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GENDER AND SHIZOPRENIA

Slađana Štrkalj Ivezić[1] & Nada John[2]

[1]Psychiatric Hospital Vrapče, Zagreb, Croatia
[2]Department of Psychiatry, Hospital Dubrovnik, Croatia

SUMMARY

In accordance with the predonimant view on the neurobiolgy of schizoprenia, most of the research on the diferences in the illness between men and women has been studied on the basis of sex difference as a biological category rather than on the basis of gender as a psychosocial category. There are gender- identity difficulties observed in schizophrenia. Problems associated with gender can be a major sorce of instability and vulnerability during the development of the first and later psychotic episodes. There is a need for future research to view sex difference through gender perspectives. Findings from a gender study may have utility for the development of differential treatment interventions for men and women and may improve the outcome of the illness in general. The study of the complex role of gender in illness processes is an important research direction that would enhance our understanding of the heterogeneity in the manifestation and subjective experience of schizophrenia.

Key words: *schizophrenia – gender - sex difference - gender role - gender identity*

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Introduction

There is a growing body of evidence of sex differences in shizophrenia in numerous rewiew articles (Andia 1991, Kulkarni 1997, Lewine 1996). In accordance with the predonimant view on the neurobiolgy of schizoprenia most of the research on differences between men and women have been studied on the basis of sex difference as a biological category rather than on the basis of gender as a psychosocial category. Therefore there has been a profound neglect of the role of psychological and sociocultural factors in the age of onset, illness presentation, outcome and treatment. in relation to gender. Elucidation of the complex role of gender in illness processes is an important research direction that would enhance our understanding of the heterogeneity in the manifestation and subjective experience of schizophrenia (Nasser 2002). This may have utility for future directions reflected in the treatment plan. Social explanations for psychiatric disorder have focused on both external enviromental stressors and support (Dohrenwend 1981, Gove 1973) and coping styles (Pearlin 1978, Seligman 1975). Theory and research on gender role suggest that both personality or coping styles and role stress may have an etiological significance for sex difference in social role impairment (Richman 1984). From the psychological point of view disturbance in the symbiotic phase is connected with the development of schizophrenia in the adult age (Mahler 1975, Searles 1965, Reichmann1974) Gender is not especially pointed out in the vast literature connected with the psychotherapy of schizoporenia but adolescent age and difficulty in handling the developmental conflict of growing up is mentioned as a weak point and special vulnerability in the development of the first psychotic episode (Pao 1979).

Sex differences identified in research are as folows: males have an earlier onset of illness (Hafner 1993, Jablensky 1992), Males are more prone to exibit more typical positive symptoms of halluciantions and delusions, antisocial bechaviour and negative symptoms such as blunted affect and avolition wheras women are more prone to show an atypcal presentation of affective symptoms such as dysphoria and depression (Lewis 1992); men have a more severe form of illness, greater cognitive (Weiser 2000), affective and social impairment and a poorer longterm outcome (Angermeyer 1989, Angermeyer 1990) but a less familial form of the disorder than do women (Maier 1993). Women have a better response to

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medication (Lewine 1990) and are found to be more compliant with medication and treatment recomendations than men (Smith 1997). Although there is a consensus that women have a better outcome than men some research has found that difference in outcome between men and women is not present later in the illness duration (Opjorsmoen 1991). In order to get a greater understanding of the background of these differences they should be looked at and redefined from a gender point of view.

Sex, gender, and gender identitiy

Sex and gender are not the same. Sex has a biological determination, gender is composed of a broad range of biological, psychological, social and cultural processes (Lewine 2004). Inaccurate terminology mistaking biologically based sex differences for psychosocially informed gender factors is common in this research area. Despite the terms being distinct they have been used both inconsistently and interchangebly (Nasser 2002). Sex should be used for comparisons in which people are selected on the basis of the demographic category of male and female and gender for comparisons involving the nature of femaleness and maleness or of masculinity and femininity (Deux 1993). Gender identity is a composite of several subcategories (La Tore 1979). According to Money (Money 1973) there are gender role, gender identitiy and core gender identitiy. Gender role is the public manifestation of one's individuality as a male or female. Gender identitiy is the private experience of one's individuality as a male or female. Gender identitiy is the self definition of oneself as being male or female, a deep belief which can be unconscious. Core gender identitiy is the term used to designate the development of gender identity. MeClelland and Watt (MeClelland 1968) speak about three levels which are mainly unconscious; one level is gender identitiy as an unconscious schema representing pride, confidence and security in one's membership of the mail or female sex, the second level is sex role style which is a more or less unconcious phenomenom caracterized by assertivness in males and yielding or interdependence in females and the third level consists of sex –typed interests, likes and attitudes, which are a product of a particular culture and a particular time. Green (Green 1974) speaks about basic conviction of being male or female what is similar to the first level pointed out by MeClelland and Watt (MeClelland 1968) People with schizoprenia are often considered genderless (Carmen 1981). This can be related to stigma and can also explain the low interest in the gender issue in shizophrenia. Confused gender role adoption and intact gender identity can be found in persons with schizophrenia (La Tore 1979).

Maculitnity has been found to be associated with lower levels of depression among women, while femininity appears to have no influence on level of depression (Nezu 1986) A meta analysis of a threefold model of sex role orientation (congruence, androginy and masculinity) found that the masculinity model had the strongest relationships to adjustment and lack of depression (Whitely 1989). On the other hand it was suggested that pressure to adhere to the masculine gender role imposed on man by culture can lead to gender role stress and unhealthy cooping behaviour (Eisler 1991).

Strict role adherence can diminish psychological wellbeing (Grimmel 1992).

Research from the gender point of view reveals some difference between persons with schizoprenia in comparation with persons without schizophrenia. Theoretically, the estabilshment of a gender identitiy is conected with the development of body image (La Torre 1976). Disturbance of body image was mentioned a long time ago in Freud's Dr Schriber case. Dr Scriber believed that he would give birth to a new mankind (Freud 1925). Two studies (Reed 1957) demonstrated that psychotic females consistently drew male-female meassurement inappropreately. There is a diference in pictures on the basis of anatomical accuracy between schizophrenic females and females without mental disorder on the other hand, small differences were found between schizophrenic females and normal females in body proportion and integration (Burotn 1964). The bulk of the studies support the notion that figure drawings of schizophrenics are sexually less differentiated than the figure drawings of normals. Establishment of a gender identitiy is connected with the development of body image (La Torre 1976). Poor sexual differentiation might be more related to a variable such as stress than schizophrenia itself (La Torre 1976). Research on gender identity shows that men and women with schizoprheina suffer form sex role reversal and disturbed sex role identification. Gender role adoption also seems impaired in schizophrenic women in comaparision with normal controls. (La Torre 1976). Analysing the differences in gender

and schizoprenia in numerous studies of LaTorre (La Torre 1976) conclude that there is a tendency for male schizophrenics to express more of a preference for female activities and roles than for male normals and surgical patients.

Theory and research on sex roles suggests that personality, coping styles and role stress may have etilogical sigfinificance for sex differences in social role impairment. Men and women differ in the extent to which they are likely to derive support from given relationships (Richman 1984). Difference in parental bechaviour and/or role relationship with regards to male vs. female children influence females to develop a sense of low self-esteem, in-adequacy and overdependence on other people, while males are likely to develop aggressive interpersonal styles and deficits in the ability to express emotions (Richman 1984, Rossi 1984) Women perform worse on instrumental work activities and men function worse in their capacity to express feelings (Richman 1984) So, Women would seen to benefit most from interventions aimed at improving their self-esteem with regard to instrumental work role activities, while men might have a greater need for work focusing on their sensitivity and capacity to express feelings in various primary group relationships (Richman 1984).

Framework for understanding the sex and gender differences between male and female

It is obvious that there are differences between male and female patients with schizoprenia. The problem is how to understand these differences and use them in a treatment plan to improve the outcome of the illness. There is a tendency that research on sex difference is expained by biological factors such as estogen, family loading for schizophrenia etc (Steven 2005), rather than psychosocial factors. La Torre (LaTorre 1979) proposed the diathesis- gender-stress model of schizophrenia, which suggested that gender identity or gender role problems are the leading target stressors. According to this theory the major stressor which increases the likehood of developing schizophrenia is gender confusion. He suggests that the preschizoprenia child develops a faulty gender identitiy from the disturbed family dynamics that inhibit the perception of self in a sex congruent gender identity. The earlier onset of illness in man (LaTorre 1979) can be explained through gender identity uncertainity in adolescence accounted for by the more agressive role imposed on males in Western societies, so early acceptance and successful integration of gender identitity and gender roles could prove more critical for social adjustment among men than among women.

The framework could be expanded to recognize the role of nonfamilial factors as well (Nasser 2002). Disturbance in gender identitiy may also emanate from social realms such as school settings, peer interactions and media exposure, all of which may configure images of ideal gender identities that individuals find objectiable, or otherwise personally unacceptable. In this sense the disturbances in gender identity can be conceived of as existing in the social rather than the individual realm.

MeClelland and Watt (MeClelland 1968) state that men and women with schizoprenia tend to deviate from the traditional role of achievement and assertivness for men and obediance, interdependence and responsibility for women The authors suggests that in such cases, some part of the males' unconscious self-image is sensitive and more feminine while some part of the females' unconscious self- image is insensitive and more masculine. This is in line with the finding of Ecker and collegues (Ecker 1973) that males and females with schizoprenia suffer from sex role reversal and disturbed sex role identification.

The psychosocial explanation of better outcome of better social functioning in women can be related to different gender expectation.by family members as well as to current culturally based sex associations and expectations in which independence is more highly valued for males, whereares dependency on family is more gender and sex role appropriate for women, so women feel able to accept family assistance more readily (Page 1987, Richman 1984). Another dimension could relate to different coping styles between men and women. Living with mental illness is seen differently by men and women. Women with severe mental illness do not see their mental illness as the main feature of their identities (Ritsher 1997). There are significant sex differences in styles and dimensions of social adjustment in socialization –derived differences in relational styles across social roles, women manifest greater feelings of inadequacy regarding their instrumental role performace while men manifest greater inhibition in the expression of feelings and agressive styles in interpersonal relationships. In the role stress perspective, women express greater conflict and resentment than men in regard to marital, and family relationships, but

not in regard to friendship relationships. Women's subjective disinterest and impaired functioning in their role at work is greater for housewives than for employed women (Richman 1984).

Conclusion

Although research can demonstrate numerous differences between men and women with schizoprenia, these differences are not comprehensively undersood, and are not usually used in an individual treatment plan. Gender is composed of a broad range of biological, psychological, social and cultural processes. Men and women as persons are unique indviduals who differ in these characteristics. There are gender- identity difficulties observed in schizophrenia, particulary at the more uncounscious level. They are not specific for schizophrenia because they are also found in other psychiatric patients. Problems associated with gender can be a major sorce of instability and vulnerability for developing the first and later psychotic episodes. Understanding the gender issue will help the therapist to plan person focus treatment and understand that some behavior is not part of the psychopathlogy /illness but is related to gender development through psychological and social infulences. There is the need for further research to see sex differences through a gender perspective. Findings from gender studies may have utility for the development and differential treatment interventions for men and women and may improve the outcome of the illness in general.

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Correspondence:
Slađana Štrkalj Ivezić
Psihijatrijska bolnica Vrapče Zagreb
Bolnička c 32, 10090 Zagreb, Croatia
E-mail: sladjana.ivezic@bolnica-vrapce.hr