her husband (Douki *et al*, 2003). Such abuse is rarely reported, for fear of shaming the family, or of retaliation with further abuse. In Qatar, the Women and Child Rights organisation provides shelter

for victims of domestic violence. Yet patients more often than not ask for a revelation of abuse not to be documented in their clinical notes and not to be raised with the authorities, as it might bring disgrace to their extended family and harsher consequences for the woman herself.

Clinical issues

In clinical encounters with women, it is often apparent that they fear their husbands finding out that they are seeking psychiatric help. They fear being shamed by their in-laws, their husbands marrying a second wife, divorce and losing custody of their children. This has detrimental effects on women's help-seeking behaviour. They often present to their primary care physician with somatic symptoms, or visit a hospital emergency department, perhaps several times, before being recognised as having mental health needs. Persistent headaches, generalised weakness and 'fits' are the commonest somatic presentations.

Anxiety and depression are more prevalent among women, while men have more 'externalising' disorders. The literature suggests that this difference will narrow as gender role equality improves (Seedat *et al*, 2009). A retrospective file review of in-patient admissions in Qatar revealed that Qatari females represented 47% of those admitted with affective disorders, while Qatari males represented only 19% (other nationalities accounting for the balance). Affective disorders were the single highest cause of admission among Qatari females, followed by schizophrenia. A recently published World Bank report stated that, in the Middle East and North Africa (MENA) region, depression is the disease with the highest prevalence among women; further, its rate in women is higher than it is in any other region. This is thought to be related to women's inability to work and other cultural factors (Freund, 2013).

Statistics from the psychiatry department at Hamad Medical Corporation, Qatar, reveal that more Qatari females attend the psychiatry out-patient clinics than males, yet a 3-year review of in-patient files showed that only 9% of admissions were of Qatari females, while 26% were of Qatari males. Families tend to resist female admission to the in-patient units as much as possible, and take extra measures to ensure care is provided at home, under the direct supervision, if needed, of family members. While it is, to a certain extent, acceptable for a female to attend the out-patient clinic, admissions are thus often refused. The reverse scenario can be seen with men, whose family may have difficulty managing their condition at home and more readily accept admission, sometimes without follow-up afterwards in out-patient clinics.

Reform

Mental health reforms are now occurring in most of the Middle East region, especially among the members of the Gulf Cooperation Council, with reforms in service provision, training, education and research. Among member states, the population is skewed, with more expatriates than nationals, and the impact of this situation on mental health has not been carefully considered.

Furthermore, gender-based service provision is not given sufficient (if any) emphasis in most of the reforms. Patients are not involved as major stakeholders in mental health planning. The current services are generic, with little gender sensitivity, apart from separate male and female units (driven by religious and cultural acceptability).

For the first time, mental health is being recognised as a national health priority in many countries in the Middle East. In its National Health Strategy, Qatar has recognised mental health as one of its top priorities. The same applies to other countries. Through many of the hospital-based reforms, or more broadly the Arab psychiatric organisations, there is deeper recognition of the similarities and differences within the Middle East region, which will, it is hoped, lead to collaborative research on gender difference in mental health and its impact on service planning.

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