Genere e prevenzione in salute mentale

Dr. Carla Comacchio, PhD

Aulss 9 Scaligera - Direttore: dott. G. Imperadore

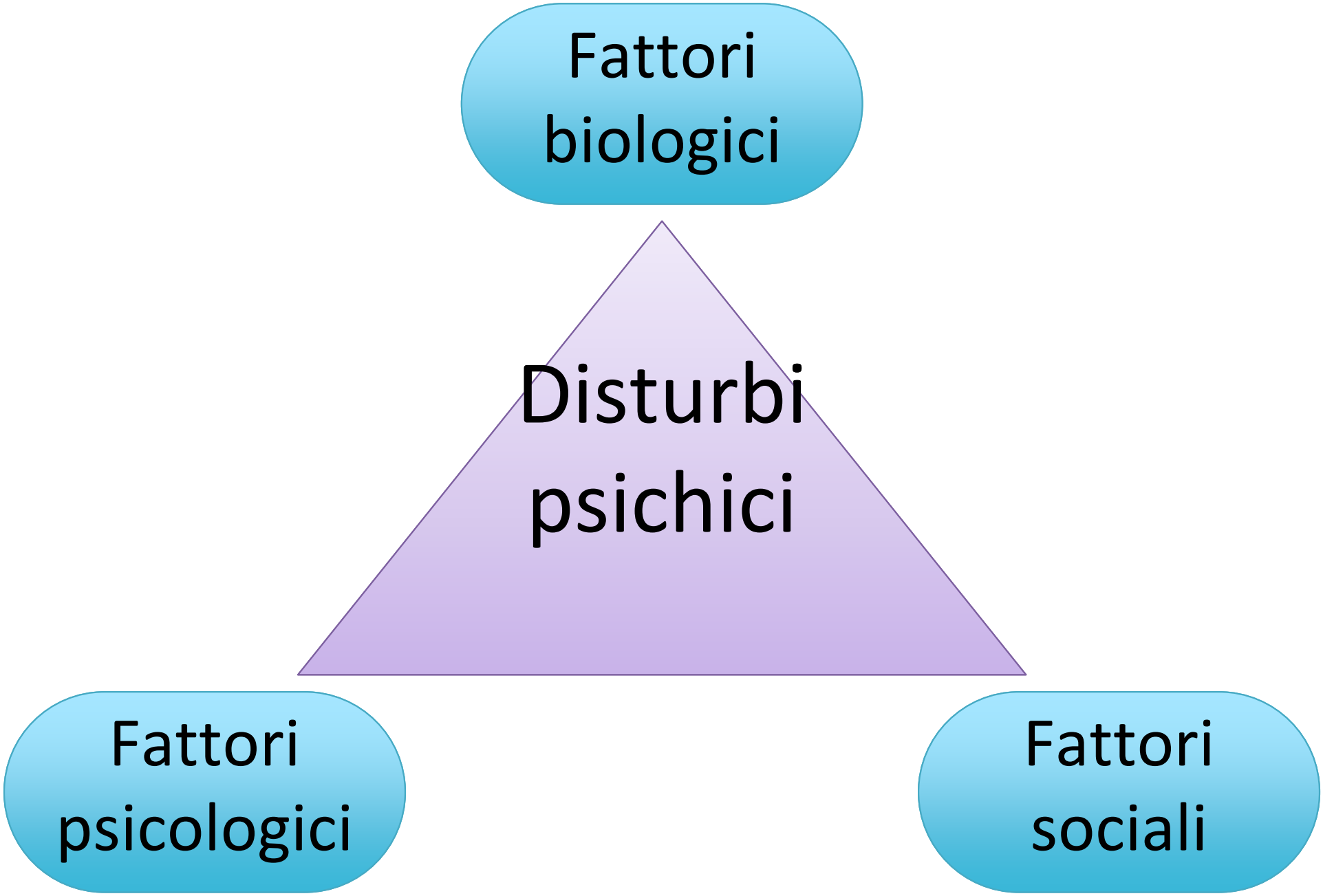
Università degli Studi di Verona - Direttore: prof. M. Ruggeri

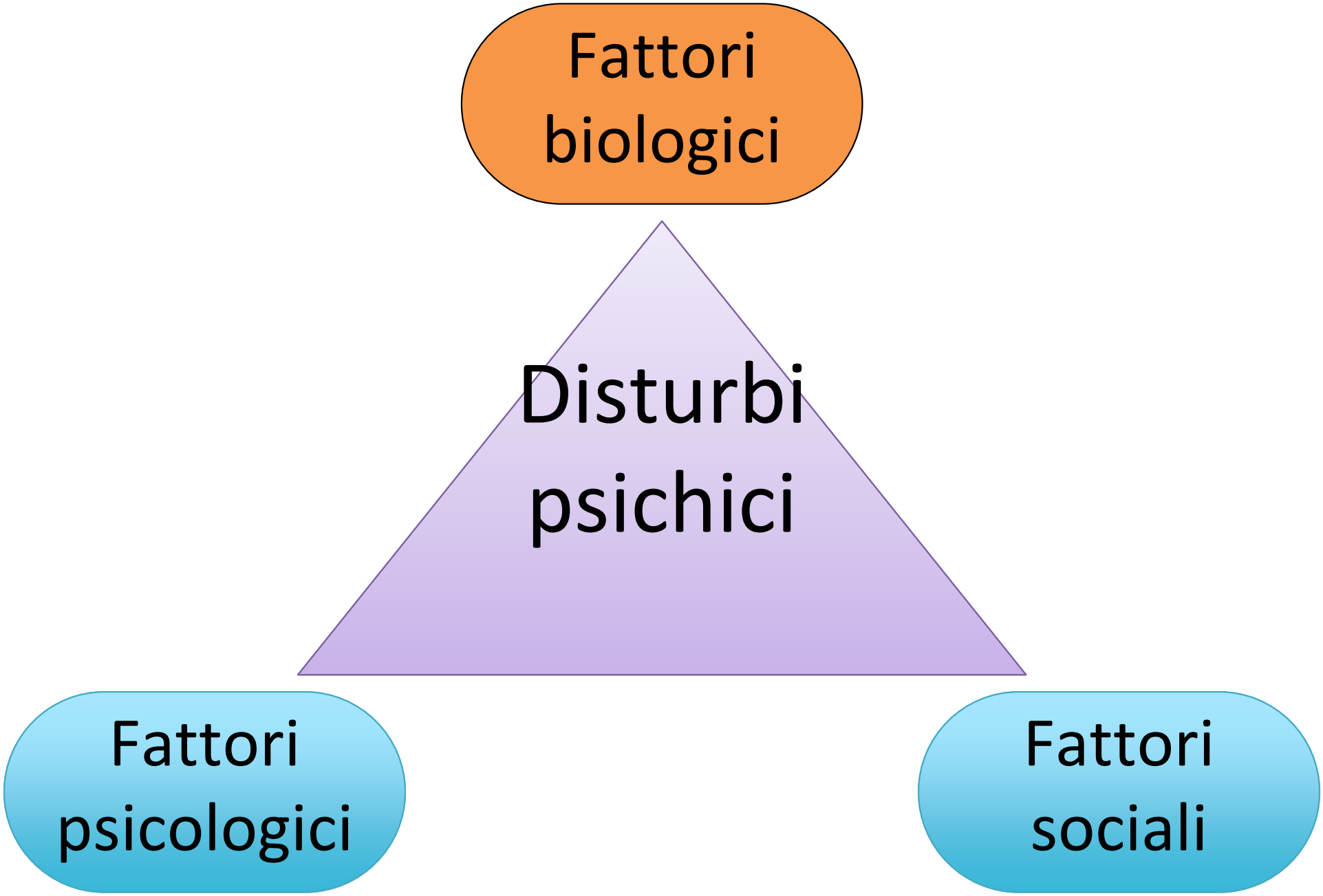
Section of Psychiatry
Department of Neurosciences, Biomedicine and Movement Sciences
University of Verona (Italy)

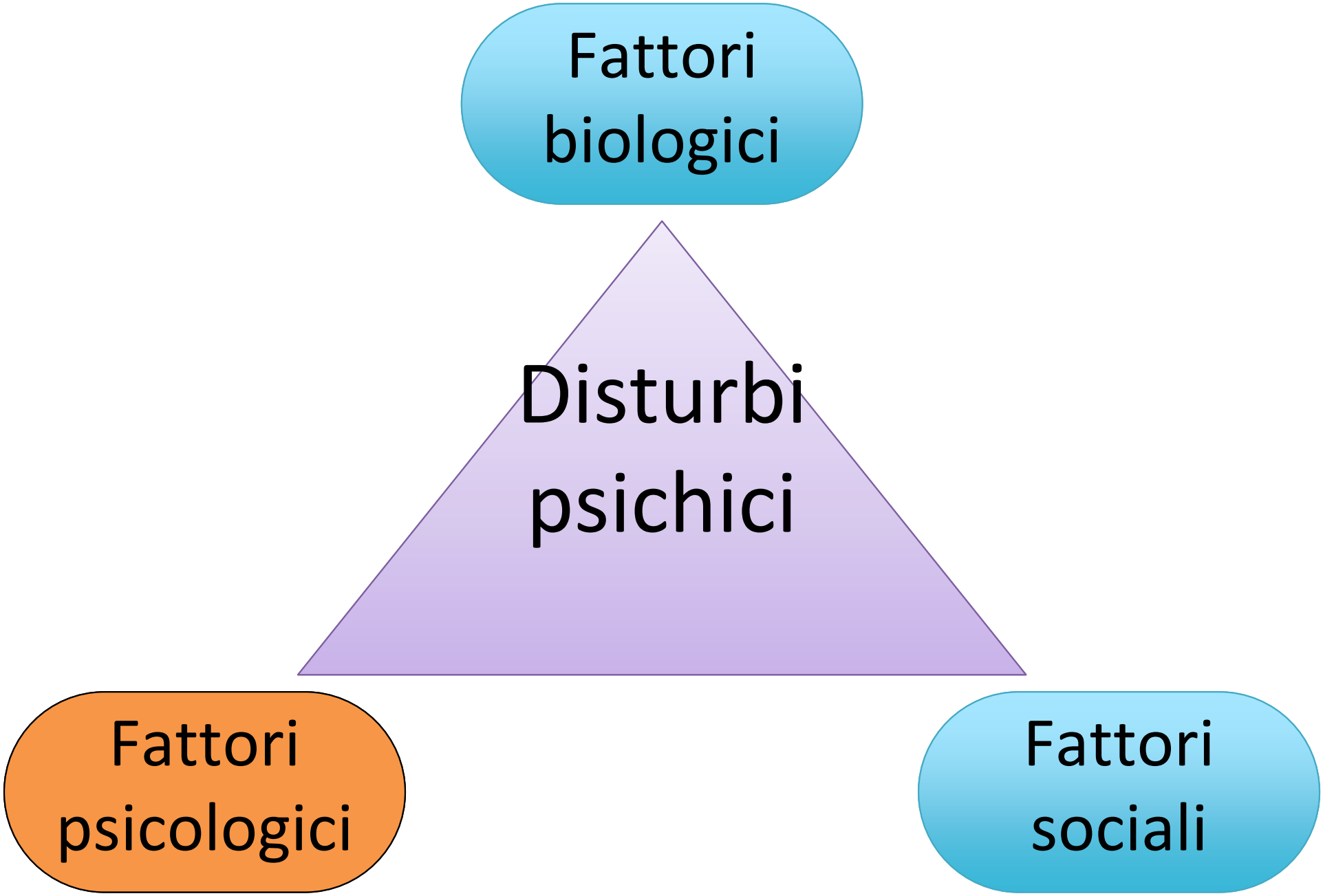
Cosa significa occuparsi di prevenzione?

I disturbi mentali sono la quinta causa di disabilità nel mondo (Trivedi, 2014)

Genere?


Fattori biologici
Disturbi psichici
Fattori psicologici
Fattori sociali


Fattori biologici
Disturbi psichici
Fattori psicologici
Fattori sociali


Fattori biologici
Disturbi psichici
Fattori psicologici
Fattori sociali

Fattori psicologici

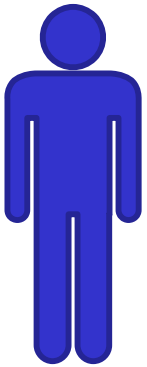
- Abusi infantili
- Maternità
- Violenza domestica

Fattori psicologici

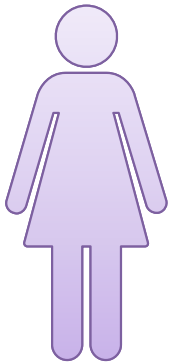
- Abusi infantili
- Maternità
- Violenza domestica

Abusi infantili

Coinvolgono fino all'80% dei bambini fino ai 16 anni di età (Sege, 2017)



Punizioni fisiche violente



Abusi sessuali
Mutilazioni genitali femminili
Infanticidio

Strategie di prevenzione

Individuazione dei nuclei familiari a rischio:

- Basso status socio-economico
- Bassa età genitoriale
- Depressione materna
- Storia di abuso di sostanze
- Tensioni familiari
- Scarso supporto sociale
- Violenza domestica

(Levey, 2017)

Erogazione di interventi domiciliari da ostetriche o infermiere formate
(Levey, 2017)

Inizio durante la gravidanza e prosecuzione fino a due anni postpartum con graduale riduzione della frequenza (DuMont, 2008)

Strategie di prevenzione (2)

Tool	Nr of items	Characteristics
CHILDHOOD ABUSE		
Trauma Symptom Checklist for Children/Trauma Symptom Checklist for Young Children (TSCC/TSCYC)	20	The clinical scales include PTS-Intrusion, PTS-Avoidance, PTS-Arousal, Sexual Concerns, Anxiety, Depression, Dissociation, and Anger/Aggression.
UCLA PTSD Reaction Index (UCLA PTSD-RI)	12	It includes parent-report and self-report versions. It asks individuals to identify the current most impairing event and asks questions about the child's reactions during or directly after exposure to that event. Finally, it assesses PTSD symptom frequency on a 5-point Likert-scale within the past month.
Child PTSD Symptom Scale (CPSS)	26	Respondents indicate how often they experienced each symptom in the past month on a 4-point Likert-scale from 0 (not at all) to 3 (5 or more times a week).

Strategie di prevenzione (3)

- Accesso alle cure prenatali e pediatriche
- Monitoraggio crescita minore
- Sostegno all'interazione mamma-bambino
- Mobilitazione delle risorse sociali
- Contraccezione
- Sostegno occupazione materna
- Miglioramento relazione genitoriale

(Levey, 2017; Bugental, 2002)

Non ci sono studi su interventi di prevenzione di genere

Fattori psicologici

- Abusi infantili
- Maternità
- Violenza domestica

Maternità & Violenza Domestica

Problemi psichiatrici nel 16% dei casi in gravidanza e nel 20% postpartum (Howard, 2014)

Solo 15% dei casi viene identificato e trattato (Guille, 2018)

Violenza Domestica interessa 1:3 donne durante la gravidanza (Belay, 2019) e rappresenta il più comune rischio di salute per la donna nel periodo perinatale (Devries, 2010)

- Compromissione relazione mamma-bambino
- Attaccamento insicuro
- Aumentato rischio di problemi emotivi, comportamentali e cognitivi in età adulta (Heckman, 2013)

Strategie di prevenzione (1)

1. Identificazione donne a rischio

2. Disponibilità di interventi perinatali

3. Disponibilità di una rete di lavoro interdisciplinare

Identificazione donne a rischio

PERINATAL MENTAL HEALTH PROBLEMS		
Antenatal Psychosocial Health Assessment (ALPHA)	35	It identifies antenatal psychosocial risk factors that would lead to poor postnatal psychosocial outcomes. Questions are scored using a three-point tick-box system of ‘low’, ‘some’ and ‘high’.
Antenatal Risk Questionnaire (ANRQ)	12	It assesses the following psychosocial risk domains: emotional support from subject's own mother in childhood, past history of depressed mood or mental illness and treatment received, perceived level of support available following the birth of the baby, partner emotional support, life stresses in the previous 12 months, personality style (anxious or perfectionistic traits) and history of abuse (emotional, physical and sexual).
Australian Routine Psychosocial Assessment (ARPA)	12	The tool assesses support, stressors, personality, mental health, childhood abuse, family violence and current mood.
Camberwell Assessment of Need—Mothers (CAN-M)	26	It covers the domains of accommodation, food, looking after the home, self-care, daytime activities, general physical health, pregnancy care, sleep, psychotic symptoms, psychological distress, information, safety to self, safety to child and others, substance misuse, company, intimate relationships, sexual health, violence and abuse, practical demands of childcare, emotional demands of childcare, basic education, telephone, transport, budgeting, benefits, language, culture and religion. Domains were assessed on a five-point Likert-scale of importance (ranging from ‘not at all’ to ‘essential’).
Contextual Assessment of Maternity Experience (CAME)	3	It explores: recent life adversity or stressors, the quality of social support and key relationships including partner relationship, and maternal feelings towards pregnancy, motherhood and the baby.
Pregnancy risk questionnaire (PRQ)	18	It assesses: the mother's attitude to her pregnancy, mother's experience of parenting in childhood, history of physical or sexual abuse, history of depression, impact of depression on psychosocial function, whether treatment was sought or recommended, presence of emotional support from partner and mother, presence of other supports, presence of stressors during pregnancy, trait anxiety, obsessional traits and self-esteem. A five-point Likert scale is used, from 1 ‘not at all’ to 5 ‘very much’.

Identificazione donne a rischio (2)

POSTNATAL DEPRESSION		
Edinburg Postnatal Depression Scale (EPDS)	10	It is the most widely tested screening tool for postnatal depression , although its sensitivity varies from 22% to 96%. Possible scores range from 0 to 30, with 11 and 13 being the most commonly used cut-offs to detect "probable" depression . It limits questions to feelings of sadness or anxiety, without screening for physical symptoms. Its reference period is narrow, since it allows patients to report symptoms felt during the week before the assessment.
Postpartum Depression Screening Scale (PDSS)	35	It assesses Sleeping/Eating Disturbances, Anxiety/Insecurity, Emotional Lability, Cognitive Impairment, Loss of Self, Guilt/Shame, and Contemplating Harming Oneself. On completing the scale, a mother is asked to select a label from (1) to (5) to reflect her degree of disagreement or agreement, where (1) means strongly disagree and (5) means strongly agree.
Becks Depression Inventory-II (BDI-II)	21	It measures the severity of depression with four response options ranging from 0 to 3 for each item, with a total maximum score for all items being 63. A score of 0–13 is considered minimal, 14–19 mild, 20–28 moderate, and 29–63 is considered severe depression.
General Health Questionnaire-12 (GHQ-12)	12	It has four response options and an overall rating from 0 to 12 used to assess mental health and psychological adjustment.
Center for Epidemiological Studies Depression Scale (CES-D)	20	It is a Likert-format screening tool that asks respondents how often they experienced a particular symptom in the past week, where 0 represents "rarely or none of the time" and 3 represents "most or all of the time" (range 0–60).
Patient Health Questionnaire (PHQ)	9	It assesses the experiencing of depressive symptoms over the last 14 days. Scores on the PHQ-9 range from 0 to 27 and are calculated by assigning scores of 0, 1, 2 or 3 to response categories of 'not at all', 'several days', 'more than half the days' or 'nearly every day', respectively and then summing up the scores.

Identificazione donne a rischio (3)

INTIMATE PARTNER VIOLENCE		
RADAR	5	It is an ancronim-mnemonic that helps summarize key action steps that physicians should take in recognizing and treating patients affected by IPV. The tool includes (1) Routinely screen adult patients, (2) Ask direct questions, (3) Document your findings, (4) Assess patient safety, and (5) Review options and referrals.
HIITS	5	The tool asks a patient the following questions: How often does your partner physically Hurt you, Insult or talk down to you, Threaten you with harm, and Scream or curse at you? Each category is graded on a scale of 1 (never) to 5 (frequently) and a sum of all the categories is generated. A total score of 10 or above is suggestive of IPV.
Abuse Assessment Screen (AAS)	5	It involves the following open-ended questions: 1. Have you ever been emotionally or physically abused by your partner or someone important to you? 2. Since I saw you last have you been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, by whom? Number of times? Nature of injury? 3. Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, by whom? Number of times? Nature of injury? 4. Within the past year has anyone made you do something sexual that you did not want to do? If YES, then who? 5. Are you afraid of your partner or anyone else?

Disponibilità di interventi perinatali

BIOLOGICAL		
Prophylactic medication in the postpartum with Nortriptyline	Wisner et al, 1994 Wisner et al, 2001	In one study, prophylactic Nortryptiline appeared to be effective in reducing postpartum depression relapse at 12 weeks postpartum (Wisner et al, 1994), whereas the other study found no difference in depressive levels at 20 weeks postpartum between women taking the antidepressant versus controls (Wisner et al, 2001).
Prophylactic effect of estrogen and progesterone therapy in preventing postpartum depression	Sichel et al, 1995 Dalton et al, 1994 Dalton et al, 1976 Lawrie et al, 1998	Results were promising for prophylactic estrogen therapy (Sichel et al, 1995), but highly inconsistent for prophylactic progesterone therapy, with two small studies showing a reduction in the postpartum depression recurrence rate (Dalton et al, 1994- 1976), and another larger trial showing an increased risk of developing depressing symptoms in women taking progesterone therapy compared to controls (Lawrie et al, 1998).
Tyroid antibodies in the postpartum	Harris et al, 2002	A small trial failed to show an effect in the occurrence of depression in thyroid-antibody-positive women taking thyroxine postpartum compared to thyroid-antibody-positive women taking placebo.
Docosahexanoic Acid (DHA) in postpartum	LLorente et al, 2003	A small trial did not show a significant effect on postpartum depression rates.
Calcium supplementation	Harrison-Hohner et al, 2001	Promising effect in preventing postpartum depression in a small trial, since Calcium metabolism is influenced by fluctuations in gonadal hormones that are exacerbated in the postpartum period.

Disponibilità di interventi perinatali (2)

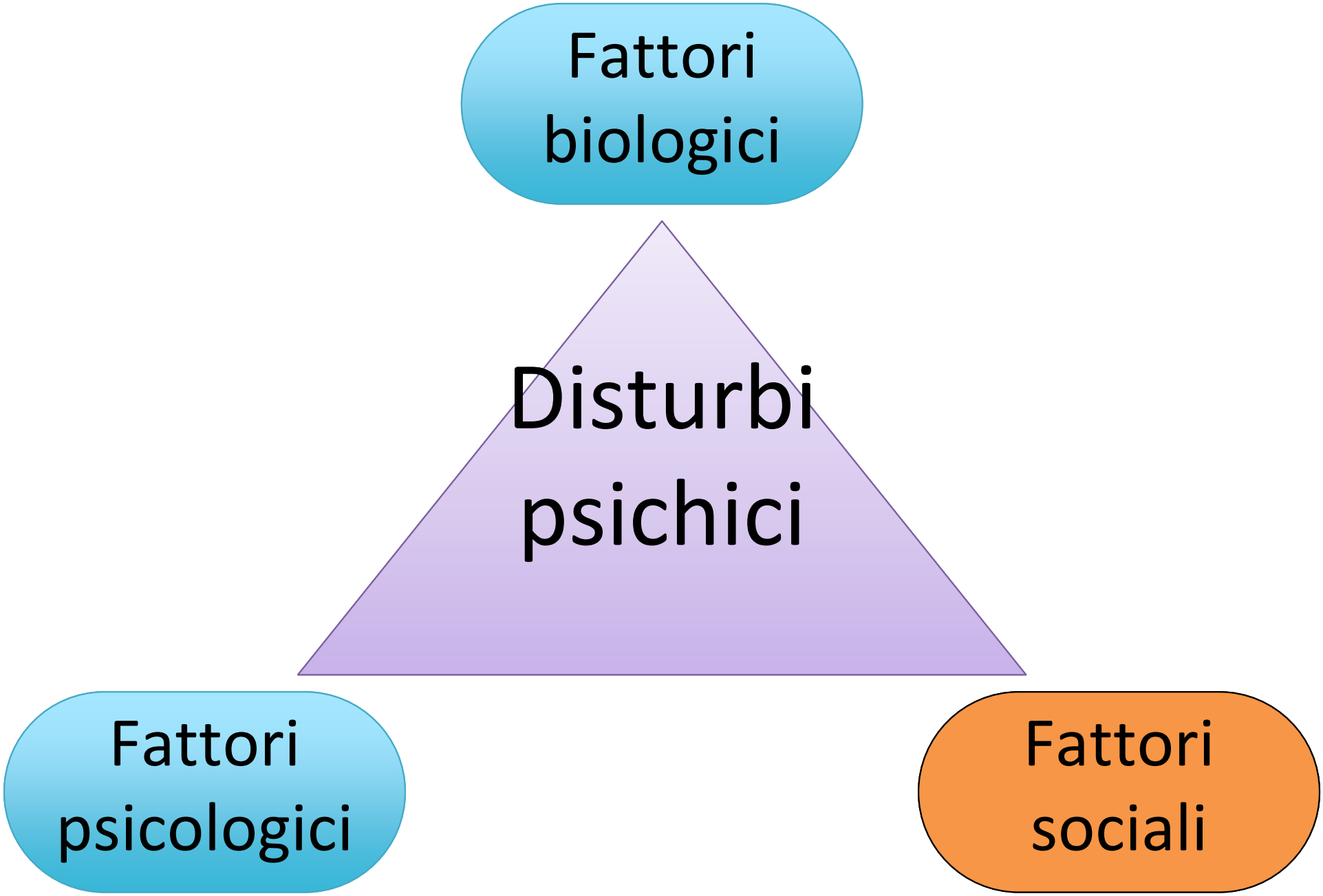
PSYCHOLOGICAL		
Interpersonal therapy	Zlotnick et al, 2001 Gorman et al, 2001	Interpersonal therapy appeared to be effective in preventing depression compared to controls at four weeks postpartum, but this prophylactic effect was not maintained at 24 weeks postpartum (Gorman et al, 2001).
Cognitive-behavioral therapy	Chabrol et al, 2002 Lavender et al, 1998	One study showed no difference in depressive levels at 12 weeks postpartum between intervention and control groups (Chabrol et al, 2002), whereas in the other study women in the CBT group showed lower levels of depressive symptoms at 6 weeks postpartum compared to controls (Lavender et al, 1998).
Midwife-led psychological debriefing	Small et al, 2000 Priest et al, 2003 Gordon et al, 1960 Elliott et al, 2000	In one study women in the psychological debriefing group presented with less depressive symptoms at 3 weeks postpartum compared to controls (Small et al, 2000), in another study women in the experimental group showed higher levels of depressive symptoms at 24 weeks postpartum compared to controls (Priest et al, 2003), and in remaining two studies no difference in depressive levels was found between treated woman and controls (Gordon et al, 1960; Elliott et al, 2000).

Disponibilità di interventi perinatali (3)

PSYCHOSOCIAL		
Antenatal classes	Stamp et al, 1995 Brugha et al, 2000 Buist et al, 1999	Effective in preventing postpartum depression only in one trials (Stamp et al, 1995), whereas in two studies no differences were found in depressive levels between experimental and control groups (Brugha et al, 2000; Buist et al, 1999).
Intrapartum support	Wolman et al, 1993 Nikodem et al, 1998 Gordon et al, 1999 Hodnett et al, 2002	Effective in preventing postpartum depression at 6 weeks but not at 1 year postpartum (Wolman et al, 1993; Nikodem et al, 1998), and the positive effect at 6 weeks postpartum was not replicated in other studies (Gordon et al, 1999; Hodnett et al, 2002)
Interaction strategies	Armstrong et al, 1999 Armstrong et al, 2000 Morrell et al, 2000 Reid et al, 2002	They include extensive nursing home visits (Armstrong et al, 1999-2000) or additional support provided by trained postpartum workers (Morrell et al, 2000; Reid et al, 2002). They showed a reduction in depressive levels at 6 weeks postpartum compared to controls, but these results were not maintained at follow-up assessments.

Disponibilità di una rete di lavoro interdisciplinare

Intervention	Author(s)	Main findings
Antenatal classes	Webster et al, 2003	A randomized controlled trial showed no differences in depression levels between experimental and control group at 16 weeks postpartum.
Early postpartum appointments	Serwint et al, 1991 Gunn et al, 1998	They were delivered 2-6 weeks postpartum in order to prevent postpartum depression and appeared to be effective in reducing depressive levels compared to controls.
Educational strategies	Okano et al, 1998 Heh et al, 2003 Hayes et al, 2002	In two trials they were successful in decreasing the severity of postpartum depression and the time between onset of depressive symptoms and seeking professional help (Okano et al, 1998; Heh et al, 2003). However, a larger trial failed to replicate the result (Hayes et al, 2002).


Fattori biologici
Disturbi psichici
Fattori psicologici
Fattori sociali

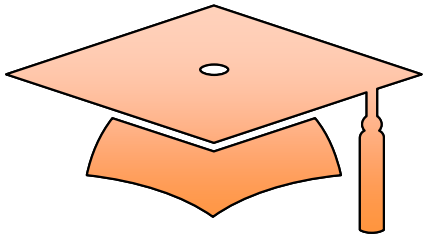
Fattori sociali

- Scolarizzazione
- Occupazione
- Relazioni affettive
- Servizi di salute mentale

Fattori sociali

- Scolarizzazione
- Occupazione
- Relazioni affettive
- Servizi di salute mentale

Scolarizzazione



Bassi livelli di scolarizzazione si associano a un aumento dell'uso dei servizi di salute mentale e depressione nelle donne (Gil-Lacruz, 2020)

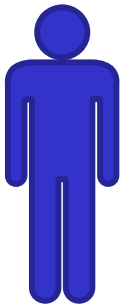
TUTTAVIA

Dati controversi sugli effetti dell'aumento aumento dei livelli di scolarizzazione nelle donne (Schaan, 2014 VS Cermakova, 2020)

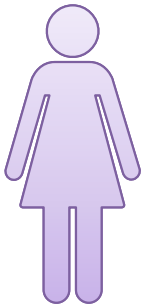
Fattori sociali

- Scolarizzazione
- Occupazione
- Relazioni affettive
- Servizi di salute mentale

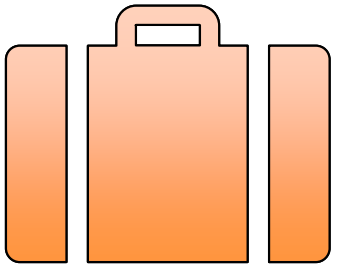
Occupazione



78%



66.5%



(Eurostat, 2018)

- Paesi conservatori (Benelux, Germania, Francia): impatto maggiore per uomini
- Paesi liberali (UK, Irlanda): impatto maggiore per donne
- Paesi area mediterranea: impatto uguale nei due generi

(Cortes-Franch, 2019)

Occupazione (2)

Alcuni settori lavorativi sono caratterizzati da una presenza maschile maggiore del 70% (Agricoltura, edilizia, estrazione) e presentano tassi molto elevati di disturbi ansiosi e Depressivi (ABS, 2008)

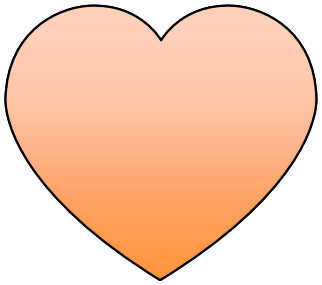
- Formazione in materia SM
- Aumento supporto sociale
- Facilità di accesso a servizi SM
- Formazione dei manager in tematiche SM sul lavoro
- Distribuzione dei carichi di lavoro e dei periodi di riposo (Lee, 2014)
- Ambiente lavoro
- Varietà di lavoro e controllo (Battams, 2014)

Interventi rivolti a tutto il contesto lavorativo, erogati per team di lavoro e tramite strategie di approccio multidisciplinari (Lamontagne, 2007)

Fattori sociali

- Scolarizzazione
- Occupazione
- Relazioni affettive
- Servizi di salute mentale

Relazioni affettive



Le persone che sono in una relazione affettiva hanno una salute mentale e una salute fisica migliori (Cotten, 1999)

TUTTAVIA

In caso di separazione le donne hanno livelli più elevati di distress (Simion, 2002) e affrontano maggiori problematiche socio-economiche (Bianchi, 1999)

Relazioni affettive (2)

Intervention	Description
Couples and marriage education programs	Change attitudes and dispel myths about marriage and to teach relationship skills—especially related to communication and conflict resolution—to adults at various life stages: single, dating, engaged, newly married, marriages in crisis, and those who are remarried.
Relationship education for students	Teaching middle and high school students about skills for building successful relationships and marriages.
Fatherhood programs	Promote the importance of fatherhood and to help fathers to become more involved with their children. They encompass job training and placement, child support payment assistance, peer support groups, parenting classes, legal assistance, and individual counseling.

Fattori sociali

- Scolarizzazione
- Occupazione
- Relazioni affettive
- Servizi di salute mentale

Servizi di salute mentale

Gli uomini ricorrono ai servizi di salute mentale molto meno delle donne (Hauge, 2018):

- Stigma internalizzato attorno alle problematiche di SM (Schnyder, 2017)
- Aderenza a modelli di comportamento maschili tradizionali (Seidler, 2016)

Soluzioni proposte per incrementare l'accesso ai servizi NON hanno attuato prospettive di genere

- Inclusione dei servizi di SM nell'assistenza primaria o di comunità
- Coinvolgimento di risorse non convenzionali (peers o membri locali influenti)
- Uso di nuovi mezzi di comunicazione
- Diffusione capillare sul territorio dei servizi di SM

Considerazioni finali

Mental health preventive strategies

PREGNANCY. To promote mental health during the perinatal period it is essential to detect at-risk mothers assessing pre-existing mental health or substance abuse disorders; screening for domestic and intimate partner violence; and evaluating familial, social and economic support. Interventions for preventing perinatal mental health disorders include medication, psychological treatments and psychosocial interventions.

EMPLOYMENT. Key elements to promote mental health among workers in male-dominated industries include: distribution of information to workers about mental health issues; provision of additional social support; access to treatment and advice for workers; education for managers about mental health in the workplace; address excessive workloads and provide relief periods from heavy workloads.

RELATIONSHIPS. Healthy marriages can be promoted via programs that target couples and marriage education and support for adults; relationships and marriage education for high school students; and fatherhood programs with co-parenting or marriage components.

Figure 1. Summary of available mental health preventive strategies.

Grazie per l'attenzione!

Section of Psychiatry
Department of Neurosciences, Biomedicine and Movement Sciences
University of Verona (Italy)