Vulnerability to Mental Illnesses: Gender Makes a Difference, and So Does Providing Good Psychiatric Care

Dedicating oneself to the understanding and treatment of mental illnesses is the life work of the psychiatrist. How we do that on an individual basis may vary. Some of us choose to work primarily with a specific subgroup, such as the elderly, children, or patients with psychosis or mood disorders. Others have a more general practice. Some emphasize pharmacotherapy, others psychotherapy (sadly less and less), and still others combined therapies.

Yet one problem that we all grapple with is understanding how and why our patients develop the particular illnesses that they do and how we can predict and affect the future course of their illnesses. Specifically, we seek to understand how illness develops as a consequence of a complex matrix of factors that impinge on each individual patient. One of these factors is gender, the topical theme of this issue. Many other factors also play a role, such as early and recent life experiences, the availability of social supports, or genetic influences. As we listen to our patients and try to determine the nature of their symptoms and the best way to treat them, we are continuously pondering what additional information we should obtain and how we can use this knowledge to inform our treatment interventions.

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Gender is an interesting example of a complex factor that may influence the development or course of mental illnesses. A person's sex is genetically determined at the time of conception and is not a matter of choice. However, the way a man or woman lives within his or her assigned sex can play out in many different directions. Gender identity is influenced by many things, such as socialization styles suggested by parents or schools or peers, location and quality of housing, the availability of education and the type provided, the kinds of toys that are given to the child, and perhaps even the kind of clothing that a child is allowed to wear. All these factors—and no doubt many others—help shape identity, and perhaps also ego strength and resilience. In turn, they may also affect differential vulnerability to mental illnesses.

This issue of the *Journal* contains two interesting papers that provide some insights about the relationship between gender and vulnerability to mood disorders. Kendler et al. examine an interesting and powerful sample: nonidentical twins who also differ by gender. As is well recognized, twins are a "natural laboratory" for studying the interactions between genetic and nongenetic influences on vulnerability to mental illnesses. This study measures the rates of depression in the twin pairs and then compares them in terms of social support networks. As is almost always observed, the female subjects have a higher rate of mood disorder than the male subjects. They also have more extensive social support networks. When Kendler et al. examine the inter-relationship between social supports and vulnerability to depression, they find that women are more sensitive to the depressogenic effects of having low levels of social support than men. For the men the association between social supports and risk for depression is modest and not significant. Paradoxically, having a lower rate of social support does not ac-

count for the higher rate of depression in the women; controlling for social supports actually augments the higher rate of depression in women. That is, women still have higher rates of depression even when the influence of social supports is taken into account. These results suggest that there may be gender differences in the mechanisms of depression, and that lack of social supports may be an important part of the causal pathway in women but not in men. It is a pity that this paper does not also examine same-sex dizygotic twins in order to help further disentangle relationships between genetic and nongenetic influences.

A second paper by Kennedy et al. examines gender differences in incidence and age at onset for bipolar disorder and mania. This study uses an excellent epidemiological design, examining all cases from the Camberwell catchment area in London over a 35-year period. This study also examines the influence of psychosocial variables on gender differences in bipolar disorder and mania. Men are found to have a slightly higher rate of bipolar disorder during their early years (ages 16–25), but women have a higher rate overall and a generally later age at onset. Women are also more likely to begin their bipolar life course with an episode of depression. Among the psychosocial variables examined, childhood antisocial behavior is found to be the strongest predictor of early-onset bipolar disorder in male subjects. Other psychosocial variables examined are not predictive, including developmental measures, premorbid functioning, and personality. The authors speculate that the observed gender differences in patterning of onset may reflect hormonal influences across the lifespan and that early-onset bipolar disorder may represent a subtype within the bipolar spectrum that arises from a different causal pathway.

Overall, both studies fit within a large literature suggesting that there are gender differences in vulnerability to mental illnesses. Men have higher rates of schizophrenia, antisocial personality, ADHD, and learning disabilities. Women are more vulnerable to mood disorders and borderline personality disorder. Understanding why these patterns of predisposition occur will ultimately improve our knowledge of the pathophysiology and etiology of these various mental illnesses. We still have much to learn, but these two studies add modestly to our knowledge.

What are the implications of the gender studies in this issue of the *Journal* for the daily practice of psychiatry? They are quite obvious, but still worth pointing out.

First, simply knowing a patient's gender gives us useful information in making diagnoses and planning treatment. This information, combined with other details, can help us predict future course of illness and risk for recurrence.

Second, we need to go beyond simply doing DSM checklists of current symptoms when we evaluate our patients. We need to take a careful social history and a comprehensive past psychiatric history. Unfortunately, economic constraints and time constraints have made this kind of "good clinical practice" increasingly more difficult. But it is still necessary, and we should fight in every way we can to preserve and maintain these standards of care.

Third, "good clinical practice" may also dictate the inclusion of some type of psychotherapeutic intervention in addition to medications. (Same problems as for implication two, of course.)

Fourth, research studies can yield some small pearls that can improve "good clinical practice" (i.e., it is good to read your *AJP* each month!)

For example, imagine having a 25-year-old married woman come to your office for the first time, complaining of feeling depressed. Of course you will go through a review of her symptoms, using DSM criteria. Suppose you reach a diagnosis of Major Depression. These articles remind us that we should do more than make a diagnosis and prescribe an antidepressant. We need to understand her as a person living within a social matrix. We need to determine whether she is close to her family—siblings, parents, and husband—and whether she has a network of close friends. If you find that her social

support network is limited (i.e., she does not feel close to family or friends), she is likely to have a greater risk for relapse and perhaps also to be slower to respond to treatment. Part of your treatment plan should focus on helping her improve her social supports. She may also need to be seen more frequently and to need more psychotherapy. Over the long run you need to be aware of the possibility that she may also develop episodes of mania and become bipolar, since women often present first with depression and then have their first episode of mania at a later age.

If the patient were a 25-year-old single man with depressive symptoms, the situation is somewhat different. His risk for subsequently becoming bipolar is less overall, since he is approaching the end of the high-risk age range for male subjects, but it will be greater if he has a history of antisocial behavior. If the latter is the case, then you will need to continue to be more vigilant for episodes of mania. You will of course inquire about his social support network, but with the awareness that (on average) having a good network will be less protective for him than for the aforementioned woman.

Admittedly, these studies provide only modest kernels of information that will help clinicians improve their treatment plans. But they reinforce with large-group empirical data what we have gleaned from observing individual cases. For vulnerability to mental illnesses, gender makes a difference. Knowing some more specific details about this vulnerability can improve prediction of course and outcome and ultimately improve our understanding of pathophysiology and etiology.

This illustrates, however, another important point. Being a good psychiatrist makes a difference too. Psychiatry is the only medical specialty that treats the whole person. We must see each patient as a unique person and understand and treat that person not only in terms of presenting symptoms and diagnosis but also as a human being who lives within a complex psychosocial matrix and whose present may be influenced by the past. This is perhaps the most important implication of these two papers.

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