GENDER AND MENTAL HEALTH

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Abstract

This paper addresses the relationship between gender and mental health. First, the field of mental health and the concept of gender is introduced. This is followed by a discussion of the forms of gender bias implicated in mental health research. Next, gender differences in mental health outcomes are described, including differences in the prevalence and course of conditions. Evidence related to a gendered, social determinants model of mental health is examined. Depression is used as an illustrative example of a mental health condition characterized by a very large gender difference in rates and one to which certain gender differences in life events and social position, such as socioeconomic disadvantage and gender based violence make a significant contribution. Policy recommendations from the evidence based review of gender and mental health conclude the paper.
1. Introduction to Mental Health

The human qualities, behaviours and experiences that might be selected to elucidate the ideas of mental health and mental illness respectively are disputed by mental health professionals and change over time. Similarly, theories about the causes of mental health and illness vary between and to some extent within the various disciplines concerned with the field of mental health including psychiatry, psychology, psychotherapy, social work and sociology (Pilgrim & Rogers, 1993).

Even the idea of normality applied to mental health is problematic. Four different approaches to defining normality can be made. First, normality can be conceived as the absence of pathology. Second, it may be equated with ideal functioning or what humanistic theorists have called 'self actualisation'. Third, normality can be taken as the average or the level of functioning enjoyed by the majority of people. Fourth, normality can be seen as the product of interacting systems that change over time according to the age of the person and the developmental goals appropriate to that age (Offer & Sabshin, 1984). Each approach implies value judgements that can be contested. For instance, the third and fourth approaches could include and endorse gender stereotypical behaviour on the grounds that it was widespread and regarded as 'normal' and appropriate in many cultures. Other notions of normality include the capacity to flexibly adjust or adapt to the external world, form emotionally satisfying relationships, master developmental tasks, learn from experience, take responsibility for one's actions and deal with conflicting emotions (Kaplan & Sadock, 1988).

In this paper, the term psychological disorder will be used for convenience because it is the term used in systems of classification and research in psychiatric epidemiology. It does need to be underlined that there is no one universally accepted system for classifying mental disorders, diagnostic categories are heterogenous and the definition of psychiatric ‘caseness’ is often arbitrary (Piccinelli & Homen, 1997).

Every culture has some notion of emotional or psychological difference and lay people as well as mental health professionals are conscious that mental health problems vary in frequency and cover a broad spectrum of severity. Poor mental health from a lay perspective tends to be identified with such readily recognisable emotions as feeling persistently sad, anxious, ‘down’ or suffering from ‘bad nerves’ together with headaches, aches and pains, or more seriously as having thoughts, feelings or behaviours that are strange, frightening, frustrating or ‘antisocial’
(Pilgrim & Rogers, 1993). Mental health professionals, while arguing about diagnostic categories and the precise limits over what should and should not be included within them, distinguish as lay people do, between common ‘neurotic’ or non psychotic disorders that manifest with a mixture of depression, anxiety and somatic symptoms and the rare, severe, ‘psychotic’ disorders such as schizophrenia and bi polar (manic depressive) disorder where people lose touch with reality. More information on the gender differences in both common and severe forms of mental disorders will be presented later in this paper.

Psychological disorders can be episodic, recurrent or chronic and cover a broad range of conditions. In the National Comorbidity Survey (Kessler et al, 1994), the disorders surveyed included affective disorders (major depressive episode, manic episode, dysthmia), anxiety disorders (panic disorder, agoraphobia without panic disorder, social phobia, simple phobia, generalized anxiety disorder) substance use disorders (alcohol abuse with and without dependence and drug abuse with and without dependence), antisocial personality and non affective psychosis.

Non psychotic mental disorders are often referred to as common mental disorders (CMD) because of their high prevalence in the general community. CMD include depression, anxiety and somatic symptoms and have been found to exceed 30% in community samples and up to 50% in some primary care samples in a wide variety of countries (Kessler et al, 1994; Ustun & Sartorius, 1995; Patel et al, 1999). There is increasing evidence that mental disorders are far more common than previously realised. In the large US National Comorbidity Survey of more than 8000 people, Kessler and his co-workers (1994) found that lifetime prevalence rates for any kind of psychiatric disorder were high, but similar for men (48.7%) and women (47.3%).

Despite being common mental disorders are underdiagnosed by doctors. In the World Health Organization’s (WHO) Collaborative Study on psychological problems in general health care, carried out in fifteen countries, less than half the patients who met diagnostic criteria for depression were identified as depressed by their doctors (Ustun & Sartorius, 1995). Even sufferers of severe mental illness may not receive adequate or indeed, any treatment. In Australia, the Human Rights and Equal Opportunity Commissioner’s Report on the human rights of people with mental illness (Burdekin, 1993) found that half of all sufferers of serious mental illness received no treatment at all. What constitutes appropriate treatment is widely disputed and varies (according to underlying beliefs about the primary causes of mental illness) from a strict
biomedical, psychopharmacological response, a counselling or psychotherapeutic intervention, to a view advocating fundamental changes in sociocultural conditions.

The primary focus of this working paper will be on common mental disorders (CMD) in general and depression in particular for the following reasons:

- It is with these disorders that the most marked gender differences in prevalence are found
- Unipolar or major depression is predicted to be the second leading cause of global disability burden by 2020 (Murray & Lopez, 1996).
- Depression occurs approximately twice as often in women as it does in men and is therefore the most frequently encountered women’s mental health problem (Piccinelli & Homen 1997).
- Any significant reduction in the overrepresentation of women who are depressed would make a significant contribution to reducing the global burden of disability.
- Depression and anxiety are the most common comorbid disorders and a significant gender difference exists in the rate of comorbidity. Moreover, comorbidity contributes significantly to the burden of disability caused by psychological disorders (Kessler et al, 1994; Ustun & Sartorius, 1995).

In the Global Burden of Disease, Murray and Lopez (1996) argue that the traditional preoccupation of biomedical research with mortality has served to seriously underestimate the burden of morbidity associated with mental illness. It has become a matter of urgency then that the morbidity caused by poor mental health should addressed, its causes elucidated and its prevalence reduced. Most of the evidence on mental health, including that reviewed here, actually relates to mental health outcomes such as emotional distress, psychiatric illness or mental disorder. Over the past twenty years, more attention has been paid to health related quality of life but there is still a pressing need for further research into the determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity. Central to this task, is the compelling need to account for the role of gender in mental health, to describe the effect of different forms of gender bias on scientific inquiry and the quality of research evidence and to increase understanding of the causes of gender differences in mental health.
2. Gender in Mental Health Research

Understood as a social construct and category, gender has the analytical power to explain the differences between men’s and women’s susceptibility and exposure to specific health risks. Gender influences the differential power men and women have to control their lives, cope with such risks and influence the process of health development (Pan American Health Organization, 1995). Without the concept of gender it is not possible to begin to ask questions about how the different social categories occupied by women and men differentially affect how they see, experience and understand the world.

Gender is able to problematize and clarify the premises, practice and methods of scientific research on mental health. Numerous researchers since the 1980’s have called for a greater emphasis on gender in research (Eichler & Parron, 1987; McGrath et al, 1990; Dennerstein, Astbury and Morse, 1993; Mastroianni, Faden and Federman, 1994). While scientific knowledge relating to gender differences in mental disorder and its treatment has increased, it is by no means comprehensive.

The role of gender in science, including what is perceived to be a problem worthy of scientific inquiry and the unequal relationship between the researcher and the researched, evaded serious scrutiny until the 1980’s, when feminist critiques of science began to appear (Keller, 1985; Bleier, 1986; Harding, 1987). Benjamin (1992) has pointed out that before this time, a mutually reinforcing relationship existed between the scientific construction of gender and the gendered construction of science such that the operation of both processes was obscured. For example, gender blind theories of mental health have gone hand in hand with research that assumed and then sought evidence to prove women’s greater, biologically based vulnerability or proneness to mental disorder. This conflation of sex, a biological given, and gender, a social and cultural construct inevitably leads to systematic bias. When this occurs, the biological and sociocultural determinants of behavior cannot be disentangled nor can their interaction be identified.

With disorders like depression, this confounding of sex and gender prompted many researchers to narrow the scope of their investigations to a search for biological causes of depression that by preordained prejudice could only be found to exist in women. Notions of women’s greater, biologically based vulnerability or proneness to disorder have proven rather resistant to change and are embedded in the long history of hysteria and the attendant belief that women have an innate tendency to mental disorder. As a result, mental disorder was believed to relate to a
corresponding derangement or malfunctioning of women’s reproductive organs and hormones (Showalter, 1987; Gitlin & Pasnau, 1989; Astbury, 1996).

More recently, a huge amount of research attention has been paid to the hypothesized relationship between reproductive related events such as menstruation, pregnancy, miscarriage, childbirth, premature delivery, infertility, abortion and menopause and women’s higher rates of depression. On their own, none of these events have explained the gender difference in depression. Nonetheless, some contemporary researchers in developed countries, while conscious of the difference between sex and gender, remain interested primarily in the contribution of biological factors and reproductive events to women’s higher rates of depression and even those disorders which have no gender difference in prevalence, such as bipolar disorder (Halbreich & Lumley, 1993; Nolen-Hoeksema & Girgus, 1994; Blehar & Oren, 1995; Leibenluft, 1997; Blehar et al, 1998). This individualising focus on reproductive and intrapsychic factors has long detracted attention and investigation of social and structural determinants of women’s mental health.

The importance and attention paid by researchers to reproductive functioning does not necessarily accord with women’s own perspectives and health priorities, but these have rarely influenced the research agenda. In developing countries, where research has been heavily concentrated on reproductive health and fertility control, women’s own health concerns and the factors they believe impact on their mental health have rarely been elicited. One exception, is a study conducted in the Volta region of Ghana. Nearly three quarters of the women in this study, when asked to identify their main health concerns, nominated psycho social health problems such as ‘thinking too much’ and ‘worrying too much’. The explanations women gave of their health problems stressed heavy workloads, the gendered division of labour, financial insecurity and responsibility for children (Avotri & Walters, 1999).

Comprehensive reviews of the evidence on the contribution women’s reproductive functioning makes to their mental health have been critical of the quality of much research, commenting on unwarranted assumptions, myths and culturally biased attitudes towards women, poor research design and untenable conclusions (Gitlin & Pasnau, 1989). The need to adopt an interactionist model is compelling.
Understanding the impact of reproductive events requires examining the interaction of biological, psychological and social factors in more sophisticated paradigms that those that currently dominate the literature. (McGrath et al, 1990)

Research undertaken in the 1990’s adopting this interactionist approach has revealed that the impact of biological factors on women’s mental health is mediated and in many cases becomes irrelevant when the effect of other social and psychological factors is taken into account. For example, research on menopause has found that emotional well being in middle aged women is positively associated with their current health status, psychosocial and lifestyle variables, but not with their menopausal status or their hormone levels (Dennerstein, 1996; Dennerstein, Dudley, Burger, 1997). Research on postnatal depression has identified partner and social support, life events, the experience of motherhood and infant temperament as critical risk factors for the development of depression in the postnatal year (Small et al, 1994)

While the relationship of women’s reproductive functioning to their mental health has received intense scrutiny, the contribution that men’s reproductive functioning might make to their mental health has been virtually ignored. This form of gender bias seems to imply that men either have no reproductive functioning or are not psychologically affected by events and conditions such as infertility, attachment to or loss of the fetus through miscarriage, stillbirth or extreme prematurity or the transition to parenthood. Yet the few studies that have been conducted suggest men are emotionally responsive to many of the same events that influence women’s emotional well being, not for biological reasons but for psychosocial ones. Several studies have now shown men as well as women can experience depression following the birth of a child and a significant correlation exists between parents regarding depressive symptoms (Ballard et al, 1994; Areias et al, 1996; Barnett & Morgan, 1996; Leathers, Kelley & Richman, 1997; Soliday, McCluskey-Fawcett & O’Brien, 1999).

The finding that depressive symptoms are highly correlated between parents argues strongly for a ‘couple in relation’ or systems approach to be incorporated into research on postpartum distress. Other reproductive events with psychological importance for men include their attachment to the fetus during pregnancy (Condon, 1993) and miscarriage (Beil, 1992). Fathers can also experience acute stress associated with the birth of a preterm infant (Handley, 1996).
The concentration by some researchers on the relationship between women’s reproductive functioning and their mental health has coexisted with a widespread failure to include women in a range of clinical trials. Gender bias, extending into the 1990’s, delayed the collection of important evidence on women’s health (Mastroianni, Faden & Federman, 1994). For example, the exclusion of women from research on such significant health issues as cardiovascular disease—the leading cause of mortality for women as well as men in developed countries has occurred primarily because of women’s reproductive functioning. The possibility of menstruation or pregnancy was regarded as being incompatible with the assumptions of androcentric research design. Another reason for biased attention is that men, on average, develop coronary heart disease earlier than women. One obvious and somewhat ironical result of this exclusion bias and the confining of research on depression in women to reproductive and hormonal factors, was the delayed discovery of the relationship between major depression in women and an increased risk of cardiovascular morbidity and mortality. Musselman, Evans and Nemeroff (1998) in their review of all research studies on the link between cardiovascular disease and depression over a thirty-year period from 1966 to 1997 conclude that:

‘Future studies should focus on women to assess gender-specific psychological and physiologic measures. Despite the fact that women are more vulnerable to depression and that CVD is the leading cause of death among adult women in the United States, relatively little research has focused on the etiology and pathogenic mechanisms of major depression among women with CVD.’ (p588)

All diagnostic criteria and assessments of mental health depend on theoretical constructs of human behaviour, what is believed to constitute the normal and how this can be clearly distinguished from the pathological. Androcentric bias, where men’s experiences are taken as the norm and/ or their symptoms and patterns of illness inform models of explanation will lead to error. For example, men who develop schizophrenia often have an earlier onset of symptoms than women. Hambrecht et al (1992) applied the criterion from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-111) that stipulated schizophrenia could only be diagnosed if symptoms were present before 45 years of age, to data obtained from the WHO Determinants of Outcome of Severe Mental Disorders (Sartorius et al, 1986; Jablensky et al, 1986). Application of this criterion resulted in the exclusion of 5% of men but more than double the percentage of women (12%). Implications for the accuracy of prevalence rates are clear.
What is included or excluded from constructs and explanatory models of mental health outcomes can change over time. Evidence on the relationship between gender based, ‘intimate’ violence and women’s mental health, to be discussed in more detail later, has only been sought consistently over the last decade. Prior to this, even social models of mental health, let alone ones that were preoccupied with reproductive functioning, ignored childhood sexual abuse or partner violence in adult life as probable ‘vulnerability factors’ in the development of depression or other disorders, as significant factors in explaining women’s generally lower self esteem compared with men’s, or even as critical ‘negative life events’ or ‘chronic stressors’. The relatively late inclusion of violence against women into the mental health research agenda represents another example of the way gender can influence the generation of a research problematic.

All levels of scientific enquiry from the formulation of research questions, through to design, methodology and interpretation of results need to explicitly articulate the contribution of gender. The fact of gendered experience must be acknowledged in the construction of test instruments and questionnaires, if items are to have gender salience and accuracy. Existing questionnaires assumed to have general validity and by implication, gender neutrality, may have neither. The task of modifying questionnaires started in the 1980’s. For example, Norbeck (1984) revised a commonly used life events questionnaire to include items that captured crucial gender differences. Revision of certain measures of personality has also occurred to prevent the psychological effects of violence being confused with the features of personality disorder (Rosewater, 1988). New instruments have been developed to overcome earlier gender bias and assess paternal antenatal emotional attachment to the fetus (Condon, 1993). Others need to be developed, for example, valid instruments are required to measure depression in fathers during pregnancy and after childbirth (Areias et al, 1996).

These historical and contemporary biases have resulted in a distorted and incomplete understanding of relationship between gender and mental health. In conclusion, three main problems persist:

- First, evidence on gender is simply not collected. If it is collected, it is not presented in the gender disaggregated form needed to inform researchers, clinicians and policy makers.
Second, evidence is lacking on how gender interacts with structural determinants including income, education, workplace and social position and roles related to family, unpaid work and caring and the experience of intimate, gender based violence, to influence mental health.

Third, conceptual remapping is required of all those explanatory models of emotional distress and disorder where large gender differences obtain but have not yet been adequately explained due to an excessive focus on biological mechanisms. This is especially important when gender differences in chronic life stresses, negative life events and violence have not been properly investigated.

3. Gender and Mental Health Outcomes
To examine the relationship between gender and mental health, a definition that identifies all salient dimensions of mental functioning is needed. The World Health Organization’s (1981) definition of mental health consists of several dimensions that are useful for this purpose because they serve to focus attention on the different levels of functioning at which the determinants of mental health will operate.

‘Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.’

This definition is significant because it goes beyond biological individualism and the notion that psychological disorder is primarily an expression of brain disease in an affected individual requiring pharmacological treatment. By adopting a positive, multi level, transactional concept of mental health the WHO definition acknowledges the complex web of interrelationships that extend from the individual to the environment, the critical role of the social context and the importance of justice and equality in determining mental health. The definition does not mention gender, but it will be argued here that gender can and does impact very markedly on the capacity of the individual, the group and the environment to attain subjective well being, justice and equality.
It is not disputed that there are gender differences in mental health. The National Comorbidity Survey (Kessler et al, 1994), in keeping with the findings of other studies (Helzer et al, 1986; Ustun & Sartorius, 1995; Brown, 1998), reported that women had a higher prevalence than men of most affective disorders and non affective psychosis, while men had higher rates of substance use disorders and antisocial personality disorder. The most common disorders were major depression and alcohol dependence and both showed large gender differences in prevalence. For major depressive episode, the lifetime prevalence rate was 21.3% for women and 12.7% for men while the 12 month prevalence was 12.9% for women and 7.7% for men. Conversely, for alcohol dependence men had a lifetime prevalence of 20.1% compared to 8.2% for women and a 12 month prevalence of 10.7% compared with 3.7% for women. For antisocial personality disorder, men had a lifetime prevalence of 5.8% compared with 1.2% for women.

Depression and anxiety are common comorbid diagnoses with the diagnosis of alcohol dependence (Lynskey, 1998) and gender socialization appears to play a part in determining which problems men and women feel comfortable in seeking help for and which conditions are more stigmatized according to gender. Allen et al (1998) found marked gender differences in response to alcohol screening instruments. Men were more likely than women to endorse items that indicated they were seeking help for alcohol related problems and expressed concern over receiving a psychiatric label while women were more likely to endorse seeking help for emotional problems and expressed concern over receiving a drinker label. Unless screening instruments and measures of mental disorder are alert to the possible bias exerted by such gender stereotyped concerns, it is possible that both under and over ascertainment of specific disorders could occur.

Nonetheless, the gender difference in depression is a robust finding. In a comprehensive review of all the general population studies conducted to date in a range of countries including the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, Piccinelli and Homen (1997) reported that women predominated over men in lifetime prevalence rates of major depression. This difference has been documented in clinical and community samples, across racial groups and even after statistically controlling for the effects of other variables which are strongly related to depression such as income level, education and occupation (McGrath et al, 1990; Kessler et al, 1994; Gater et al, 1998). In subsequent sections, mechanisms that might explain this gender difference will be explored in more detail.
In contrast to the marked gender differences in the rates of common mental disorders, few gender differences in prevalence have emerged from studies on severe mental disorders, such as schizophrenia and bi polar disorder. Not only are lifetime prevalence rates for schizophrenia and bi polar disorder much lower, with reported rates from general population studies ranging from 0.1% to 3% for schizophrenia and from 0.2% to 1.6% but these disorders have a much stronger genetic component, with the familial nature of schizophrenia, for example, being very well documented (Piccinelli & Homen, 1997).

However, even with serious mental illness, where there is little evidence of gender differences in prevalence rates, gender differences do exist along other dimensions within these mental disorders. A comprehensive review of studies on schizophrenia found that differences in age of onset of symptoms between men and women have frequently been reported. Generally men were found to have an earlier onset of symptoms than women and poorer premorbid psychosocial development and functioning (Piccinelli & Homen, 1997). Despite later onset, some studies have reported that women experience a higher frequency of hallucinations or more positive psychotic symptoms than men (Sharma, Dowd & Janicak, 1999; Lindamer et al 1999). Similarly, while the population prevalence of bipolar disorder appears to be similar between men and women, there is some evidence regarding gender differences in the course of the illness. Women are more likely than men to develop the rapid cycling form of the illness and more comorbidity, especially depression (Leibenluft, 1997; Robb et al, 1998; Benazzi, 1999)

A number of studies report that women with schizophrenia have higher quality social relationships than men. One exception, reported by Vandiver (1998) concerns results from a cross national survey in Canada, Cuba and the USA. This found that while Canadian women reported a higher quality of life than Canadian men, in the Cuban sample men with schizophrenia reported higher quality of life than Cuban women. In a Finnish study on gender differences in living skills such as being able to provide adequate levels of self care and shop, cook and clean for oneself, men were significantly less likely to have independent living skills than women. Over half the men in their sample but only a third of the women with schizophrenia lacked independent skills related to a personal or domestic activity (Hintikka et al, 1999). This finding illustrates how gender socialization and the skills it inculcates can mediate the long term adjustment to and outcome of a severe mental disorder like schizophrenia.
Similarly, gender specific exposure to risk can further complicate the number of adverse outcomes associated with a severe mental disorder. When schizophrenia coexists with homelessness, an increasingly common phenomenon, it has been reported that women experience higher rates of sexual and physical victimization, comorbid anxiety and depression and more medical illness than men (Brunette & Drake, 1998).

The importance of comorbidity as a gender issue emerged from the WHO Collaborative study (Ustun & Sartorius, 1995) and the National Comorbidity Study (Kessler et al, 1994). Kessler et al. (1994) reporting on the US National Co-morbidity Survey noted that women had higher prevalences than men of both lifetime and 12 month comorbidity of three of more disorders. In the Ustin and Sartorius (1995) study, almost half of the patients with at least one psychiatric disorder had a disorder from at least one other cluster of psychiatric disorders. These clusters included most disorders, apart from alcohol dependence, in which women have been found to predominate (Eaton & Kessler, 1985; Russo, 1990). The clusters were depressive episode, agoraphobia, panic disorder and generalised anxiety; somatisation, hypochondriasis and somatoform pain and alcohol dependence. Psychiatric comorbidity, with depression as a common factor, is a characteristic finding of many studies on women’s mental health (Brown & Anderson, 1991; Mullen et al., 1993; Ustin & Sartorius, 1995; Kessler et al., 1994; Brown, Harris & Eales, 1996). In addition, a high level of psychiatric and medical comorbidity has been documented amongst women who have been affected by violence and will be discussed in the next section of this report.

In conclusion, gender differences in mental disorder extend far beyond differences in the rates of various disorders or indeed their differential time of onset or course and include a number of factors that can affect risk or susceptibility, diagnosis, treatment and adjustment to mental disorder. As the WHO definition makes clear, the determinants of mental health occur at three main levels- the individual, the group and the environment. All three must be considered if gender differences in mental health outcomes are to be adequately understood.

In the remaining part of this paper, evidence will be examined that is relevant to considering the links between gender and the common mental disorders.
This will be addressed by:

- examining the relationship between gender, social position, social disadvantage and inequality and increased risk of common mental disorder, especially depression
- reviewing evidence on gender based violence and its consequences for women’s mental health

4. Gender, Social Position and Mental Health

Gender intersects with other critical structural determinants of social position and these typically cluster together. Gender differences in material well being and human development are widely acknowledged. The World Health Report (WHO, 1998) states categorically that:

> Women’s health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today, the status and well-being of countless millions of women worldwide remain tragically low. As a result, human well-being suffers, and the prospects for future generations are dimmer. (Executive Summary, p6)

The United Nations Development Program has attempted to operationalize gender development and capture the disparity between human and gender development by comparing countries rankings on the gender related development index (GDI) with those on the Human Development Index (HDI). The same three indicators are used in both indexes, namely life expectancy, educational attainment and income. There is also a Gender Empowerment Measure (GEM) that provides a measure of gender inequality in the key areas of economic and political participation and decision making. All available data point to the universally inferior position of women. As the 1997 UNDP report (1997) puts it: ‘no society treats its women as well as its men.’ The GDI was calculated for 146 countries (UNDP 1997). The top five ranking countries for gender development were, in order, Canada, Norway, Sweden, Iceland and the USA. Of these, the GDI was the same or higher than the HDI for Canada, Norway, Sweden and Iceland but lower than the HDI for the USA. At the other extreme 39 countries had a GDI value of less than 0.500, indicating that women did not reach even half the average level of human development attainable in these countries.

There are strong, albeit varying, links between gender inequality, human poverty and socioeconomic differentials in all countries. Women constitute more than 70% of the world’s
poor (United Nations Development Report, 1995), the numbers becoming poor are increasing (UNDP, 1998) and women with children are the largest group of people living in poverty, even in developed countries (Belle, 1990; Shaver, 1998). Gender must therefore be taken into account in looking at the way income inequality and poverty impacts on mental health because poverty and female gender are almost coterminous.

Current evidence suggests that inequalities in many countries are widening rather than narrowing (UNDP, 1998). It has been argued that the impact of structural adjustment programs has been especially severe on the poorest nations. Data shows that International Monetary Fund loan conditions demanding lower government expenditures have led to sharp reductions in social spending, with the wealthiest 20% of the population receiving a disproportionately larger share of outlays for health and education (Kolko, 1999).

Although men and women are both affected by ‘restructuring’ in developed countries and Structural Adjustment Programs (SAP) in developing ones, it cannot be assumed they are equally affected. The impact of such programs can occur in gender distinct ways because of the separate roles men and women play and the different constraints they face in responding to policy changes and shifts in relative prices (Kirmani and Munyakho (1996). The conditions attached to structural adjustment loans to developing countries can lead to cutbacks in public sector employment and social welfare spending so that the costs of health care, education and basic foodstuffs can rapidly become unaffordable, especially to the poor, the majority of whom are women (Bandarage, 1997).

Economic policies that cause sudden, disruptive and severe changes to the income, employment and living conditions of large numbers of people who are powerless to resist them, pose overwhelming threats to mental health. It is precisely such disruptive, negative life events that cannot be controlled or evaded that are most strongly related to the onset of depressive symptoms (Broadhead & Abas, 1998; Brown, 1998). For poor, unskilled women even when the impact of international trade changes has been to expand employment opportunities, these have been predominantly in low paid jobs (LeQuesne, 1996). If most job growth for women arising out of globalization is in poor quality, insecure work and goes together with weakened social support systems then occupationally related ill health is likely to increase (Loewenson, 1999).
Evidence is beginning to emerge on the gender specific effect of restructuring on mental health. Patel et al (1999) examined the relationship between common mental disorders - depression, anxiety and somatic symptoms - and restructuring in four developing countries. Data was obtained from primary care attenders in Goa, India, Haraare, Zimbabwe, Santiago, Chile and from community samples in Pelotas and Olinda in Brazil. Significant associations were found across all data sets between high rates of CMD and female gender, low education and poverty. The results of this study underline how gender inequality both accompanies and is exacerbated by economic inequality and rising income disparity and not surprisingly, gives rise to the very mental disorders in which women predominate.

Increasingly, evidence from research shows that policies which bring about significant decreases in social cohesion and increases in inequality, are strongly linked to poor health outcomes. An analysis of the factors associated with decreasing life expectancy between 1990-1994 amongst both men and women in Russia, reported that premature deaths were concentrated in the 30-60 year age group. The most important predictors of decreased life expectancy were the pace of economic transition, characterised by a high turnover of the labour force, inequality and decreased social cohesion together with a concomitant increase in crime and alcoholism (Walberg et al., 1998). Similar findings have emerged from developed countries, where high economic growth but increasing inequality has occurred. In the US increasing income disparity and decreasing social cohesion has been linked to increasing mortality rates (Kawachi & Kennedy, 1997) and poorer, self rated health (Kawachi et al, 1999).

Of course it has long been known that the social environment is of critical importance for health even though the role of gender has not been adequately investigated. Variations in both mortality and morbidity rates by social class are a consistent finding of epidemiology (Macintyre, 1986; Dohrenwend, 1990; Dohrenwend, Levav, Shroult al et al, 1992; Najman, 1993; Kessler et al., 1994; Bartley & Owen, 1996; Stansfield, Head & Marmot, 1998). A steep socioeconomic gradient in health outcomes has been found in most countries and is related to inequalities in health outcomes. Both adverse physical and mental health outcomes are two to two and a half times higher amongst those experiencing greatest social disadvantage compared with those experiencing least disadvantage (Feinstein, 1993; Whitehead et al., 1993; Power, 1994; Kessler et al, 1994; Lahelma et al, 1994; Kunst, Geurt & Van den Berg, 1995; Bartley & Owen, 1996; Macran, Clarke & Joshi, 1996; Wadsworth, 1997; Wilkinson, 1997; Stansfield, Head & Marmot, 1998). Large socioeconomic inequalities in the United States of America and relatively small
ones in Sweden go hand in hand with differences in the health outcomes found in the two countries (Kunst, Geurts & Van den Berg, 1995; Kaplan et al., 1996). This relationship indicates that a steep socioeconomic gradient, with a large discrepancy between the best compared with the worst off, is antagonistic to increasing overall health status and is particularly inimical to improving the health status of women.

In the 1980’s, Helzer et al (1986) summed data across all five research sites involved the very large US Epidemiologic Catchment Area (ECA) study and found that the six month prevalence of any DSM-111 disorder was 2.86 times higher in the lowest socioeconomic status category than in the highest, controlling for age and sex. In this decade, the US National Comorbidity Study, (Kessler et al. 1994) found that for lifetime prevalence, those in the lowest income group were 1.56 times more likely to have an affective disorder, twice as likely to have an anxiety disorder, 1.27 times more likely to have a substance use disorder and 2.98 times more likely to have antisocial personality disorder than those in the highest income group.

There is strong evidence suggesting that environmental stressors such as life events and chronic difficulties are particularly significant in accounting for the lower social class predominance for non-psychotic psychiatric disorders like depression and anxiety. Less control over decision making and the determinants of health and less access to supportive social networks, at both an immediate personal, contextual level and at broader societal level, have also been linked with higher levels of morbidity and mortality (Brown & Harris, 1978; Berkman & Syme, 1979; Brown & Prudo 1981; Milo, 1981; Paykel, 1994; Kessler et al., 1994; Turner & Marino, 1994). Lone mothers with dependent children living in poverty are at particularly high risk for the development of depression (Belle, 1990).

In general, analyses of the social gradient in health outcomes have concentrated on the material indicators of inequality and social disadvantage. However, the widely observed social gradient in physical and mental health also operates on a symbolic and psychological level. Social position implies a certain social rank and knowledge of this rank entails a clear understanding of where one stands in the scale of things. The pervasive finding that GDI is lower than HDI serves as a powerful indication of where women stand. A sense of shame and inferiority, low self esteem, passivity, submissiveness, helplessness and depression have all been documented in relation to perceptions of low or subordinate social rank (Gilbert & Allan, 1998). Yet the very qualities associated with depression, have been regarded as normal and desirable qualities of ‘femininity’
and have been encouraged, reinforced via socialization, custom and tradition and continue to characterize many women’s self regard and social position.

The gender related risks to mental health posed by poverty and inequality link to other psychological, behavioural and gender socialized risk factors known to contribute to higher risks of depression such as rape and violent victimization. Where women lack autonomy, decision making power and access to independent income, many other aspects of their lives and health will necessarily be outside their control (Okojie, 1994) including their susceptibility to communicable diseases (Hartigan, 1999). Gender determined and differentiated levels of susceptibility and exposure to health risks mean that women compared with men confront more stringent limitations on their ability to exercise control over the determinants of their mental health.

5. A Gendered, Social Model of Depression

As noted in the first section depression has been chosen, not only because it is the most prevalent women’s mental health problem, but also because it is likely to be accompanied by other psychological disorders which are more common in women such as anxiety disorders. Furthermore, by far the greatest burden of disability related to mental illness worldwide is that caused by depression (Murray & Lopez, 1996).

The findings of higher rates of depression in women in the National Comorbidity Study (Kessler et al, 1994) are consistent with the results of earlier large scale epidemiologic investigations such as the five site Epidemiologic Catchment Area (ECA) study of more than 20,000 people in the United States (Regier et al, 1993) and the more recent World Health Organization’s (WHO) Collaborative Study on psychological problems in general health care (Gater et al, 1998). The latter study provides invaluable information about depression and anxiety disorders in a range of countries and cultures and reported a female preponderance in diagnoses of depression in many but not all participating centers. Women had consistently higher rates of agoraphobia and panic disorder than men but there was considerable variation between centers in rates of generalized anxiety (Gater et al, 1998). Gender differences in rates of depression are strongly age related with the greatest differences occurring in adult life with no reported differences in childhood and few in the elderly (Vazquez- Barquero et al., 1992; Beekman, Kriegsman & Deeg, 1995; Zunzunegui et al., 1998).
A gendered view of the social conditions and arrangements most likely to produce depression is required. To proceed from a gendered, social model of health requires that women’s mental health is appraised according to theoretical models that can adequately explain how ‘proneness’ and ‘vulnerability’ arise out of women’s social position and their differential susceptibility and exposure to risk factors that might correlate with or lead to poor mental health outcomes. Consequently, social theories and the evidence relating to them will be examined to elucidate the extent to which women’s perceptions of their place in the scale of things and the events which trigger these perceptions, might account for their higher rate of depression.

Wide variations between countries in rates of depression amongst women and men have been reported and suggest the importance of cultural factors and social arrangements in the onset of depressive symptoms (Ustin & Sartorius, 1995; Brown, 1998). In the WHO multicentre study of psychological problems in primary health care, the lowest rate of depression for women, 2.8% was found in Nagasaki while the highest, 36.8% was found in Santiago. Similarly, Brown (1998) commenting on general population studies of women in Zimbabwe, London, Bilbao, the Outer Hebrides, rural Spain and rural Basque Country between 18 and 65 years, reports that the percentage of women meeting criteria for depression varied from a low of 2.4% in the Basque Country to a high of 30% in Zimbabwe. Environmental and social factors, especially, negative, irregular, disruptive life events were found to trigger depression in all six countries as evidenced by the high correlation between such events and rates depression.

Psychosocial factors have been found to contribute significantly to both depression and anxiety, with the population attributable risk around 60% to 65% (Brown, Andrews & Harris, 1986; Finlay-Jones, 1989). In particular Belle’s (1990) review of studies on the psychological effects of poverty, noted that poor women experience more frequent, more threatening and more uncontrollable life events than the general population, including the illness and death of children and the imprisonment of husbands. Mental health risks inherent in poverty include reduced autonomy and decision making latitude, increased exposure to dangerous environments and violence and discrimination, especially for women belonging to minority groups. Conversely, psychosocial resources and the wherewithal to exercise choice and have a sense of control over one’s life are critical bulwarks against depression regardless of a woman’s age. One Spanish study (Zunzunegui et al., 1998), found that for women over the age of 65, the same factors of social and emotional support, having a confidant, social activities and a sense of control over life,
previously identified as important in younger women of childbearing age, were critical in
decreasing the risk of depression.

Other interconnecting risk factors for depression that have been confirmed are childhood
adversity, current marked interpersonal difficulties, lack of social support and severe events.
There is also an increased risk of a depressive episode occurring in the presence of ongoing
anxiety (Goldberg et al., 1990; Brown & Moran, 1994; Brown, Harris & Eales, 1996). This has
led to the identification of three main, interconnecting features of depression in the research of
Brown and his colleagues since the late 1970's. These are: 1) provoking elements or severe life
events, 2) vulnerability factors, which increase risk in the presence of a provoking agent and 3)
symptom formation factors which influence the form, but not the risk of a depressive disorder
occurring, such as the co-morbidity of an anxiety disorder.

Recent research (Brown, Harris and Hepworth, 1995) suggests that 85% of women from the
community (as opposed to a patient group) who developed ‘caseness’ for depression in a 2 year
study period had experienced a severe event in the 6 months before onset. For depression to
occur, the severe event or events will be accompanied by provoking agents and vulnerability
factors, especially those associated with low self-esteem and inadequate support. A matching of
the nature of a current severe event with a pronounced ongoing difficulty has been found to be
While the role of social disadvantage and poverty has been researched from the outset, more
recently, other aspects of adversity have been investigated including such experiences as the
death of a child of any age, death of a husband or partner, two or more abortions, sexual abuse,
and physical violence in the marriage or relationship. (Brown, Bifulco & Andrews, 1990; Bifulco,

Brown, Harris and Eales (1996) argue that:

‘The losses and abuses would be expected to have acted adversely not only on the
availability of support, but also to have increased the negative elements of her self-
evaluation.’
Severe events are defined in terms of immediate and more long term impact of the situation up to 14 days after the event has occurred (Brown, Harris & Hepworth, 1995). Events are also classified with regard to the dimensions of loss and danger. Loss can include the actual loss of a person, through for example death or separation, the loss of a role or of resources, such as might follow unemployment and the loss of a cherished idea. Danger is defined as the threat of a future loss.

However, in reality the same event can involve both loss and danger. In both a patient and non patient sample it was found that loss or danger played a much less important aetiological role in the development of depression, once the humiliation and entrapment aspects of severe events were taken into account (Brown, Harris & Hepworth, 1995). Humiliation and a sense of entrapment could also be used as indicators of a profound sense of inequality and low social position. It is thus highly significant that they so strongly predict the onset of depression when severe events occurred. Almost three quarters of the severe events occurring in the six months prior to the onset of depression involved entrapment or humiliation. Just over one fifth involved loss alone and only 5% concerned danger alone (Brown, Harris & Hepworth, 1995).

Significantly the provoking severe events in almost all instances, concerned a core relationship or tie. This finding accords with theories advanced by self in relation psychologists who posit that women generally subscribe to an ethic of care and place a high degree of importance on the quality of their interpersonal relationships. Women’s sense of self and self regard or esteem is seen to be largely contingent on the perceived success of the interpersonal relationships in which they are strongly psychologically invested (Jordan, Kaylan & Surrey, 1991). Brown, Harris and Hepworth’s (1995) finding that depression during the follow-up period was more likely in women who experienced a loss or sense of defeat in relation to a core role or relationship and for which they had been rated as showing marked commitment at their first interview, further supports this view.

Humiliation remained a defining characteristic of the life difficulties encountered. Brown, Harris and Hepworth (1995) observe it is the meaning attached to an event, or its symbolism, not the event per se, which must be captured accurately if valid constructs of depression are to be developed:
‘Probably equally significant to being humiliated and devalued is what is symbolised by such atypical events in terms of the woman’s life as a whole- in particular, the experience of being confirmed as marginal and unwanted.’ (p19)

On the other hand, autonomy and control, as the obverse of entrapment and humiliation, appear to play a highly significant role in lessening the risk of depression occurring in the context of what might otherwise be considered as a loss. When a separation was initiated by the woman, only about 10% of such subjects subsequently developed depression. When the separation was almost entirely initiated by her partner, around half the women developed depression. The rate of depression increased again, if infidelity was discovered and not followed by separation (Brown, Harris and Hepworth, 1995).

The findings of the research just outlined have been confirmed in the context of a developing country. Broadhead and Abas (1998) conducted a study in a Zimbabwean township, which offered further insight into the strength of the relationship between the nature and frequency of severe events and associated rates of depression. They studied 172 women who were randomly selected, using a modified version of the Life Events and Difficulties Scale (Brown, Harris and Hepworth, 1995) and measured depression and anxiety with the Shona Screen for Mental Disorders. 30.8% of the women were diagnosed as having had a depressive or anxiety disorder during the previous year.

A previous study in Zimbabwe (Abas & Broadhead, 1997) reported an 18% annual incidence of depression, double that found in inner London. In accounting for the much higher rate again in the most recent study, Broadhead and Abas (1998) attributed the excess of onset cases in the study year primarily to the increased numbers of severe and disruptive events and difficulties occurring in these women’s lives. A proportion of the severe events experienced were more threatening than those described in the British research. The severe events reflected, ‘the high levels of physical illness and premature death in family members, the predicaments associated with seasonal migration between rural and urban homes, problems associated with infertility and the large number of marital and other relationship crises.’ (Broadhead & Abas, 1998, p37)

These findings confirm that a linear positive relationship exists between the number and severity of events and the prevalence of depression (Brown, 1998). They also indicate how interpersonal relationships can function as ‘conduits of stress’ (Belle, 1990) rather than sources of social
support and that these are heavily impacted upon by the social, occupational and environmental difficulties linked to particular places.

The idea that depression is closely connected to a sense of loss and defeat, especially that characterised by entrapment, and humiliation denoting devaluation and marginalisation, has also been advanced from a slightly different perspective by another group of researchers (Gilbert, 1992; Craig, 1996; Allan & Gilbert, 1997; Broadhead & Abas, 1998; Gilbert & Allan, 1998). Social rank theory highlights several key variables in the development of depression. These include perceptions of the self as inferior or in an unwanted subordinate position, low self confidence and behaving in submissive or non assertive ways, having a sense of defeat in relation to important battles, and at the same time, wanting to escape but being trapped. All these variables have a high risk of occurring in women.

Rank in a work situation has also been found to be highly predictive of depression. Stansfield, Head and Marmot (1998) found that the rank or grade of employment was significantly related to well being. Work characteristics, especially skill discretion and decision authority were closely related to employment grade and made the largest contribution to explaining differences in well being and depression. Those in the highest grades had the highest levels of well being and the least depression and those in the lowest grades had the highest levels of depression. Those in the lowest employment grades also had a higher prevalence of negative life events and chronic stressors and less social support. Interesting gender differences to emerge were that women’s well being was improved more by contact with friends than relatives and that material problems were more important for women than men in explaining the gradient in well being. It goes without saying that women generally occupy lower status jobs with little decision making discretion.

Gender socialization which stresses passivity, submission and low self esteem in women is reinforced by their structural position in paid employment where they typically receive less pay and have lower status jobs than men - both risk factors for depression. Taken together the evidence relating to social theories of depression as described here, support Stein’s (1997) view that perceptions of equity and equality - the meaning and symbolism attached to particular events and experiences - accurately reflect where one stands in the scale of things, and strongly influences women’s mental health.
While the research reviewed in this section has concentrated on the subjective correlates of events related to subordinate status or lower rank, much previous research has documented the relationship between various objective measures of rank and the increased likelihood of depression and anxiety. These included a series of factors which are often reciprocally related with gender and with one another such as low educational status, unemployment or low employment status, single parent status, homelessness and insecure housing tenure, inadequate income and poor social support including unsatisfactory interactions with neighbours and relatives (Goldberg et al., 1990; Belle, 1990; Pill, Peters & Robling, 1993; Ustin & Sartorius, 1995).

### 6. Gender Based Violence and Mental Health

Perhaps the most potent gender difference in determining a sense of where one stands in the scale of things, is the repeated experience of interpersonal violence and its characteristic emotional abuse. As one of the Nicaraguan respondents in Ellsberg’s (1997) study described:

> He used to tell me, “you’re an animal, an idiot, you are worthless”. That made me feel even more stupid. I couldn’t raise my head.

Violence against women whether by their intimate partners or men not known to them, is probably the most prevalent and certainly, the most emblematic gender based cause of depression in women. This is because violence against women encapsulates all three features identified in social theories of depression - humiliation, inferior social ranking and subordination, and blocked escape or entrapment.

Violence is a solvent of autonomy, a crucial violation of the human right to liberty and freedom from fear and the means by which coercive control can be gained over every aspect of a woman’s functioning that affects her physically, sexually, emotionally, socially and economically. Violence against women is rightfully perceived as a priority public health and human rights issue (WHO, 1997). In 1992, the American Medical Association Council on Scientific Affairs noted that:

> 'Women in the United States are more likely to be assaulted and injured, raped, or killed by a current or ex-male partner than by all other types of assailants combined.’ (p3185)
A variety of terms have been used to describe this violence including spouse abuse, wife abuse, intimate partner violence, gender based violence, sexualised violence, domestic violence and family violence. No single term is universally agreed upon but there is broad consensus on the interrelated elements that define violence. Characteristically these elements are highly congruent and sometimes identical with the features of depression previously described. Violence has been taken to include any act of verbal or physical force, coercion or life-threatening deprivation, directed at any individual woman or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty and that perpetuates female subordination (Heise, Pitanguy, & Germain, 1994).

Such violence can and does occur over the lifespan, although the peak incidence of physical and sexual violence occurs in young women (Australian Bureau of Statistics (ABS), 1996; Coyle Wolan & Van Horn, 1996; Acierno, Resnick & Kilpatrick, 1997; Fleming, 1997). Studies on the prevalence and physical health outcomes of violence against women will not be reviewed here as they are discussed fully in another working paper (Garcia-Moreno, 1999).

Violence against women takes place in a variety of settings. While most violence takes place at home, being at work offers no immunity, although data are still sparse (Chappell & Di Martino, 1998). In 1993, workplace homicide in the US was primary cause of fatal occupational injuries for women (Hewitt & Levin, 1997). Women can also encounter violence when seeking health care. Women with a prior history of childhood sexual abuse who consult psychiatrists for help may be at special risk of professional sexual misconduct and ‘boundary violations’ (Gabbard & Nadelson, 1995). Furthermore, most research conducted so far has been on violence against women perpetrated in ‘peace’ time in their own countries and their own homes. In wartime, violence typically escalates when women become a particular focus of brutal, organised sexual violence by the opposing armed forces (Littlewood, 1997; Dahl, Mutapcic & Schei, 1998) (1997).

What most distinguishes the violence women experience compared to that experienced by men, is the likelihood of the violence being perpetrated by someone they know and usually, someone they should be able to trust. If the idea of having a home encompasses living in a place that affords physical and psychological safety and security, then a child or a woman experiencing violence in her own home is in a very real sense, homeless. Such a woman may have shelter, but she does not have a place where she can safely let her defences down. Violence in the home tends to be repetitive and to escalate in severity over time (American Medical Association, 1992).
The increased risk of violence from an intimate has been documented for children and adults. Studies on childhood sexual abuse have consistently found children are most at risk of abuse from family members and those known to them, who often occupy a caretaking role (Russell, 1983, 1986; Margolin, 1992; Yama, Tovey & Fogas, 1993). When a child is abused by a relative, the abuse is more likely to occur repeatedly and over a longer period of time, than if the abuser is someone outside the family (Russell, 1986; Brown & Anderson, 1991; Beitchman et al., 1992; Anderson et al., 1993; Fleming, 1997). For adults too, the perpetrator is usually someone known. The National Comorbidity Study (Kessler, Sonnega, Bromet, Hughes, Nelson, 1995) found women compared with men had a greatly increased risk of being assaulted by intimates, although they had lower lifetime rates of physical attack. This fact deserves special attention when seeking to explain the gender difference in depression, psychotropic drug use and the gender specific psychological response to violence such as the higher rates of posttraumatic stress disorder in women compared with men and their related increased risk of experiencing sexual assault and rape (Breslau, Chilcoat, Kessler et al, 1999).

It is important to note that the different forms of violence described often occur together, thus exacerbating the traumatic potential of the experience. For example, physically threatening acts are often accompanied by verbal abuse, threats and by sexual violence as well (American Medical Association on Scientific Affairs, 1992). Thirty three to 50% women who are physically assaulted by their partners are sexually assaulted as well (Frieze & Browne, 1989; Ellsberg, 1997) and Coyle, Wolan and Van Horn (1996) found that 27% of the women in their study, reported all three forms of abuse- physical, sexual and emotional.

Emotional and psychological abuse often includes manipulation, social isolation from family and friends, economic dependence and intimidation as well as denigration and humiliation. More importantly, the coexistence of emotional or psychological abuse with physical violence appears to be even higher than the coexistence of physical and sexual abuse. Ratner (1993) in a Canadian study reported that 93% of women who were experiencing physical violence also reported concurrent psychological abuse. In her study on domestic violence against women in Nicaragua, Ellsberg (1997) found that 94% of the women living with physical violence also reported verbal insults and humiliations, while 36% reported they were commonly forced to have sex while being beaten.

Evidence strongly suggests that violence is linked to a high rate of co morbid psychopathology, multi-somatisation, altered health behaviours and increased rates of health problems affecting many
body systems. A few studies designed to be able to make multiple diagnoses have found them but most studies have concentrated on either psychological or physical comorbidity but not both together (Brown & Anderson, 1991; Pribor & Dinwiddie, 1992; Walker et al., 1995; Resnick, Acierno, Kilpatrick, 1997; Roberts et al., 1998). There is an obvious need to examine whether the comorbid conditions associated with violence explain the predominance of women with comorbid disorders identified in the National Comorbidity Study (Kessler et al, 1994).

The severity of the psychological response to violence is partly dependent on whether there is a previous history of victimization. Those who have experienced violence in childhood are far more likely to experience later victimization than those who have not (Beitchman et al., 1992; Resnick et al., 1993). Victims of child sexual assault are two to four times more likely to be raped in adulthood than non-victims, and are at heightened risk of experiencing other forms of victimisation (Russell, 1986; Simons & Whitbeck, 1991; Wyatt, Guthrie & Notgrass, 1992). The risk of experiencing an additional assault, even after controlling statistically for the effect of age, race, education and substance use, has been found to be five times greater for women who had already been assaulted (Resnick et al, 1997). Not only is revictimization common, but it increases the psychological harm which occurs. For women with histories of prior victimisation, rape is followed by particularly severe after effects (Sorenson & Golding, 1990). As a result revictimisation represents an outcome of past violence and a risk factor for increasing the occurrence of and compounding the psychological effects of current or future violence.

7. Psychological Consequences of Violence

It is indisputable that violence is associated with multiple negative mental health consequences. Markedly increased rates of depression and anxiety among women who have a history of CSA have been identified in community samples (Finkelhor et al., 1990; Bifulco, Brown & Adler, 1991; Mullen et al., 1988; Anderson et al., 1993) and psychiatric samples (Brown & Anderson, 1991; Pribor & Dinwiddie, 1992; Waller, 1994). Multiple psychiatric diagnoses have commonly been found amongst survivors of CSA (Pribor & Dinwiddie, 1992). Women who have experienced violence also have increased rates of depression and anxiety, dysthymia, stress related syndromes, phobias, substance use and suicidality, to name but some (Beitchman et al, 1992; Koss & Heslet, 1992; Koss, 1994; Fischbach & Herbert, 1997; Golding, Cooper & George, 1997; Campbell & Lewandowski, 1997; Resnick, Acierno & Kilpatrick, 1997; Morris, Martin & Romans, 1998; Roberts et al, 1998). Of all the adverse psychological outcomes documented by far the most commonest are markedly increased rates of depression and anxiety (Mullen et al., 1988; American
Medical Association on Scientific Affairs, 1992; Gleason, 1993; Saunders, Hamberger & Hovey, 1993; Campbell, Kub & Rose, 1996; Campbell & Lewandowski, 1997).

Moreover, there is growing evidence to support the view that the relationship between violence and depression is causal. This is suggested by several findings. First, marked reductions in the level of depression and anxiety once women stop experiencing violence (Campbell et al, 1994) compare to increases in depression and anxiety when violence is ongoing (Sutherland, Bybee & Sullivan, 1998). Second, the severity of violence appears to predict the severity of the psychological outcomes. This ordinal relationship has been found in studies on the mental health impact of domestic violence (Roberts et al 1998) and of child sexual abuse. Third, case control studies have found significantly different rates of depression and anxiety between cases, who have experienced violence and controls who have not (Mullen et al, 1988; Saunders, Hamberger & Hovey, 1993).

It is therefore of considerable interest to examine the common features of violence and depression using the social model of depression described in the previous section as an explanatory framework. To begin with, humiliation and entrapment, which played such a prominent role in determining caseness for depression, are the defining features of partner violence. Ellsberg (1997) in summarising 25 years of research on partner violence concluded that:

‘This research has consistently pointed to a series of characteristics which define the experience of battering for women, and conceptualizes violent relationships as an ongoing process of entrapment and diminished coping capacity.’ (p11)

The way in which constant denigration and humiliation enforce a sense of subordination and inferior social ranking and serve to diminish coping capacity is evident in the comment from one of the participants in Ellsberg’s research some time after she had left her violent husband:

'I think I still have scars from this, and I have always been insecure… I would think, could it be that I really am stupid? I accepted it, because after a point… he had destroyed me by blows and psychologically….‘ (Ana Christina, Paper 11, p8)

The notions of loss and defeat (Brown, Harris & Hepworth, 1995), implicated in the development of depression in women, also figure significantly as psychological reactions to the experience of violence. Violence involves loss and defeat on several levels - the loss of a sense of self and other (as
previously imagined), the loss of a safe relationship and the loss of a cherished idea (being loved and unharmed).

In the context of an intimate attachment relationship and a role to which a woman is often highly committed psychologically, the cyclical, generally escalating nature of physical violence punctuated by acute battering incidents corresponds to the matching of ongoing marked difficulty with a severe event (the acute battering incident). Brown, Harris and Hepworth (1995) contend this combination is particularly likely to provoke a depressive disorder.

Self blame, loss of sense of self, and damaged self esteem are common consequences of violence. Violence is a means of forcing submission and enforcing inferior social ranking and subordination. Both effects engender a sense of defeat and a loss of self esteem. The coercive control characteristic of violent relationships appears to be likely to cause the ‘entrapment’, already identified as playing a crucial role in the development of depression. This becomes clear if the increased rates of suicidal behaviour consequent on the experience of violence are considered.

One quarter of all suicide attempts by women in one study were preceded by physical abuse and in African American women this increased to half of all those who had attempted suicide (Stark & Flitcraft, 1996). In other countries, such as China and India, high rates of suicide by women have also been noted (Murray and Lopez, 1996) although the precipitating role of violence has not been fully documented. In community samples of non treatment seeking women, between 17% and 19% of those who had been raped had made suicide attempts (Kilpatrick, Veronen & Best, 1985; Resick et al., 1989) Feelings of self blame, a heightened sense of vulnerability, isolation and mistrust of others were common.

Suicidal behaviour needs to be placed within the context of violent victimisation of increasing severity up to and including murder as between one third and one half of all female homicide victims in the US have been murdered by their male partners, many after prolonged periods of victimisation (Kellerman & Mercy, 1995). From this perspective suicide may represent to the battered woman, the only remaining escape from a situation of entrapment when all other forms of escape are literally and metaphorically ‘blocked’ (Brown, Harris & Hepworth, 1995; Stark & Flitcraft, 1996). In other words entrapment, which plays such a critical role in the onset of depression, is a defining characteristic of violent relationships.
The psychological impact of violence may be seen to proceed from an experience of personal informed by a broader social context where the unequal treatment of women remains normative, as shown in the gender development and empowerment rankings discussed earlier.


Not only is there a social gradient for depression which is heavily gendered but this in turn is women experience an increased risk for victimization when their income is below the poverty level unemployment, reduced income and divorce (Byrne et al, 1999). In other words, violence can further depression and other disorders.

Increased rates of depression and anxiety figure prominently in these adverse outcomes but violence process involved in increasing the multiple and interrelated conditions associated with violence is the

8. Policy Recommendations

several developments are necessary in the area of policy, research and clinical practice if the reduced by 2020. Extrapolating from the WHO (1981) definition of mental health implies that the environment must inform policy development. Gendered public policy, cognisant of these facilitate optimal development and the use of mental abilities, and work towards the achievement
of goals consistent with justice and gender equality. In particular, a gendered view of social
capital is essential. Without this perspective long standing gender inequities and gender blind
policy making will continue to systemically disadvantage women, erode the social capital
available to them and thus continue to compromise their mental health.

Attention is required in three main areas, namely the gender determinants of mental health,
gender considerations in health promotion and health care and gender focus in mental health
research.

Gender determinants of mental health:

- Increased research needs to be undertaken with a sharper focus on gender specific structural
disadvantage and increased vulnerability to the negative mental health impacts of rapid
socioeconomic change consequent on structural adjustment and globalization. Such evidence
is urgently needed to inform policy and programs and provide accurate information on the
health and human costs of economic change. Without gender equity in the distribution of the
profits associated with economic growth, an unacceptable rise in the rates of common mental
disorders concentrated amongst poor women is likely to occur (Patel et al, 1999).

- Intersectoral collaboration and 'across government' gender sensitive policy making in
education, social security, housing, transport and employment as well as health, is needed to
ensure that the multiple structural determinants of mental health can be facilitated to work in
positive synergy with one another and maintain social capital and support social networks
(Kawachi et al, 1997; 1999). Social 'safety nets' are particularly important for women given
their overrepresentation amongst those living in poverty and dependent on social security
support.

Gender considerations in health promotion and health care:

- Mental health promotion strategies must embrace a broader conceptualization of mental
health such that multiple, reciprocal levels of functioning between the individual, the group
and the broader social environment are recognised in any program that attempts to increase
control over the determinants of mental health and behavioural change.
Gender equity and access considerations must be recognised in mental health promotion and
and modifiability of health risk factors. Programs that focus solely on individual 'lifestyle'
factors are in danger of ignoring the structural disadvantage in which behavioural risk factors

- mental health risks and the socioeconomic and cultural determinants of mental health. There is
an especially pressing need for improved detection and treatment of both depression and

- to be designed using culturally appropriate formats in order to counter cultural beliefs and
attitudes that condone and perpetuate violence and to reduce the prevalence and adverse mental

- unmet need for improved access, to low or preferably no cost gender sensitive counselling
services.

- together with the heightened burden of disability associated with comorbidity argues for gender
focussed research to clearly identify risk factors for comorbidity. In particular, the complex
context of a history of violent victimization need to be clarified.

- The mental health aspects of reproductive health for both women and men need to be better
recognised. To extend understanding beyond a simple, biological reductionist model, a gendered,
and alleviation of emotional distress related to infertility, pregnancy, childbirth and parenting.
Improving reproductive health outcomes of women in developing countries is unlikely to be
achieved unless women’s own mental health concerns and life priorities are taken into account in program design and implementation (Avotri & Walters, 1999).

- The gendered mental health aspects of physical health problems outside the sphere of reproductive health are not well understood and have received little investigation. The link between gender, depression and cardiovascular disease (Musselman, Evans & Nemeroff, 1998) suggests the need for a broader research agenda incorporating gender, mental and physical dimensions of health, if significant associations are not to be overlooked.

Finally, women's status and life opportunities remain 'tragically low' worldwide (WHO, 1998) and must be improved. The experiences of self worth, competence, autonomy, economic independence and physical, sexual and emotional safety and security so essential to good mental health are systematically denied to countless women simply because they are women. Such gender based discrimination is not only a gross violation of human rights but directly contributes to the growing burden of disability caused by poor mental health.
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