

**DEPARTMENT OF MENTAL HEALTH AND
SUBSTANCE DEPENDENCE**

GENDER DISPARITIES IN MENTAL HEALTH



WORLD HEALTH ORGANIZATION

EXECUTIVE SUMMARY

This paper examines current evidence regarding rates, risk factors, correlates and consequences of gender disparities in mental health. Gender is conceptualized as a structural determinant of mental health and mental illness that runs like a fault line, interconnecting with and deepening the disparities associated with other important socioeconomic determinants such as income, employment and social position.

Gender differentially affects the power and control men and women have over these socioeconomic determinants, their access to resources, and their status, roles, options and treatment in society. Gender has significant explanatory power regarding differential susceptibility and exposure to mental health risks and differences in mental health outcomes. Gender differences in rates of overall mental disorder, including rare disorders such as schizophrenia and bipolar disorders, are negligible. However, highly significant gender differences exist for depression, anxiety and somatic complaints that affect more than 20% of the population in established economies. Depression accounts for the largest proportion of the burden associated with all the mental and neurological disorders and is a particular focus of this paper. It is predicted to be the second leading cause of global burden of disease by 2020.

To address this mounting problem, a much improved understanding of the gender dimensions of mental health is mandatory. Evidence is available on some aspects of the problem but serious gaps remain. It is known that:

- Rates of depression vary markedly between countries suggesting the importance of macrosocial factors. Nevertheless, depression is almost always reported to be twice as common in women compared with men across diverse societies and social contexts.
- Despite its high prevalence, less than half the patients with depression disorder are likely to be identified by their doctors in primary care settings. Gender differences in patterns of help seeking and gender stereotyping in diagnosis compound difficulties with identification and treatment. Female gender predicts being prescribed psychotropic drugs. Even when presenting with identical symptoms, women are more likely to be diagnosed as depressed than men and less likely to be diagnosed as having problems with alcohol.
- Men predominate in diagnoses of alcohol dependence with lifetime prevalence rates of 20% compared with 8% for women, reported in population based studies in established economies. However, depression and anxiety are also common comorbid diagnoses, highlighting the need for gender awareness training to overcome gender stereotypes and promote accurate diagnosis of both depression and alcohol dependence in men and women if they are present.
- Comorbidity is associated with mental illness of increased severity, higher levels of disability and higher utilization of services. Women have higher prevalence rates than men of both lifetime and 12 month comorbidity involving three or more disorders. Depression and anxiety are the most common comorbid disorders but concurrent disorders include many of those in which women predominate such as agoraphobia, panic disorder, somatoform disorders and post traumatic stress disorder.
- Reducing the overrepresentation of women who are depressed must be tackled as a matter of urgency in order to lessen the global burden caused by mental and behavioural disorders by 2020. This requires a multi-level, intersectoral approach, gendered mental health policy with a public health focus and gender-specific risk factor reduction strategies, as well as gender sensitive services and equitable access to them.

- Gender acquired risks are multiple and interconnected. Many arise from women's greater exposure to poverty, discrimination and socioeconomic disadvantage. The social gradient in health is heavily gendered, as women constitute around 70% of the world's poor and earn significantly less than men when in paid work.
- Low rank is a powerful predictor of depression. Women's subordinate social status is reinforced in the workplace as they are more likely to occupy insecure, low status jobs with no decision making authority. Those in such jobs experience higher levels of negative life events, insecure housing tenure, more chronic stressors and reduced social support. Traditional gender roles further increase susceptibility by stressing passivity, submission and dependence and impose a duty to take on the unremitting care of others and unpaid domestic and agricultural labour. Conversely, gains in gender development that improve women's status are likely to bring with them improvements in women's mental health.
- Globalization has overseen a dramatic widening of inequality within and between countries including gender-based income disparities. For poor women in developing countries undergoing restructuring, rates of depression and anxiety have increased significantly. Increased sexual trafficking of girls and women is another mental, physical, sexual health and human rights issue. The mental health costs of economic reforms need to be carefully monitored.
- Finally, the epidemic of gender based violence must be arrested. The severity and the duration of exposure to violence are highly predictive of the severity of mental health outcomes. Rates of depression in adult life are 3 to 4 fold higher in women exposed to childhood sexual abuse or physical partner violence in adult life. Following rape, nearly 1 in 3 women will develop PTSD compared with 1 in 20 non victims. Current levels of detection of violent victimization are poor and primary health care providers require better training to intervene successfully to arrest the compounding of mental health problems.
- Rates of psychiatric comorbidity and multi somatization are high, but neither well identified nor treated. The gendered nature of comorbidity poses complex therapeutic challenges regarding detection and appropriate models of care.
- Research needs to be conducted into the relationship of violence to comorbidity. Women are at significantly increased risk of violence from an intimate and are over represented amongst the population of highly comorbid people who carry the major burden of psychiatric disorder. Equally, research is needed to understand better the sources of resilience and capacity for good mental health that the majority of women maintain, despite the experience of violence in their lives.
- Access to safe affordable housing is essential if women and children are to escape violent victimization and the cessation of violence is highly therapeutic in reducing depression. Improved balance in gender roles and obligations, pay equity, poverty reduction and renewed attention to the maintenance of social capital would further redress the gender disparities in mental health.

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GENDER DISPARITIES IN MENTAL HEALTH

BACKGROUND

Data on the size of the global burden of mental disorders reveal a significant and growing public health problem (Murray & Lopez, 1996). Mental illness is associated with a significant burden of morbidity and disability and lifetime prevalence rates for any kind of psychological disorder are higher than previously thought. Rates are increasing in recent cohorts and affect nearly half the population (Kessler, McGonagle, Zhao et al, 1994; WHO & ICPE, 2000).

Despite being common, mental illnesses are under diagnosed by doctors. Less than half of those who meet diagnostic criteria for psychological disorders are identified by their primary care providers (Üstün & Sartorius, 1995). Patients, too, appear reluctant to seek professional help. Only 2 in every 5 people experiencing a mood, anxiety or substance use disorder report seeking assistance in the year of the onset of the disorder (WHO & ICPE, 2000).

Other factors besides patient reluctance determine mental health care service utilization. Of increasing importance is the way mental health care is financed and organized including the shift to 'user pays' health policies. Income level and medical insurance status can significantly predict access, particularly to specialist care (McAlpine & Mechanic, 2000; Alegria, Bijl, Lin et al, 2000)

Overall rates of mental disorder are almost identical for men and women (Kessler, McGonagle, Zhao et al, 1994) but striking gender differences in the patterns of mental illness.

GENDER, HUMAN RIGHTS AND THE GLOBAL BURDEN OF DISEASE

Gender is a critical determinant of health, including mental health. It influences the power and control men and women have over the determinants of their mental health, including their socioeconomic position, roles, rank and social status, access to resources and treatment in society. As such, gender is important in defining susceptibility and exposure to a number of mental health risks.

If it is accepted that both women and men have a fundamental right to mental health, it becomes impossible to examine the impact of gender on mental health without considering gender-based discrimination and gender-based violence. Consequently, a human rights framework is needed to interpret gender differences in mental health and to identify and redress the injustices that lead to poor mental health. Many of the negative experiences and exposures to mental health risk factors that lead to and maintain the psychological disorders in which women predominate involve serious violations of their rights as human beings including their sexual and reproductive rights. The 1999 Human Development Report, referring to the increase in organized crime related to globalization, noted an escalation in the trafficking of women and girls for sexual exploitation - some 500,000 girls and women trafficked to Western Europe alone - and described trafficking as one of the 'most heinous violations of human rights'. The multiple, severe mental health consequences of sexual violence and abuse are discussed below.

GENDER AND PATTERNS OF MENTAL DISORDER

In examining the role of gender in mental illness a distinction needs to be made between the low-prevalence and severe mental disorders such as schizophrenia and bipolar disorder, where no consistent gender differences in prevalence rates have been found, and the high-prevalence disorders of depression and anxiety where large gender differences in rates have been consistently reported. Depression and anxiety, often associated with somatic complaints, are known to affect around 1 in 5 people in the general community and more than 2 in 5 primary care attenders in a variety of countries (Üstün & Sartorius, 1995; Patel, 1999).

General population studies indicate that lifetime prevalence rates for schizophrenia and bipolar disorder range from 0.1% to 3% for schizophrenia and from 0.2% to 1.6% for bipolar disorders (Piccinelli & Homen 1997) and no significant gender differences have been reported.

Differences in rates of disorder are only one dimension of the role played by gender in mental health and illness. Beyond rates, gender is related to differences in risk and susceptibility, the timing of onset and course of disorders, diagnosis, treatment and adjustment to mental disorder.

A comprehensive review of schizophrenia research found frequent reports of gender differences in age of onset of symptoms. Men typically had an earlier onset of symptoms than women and poorer premorbid psychosocial development and functioning (Piccinelli & Homen, 1997). Despite later onset, some studies report that women experience a higher frequency of hallucinations or more positive psychotic symptoms than men (Lindamer et al. 1999). Similarly, while the population prevalence rates of bipolar disorder appear not to differ, gender differences occur in the course of the illness. Women are more likely to develop the rapid cycling form of the illness, exhibit more comorbidity (Leibenluft, 1997) and have a greater likelihood of being hospitalized during the manic phase of the disorder (Hendrick, Altschuler, Gitlin et al. 2000).

A number of studies report that women with schizophrenia have higher quality social relationships than men. However, a cross national survey drawn from Canada, Cuba and the USA (Vandiver, 1998) found that this was only true for Canadian women; Cuban men reported higher quality of life than Cuban women. A Finnish study on gender differences in living skills, involving self care and shopping, cooking and cleaning for oneself, found that half the men but only a third of the women lacked these skills that are so important for independent living (Hintikka et al., 1999). Thus skills inculcated through gender socialization can affect long term adjustment to and outcome of a severe mental disorder.

Gender specific exposure to risk also complicates the type and range of adverse outcomes associated with severe mental disorder. When schizophrenia coexists with homelessness, women experience higher rates of sexual and physical victimization, and more comorbid anxiety, depression and medical illness than men (Brunette & Drake, 1998).

1. Gender and Depression

Depression contributes most significantly to the global burden of disease and it is the most frequently encountered women's mental health problem (Piccinelli & Homen, 1997). Unipolar or major depression occurs approximately twice as often in women as in

men and is predicted to be the second leading cause of global disease burden by 2020 (Murray & Lopez 1996). Any significant reduction in the overrepresentation of women who are depressed would make a significant contribution to reducing the global burden of disease and disability. Depression and anxiety are the most common comorbid disorders and a significant gender difference exists in the rate of comorbidity (Linzer et al., 1996). Comorbidity contributes significantly to the burden of disability caused by psychological disorders (Kessler et al, 1994; Üstün & Sartorius 1995, WHO & ICPE, 2000).

The gender difference in depression is one of the most robust findings in psychiatric epidemiology. A comprehensive review of almost all general population studies conducted to date in the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, reported that women predominated over men in lifetime prevalence rates of major depression (Piccinelli & Homen, 1997). This difference is documented in clinical and community samples and across racial groups (Kessler et al., 1994; Gater et al., 1998, WHO & ICPE, 2000). Depression may also be more persistent in women (Bracke, 2000) and female gender is a significant predictor of relapse (Kuehner, 1999).

The US National Comorbidity Survey (Kessler et al.,1994), like many other studies before and since (Üstün & Sartorius 1995; Linzer et al., 1996; Brown, 1998), found women had a higher prevalence of most affective disorders and non affective psychosis and men had higher rates of substance use disorders and antisocial personality disorder.

The most common disorders were major depression and alcohol dependence and these disorders are often co-morbid for men with alcohol dependence. Both showed large gender differences in prevalence, as seen in the following table.

National Comorbidity Survey: Prevalence rates of selected disorders

Mental Disorders	Lifetime Prevalence Female	Lifetime Prevalence Male	12 Month Prevalence Female	12 Month Prevalence Male
Major depressive episode	21.3%	12.7%	12.9%	7.7%
Alcohol dependence	8.2%	20.1%	3.7%	10.7%
Antisocial personality disorder	1.2%	5.8%	NA	NA

(Source: Kessler et al., 1994)

In addition, while completed suicide rates are higher in men, a nine country study reported that women had consistently higher rates for suicide attempts (Weissman, Bland, Canino et al, 1999). Gender-based violence is a significant predictor of suicidality in women, with more than 20% of women who have experienced violence attempting suicide (Stark & Flitcraft, 1996). Rates of both suicide ideation and suicide attempts vary widely between countries (Weissman, Bland, Canino et al, 1999).

Women also have significantly higher rates of post traumatic stress disorder (PTSD) than men (Kessler et al, 1995). General population surveys have reported that around 1 in every 12 adults experiences PTSD at some time in their lives and women’s risk of developing PTSD following exposure to trauma is approximately twofold higher than

men's (Breslau et al, 1998), and thus paralleling the difference found in rates of depression.

2. Gender and Comorbidity

Depression and anxiety are common comorbid diagnoses and women have higher prevalence than men of both lifetime and 12 month comorbidity of three or more disorders (Kessler et. al., 1994, WHO & ICPE, 2000). Almost half of patients with at least one psychiatric disorder have a disorder from at least one other cluster of psychiatric disorders (Üstün & Sartorius, 1995). These clusters included most disorders, apart from alcohol dependence, in which women have already been found to predominate (Russo, 1990), including depressive episode, agoraphobia, panic disorder and generalized anxiety; somatisation, hypochondriasis and somatoform pain. Psychiatric comorbidity, with depression as a common factor, is a characteristic finding of many studies on women's mental health (Brown et al. 1996; Linzer, Spitzer, Kroenke et al, 1996) and a repeated finding from studies on the mental health effects of violence from an intimate (Resnick et al., 1997).

Recent research findings have pointed to the need for improved recognition of the presence and significance of comorbid conditions. Comorbidity is associated with increased severity, higher levels of disability and higher utilization of services and is concentrated in a small group of people. Highly comorbid people, who as a group represent about one sixth of the population between 15 and 54 years in the US, have been found to carry the major burden of psychiatric disorder (Kessler et al, 1994). When all lifetime disorders were examined in the National Comorbidity Survey only 21% occurred in people who over their lifetime had experienced only one disorder, while 79% of lifetime disorders, in this sample, were comorbid disorders. For 12 month disorders, the findings were even stronger. It is therefore of considerable importance that women had significantly higher lifetime and 12 month comorbidity of three or more disorders than men in this and other studies (Üstün & Sartorius 1995, WHO ICPE, 2000).

Subsequent analysis of data from the National Comorbidity Survey reported strong associations between panic attacks and panic disorder and major depression, with panic attacks being predictive of the first onset of major depression and primary depression predicting a first onset of subsequent panic attacks. Of gender significance was the finding that this relationship was weaker when the influence of prior traumatic experiences and histories of other mental disorders were statistically controlled in the analysis (Kessler, Stang, Wittchen et al, 1998).

The multi-country WHO study on Psychological Problems in General Health Care also found that current panic attacks and a diagnosis of panic disorder were frequently associated with the presence of a depressive disorder. Women predominate in all three disorders- panic attacks, panic disorder and depressive disorder. The combination of these disorders resulted in a long lasting and severe disorder that was linked to a higher rate of suicidality. (Lecrubier & Ustun, 1998).

3. Comorbidity and compounding over time

It is not only the co presence of multiple disorders at one point in time that needs urgent attention. Clinicians, policy makers and researchers also require a better understanding of why psychological disorders compound and proliferate over the life course of a sub group of highly comorbid people, women in particular, in order to devise effective interventions.

For example, patients who are initially free from disability, but then experience a depressive illness, can experience a change in their disability status which may gather momentum over time. Ormel, Vonkorff, Oldehinkel et al. (1999) found that the risk of onset of physical disability, even after controlling for the severity of the physical disease, increased 1.5 fold three months after the onset of a depressive illness and 1.8 fold at 12 months. The risk of onset of social disability increased even more significantly from a 2.2 fold risk at 3 months to a 23 fold risk at 12 months.

Of particular importance is the need to identify women who have a history of and/or are currently experiencing violent victimization. Violence related health outcomes including higher rates of depression and post traumatic stress disorder increase and compound when victimization goes undetected. This results in increased and more costly utilization of the health and mental health care system (AMA, 1992; Koss, 1994; Acierno, Resnick and Kilpatrick, 1998).

GENDER BIAS

I Research

Gender bias has skewed the research agenda. The relationship of women's reproductive functioning to their mental health has received protracted and intense scrutiny over many years while other areas of women's health have been neglected. Recent research suggests that the impact of biological and reproductive factors on women's mental health is strongly mediated and, in many cases disappears, when psychosocial factors are taken into account. For example, research on menopause has revealed that emotional well being in middle aged women is positively associated with their current general health status, psychosocial and lifestyle variables, but not with their menopausal status nor their hormone levels (Dennerstein, Dudley and Burger, 1997).

By contrast, the contribution of men's reproductive functioning to their mental health has been virtually ignored. The few studies that have been conducted reveal that men are emotionally responsive to many of the same events as women. For example, men as well as women experience depression following the birth of a child and there is a high level of correlation between parents regarding depressive symptoms (Soliday, McCluskey-Fawcett and O'Brien, 1999).

Health programmes directed towards women have typically had a narrow focus on reproductive health and fertility control, especially in developing countries. The preoccupations of health planners, aid agencies and researchers are not necessarily shared by the women towards whom these programmes are directed. In a study conducted in the Volta region of Ghana, nearly three quarters of the women, when asked to identify their most important health concerns, nominated psychosocial health problems such as 'thinking too much' and 'worrying too much', not reproductive health concerns (Avotri & Walters, 1999). The explanations women gave of their health problems stressed heavy workloads, the gendered division of labour, financial insecurity and unremitting responsibility for the care of children.

2. Treatment

Gender bias and stereotyping in the treatment of female patients and the diagnosis of psychological disorders has been reported since the 1970's (Broverman, Vogel,

Broverman et al., 1972). Recent research findings are less consistent. Some have found that doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms (Callahan, Bertakis, Azari et al, 1997; Stoppe, Sandholzer, Huppertz et al, 1999). However, no gender difference in the detection of depression and anxiety disorders by doctors was found in the multi country WHO study of psychological problems in general health care (Gater et al, 1998). Detection or identification of psychological disorder is an important first step in improving the quality of care, but one which must be followed by effective treatment to have a positive effect on outcome.

Female gender is a significant predictor of being prescribed psychotropic drugs. It has also been reported that women are 48% more likely than men to use any psychotropic medication after statistically controlling for demographics, health status, economic status and diagnosis (Simoni-Wastila, 2000).

Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Men are also more likely than women to disclose problems with alcohol use to their health care provider (Allen, Nelson, Rouhbakhsh et al, 1998). This suggests that gender based expectations regarding proneness to emotional problems in women and proneness to alcohol problems in men, as well as a reluctance in men to disclose symptoms of depression, reinforce social stigma and constrain help seeking along stereotypical lines.

Despite these gender differences, most women and men experiencing emotional distress and/or psychological disorder are neither identified or treated by their doctor (Üstün & Sartorius, 1995). An additional problem is that many people with psychological disorders do not go to their doctors. In a recent US study, almost three fifths of those with severe mental illness received no speciality care over a 12 month period (McAlpine & Mechanic, 2000). If help is not sought in the year of onset of a disorder, delays in help seeking of more than 10 years are common in many countries (WHO & ICPE, 2000). If there is significant unmet need, as well as poor identification of disorder in people who do go to primary care providers in relatively well-resourced developed countries, the situation is likely to be much worse in developing countries.

3. Funding, organization and insurance

The organization and financing of mental health care makes an important contribution to social capital, and is an indicator of access and equity in mental health care.

To reduce gender disparities in health care in relation to the disorders in which women predominate, requires that barriers to accessing care are lowered and patient preferences are heeded. Women's overrepresentation amongst those living in poverty, means that cost will be a significant barrier to mental health care. A 'user pays' system where consumers either pay directly out of their own pockets for services or to cover the cost of health insurance, will further disadvantage poor women who are over represented amongst those experiencing depression, anxiety, panic disorder, somatization disorder and posttraumatic stress disorder.

Depending on the way mental health care is funded, medical insurance status can significantly predict access to speciality care. One US study reported that those with insurance were six times more likely to have access to care than those without (McAlpine & Mechanic, 2000). Lack of insurance interacts with other aspects of the socioeconomic disadvantage experienced by the severely mentally ill, in comparison with those with no identifiable mental disorder.

Both income level and the organization and financing of mental health can exert an influence on the likelihood of mental health services being utilized and the particular sector of service provision likely to be accessible. A three country study, using data from the 1990-1992 National Comorbidity Survey, the 1990-1991 Mental Health Supplement to the Ontario Health Survey and the 1996 Netherlands Mental health Survey and Incidence study, examined interrelationships between income, organization and financing of mental health care and differential use of mental health treatment. The three sectors of mental health care provision examined were the general medical, speciality and human services sectors. Ontario was the only place where income was unrelated to the sector of care for patients, indicating equity of access. In relation to human development, it is perhaps no coincidence that Canada also ranks first on the Human Development Index and the Gender Development Index (UNDP, 2000). In the US, income was positively related to speciality sector treatment and negatively related to treatment in the human services sector. In the Netherlands, patients in the middle income group were less likely to receive speciality care and those in the high income group less likely to receive care from the human service sector (Alegria, Bijl, Lin et al, 2000).

If access to care is not blocked by cost considerations, those in greatest need are likely to seek treatment. Another Canadian study revealed that single motherhood status was the strongest independent predictor of mental health morbidity and utilization of mental health services. Low income was the next strongest predictor and of course, low income is highly related to single motherhood status (Lipman, Offord and Boyle, 1997).

The trend to managed care in some countries, when associated with reductions in the intensity and duration of treatment, is likely to impact most on those with chronic disorders who are also most likely to be experiencing social disadvantage.

4. Gender sensitive services

To reduce gender disparities in mental health treatment, gender sensitive services are essential. If women are to be able to access treatment at all levels from primary to specialist care and inpatient as well as outpatient facilities, services must be tailored to meet their needs.

To ensure that the assistance available is also meaningful to those seeking treatment, the full range of patients' psychosocial and mental health needs must be addressed. This involves services adopting a life course approach, by acknowledging current and past gender specific exposures to stressors and risks and by responding sensitively to life circumstances and ongoing gender based roles and responsibilities.

Gender sensitivity will not improve unless client based preferences inform models of treatment and the provision of care. For women generally, but especially low income ones, services have to be made genuinely accessible. This includes having access to services during the weekend or evening hours, short waiting times and being on public

transport routes. With regard to the doctor patient relationship, preferred health care providers are those who show a sense of concern and respect and are willing to talk and spend time with patients. Integrated services where social and clinical services are available on one site are also preferred by women (O'Malley, Forrest and O'Malley 2000).

Some women with mental illness or substance use disorders are also parents and carers. Services need to be aware of the impact of this role on women's lives and their willingness to seek help, including fears that their children will be taken from them, if they do seek treatment (Mowbray et al., 1995). For women experiencing postnatal psychological disorder such as postnatal depression and postpartum psychosis, but also for women experiencing emotional distress, exhaustion and parenting difficulties, mother-baby units that allow joint admission can be useful. To reduce stigma, such units should operate as part of general maternity hospitals and services. Mothers and babies should not be sent to psychiatric hospitals.

Services that attempt to assist women with severe mental illness need to move beyond stereotypical assumptions and roles regarding women and not only provide access to living and social skills but also to vocational training and employment support.

5. Violence and severe mental illness

Violence-related mental health problems are poorly identified, victimization histories are not routinely taken and women are reluctant to disclose a history of violent victimization unless physicians ask about it directly (Mazza & Dennerstein, 1996).

At the same time, violent victimization, especially severe childhood sexual abuse (CSA), significantly predicts admission as an inpatient to a psychiatric facility during adulthood. A New Zealand study (Mullen, 1993) found women whose childhood sexual abuse involved penetrative sex, were sixteen times more likely to report psychiatric admissions than those who had been subjected to lesser forms of abuse. Given the significance of CSA as a predictor of inpatient admission, it is important that inpatient and residential services provide women with adequate safety and privacy. Even after controlling for the effect of coming from an unstable family home where one or both parents were absent, had mental health problems or were in conflict, CSA remained a significant predictor of later psychopathology.

GENDER AND RISK

Emerging evidence indicates that the impact of gender in mental health is compounded by its interrelationships with other social, structural determinants of mental health status, including education, income and employment as well as social roles and rank. There are strong, albeit varying, links between gender inequality, human poverty and socioeconomic differentials in all countries. Gender differences in material well being and human development are widely acknowledged. According to the 1998 World Health Report :

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 world-wide remain tragically low (WHO, 1998: 6).

In every country, gender development continues to lag behind human development (UNDP, 2000) or as an earlier Human Development Report (UNDP, 1997) put it: 'no society treats its women as well as its men'. Women constitute more than 70% of the world's poor (UNDP 1995) and carry the triple burden of productive, reproductive and caring work. Even in developed countries, lone mothers with children are the largest group of people living in poverty (Belle 1990) and are at especially high risk for poor physical and mental health (Macran et al., 1996; Lipman, Offord and Boyle, 1997). Clearly, gender must be taken into account in looking at the way income disparities, inequalities and poverty impacts on mental health.

GENDER AND RANK

There is a strong social gradient in health. Adverse mental health outcomes are 2 to 2 ½ times higher amongst those experiencing greatest social disadvantage compared with those experiencing least disadvantage (Kessler et al., 1994; Kunst et al., 1995; Bartley & Owen, 1996; Macran et al., 1996; Stansfeld et al., 1998). Environmental stressors, including increased numbers of negative life events, experiences and chronic difficulties, are highly significant in accounting for the lower social class predominance of non-psychotic psychiatric disorders like depression and anxiety. Less control over decision making, the structural determinants of health and less access to supportive social networks correlate with higher levels of morbidity and mortality (Kessler et al., 1994; Turner & Marino, 1994; Brown, 1998).

While there is a large amount of evidence that confirms a strong relationship between socioeconomic status, position in the social hierarchy and mental health, most research has lacked a gender perspective.

Analyses of the social gradient in health have concentrated on the material indicators of inequality and social disadvantage. However, the social gradient in physical and mental health also operates on a symbolic and subjective level. Social position carries with it an awareness of social rank and a clear understanding of where one stands in the scale of things. The link between a sense of loss and defeat, entrapment, and humiliation denoting devaluation and marginalisation, is strengthened by related research on social rank (Gilbert & Allan 1998). Depression is strongly related to several interrelated factors:

- Perceptions of the self as inferior or in an unwanted subordinate position, with low self confidence.
- Behaving in submissive or in non assertive ways.
- Experiencing a sense of defeat in relation to important battles, and wanting to escape but being trapped.

The very same qualities that characterize depression and low social rank, have been regarded as normal and desirable qualities of 'femininity' and encouraged if not enforced through socialization, 'tradition' and outright discrimination. By contrast, psychosocial resources, the wherewithal to exercise choice, having a confidant, social activities and a sense of control over one's life, form critical bulwarks against depression regardless of a woman's age (Zunzunegui et al., 1998). Feelings of autonomy and control significantly lessen the risk of depression occurring in the context of what might otherwise be considered as an important loss. Brown, Harris and Hepworth (1995) found that when marital separation was initiated by the woman, only about 10% of such women subsequently developed depression. When the

separation was almost entirely initiated by her partner, around half the women developed depression. Interestingly, the rate of depression increased again, if infidelity was discovered and not followed by separation.

GENDER AND WORK

Women in paid work receive significantly lower wages than their male counterparts. Relative income inequality penalising women and favouring men is structurally embedded as women typically earn around two thirds of the average male wage and this disparity has persisted over time. The level of gender development in a country is strongly related to rates of pay. Between 1993-1995, less than 10% of women were in low paid work in Sweden, where the ranking for gender development is higher than for human development. In contrast, in Japan and the US where gender development rankings are lower than human development rankings, more than 30% of women were in low paid jobs (UNDP, 1997).

The weakening of worker protection laws to attract foreign investment and the employment of girls and women as 'outworkers' or sweated labour in garment and footwear industries and in export processing zones (EPZ), as well as their overrepresentation amongst sex workers, represent significant threats to mental and physical health and violations of women's human rights.

The workplace itself is another area where rank is predictive of depression and linked to gender. Work characteristics, especially skill discretion and decision making authority are closely allied to employment grade and make the largest contribution to explaining differences in well being and depression. The highest levels of well being and the least depression are found in the highest employment grade; the reverse is true for those in the lowest grades who have a higher prevalence of negative life events, chronic stressors and less social support. Women are more likely to occupy lower status jobs with little decision-making discretion (Stansfeld, Head and Marmot, 1998).

Research on the subjective correlates of events related to subordinate status or lower rank, complements earlier work that documented the relationship between various objective measures of rank and the increased likelihood of poor health, depression and anxiety. Rank related variables are found in clusters, rarely in isolation and combine structural, material determinants, rank and symbolic indicators of social standing and gender roles. The resultant mix is strongly predictive of the common mental disorders. It includes low educational status, unemployment, low employment status and pay, insecure, 'casual' employment, single parent status, homelessness and insecure housing tenure and inadequate income, poor social support and diminished social capital (Belle, 1990; Macran, Clarke and Joshi; 1996, Brown et al, 1996; Kawachi et al., 1999).

GENDER ROLES

Gender socialization, which stresses passivity, submission and lower rank, are not only reinforced for women by their structural position in paid employment - lower status, more 'casual', part-time and insecure jobs and lower rates of pay - but by their much larger contribution to unpaid domestic and caring work in the home. Women of reproductive age may carry the triple burden of productive, reproductive and caring work. Not surprisingly, gender differences in rates of depression are strongly age related. The largest differences

occur in adult life, no differences are found in childhood and few in the elderly (Vazquez-Barquero et al., 1992; Beekman et al., 1995; Zunzunegui et al., 1998).

Gender differences in mental health cannot be explained by relying solely on role analysis to examine women's mental health and structural analysis to examine men's mental health. Even so, when social role variables such as marital status, children and occupational status were matched between women and men who participated in the multi country WHO study on Psychological Problems in Primary Care, the female excess in depression was reduced by 50% across all centres in the study (Maier, Gansicke, Gater et al, 1999).

To fully understand gender differences in mental health, there is a need to integrate a gender role analysis with a structural analysis of the determinants of health because gender roles intersect with critical structural determinants of health including social position, income, education and occupational and health insurance status. Role patterns of women are not evenly distributed across income levels. A French study found that housewives and lone mothers are more common at the bottom and middle of the income scale and working women without children, married or not, are more common at the top (Khlaf, Sermet and Le Pape, 2000). In addition, the measurement of women's income is problematic. A significant amount of income data is missing for women in many large scale surveys (Macran et al., 1996). The substitution of 'family income' or 'total household income', as a proxy measure of socioeconomic status has inherent problems. This proxy measure may bear little relationship to the way income is distributed within the household, especially in households where women are subjected to violence and experience high levels of coercive control over all aspects of their lives including the spending of money. To accurately assess women's income, information is necessary on their levels of access to and control over income within the household. Assuming equitable access to and distribution of 'family income' is unwarranted, but continues to be widely practised (WHO & ICPE, 2000)

Numerous studies have reported that low income mothers, especially lone mothers, have significantly higher levels of depression than the general population (Macran & Joshi, 1996; Salsberry, Nickel, Polivka et al., 1999). Compared with the general population, poor women are exposed to more frequent, more threatening and more uncontrollable life events, such as the illness and death of children and the imprisonment or death of husbands. They face more dangerous neighbourhoods, hazardous workplaces, greater job insecurity, violence and discrimination, especially if they belong to minority groups (Belle 1990, Brown 1998; Patel et al. 1999). Other gender based experiences, such as having two or more abortions, or experiencing sexual abuse or other forms of violence and adversity in childhood or adult life also contribute significantly to poorer mental health (Bifulco et al. 1991; Fellitti et al., 1998). These factors, separately and together, work to reduce the degree of autonomy, control and decision making latitude possible for women on low incomes.

ECONOMIC POLICIES

Current evidence on the consequences of globalization and restructuring indicates that socioeconomic deprivation is increasing and income inequality is widening within and between many countries (UNDP, 2000). Considerable evidence links rising income inequality to increasing rates of common mental disorders, like depression, anxiety and somatic symptoms (Patel et al, 1999), increased rates of mortality from physical conditions (Lynch, Smith, Kaplan, House, 2000) and increased mental health related mortality associated with substance use disorders and suicide (Lorant, 2000). In Russia, the predictors of significant

falls in life expectancy include fast paced economic change, high turnover of the labour force, increased levels of crime, alcoholism, inequality and decreasing social cohesion (Walberg, McKee, Shkolnikov et al, 1998).

The impact of globalization and structural adjustment programmes is especially severe in the poorest nations. Moreover, it occurs 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 & Munyakho, 1996). Cutbacks in public sector employment and social welfare spending can cause the costs of health care, education and basic foodstuffs to become unaffordable, especially to the poor, the majority of whom are women (Bandarage, 1997).

Evidence on the gender specific effect of restructuring on mental health is persuasive. Data obtained from primary care attenders in Goa (India), Harare (Zimbabwe), Santiago (Chile) and from community samples in Pelotas and Olinda (Brazil) showed significant associations between high rates of depression, anxiety and somatic symptoms and female gender, low education and poverty (Patel et al., 1999). This study reveals how gender inequality accompanies but is also worsened by economic inequality and rising income disparity. The result of this interaction is a steep rise in the very mental disorders in which women already predominate.

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. Disruptive, negative life events that cannot be controlled or evaded are most strongly related to the onset of depressive symptoms. An increase in the number of such events is paralleled by an increase in the numbers of women becoming depressed. The size of the contribution made by these events to common mental disorders is evident from a number of studies on women's mental health carried out over recent years in a range of countries.

Based on research carried out in Great Britain, Brown, Harris and Hepworth (1995) calculate that 85% of women from the community (as opposed to a patient group) who developed 'caseness' for depression in a 2 year study period experienced a severe event in the 6 months before onset. Depression was particularly likely to occur when a severe event (or events) was accompanied by vulnerability factors, especially those associated with low self-esteem and inadequate support. The matching of a current severe event with a pronounced ongoing difficulty was also critical to the onset of depression (Brown et al., 1990; Brown, 1998).

Severe, disruptive negative events could involve loss or danger but other features were more important in initiating depression. Most important of all was the experience of humiliation, defeat and a sense of entrapment, often in relation to a core relationship. Almost three-quarters of the severe events occurring in the six months prior to the onset of depression involved entrapment or humiliation whereas just over one fifth involved loss alone and only 5% concerned danger alone (Brown et al., 1995). Studies conducted in Zimbabwe at two different time points offer further insight into the strength of the relationship between the nature and frequency of severe events and associated rates of depression. In the first study, the annual incidence of depression was 18%, double that found in inner London (Abas & Broadhead, 1997). This increased to 30.8% in the second study (Broadhead & Abas, 1998). The excess of onset cases in the second study was primarily due to the increased numbers of severe and disruptive events and difficulties occurring in the intervening time period. 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: 37).

Population based studies of women in Zimbabwe, London, Bilbao, the Outer Hebrides, rural Spain and rural Basque Country, Spain, found that women meeting the criteria for depression varied from a low of 2.4% in the Basque Country to a high of 30% in Zimbabwe. Negative, irregular, disruptive life events were found to trigger depression in all six sites. Taken together, these findings indicate that a strong linear relationship exists between the number and severity of events and the prevalence of depression (Brown, 1998).

IMPACT OF GENDER-BASED VIOLENCE ON MENTAL HEALTH

Where women lack autonomy, decision making power and access to income, many other aspects of their lives and health will necessarily be outside their control. In particular, gender differentiated levels of susceptibility and exposure to the risk of violence place stringent limitations on women's ability to exercise control over the determinants of their mental health. Social research indicates that depression in women is triggered by situations that are characterized by humiliation and entrapment and that this occurs in relation to 'atypical events' (Brown, Harris and Hepworth, 1995). This view is challenged by evidence about the chronic nature of much gender based violence and its direct link to increased rates of depression.

The prevalence of violence against women (VAW) is alarmingly high (WHO, 1998). Women compared to men are at greatly increased risk of being assaulted by an intimate (Kessler, Sonnega, Bromet et al., 1995). Violence in the home tends to be repetitive and escalate in severity over time (AMA 1992) and encapsulates all three features identified in social research on depression in women: humiliation, enforced inferior ranking and subordination, and blocked escape or entrapment.

Violence- physical, sexual and psychological- is related to high rates of depression and co morbid psychopathology, including posttraumatic stress disorder (PTSD), dissociative disorders, phobias and substance use and suicidality (Roberts et al 1998). Moreover, psychological disorders are accompanied by multi somatisation, altered health behaviours, changed patterns of health care utilization and health problems affecting many body systems (Resnick et al., 1997; Roberts et al. 1998; Felitti et al., 1998). Being subjected to the exercise of coercive control leads to diminished self esteem and coping ability.

Violent victimization increases women's risk for unemployment, reduced income and divorce (Byrne et al, 1999). For this reason, gender based violence is a particularly important cause of poor mental health because it further weakens women's social position by operating on the structural determinants of health at the same time as it increases vulnerability to depression and other psychological disorders.

The high incidence of sexual violence against girls and women has prompted researchers to suggest that female victims make up the single largest group of those suffering from post traumatic stress disorder (Calhoun & Resick, 1993). A nationwide survey of rape in the US, found 31% of rape victims developed PTSD at some point in their lives compared with 5% of

non victims (Kilpatrick, Edmunds & Seymour, 1992). PTSD also persists longer in women than in men (Breslau et al, 1998).

The mental health impact on the millions of women who are caught up in sexual trafficking has not been assessed. The trauma of repeated abuse and denial of any human rights is severe and ongoing. Mental health effects are likely to include all those previously identified in research on VAW and to parallel those experienced by other victims of torture. The likely causal role of violence in depression, anxiety and other disorders such as posttraumatic stress disorder is suggested by:

- Three to four fold increases in rates of depression and anxiety in large community samples amongst those exposed to violence compared with those not exposed (Mullen et al. 1998; Saunders et al. 1993).
- Severity and duration of violence predicts severity and number of adverse psychological outcomes, even when other potentially significant factors have been statistically controlled in data analysis. This has been found in studies on the mental health impact of domestic violence (Campbell & Lewandowski, 1997; Roberts et al. 1998) and childhood sexual abuse (Mullen et al., 1993).
- Marked reductions in the level of depression and anxiety once women stop experiencing violence and feel safe (Campbell et al., 1996) compared with increases in depression and anxiety when violence continues (Sutherland et al., 1998).

The evidence presented here indicates that the female excess in depression and other disorders reflects women's greater exposure to a range of stressors and risks to their mental health, rather than an increased, biologically based vulnerability to psychological disorder.

IMPLICATIONS FOR POLICIES AND PROGRAMMES

To reduce gender disparities in mental health involves looking beyond mental illness as a disease of the brain. This is not to deny that distress and disorder exist and require compassionate and scientifically based treatment nor that the stigma associated with all forms of mental illness must be eradicated. However, clinicians, researchers and policy makers also need to socially contextualize the mental disorders affecting individuals and the risk factors associated with them.

There is strong evidence that globalization and large scale restructuring have increased income inequalities and adverse life events and difficulties, with particularly severe impacts on women. Moreover this increase in gender based income disparities is associated with increasing rates of common mental disorders amongst women in a number of countries (Patel et al, 1999; Broadhead and Abas, 1998).

Governments need to monitor the mental health effects of their economic reforms and take urgent action to bring about a more gender equitable distribution of the benefits of globalization. Active measures need to be taken to protect social capital, as this too, is powerfully related to how people rate their health (Kawachi et al, 1999). If gender based income inequalities are not reduced, the numbers of girls and women who are forced to rely on harmful and/or illegal activities for income, such as work in the sex industry, will continue to escalate.

Budgets for mental health will become rapidly depleted if funding is focussed on curative treatment and care. Medical treatment that is confined to the alleviation of presenting symptoms is at best a partial response. It fails to address ongoing high levels of exposure to mental health risks or to reduce gender based levels of susceptibility. In other words, while improving identification and treatment of mental disorders is certainly necessary, it is clearly not sufficient to reduce their incidence.

Currently, the rates of detection, treatment and appropriate referral of psychological disorders in primary health care settings are unacceptably low. The high rates of depression in women and alcohol dependence in men strongly indicate a large unmet need for improved access, at a community level, to low or preferably no cost gender sensitive counselling services. Psychologists and social workers working in community based health services that are responsive to the psychosocial issues of those they serve, are well placed to provide cost effective mental health services.

All health care providers need to be better trained so that they are able to recognize and treat not just single disorders such as depression and alcohol dependence, but also their co occurrence. Clinicians need to be equipped to assess and respond to gender specific, structurally determined risk factors and to become proficient in providing much needed advocacy for their patients with other sectors of the health and social welfare system. Without these skills, rates of comorbidity among patients will compound. Skill in trauma focussed counselling is a priority for clinicians in all health sectors who encounter women (Acierno, Resnick and Kilpatrick, 1997).

Women's overrepresentation amongst those with psychiatric comorbidity (Kessler et al., 1994) together with the heightened burden of disability associated with comorbidity indicates the need to clearly identify gender specific risk factors for comorbidity. In particular, the complex linkages between depression in women, multi somatisation and psychiatric comorbidity in the context of a history of violent victimization need to be clarified.

Mental health care funding, too, must be responsive to the issue of psychiatric comorbidity. Clinicians need to have adequate consultation time with their patients to permit accurate diagnosis. Time and cost pressures on 'throughput' may appear economic and efficient in the short term but are incompatible with providing patients gender sensitive, meaningful assistance with their mental health problems. Repeated utilization of the mental health care system consequent on the failure to accurately diagnose and treat is a far more expensive outcome in the long term.

The concept of 'meaningful assistance' in mental health care needs to be promoted. Meaningful assistance implies a patient centred approach. Gender disparities in mental health will not be reduced until women's own mental health concerns and life priorities are taken into account in programme design and implementation (Avotri & Walters, 1999). Currently under diagnosed and poorly treated conditions, especially the combination of depression, violence related health conditions and significant psychosocial problems urgently require meaningful assistance.

Gender based barriers to mental health care, especially cost and access, bias and discrimination must be removed. Intersectoral collaboration across government departments and gender sensitive policy making in education, housing, transport and employment are required to ensure that the multiple structural determinants of mental health are facilitated to

work in positive synergy, maintain social capital and support social networks (Kawachi et al, 1999). A free, universal medical insurance scheme is the only way to ensure mental health care will be accessible to the most socioeconomically disadvantaged group (Lipman, Offord and Boyle, 1997).

A public health approach to improve primary prevention and address gender specific risk factors for depression and anxiety disorders is indicated by a large body of evidence. Social safety nets and income security are especially important for women and their mental health. A public health approach necessarily broadens the notion of effective treatment. The most obvious way of reducing violence related mental health problems is to reduce women's exposure to violence. Women who have been but are no longer being battered show significant reductions in their level of depressive symptoms, while those who continue to experience violence do not (Campbell et al, 1993). Providing access to refuges and alternative forms of safe housing is thus a powerful mental health 'treatment.'

Better quality evidence needs to be collected that is informed by a gendered, social determinants, life course approach. Cross sectional research has revealed significant factors in the onset of depression but much more longitudinal research is required to understand how changes in social and household conditions mediate the course of depression and its chronicity (Bracke, 2000). If persistence in adversity is neither accurately measured nor disentangled from persistence in depressive symptoms, its role in the chronicity of depressive symptoms cannot be ascertained.

A priority for mental health promotion and intervention programmes is to incorporate a mental health focus in all programmes related to child health. The level of exposure to adverse childhood events has a strong graded relationship with all the major causes of adult morbidity and mortality and the behavioural risk factors associated with them (Felitti et al, 1999). Childhood sexual abuse, in particular, is predictive of multiple negative health outcomes including high rates of psychiatric morbidity as well as homelessness, prostitution, substance use disorders and suicidality. The earliest possible identification and protection of those exposed to adverse childhood events, and ideally the elimination of these events, is necessary to prevent re-victimization and arrest the progression and compounding of poor mental, physical, sexual and social health outcomes. Consequently, the goal of preventing childhood neglect and exposure to all forms of trauma and adversity must inform the design and implementation of maternal and child health, family violence services and social welfare and social security services.

At the same time, 'zero tolerance' health education and promotion campaigns to reduce violence against women and children need to be designed using culturally appropriate formats in order to counter traditional beliefs and attitudes that condone and perpetuate violence.

CONCLUSION

To address gender disparities in mental health requires action at many levels. In particular, national mental health policies must be developed that are based on an explicit analysis of gender disparities in risk and outcome.

Effective strategies for risk factor reduction in relation to mental health cannot be gender neutral while the risks themselves are gender specific and women's status and life opportunities remain 'tragically low' worldwide (WHO, 1998). Low status is a potent mental health risk. For

too many women, experiences of self worth, competence, autonomy, adequate income and a sense of physical, sexual and psychological safety and security, so essential to good mental health, are systematically denied. The pervasive violation of women's rights, including their reproductive rights, contributes directly to the growing burden of disability caused by poor mental health.

Consequently, a rights framework needs to be adopted to improve the ethical and interpretative dimensions of research, mental health care practice and policy. Mental health research has scarcely begun to address the impact of patient and human rights violations on mental health. These include the psychological effect of failure to gain informed consent, denial of patient privacy and dignity, and the use of treatments that may successfully alter mood but neglect ongoing exposure to experiences that grossly violate the right to mental health such as living in safety and freedom from fear. This omission needs to be rectified.

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