Mental Health, Gender and Structural Violence

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Abstract

Anxiety disorders and depression are common diagnoses in the Western world. Authors define them as common mental disorders, and researches have indicated a high correlation between their appearance and socioeconomic conditions, such as gender, poverty and low education level, amongst others. This paper analyzed the symptoms and diagnoses found in medical records of male and female patients from two large psychiatric hospitals in the Federal District of Brazil. We examined 72 male records and 165 female records. The frequency of the symptoms was registered, as well as the diagnoses. It was observed that 27.5% of male and 59.6% of female diagnoses may be considered as common mental disorders. Furthermore, the biometric profile shows the prevalence of maidservant, poor, black women as the main users of such services. This paper questions if such diagnoses point clinical conditions or a medicalization of social issues has occurred.

Key words: Mental health. Community psychiatry. Feminism.

Resumo

Saúde mental, gênero e violência estrutural

Transtornos de ansiedade e depressão são diagnósticos frequentes no mundo ocidental. Autores os definem como transtornos mentais comuns e pesquisas têm apontado alta correlação entre seu aparecimento e condições socioeconômicas tais como gênero, pobreza e baixa escolaridade, dentre outras. O presente artigo fez uma análise dos sintomas e diagnósticos encontrados em prontuários de pacientes homens e mulheres de dois grandes hospitais psiquiátricos do Distrito Federal. Foram analisados 72 prontuários masculinos e 165 femininos. A frequência dos sintomas foi contabilizada da mesma maneira que os diagnósticos. Observou-se que 27,5% dos diagnósticos masculinos e 59,6% dos femininos podem ser considerados transtornos mentais comuns. Além disso, o perfil biométrico levantado aponta para a prevalência de mulheres, negras, pobres e domésticas como usuárias destes serviços. Discussão: questiona-se se tais diagnósticos apontam para um quadro médico ou se o que está ocorrendo é uma medicalização de mazelas sociais.

Palavras-chave: Saúde mental. Psiquiatria comunitária. Feminismo.

Resumen

Salud mental, género y violencia estructural

Trastornos de ansiedad y depresión son diagnósticos frecuentes en el mundo occidental. Autores los definen como trastornos mentales comunes y las investigaciones han demostrado alta correlación entre su aparecimiento y condiciones socioeconómicas, tales como género, pobreza y baja escolaridad, entre otras. El presente artículo hizo un análisis de los síntomas y diagnósticos encontrados en los historiales de pacientes hombres y mujeres de dos grandes hospitales psiquiátricos del Distrito Federal. Fueron analizados 72 historiales masculinos y 165 femeninos. La frecuencia de los síntomas fue contabilizada de la misma manera que los diagnósticos. Se Observó que el 27,5% de los diagnósticos masculinos y el 59,6% de los femeninos pueden ser considerados trastornos mentales comunes. Además, el perfil biométrico planteado señala la prevalencia de mujeres, negras, pobres y empleadas domésticas como las usuarias de estos servicios. Discusión: se cuestiona si dichos diagnósticos señalan hacia un cuadro médico o si lo que está ocurriendo es una medicación de enfermedades sociales.

Palabras-clave: Salud mental. Psiquiatría comunitaria. Feminismo.

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Philipps and First point out how much Gender is a window for understanding mental illness. According to them, in recent publications, the Institute of Medicine has emphasized the importance of considering sex/gender for understanding such “illness”. And they state that gender might virtually affect all aspects of psychopathology, including the prevalence of mental disorders, the way how symptoms are expressed, the disorder course, the search for treatment by patient and improvements with treatment[1]. What is, therefore, Gender and its relations?

The concept of gender first appeared with the feminist movement as a description and analysis category for social interactions against the assumed biological determinism in the use of terms like “sex” or “sexual difference”[2]. When used, such terms would reduce the analysis of the subject to the differences between bodies, especially regarding genitalia. Casares[3] addresses how the sense of the term has changed throughout history. If in the beginning it would refer to the study on women and their specificities, this term has increasingly become relational. Thus, the expression gender relations with the meaning of values and social roles related to men and women started to be used.

Such roles and values are relational, asymmetrical and totally tangled. As a basic principle, gender relations are influenced by power. In our culture, gender is set by western societies’ patriarchal system, in which women have been historically sidelined[4]. Examples of roles and values assigned to genders can be easily given.

Gender Invisibility

A recent four years research[5-7] with subjects of various ages and social classes has raised several valued categories for each gender. In women, it was found a sexual behavior oriented by resignation and modesty, that is to say, features of a relational nature and qualities related to self-denial and cares for others, as well as body care in the sense of searching for an aesthetic ideal. In men, the following categories were found: active sexual behavior (sexually virile), traits of a self-investment nature, that is, in our culture "a real man" must be a “womanizer” and also hard-working, preferably successful, considered as the traditional "provider".

Another paper[8] demonstrates how such values are present in mental suffering and speech of the patient under psychiatry. These values and roles are regarded as limits for self-judgment, directly affecting narcissism and self-esteem, as well as becoming constitutive. It is important to develop research on them, as well as consider them in the forms of intervention, especially when one thinks about the effectiveness of interventions[9].

Reflecting about gender means not taking some differences as natural and intrinsic, whose biologization would lead to its rectification and assumption of inevitability. It is more evident in the field of mental health, in which the brain-oriented[10] and biological speeches are strengthened and social matters can be ignored and medicalized. Further readings about mental health under the concepts of gender relations lead, therefore, to other reflections and understandings on how much madness can be engendered [8,11].

Philipps and First[1] point out that Gender Studies may contribute to the understanding of at least two important issues regarding mental health: epidemiology and ethology of disorders. Regarding epidemiology, the reason of a larger incidence of depression in women all over the world is questioned (from 2 to 3 cases for each one in men). There are two scientific thoughts that explain this phenomenon. One, of a biological nature has been growing over the last decades. From this perspective, the predominance of depression in women would be caused by hormones specificities[12-15]. At the same time, the social-historic thought that concerns material and existential conditions as promoters of psych suffering and worsening, has been demonstrating how much risk factors related to depression are engendered. They refer to greater poverty, lower education indexes, very low incomes, violence (physical, sexual, spoken, etc.), a pattern adopted by the

World Health Organization (WHO).

Regarding ethology, all specificities of bodies and their differences are being questioned, and also besides that, the interaction of such differences and the distinct engendered roles and social positions that subjects hold in society. The background of these researches has been the concept of brain plasticity and also the correlation among some phases of child development and a greatest vulnerability in some psychopathological pictures in adulthood. However, some distinguished risk factors are highlighted for boys and girls, that is, social issues that occur most frequent with one gender, such as how would child abuse occur among girls and boys[16].

Another important issue regarding the mental health field under the concept of Gender, concerns about the clinical eye that evaluates the patient. Our points of view are settled by Gender values, becoming a determining factor for the hermeneutic activity when reading symptoms. We tend to judge and evaluate from certain ideal standards, culturally included and established. On the other hand, even when symptoms are pathoplastic, their forms of expression are also engendered.

For instance, it is more common to find a tearful woman than a tearful man, as well as an aggressive man than an aggressive woman instead. Thus, it seems like our tolerance level for determining a behavior of disproportionate crying and aggressiveness would be different between male and female patients. Such fact has been leading academics to state the need of developing different diagnosis criteria for men and women. What can be realized in some researches is the trend towards hyperdiagnosis of certain syndromes in women and the sub-diagnosis in men (such as in depression), and also de contrary for other disorders. It would depend, therefore, on symptoms choice and description, selected for composing the syndrome picture.

If symptoms are engendered, by choosing and gathering them in syndromes, the diagnosis in women or men might be favored. In summary, if symptoms occur in an engendered way, it is necessary to rethink about the disorder expression and the need of creating different diagnosis criteria for men and women that consider gender roles and values. And more seriously, regarding currently known disorders, it is not known whether this reading would lead to a new epidemiological survey with different prevalence of disorders or not. Whether one likes it or not, it is mainly necessary to train the clinical view in order to make it critical about its own gender values that are ignored in the diagnosis.

Concerning the changes that such aspects would bring for the epidemiological survey on mental disorders itself, Grant and Weissman state that:

When considering the possible differences of gender, the failure is in the way how psychiatric disorders occur and how they are expressed, significantly complicating the estimation of prevalence rates valid in epidemiological studies, due to possible views in diagnosis criteria. Future research on epidemiology must focus the empirical identification of diagnosis criteria skewed by gender[19].

According to Morgado and Coutinho[20], epidemiological data on mental health only make sense if interpreted under the factors that determine them. However, gender has been still underestimated in mental health studies. It can be realized in the history itself of DSM (Diagnostic and Statistical Manual of Mental Disorders)[21]. In DSMs, Widiger[22] points out small changes in relation to gender:

- *DSM I*

In the first edition, the gender of patients was incorporated, amongt many other items, with recommendation for inclusion. However, no real findings related to genders, such as proportion among them was related.

- *DSM II*

It included information about the proportion of disorder between genders, but only in the Group Delinquent Response during

childhood. Comments about the difference between genders of the disorder expression have also emerged. Nevertheless, no other information about gender was provided for any other diagnosis, even those that are reasonably applicable to one only gender, such as postpartum psychosis.

- *DSM III*

More focused on Gender, although information would be still limited. The relating frequency with which a disorder was diagnosed in men and women was provided and a section specifically dedicated to proportions between genders was created. Occasionally, additional information specific to gender about the course or occurrence of the disorder were provided in other excerpts. For some disorders it was simply admitted that there are no available information about gender. For the first time, in some disorders cases, different criteria for men and women were included, such as gender identity disorder in childhood and inhibited sexual arousal.

Several controversies have arisen with DSM III-R, especially regarding the creation of the Late Luteal Phase Dysphoric Disorder (LLPDD). Criticisms indicated the possibility of misuse of such diagnosis "against" women. DSM IV kept including a section specifically dedicated to proportion between genders, however with more precise data. LLPDD has become a Premenstrual Dysphoric Disorder (PMDD). This version has expanded the text of the manual, including additional information about how disorders vary in terms of expression and course between genders. Information about proportion between genders were tabbed in an extensive way, concerning lack of consistency regarding the quantity and quality of information. There were systematic reviews of bibliography, leading to changes in proportion among men and women regarding incidence in relation to the controversial DSM III-R. DSM IV-R also included possible explanations for some of the related proportions between genders: a) the appearance of the possibility that some findings could be originated from inaccurate evaluations; b) these proportions could derive from age differences among surveyed individuals (development factor); c) there could be differences among women and men regarding symptoms report or search for treatment; d) there could be differences about environment; e) and differences could be cultural[22].

The brief above described scenario demonstrates that the invisibility in gender category remains as a determining factor and/or a conditioning illness. Although this situation has been gradually changing through gender incorporation in mental disorders characterization, this issue is worth deep reflecting and discussing, a gap that this paper has intended to fill.

Methods

Aiming at the importance of qualifying gender as an essential pattern, not only to serve as basis for future researches but also to review the mental health field itself, this paper targeted in raising symptoms and diagnosis, as well as social conditions of male and female patients, users of mental healthcare services in the Federal District (DF).

Two large reference hospitals of the area were chosen and data were gathered from medical records of patients that have been there over the last three decades. The file was very damaged, as well as medical records, in such a way that only preserved and readable copies were selected. The research was approved by the Ethics Board of the Health Secretariat of the Federal District Government. In total and separately, 72 male and 165 female medical records were analyzed. Symptoms were one by one noted and afterwards counted, either in terms of frequency regarding the number of each gender patients or in view of the total number of symptoms found in the group of men/women. The same process was carried out with regards to diagnosis.

Results

Incidence of Symptoms and Diagnosis in Men

In the 72 male medical records, 290 symptoms were found, divided into 107 types (according to terms used by psychiatrists). Only 67 medical records could be analyzed because in five of them (7%) there was no pointed symptom.

The most regular symptoms by number of patients were: madness (27%); auditory hallucination (24%); aggressiveness (22,4%); anxiety (13,5%); suicidal ideation (13,5%); depression (13,5%); delirium (13,5%); isolation (12%); fear (12%); irritability (12%); sadness (12%); agitation (11%); tachycardia (9%); alcoholism (9%); inappetence (7,5%) and restlessness (7,5%).

The presence of certain “symptoms” pointed out in male medical records that do not appear in the female ones draws attention, such as “idleness”, sexual insecurity”, “difficulties in having sexual relations", "preoccupation about the sex life".

Regarding diagnosis, 34 medical records without details were found, that is to say, 48% of total medical records of male patients. In some cases, the presence of two or more (even five) different diagnosis for the same patient could be observed. In such cases, all of them were counted. In total, 70 diagnostics were found, divided into 24 types of disorders in the 38 medical records with this blank filled out.

The diagnosed disorders were gathered according to DSM criteria, presenting the following frequency: psychosis (44%); humor disorder (19%); anxiety disorder (8.5%); organic-based disorders (6,5%); cognitive deficit (6.5%); disorder caused by drugs use (5%) and personality disorder (2%). In some cases (8.5%), it was noted that the given diagnosis would receive the name of certain symptoms, such as “hetero-aggressiveness”.

Incidence of Symptoms and Diagnosis in Women

In the female medical records, 913 symptoms were found, divided into 174 types (according to terms used by psychiatrists). Only 162 medical records could be analyzed because in three of them (2%) there was no pointed symptom. Among the most regular symptoms (by number of patients), were found: madness (46%); anxiety (34%); sadness (28.5%); weeping feeling or uncontrollable and unmotivated weeping (25%); anguish (23.5%); irritability (23%); depression (19%); nervous tension (19%); aggressiveness (18%); headache (18%); social isolation (15.5%); auditory hallucination (14%); discouragement (14%); fear (12%); dizziness/ vertigo (12%); difficulties in relations (10%); inappetence (10%); pain/corpalgia (9%); psychomotor agitation (8%); suicidal ideation (7%); forgetfulness/ amnesia (7%) and restlessness (7%). The presence of certain “symptoms”, pointed out in the female medical records drew attention, some of which have appeared in the male ones, however with irrelevant frequency such as “troubles in relationships”, especially with the husband and family. Specific symptoms of this group were: “menopause”, “frustration for not being loved”, “hysterical sensitivity”, “frustration with family responsibilities", "manipulative", “rebel”, “jealousy”, “lack of emotional support”, “likes drawing attention”, “guilty”, “narcissistic personality”, “single mother”, “disinterest in household chores”, “distrust in the husband”, "emotional fragility”, "overweight”, “lack of or decreased libido”, “controlling party in affective relationships", "bitterness", amongst others.

Another important aspect concerns the occurrence of the “weeping" symptom that appeared only in one male medical record under the term “tearful”. In female medical records, “weeping” has occurred at a frequency of 25%, most of the times followed by an adjective that did not occurred at any circumstances in the male medical records, which is “unmotivated”. Besides that, an invisible incidence of diazepam addiction was observed. In four medical records, the addiction was listed as a symptom of the female patient. In the rest of them, it would appear as a comment on anamnesis.

Regarding diagnosis, 80 medical records with no indication of it were found, that is, 48% of total female medical records, a rate that is close to the incidence of male patients. In the same way as in male medical records, in some cases, the presence of two or more diagnosis for

the same female patient could be observed. Equally, all diagnostics were considered.

In total, 174 diagnostics were found, divided into 46 types of disorders in the 85 medical records in which the "diagnosis" section was filled out. They were gathered as per DSM classification criteria, with the following frequency: humor disorders (38.3%); psychosis (23.4%); anxiety disorders (15%); personality disorders (neurotic/ histrionic - 11%); mixed disorders of depression and anxiety (6.3%); cognitive deficits (4%) and organic-based disorders (2%).

Table 1 - Comparison between the relative frequency of symptoms occurrence by the total number of patients of each gender

Male Symptoms	Female Symptoms
Madness (27%)	Madness (46%)
Anxiety (13.5%)	Anxiety (34%)
Sadness (12%)	Sadness (28,5%)
Tearful (1.4%)	Weeping Feeling / Uncontrollable and Unmotivated Weeping (25%)
Anguish (2.8%)	Anguish (23.5%)
Irritability (12%)	Irritability (23%)
Depression (13.5%)	Depression (19%)
Nervous Tension (4.4%)	Nervous Tension (19%)
Aggressiveness (22.4%)	Aggressiveness (18%)
Headache (4.4%)	Headache (18%)
Social Isolation (12%)	Social Isolation (15.5%)
Auditory Hallucination (24%)	Auditory Hallucination (14%)
Discouragement (4.4%)	Discouragement (14%)
Fear (12%)	Fear (12%)
Dizziness / Vertigo (3.3%)	Dizziness / Vertigo (12%)
Difficulties in relationships (4.4%)	Difficulties in relationships (10%)
Inappetence (7.5%)	Inappetence (10%)
Pain/ Corpalgia (4.4%)	Pain/ Corpalgia (9%)
Psychomotor Agitation (11%)	Psychomotor Agitation (8%)
Suicidal Ideation (13.5%)	Suicidal Ideation (7%)
Forgetfulness/ amnesia (2.8%)	Forgetfulness/ amnesia (7%)
Restlessness (7.5%)	Restlessness (7%)
Alcoholism (9%)	Alcoholism (2%)
_	Dependence on diazepam (2.7%)

Significant percentage differences in the incidence of certain symptoms by gender can be realized. It is important to note among women the presence of madness, anxiety, sadness, weeping (unmotivated?), anguish, irritability, depression, nervous tension, discouragement, difficulties in relationships, pain (and dependence on diazepam, invisibilized). Many of them are part of what is considered "Common Mental Disorders (CMD), most diagnosed in women. Among men, comparatively, the highlights are aggressiveness, auditory hallucination, psychomotor agitation, suicidal ideation and alcoholism. Below the table comparing diagnosis between men and women is presented, with its respective frequencies.

Table 2 - Percentage of diagnostics assigned to men and women from analyzed medical records

Male Diagnostics	Female Diagnostics
Humor Disorders (19%)	Humor Disorders (38.3%)
Psychosis	Psychosis (23.4%)
Anxiety Disorder (8.5%)	Anxiety Disorder (15%)
Personality Disorder (2%)	Neurotic / Histrionic Personality Disorders (11%)
-	Mixed Depression and Anxiety Disorders (6.3%)
Cognitive Deficit (6.5%)	Cognitive Deficit (4%)
Organic-Based Disorders (6.5%)	Organic-Based Disorders (2%)
Disorder caused by drug use (5%)	-
Symptom Name (8.5%)	-

According to Andrade, Viana and Silveira[12], the incidence rates of disorders are different for men and women: women present larger rates of anxiety and humor disorders prevalence, while men present more prevalence of disorders associated to the use of psychoactive substances, including alcohol, disorders of anti-social and schizotypal personality, impulse control disorders and attention deficit, as well as hyperactivity in childhood and adulthood.

Goldberg and Huxley[23] propose that somatoform disorders of anxiety and depression must be considered as CMD, aiming their high incidence and frequency correlation with certain socioeconomic and life-style factors. Studies carried out by Ludermir and Melo Filho[24], Marin-Leon et al[25], Araújo, Pinho and Almeida[26] and Costa and Ludermir[27] point out rates of CMD prevalence in the studied population that may reach more than 30%. CMD symptoms would be mainly madness, fatigue, irritability, forgetfulness, difficulties in concentrating and somatic complaints[28]:

The social character of the mental illness is objectively expressed in its unequal distribution among men and women, as well as different social classes. Such inequalities represent a persistent finding in bibliography. Several authors have been finding high prevalence of common mental disorders (CMD) in women, in the ones excluded from the formal job market, in individuals of low income and in the ones of low-literacy levels[29].

According to Araújo, Pinho and Almeida[26], among mental disorders that predominate in women, besides depressive symptoms, there are the ones related to psycho-social and environmental factors: anxiety and adjustment disorders, madness, stress, eating disorder and anorexia nervosa.

Considering the definition of CMD, one can raise the possibility that among male medical records, the incidence of these

disorders (in the set of medical records with diagnosis) was of 27.5%. Among women, the incidence can be even greater, around 59.6%. Such information finds support in papers that demonstrate gender as an important factor, while social conditions in the pictures of common mental disorder. In this respect, they occur more frequently in women than in men.

Other risk factors, also pointed out by bibliography would be age (in the case of the older ones), skin color (black), marital status (divorced or widow), low income, low education level, unemployment or informality in work relations, submission to violence (physical and sexual), having children, having no time for leisure, etc. In summary, according to researchers, common mental disorders designate situations of mental suffering.

These data rose the questioning about high frequency of non-fulfillment of diagnostics in the medical records of patients (almost 50% in both genders). Would this situation be caused by neglect, lack of time and troubles with identifying problems of life, daily routine and social conditions of suffering? We believe that the empty space, more than silence, would express an implied speech, whose senses should be revealed. Would it be the confession of certain impotence? In this case, there are no studies to raise questions about the reasons why doctors, at a high level, do not provide diagnostics.

In parallel, little space for the qualification of the mental suffering of patients was found, even more evident if considering the short period of time dedicated to evaluation. In reception, the time spent is in average three minutes, proven by other observation[30]. In evaluation, performed in the evolution, the estimated time for each patient is in average one minute[31]. It was wondered if the adjective "unmotivated", added to the "weeping" symptom would not point out the lack of knowledge and qualification by the psychiatrist about the patient psychic suffering. Besides, concerning weeping motivation, who is able to judge whether it is enough or not? In several female medical records, where the "unmotivated weeping" symptom was found, it is possible to observe important aspects that were summarized in anamnesis: "it gets better when the husband is travelling" and "it got worse after marriage".

Another important fact concerns how often "relationship problems" appear in female medical records, either as symptoms or in the anamnesis description.

There is another research[8], also carried out in the public mental care service of the Federal District, that has identified high levels of occurrence of marital troubles, as well as in relationships (27%), family problems (40%), and also physical, verbal and sexual violence in female patients.

Having occurred more frequently in men than in women, it is necessary to highlight the appearance of alcoholism symptom, even if the hospital in question was not focused on addiction treatment. Such fact meets epidemiological surveys that point out the preponderance of alcohol addiction among men. Additionally, the hidden diazepam addiction was perceptible in women. It should be noted that such data are in accordance with bibliography, demonstrating an exacerbate legal chemical dependency still little discussed in this class of population[18,31-34].

Possible of being demonstrated in another study[11], this difference indicates the deep ideological perversion of the system that considers alcoholism as a disease to be treated (currently in CAPSads, centers for psychosocial care for users of alcohol and drugs), however developing legal chemical dependency among women as a solution for their lives. Alcohol would be a "drug" while diazepam and other benzodiazepine types "medicines", both with the depressor effect that "calms people down".

In the case of men, alcohol addiction would prevent them of taking their social roles ahead, especially the one that makes them the provider worker that, as previously seen, is essential for their social classification. This, when taken in excess, must be combated. In parallel, diazepam would enable women to keep fulfilling their social roles, providing them peace and gentleness for performing their chores, taking care of their children, husband, accepting

mistreatments and double work shifts, even submitting themselves to violence situations.

Therefore, it is essential for us to rescue the daily routine and the lifestyle of these people, under the penalty of silencing social evils of gender, race and poverty, from the point of view of a science regarded as neutral and impartial. For this purpose, it is necessary to be aware of the socio-demographic features of the public mental care users, as well as their life specificities.

As previously stated, the CMDs identified in this paper are highly correlated with such features, being part of the objective that guided this research.

Discussion

The user's profile: Structural Violence

The first fact to be shown is the difficulty of raising the user profile regarding mental health, personal characteristics (such as race, age) and socio-demographic data (income and profession). The main reason is the non-fulfillment of the record, either when the patient arrives the hospital or in its medical record. Besides, there were cases in which characteristics would receive different classifications, even of opposition nature (white woman / brunette woman).

In the same way that blank spaces were provided by doctors regarding diagnosis, the absence of data must be also treated in the light of a deep reflection and the interpretation of such practice shall be better investigated. It is believed that, regarding data to be collected about the patient, there is a differentiated appraisement of professionals that work there. In the reception, data about the conditions of the patient, or a short anamnesis are rarely left blank. In paralell, personal characteristics (physical, familiar, professional occupation, religious, etc.) whose socio-demographic indicators are highly significant for the reflection on CMD are left aside.

One may think that there is a comprehension based on the "picture" of the patient as a mental "disease". In other words, one may assume a biomedical model, reducing mental and social factors to cerebral or physical factors, describing what Azize[10] classified as physicalist cerebralism. It is not by chance that most of the "healing" interventions performed by these institutions may be summarized into the administration of medicines[9,35] and supression of symptons[31]. Despite the found limitations and as far as possible, a survey was conducted on the general data of users from the mental healthcare system of the Federal District.

The first analyzed variable concerns the gender of the patient. From the 237 analyzed medical records, 167 (70%) covered female patients and only 30% covered male patients. This proportion surely is far from the one indicated by IBGE (Brazilian Institute of Geography and Statistics) in 2010 Census, which concluded that, despite women represent the majority of puplation in the country, they are slightly more than 50% of total inhabitants, that is to say 51,03%. The presented information indicates, therefore, that in the analyzed treatment centers, the majority of population belongs to the female gender[37]. It seems to indicate direct relations with social roles, social status and power of women in society.

As previously seen, almost 60% of diagnosed disorders of this sector may be regarded as CMD, highly correlating with social-demographic risk factors.

Regarding the origin of the patient (birthplace), such information could be found in 204 medical records. The result was quite impressive: more than 80% of medical records registered patients from cities of the Notheast area. It is well-known that this is one of the poorest areas of Brazil, from where comes the migratory mass of cheap labor, becoming part of more industrialized areas.

Regarding the current place of residence of patients, 224 filled medical records were found. In average, 60,7% of the hospitalized patients lived in Taguatinga, Ceilândia and Samambaia. Supporting hypothetical social-demographic conditions regarding the origin of migrant users, the predominance of patients with more restricted life conditions could be observed in these data.

The age of patients seems to be well-distributed over the interval, varying from 23 to 84 years-old, with the register of birth year from 1928 and 1989. However, comparing this average with data from 2010 Census of IBGE[36], one can conclude that, in fact, the sampled patients are in higher age groups, that is, they are older than the population of Brazil as a whole[37]. Besides, the average age of women is higher if compared with men's.Carvalho and Coelho[38] point out the high rate of depression diagnosis among fourty to sixty years old women. According to the authors, such association is usually related to hormonal changes and the self-image of menopausal women. However, little is heard about these women lives. Regarded by the authours as one of the usual factors that occur in this populational group, there is violence vulnerability, mainly when coming from close people or family (husband, children, etc.). According to Mendonça, Carvalho Vieira and Adorno[39], after the fourties, the use of mental healthcare services becomes more intense among women. This research highlights that the most usual complaints registered in medical records of older women were sadness, depression, anxiety, madness and nervous tension. For the authors, elderly women starts to face conflicts and day-to-day issues through the use of medicines, intensifying the consumption of tranquilizers and in many cases developing legal addiction. Family conflicts almost never come to the doctor, only symptoms[39]. In this respect, the procedure is to medicalize the social factor, either the professional side or the own patients demand[11].

According to Galvão and cooperators[40], in a study about the prevalence of common mental disorders and the assessment of life quality in menopause, a high correlation of the occurrence of such disorders and factors like family income, education, occupation and physical activities practice was observed. One of the essential aspects is the significance of the social pattern for determining the occurrence of common mental disorders and life quality related to healthcare[40]. According to these authors, CMD results are higher in women of low education levels, low family income self-declared as "housewives", which is the case of many women herein studied.

Regarding the subject of occupation (only 57 medical records containing such information), most of women would be housewives (33%) or domestic workers (14.4%). It means that almost 50% of them are devoted to household routines. Araújo Pinho and Almeida state that among aspects regarding household labor associated with depressive, anxious or psychosomatic symptoms, the highlights are routinization and constant interruptions of the performed chores[41]. Porto[42] discusses the danger of considering such signs in a pathologic manner.

In these authors point of view, one of the reasons of psychic suffering related to household activities is the social invisibility deriving from the perception itself of this kind of activity, which is not considered work, once it does not produce value and there is no either social recognition or remuneration. Additionaly, suffering derives from tensions created by its characteristics of monotony, repeatability, depreciation and demands of social roles that women need to perform. The daily living of such tensions, accumulated over time, may therefore compact different ways of psychic illness.

Araújo Pinho and Almeida[26] would still observe that women overburdened with domestic work would present a higher CMD prevalence (48.1%) if compared to the ones with lower overburden (22.5%). It is worth highlighting that the difference between these two percentages concerns the amount of activities that, in both cases, is classified as overload. Additionally, it was not only about the activity itself, but also its disqualification.

Other important features were pointed out for CMD settings, such as low education level, skin color (black or brown), absence of partner due to widowhood or divorce, low income level and lack of leisure time.

Among women, besides domestic workers and housewives, the predominance of activities culturally considered as female was found regarding service and care, such as kitchen helper, auxiliary nurse, seamstress,

catering services provider, teacher, etc. Among men, activities culturally related to the gender were also found, such as electrician helper, air traffic employee, trader, waiter, gardener, mechanical, driver, etc.

Another important information regards the number of unemployed patients found in the sample: 17% of men and 14% of women. Unemployment is a risk factor for mental health, being highly correlated with CMD, especially when the economic condition of the family is precarious, resulting in severe financial difficulties. However, unemployment is a higher risk factor for men[43].

Such fact propably happens due to different values and roles of genders that classifies the "essence" of a man according to his productive capacity at work. A study mentioned in our references[8] has shown the importance of such value in the speech of hospitalized patients. It is also worth highlighting the appearance of the symptom "idleness" in male medical records, maybe suggesting that this value is not only of the patient himself, but also of the doctor in charge of the case. In women, even though many of them were not working, this symptom was not identified in any record. In parallel, the symptom "disinterest in household chores" that also suggests gender criterium for evaluating the patient status was found.

Regarding education levels (141 answered medical records) it was found 62% of patients that have completed the basic education only: 60% of women and 67% of men. Therefore, in average, the education level is low, resulting in little expectancy of social mobility, worse employment opportunities and greater chances of low remmuneration. As previously outlined, many authors point out the inverse association between education level and mental health[24,28].

Data on the patient skin color are extremely scarce. From the 237 medical records, 165 (almost 70%) do not mention skin color. From the 73 records containing such information in a valid way, in 37 of them (51%) the patient was classified as brown, in 28 (almost 40%) as white and in 8 (11%) as black. One can suggest, therefore, that the majority of users (62.50%) consists of the non-white (black and brown), not representing the populational percentage of the Federal District disclosured by IBGE, that is to say, in such institutions there is a predominance of non-white people.

Regarding the number of children, 74% of the medical records did not present such information. In the other 26% there was an average record of two kids, characterizing small families. However, in this respect, the scarcity of valid medical records makes this statement harder.

The most serious case of data omission is correlated with the most important factors in terms of CMD: income level and material conditions of patients. Information about income and housing conditions could not be used. The number of omissions surpassed 90% of total data, impeding patients profile to be described in these terms. Such information is extremely important because it demonstrates the low or absent concern of professionals reagarding material conditions of users, as well as the big chance of medicalizing social problems.

The association between income and CMD is one of the most studied and consistent facts in bibliography[24]. Such information (in fact lack of information) points out how much social conditions of people are not considered in their psychic suffering. Suffering is targeted and treated as "disorder" (in analogy with physical disease), in such a way that the search for symptoms is overestimated and the person subjectivity and reality is little qualified. In view of these "blank gaps" in medical records, one question persists in breaking the silence: What are we effectively medicating?

Final Considerations

We agree with Farmer, whose point of view is that *those victims shared in the past and keeps sharing (...) the experience of occupying the lowest position in the social scale of unequal societies.* This is what seems to be pointed out by this study regarding the biometric profile: the average patient is a non-white woman,

domestic worker or housewife, with low level of education. According to the author, it is essential to describe the social conditions of suffering, that is to say, to understand it as a stage of structural violence[44].

Farmer states that *while some ways of suffering are promptly notable, also topics of several movies, novels and poems, the structural violence very often defeats those who could describe them*[45]. It occurs for three reasons: 1) the exotization of suffering, *implying that individuals whose lives and difficulties remit to our own lives, tend to stir us; the suffering of those who are distant, either for geographical, gender, racial or cultural factors, may sensitize us less*[45]*;* 2) the existence of great amounts of suffering, even more difficult to be understood (numbers overshadow anonymous aspects of sufferers); 3) the dynamics and distribution of suffering are still superficially comprehended.

In the author's point of view, besides epidemiological statistics, a solid analysis should be historically deep, covering factors like gender, ethnicity (race) and economic conditions, once such factors develop circumstances that let individuals more vulnerable to suffering.

The poor ones, as well as women and black people are not only more vulnerable to suffering, but they also run the risk of counting on the silence of the rich ones. It is necessary, therefore, to think about some mechanisms through which social forces at a large scale can crystallize the aspects of individual suffering.

Such suffering is structured by historical processes (usually guided by economics), as well as by forces that most of the time conspire through social-cultural constraints. For many, life choices have been structured by racism, sexism, political violence and constant poverty[45]. It is strongly necessary to put into practice the Universal Declaration on Bioethics and Human Rights (Unesco) [46], which says that in the application and enhancement of the scientific knowledge of medical practice and technologies that are associated with it, human vulnerability shall be taken into consideration. Individuals and groups particularly vulnerable must be protected, respecting the personal integrity of the individual concerned. To rescue the voice of the patient and to qualify his speech is only one first and shy step[47]. As constantly possible of being perceived, the experience of suffering is not effectively reached by statistics and graphics. The texture of extreme affliction may be further felt in little biographic details[48]. Additionally, it is necessary to rethink about our practices and to reword the concept of interventions, once social determinants of mental illness point out specific challenges for the development of public policies on health[24], so that under the auspices of a supposed science we do not perform a new way of committing violence.

References

1. Phillips KA, First MB. Introdução. In: Narrow WE, First MB, Sirovatka PJ, Regier DA, organizadores. Gênero e idade: considerações no diagnóstico psiquiátrico. Agenda de pesquisa para DSM V. São Paulo: Roca; 2008. p. 2.
2. Scott J. Gênero: uma categoria uti para análise histérica. Revista Educação e Realidade. [internet]. 1980;15(2):5-22. [acesso 12 dez. 2010] Disponivel: http://www.dhnet.org.br/direitos/textos/generodh/genfcategoria.html
3. Casares AM. Antropologia del gênero: cultura, mitos e estereótipos sexuales. Madri: Cátedra; 2008.
4. Lima BS. Violência de gênero nas ciências: corpo, violência e poder. In: Seminário Internacional Fazendo Gênero 8: Corpo, Violência e Poder; 25-28 ago. 2008; Florianópolis [internet]. Florianópolis: UFSC; 2008 [acesso 13 jan. 2011]. Disponível: http://www.fazendogenero.ufsc.br/8/sts/ST38/BeatnafStefanelloJLimaf38.pdf
5. Zanello V, Gomes T. Xingamentos masculinos: a falência da virilidade e da produtividade. Caderno Espaço Feminino. 2010;23(1-2):265-80.
6. Zanello V, Romero AC. Vagabundo or vagabunda: swearing and gender relations. Labrys. [internet]. 2012; 22 [acesso 12 jul. 2012]. Disponivel: http://www.tanianavarroswain.com.br/labrys/labrys22/libre/valeska2.htm
7. Zanello V, Bukowitz B, Coelho E. Xingamentos entre adolescentes em Brasília: linguagem, gênero e poder. Interações. 2011;7:151-69.
8. Zanello V, Bukowitz, B. Insanity and culture: an approach to the gender relatiins in the speeches of psychiatrized patients. Labrys. [internet] 2011 [acesso 2 mar. 2012];20-21. Disponivel: http://www.tanianavarroswain.com.br/labrys/labrys20/bresil/valeska.htm
9. Zanello V, Souza G. More music, less haldol: an experience among music, phármakon and madness. Mental. [internet]. 2009;7(13). [acesso 2 mar. 2012] Disponível: http://pepsic.bvsalud.org/pdf/mental/v7n13/v7n13a09.pdf
10. Azize RL. A nova ordem cerebral: a concepção de 'pessoa' na difusão neurocientífica [tese] [internet]. Rio de Janeiro: UFRJ; 2010 [acesso 12 fev. 2012]. Disponível: http://teses2.ufrj.br/Teses/PPGASJD/RogerioLopesAzize.pdf

11. Zanello V. Loucura e mulheres: questões de gênero para a psicologia clinica. In: Zanello V, Stevens C, Almeida T, Brasil K, organizadoras. Gênero e feminismos: convergências (in)disciplinares. Brasília: Ex Libris; 2010. p. 307-20.
12. Andrade LHSG, Viana MC, Silveira CM. Epidemiologia dos transtornos psiquiátricos na mulher. Rev Psiquiatr Clin. [internet]. 2006;33(2):43-54. [acesso 22 set. 2000] Disponível: http://www.scielo.br/pdf/rpc/v33n2/a03v33n2.pdf
13. Andreatini R, Lacerda R, Filho D. Tratamento farmacológico do transtorno de ansiedade generalizada: perspectivas futuras. Rev Bras Psiquiatr. [internet]. 2001;23(4):233-42. [acesso 28 set. 2009]. Disponível: http://www.scielo.br/pdf/rbp/v23n4/7172.pdf
14. Vieira EMA. A medicalização do corpo feminino. Rio de Janeiro: Fiocruz; 2002.
15. Cordasv TA, Salzano FT. Saúde mental da mulher. São Paulo: Atheneu; 2006.
16. Angold A, Heim CM. Perspectiva de desenvolvimento com foco em trauma infantil. In: Narrow WE, First MB, Sirovatka PJ, Regier DA, organizadores. Gênero e idade: considerações no diagnóstico psiquiátrico. Agenda de pesquisa para DSM V. São Paulo: Roca; 2008. p. 78-98.
17. Grant B.F, Weissman MM. Gênero e prevalência de transtornos psiquiátricos. In: Narrow WE, First MB, Sirovatka PJ, Regier DA, organizadores. 0p. cit. p. 28-44.
18. 0liveira EN. Saüde mental e mulheres: sobrevivência, sofrimento e dependência. Sobral: Ed. UVA; 2000.
19. Grant BF, Weissman MM. 0p. cit. p. 42.
20. Morgado AF, Coutinho ESF. Dados de epidemiologia descritiva de transtornos mentais em grupos populacionais do Brasil. Cad Saúde Pública [internet]. 1985;1(3):327-47. [acesso 28 set. 2009] Disponível: http://www.scielosp.org/pdf/csp/v1n3/v1n3a06.pdf
21. Associação Americana de Psiquiatria. DSM IV C Manual diagnóstico e estatístico de transtornos mentais [internet]. 4† ed. Porto Alegre: Artmed; 2000. [acesso 2 jun. 2012]. Disponível: http://www.psiqweb.med.br/dsm/dsm.html
22. Widiger T. Abordagem ao Diagnosic and Statistical Manual of Mental Disorders quanto ao gênero: histeria e controvérsias. In: Narrow WE, First MB, Sirovatka PJ, Regier DA, organizadores. Op. cit. p. 18-28.
23. Goldberg DP, Huxley P. Common mental disorders: a biosocial model. London: Routledge; 1992.
24. Ludermir AB, Melo Filho DA. Condições de vida e estrutura ocupacional associadas a transtornos mentais comuns. Rev Saúde Pública. 2002;36(2):213-21.
25. Marin-Leon L, Oliveira HB, Marilisa BAB, Dalgalarrondo P, Botega NJ. Social inequality and common mental disorders. Rev Bras Psiquiat. [internet]. 2007;29(3):250-3. [acesso 22 set. 2009] Disponível: http://www.scielo.br/pdf/rbp/v29n3/2367.pdf
26. Araújo TM, Pinho OS, Almeida M. Prevalência de transtornos mentais comuns em mulheres e sua relação com as caracteristícas sociodemográficas e o trabalho doméstico. Rev Bras Saüde Matern Infant. [internet]. 2005;5(3):337-48. [acesso 28 fev. 2009] Disponível: http://www.scielo.br/pdf/rbsmi/v5n3/a10v5n3.pdf
27. Costa AG, Ludermir AB. Transtornos mentais comuns e apoio social: estudo em comunidade rural da Zona da Mata de Pernambuco, Brasil. Cad Saúde Pública. 2005;21(1):73-9.
28. Ludermir AB. Desigualdades de classe e gênero e saúde mental nas cidades. Physis. 2008;18(3):451-67.
29. Ludermir AB. Op. cit.:451.
30. Pacheco J. Representação social da loucura e práticas sociais: o desafio cotidiano da desinstitucionalização [tese]. Brasília: Universidade de Brasília; 2011.
31. Zanello V, Macedo G, Romero AC. Entrevista de evolução: entre a doença mental e a medicalização. Mental. 2012;8(16):621-40. [acesso 7 jun. 2012] Disponível: http://issuu.com/zeppelini/docs/rmpv9n17
32. Ribeiro CS; Azevedo RCS; Silva VF; Botega NJ. Chronic use of diazepam in primary healthcare centers: user profile and usage pattern. São Paulo Med J. [internet]. 2007;125(5):270-4. [acesso 22 set. 2009] Disponível: http://www.scielo.br/pdf/spmj/v125n5/03.pdf
33. Carvalho R, Dimenstein M. A mulher, seu médico e o psicotrópico: redes de interfaces e a produção de subjetividade nos serviços de saúde. Interações [internet]. 2003;8(15):37-64. [acesso 20 fev. 2012] Disponível: http://pepsic.bvsalud.org/pdf/inter/v8n15/v8n15a03.pdf
34. Carvalho LF, Dimenstein M. O modelo de atenção a saúde e o uso de ansiolíticos entre mulheres. Estud Psicol (Natal) [internet]. 2004; 9(1):121-9. [acesso 28 set. 2009] Disponível: http://www.scielo.br/pdf/epsic/v9n1/22388.pdf
35. Gebrim S, Zanello V. A loucura entre grades e perdas de identidade. Psicologia do Iesb. [internet]. 2010;2(1):26-36. [acesso 2 mar. 2011] Disponível: http://php.iesb.br/ojs/index.php/psicologiaiesb/aricle/view/24/27
36. Instituto Brasileiro de Geografia e Estatística. Censo 2010 [internet]. [acesso 8 jun. 2012]. Disponível: http://www.ibge.gov.br/home/estatistica/populacao/censo2010/default.shtm
37. Silva RM. Raça e gênero na saúde mental do Distrito Federal. Brasília: Editora CRV; 2011.
38. Carvalho IS, Coelho VL. Mulheres na maturidade: histórias de vida e queixa depressiva. Estud Psicol (Natal). 2005;10(2):231-8.
39. Mendonça RT, Carvalho ACD, Vieira EM, Adorno RCF. Medicalização de mulheres idosas e interação com consumo de calmantes. Saúde Soc. 2008;17(2):95-106.
40. Galvão LL, Farias MC, Azevedo PR, Vilar MJ, Azevedo GD. Prevalência de transtornos mentais comuns e avaliação de qualidade de vida no climatério. AMB Rev Associ Med Bras. 2007;53(5):414-20.
41. Araújo TM, Pinho OS, Almeida M. Op. cit:338.
42. Porto D. Trabalho doméstico e emprego doméstico: atribuições de gênero marcadas pela desigualdade. Rev Bioét (Impr.). 2008;16(2):287-303.
43. Shearm K, Halmi K, Widiger T, Boyce C. Gênero e fatores socioculturais. In: Narrow WE, First MB, Sirovatka PJ, Regier DA, organizadores. Op. cit. p. 63-77.
44. Farmer P. On suffering and structural violence: a view from below. In: Vincent J, editor. The anthropology of politics: a reader in ethnography, theory and critique. Oxford: Blackwell; 2002. p. 424-37.
45. Farmer P. Op. cit. p. 435.
46. Organização das Nações Unidas para a Educação, a Ciência e a Cultura. Declaração universal sobre bioética e direitos humanos [internet]. 2005 [acesso 2 jun. 2012].

Disponível: http://unesdoc.unesco.org/images/0014/001461/146180por.pdf
47. Santos AMCC. Articular saüde mental e relações de gênero: dar voz aos sujeitos silenciados. Ciênc Saúde Coletiva. 2009;14(4): 1177-82.
48. Farmer P. Op. cit. p. 425-6.

Authors' Participation

René Silva carried out the biometric survey and Valeska Zanello conducted the frequency analysis of symptoms and diagnosis by the gender of patients. The authors have equally participated on the paper's production.

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