

A renewed call for international representation in editorial boards of international psychiatry journals

In a 2003 letter to *The Lancet*, Saxena et al¹ reported on the international nature of the editorial and advisory boards of the top ten general psychiatry journals (excluding those focused primarily on biological psychiatry). They noted that “most journals claim to be international”, but found that the actual journal leadership was overwhelmingly from high-income and Western countries. Only four editorial or advisory board members were from low- and middle-income countries (LMICs) across the top ten journals. The authors deemed this an “unsatisfactory situation” of underrepresentation and called for increased LMIC presence in those leading international journals. Subsequently, similar observations were made for other areas of medicine²⁻⁴, including an editorial in *The Lancet* questioning whether “widespread systemic bias” in medical journals exemplified “institutional racism” in medicine⁵.

Where do we stand now? Hoping to find an improvement in LMIC representation, we reviewed the editorial and advisory boards of the top ten psychiatry journals, ranked by impact factor, in 2016. Given the evolution of journal content, we included the top ten journals by ranking without regard to emphasis. This resulted in the additional inclusion of *World Psychiatry* (founded in 2002), *Molecular Psychiatry*, *Biological Psychiatry*, and *Psychotherapy and Psychosomatics*, as well as the exclusion of *Journal of Clinical Psychiatry*, *Schizophrenia Research*, *Psychological Medicine*, and *Psychosomatic Medicine*. Consistent with the methodology of Saxena et al¹, we used the most recent World Bank country income groupings⁶ to identify editorial and advisory board members from LMICs.

Our search revealed minimal improvement: 21 editorial board members from LMICs out of a total of 607 (3.46%) in 2016, as compared to 4 out of 470 (0.85%) in 2003. Although this is a small step in the right direction, the increase is largely due to *World Psychiatry*, which alone has ten LMIC members out of 31 editorial board members (32.26%). Among the remaining nine journals, LMIC representation is 11/576 (1.91%). In contrast, more than 80% of the world population lives in LMICs⁶. Clearly, the situation remains unsatisfactory – indeed, unacceptable.

We must address serious inequities as a field if we are to fully advance a global understanding of mental health, and scientific journals provide a critical leadership function. While the publication process is meritocratic in theory, lack of global representation in editorial boards represents a systemic disparity that may perpetuate a limited understanding of international issues, as well as a limited access and guidance for individuals from LMICs. This guidance could facilitate the capacity building necessary to increase research activity aligned with the global standards of those journals. Indeed, it has been reported that “the gap in scientific publications between low-income countries and the rest of the world has widened”⁷ and “only about 6% (or less) of

[mental health] publications are from low- and middle- income countries”⁸. More diversity among editorial board members can also help to ensure that published research accurately incorporates and represents data from LMICs through better understanding of the communities from which the data are drawn.

The lack of representation of LMICs in leadership positions is not unique to scientific journals. The most recent Egon Zehnder Global Board Index⁹, an assessment that tracks and evaluates trends among US Standard and Poor’s 500 companies in terms of board composition, global capability, and business performance, noted in 2014 that while 37% of the revenue of those companies comes from international sources, a mere 7.2% of the directors are foreign nationals. This has led to the development of the Board Global Capability Gap, a measure of the difference between global representation in the boardroom and global footprint of each company, intended to promote board membership that is more closely aligned with the current business market. An analogous metric for scientific journals could serve as an effective tool to help promote LMIC representation in editorial leadership.

Successful engagement of individuals from LMICs in editorial boards will require focused attention and intention. Possible steps for scientific journals include: a) setting a minimum goal of having at least 10% of editorial board members from LMICs by 2018; b) including a minimum number of members from LMICs of each of the World Health Organization (WHO) regions; c) inviting experts from LMICs to serve as guest editors for special sections throughout the course of the year; and d) developing a mentorship program to build capacity in editorial skills among individuals from LMICs. This may require journals to increase the number of members in their editorial boards or consider term limits to make room for increased diversity among their membership. The WHO can facilitate this process by identifying suitable advisors from LMICs and working with journals and editors to establish suitable training and mentorship opportunities¹⁰.

It has been over 13 years since the first call to action for greater diversity of membership in the top editorial and advisory boards in our field. Global leaders are entrusted with the responsibility to use their positions of influence to set an example, and the world’s premier international psychiatry journals are poised to demonstrate such leadership. Progress is long overdue, but it is achievable. The time to start is now.

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1. Saxena S, Levav I, Maulik P et al. *Lancet* 2003;361:609.
2. Keiser J, Utzinger J, Tanner M et al. *BMJ* 2004;328:1229-32.
3. Sumathipala A, Siribaddana S, Patel V. *BMC Med Ethics* 2004;5:5.

4. Kieling C, Herrman H, Patel V et al. *World Psychiatry* 2009;8:40-4.
5. Horton R. *Lancet* 2003;361:712-3.
6. World Bank. Country and lending groups, 2016. <http://data.worldbank.org>.
7. Paraje G, Sadana R, Karam G. *Science* 2005;308:959-60.
8. Saxena S, Paraje G, Sharan P et al. *Br J Psychiatry* 2006;188:81-2.
9. Harvard Business Review. Boards aren't as global as their businesses. <https://hbr.org>.
10. Wilkinson G. *Lancet* 2003;361:1229.

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The relationship of subjective social status to mental health in South Korean adults

South Korea has witnessed an unprecedented rise in suicide rates following the 1997 Asian financial crisis. Unfortunately, the rate has not decreased and still remains the highest among the 34 countries which are part of the Organization for Economic Co-operation and Development (OECD).

Several researchers^{1,2} have suggested that, in high-income countries, it is no longer the absolute level of one's socioeconomic status (SES) that is most important for health, but rather inequality or a sense of inequality. A number of studies have been undertaken to examine the relationship of inequality (at the country level) or a sense of inequality (at the individual level) to health. Some of these studies have focused on subjective SES, which measures one's perception of his/her own position in the social hierarchy³.

We aimed to examine how both objective and subjective SES are related to mental health problems (suicidal ideation, depressive symptoms and psychological distress) in South Korea, using data from the 2013 Korea Health Panel survey. Subjective SES was measured using the MacArthur scale, a 10-rung ladder on which individuals indicate their perceived standing in the social hierarchy¹. The assessment of suicidal ideation and depression was based on self-report ("yes" versus "no" in the past 12 months). Psychological distress in the past month was assessed using the Korean version of the Brief Encounter Psychosocial Instrument (BEPsi-K)⁴. A score ≥ 2.4 was defined as "severe stress". Of the 16,313 respondents aged 19 years or older, the 14,432 who had no missing data were included in this analysis. All data were weighted to represent the structure of the Korean population.

Of the 14,432 participants, 5.4% and 7.2% had suicidal ideation and depression, respectively, in the past 12 months, and 13.6% had severe psychological distress in the past month. A clear social gradient was found in the prevalence of these mental health problems, especially when SES was measured subjectively (subjective SES) rather than objectively (income quintile) ($p < 0.001$). Notably, this pattern was more apparent in the case of severe psychological distress. Of those with the lowest subjective SES (i.e., a rating of 1 on the 10-rung ladder), nearly one in three (29.6%) reported the experience of severe psychological distress in the past month, while only 7.2% reported the same experience among those with the highest subjective SES (i.e., a rating ≥ 5). The equivalent rates were 19.3% in the lowest income quintile and 10.2% in the highest income quintile.

The associations with subjective SES appeared to far outweigh those with conventional measures of SES when considering both in logistic regression models. Subjective SES was the only factor that was consistently associated with any type of mental health problems. For instance, compared to the respondents with the lowest subjective SES (i.e., a rating of 1 on the 10-rung ladder), those with higher subjective SES were much less likely to report suicidal ideation (OR=0.60 in the group with a rating of 2, OR=0.40 in those with a rating of 3, OR=0.24 in those with a rating of 4, and OR=0.20 in respondents with a rating ≥ 5 ; $p < 0.001$ for all). The same applied to depression (OR=0.50, 0.38, 0.26, and 0.20; $p < 0.001$ for all), and severe psychological distress (OR=0.52, 0.32, 0.25, and 0.19; $p < 0.001$ for all). Associations with objective SES measures (education, employment status, income quintiles) were infrequently observed.

Previous studies have shown that the strength of the association between subjective SES and health varies across countries⁵. Contextual factors such as social structure and culture are likely to strengthen or weaken the association between the two. What factors might then have strengthened the relationship between subjective SES and mental health in South Korea?

This country achieved rapid economic growth while maintaining a relatively equitable income distribution up until the mid-1990s. However, it fell into a severe recession following the 1997 Asian financial crisis, which in turn served as a major turning point in the Korean society. Massive structural reforms were undertaken to promote economic productivity and globalization. These reforms have had a significant impact on the labour market, increasing labour flexibility and job insecurity. As a result, the labor market has become highly segmented between regular and non-regular workers. Income inequality has also worsened since the 1997 crisis, despite the resurgence of economic growth (the average gross domestic product increased by 5.4% between 1999 and 2010⁶). The average Gini coefficient, a measure of income inequality, was 0.258 in the period 1990-1995, but increased to 0.298 in 1999 and peaked at 0.320 in 2009⁷.

Concomitant to these social changes, a limited number of studies have demonstrated a worsening trend of SES-related inequalities in health. For example, our study published in this journal in 2011⁸ showed a widening income-related inequality in the prevalence of depression and suicidal behaviour over the 1998-2007 period. Nevertheless, our current finding of a strong