

1. HEALTH, WOMEN'S HEALTH AND MENTAL HEALTH CONCEPTS

Health is a relative state of existence, multidimensional and specific for each individual. In 1946 the World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". On 12 September 1978 the Alma Ata Declaration reaffirmed this definition and outlined a fundamental health strategy of health promotion and of preventive health services. The Second International Conference on Health Promotion held in Adelaide in 1988 identified "Supporting the Health of Women" in the recommendations of four action areas. The issue of "women's health" as a separate field has emerged relatively recently. Historically the health needs of women were recognized largely in relation to women's reproductive functioning as in obstetrics and gynaecology, and family planning. There has been general recognition that although women live longer than men in most of the developed world, women suffer from more acute and chronic symptoms and use health services more frequently. A major health problem area for women is that of mental health. Mental health cannot be separated from total health. The dichotomy between body and mind is seen as a product of Western scientific thinking.

Four concepts of normality in mental health are provided by Offer and Sabshin (1984). The first perspective is that of normality as health, a traditional medical-psychiatric approach which focuses on defining pathology. Thus normality is the absence of pathology. The second perspective is that of normality as utopia or the ideal. This perspective is propounded by psychoanalytic and humanistic theorists who define normality as ideal functioning or self-actualisation. Critics of this approach comment that ideal functioning is seldom realized. Further, in other cultures such as that of the New Zealand Maori, this concentration on the individual is considered the antithesis of mental health. Interdependence rather than independence is valued. The third perspective is that of normality as "average". This perspective is employed by sociologists and is based on the normal distribution with the middle range seen as normal and both extremes as deviant. Thus normal may not mean asymptomatic. The fourth perspective is that of normality as transactional systems. Normal behaviour is the end result of interacting systems which change over time as a function of development and the type of environment.

This transactional approach is further developed in the Canadian Report: Mental Health for all Canadians (1988). This report utilizes the World Health Organization's description of mental life as "inner experience linked to interpersonal group experience" (World Health Organization Report, 1981). Mental life thus combines together experience of three kinds: cognitive experiences (perceptions, thinking processes); affective experiences (emotions, moods, feelings); and relational experiences (the way in which people interact with each other and the environment). Increasing recognition of the importance of external forces such as social and economic factors, relationships, physical and organisational environments have led to a broader concept of mental health. Instead of mental health consisting of the individual's characteristics it becomes a resource enabling an individual to interact with the group and opportunities

and influences in the environment. The definition developed therefore reflects values and goals of the desired society: "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 does not define mental health in the terms of mental disorder, nor does it imply that mental health and mental disorder are opposite poles on a single continuum. Mental disorders are but one of a number of possible obstacles to the individual's utilisation of inner strengths and resources. Other obstacles may be physical illness, poverty, or discriminatory social attitudes, all of which more commonly affect women. Mental disorder may be defined as a recognized medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental or psychosocial factors. The opposite of mental disorder would be a complete absence of symptoms. A mental health continuum on the other hand would have two poles of optimal mental health and poor mental health. Optimal mental health would imply that individual, group and environmental factors work together effectively ensuring: subjective well-being, optimal development and use of mental abilities, and achievement of goals consistent with justice and equality. Minimal mental health results from conflict between individual, group and environmental factors producing subjective distress, impairment or underdevelopment of mental abilities, failure to achieve goals, destructive behaviours and entrenchment of inequities. This definition offers hope for those who suffer from chronic mental disorders, a broader range of strategies to address mental health goals and makes unnecessary the need to describe goals in psychiatric terms. Further it acknowledges that the distribution of power among individuals, groups and their environments is a crucial determinant of mental health.

The long and arduous struggle for women's rights, for equality with men in political, economic, social, cultural and civil rights is described by Aldaba-Lim (1991). In 1979 the United Nations General Assembly adopted the 30-article Convention on the Elimination of All Forms of Discrimination Against Women. By April 1991, 104 member states had ratified the Convention. Nevertheless, a number of countries including India, Pakistan and the USA had not yet ratified the convention. There remains a wide gap between reality and plans. At least 444 million Asian women are illiterate, with rural women at the bottom and urban males at the top of the literacy pyramid. Some villages have no literate women. The proportion of women as illiterates has increased in the last 25 years. Although there have been some signs of progress, women's development is lagging behind in many countries. The lesson of the UN Decade for Women is, "If the world is going to change for women, women must change it".

The last decades have seen increasing recognition of the pervasive and destructive effects of gender inequalities and the stresses that differentially affect women by virtue of their unequal social status especially in their family

roles. Circumstances and conditions that society accepts as normal or ordinary often lead to mental health problems in women. Women face dilemmas and conflicts in the contexts of marriage, family relationships, reproduction, childrearing, divorce, aging, education, and work. Stresses that have more impact on women and may contribute to a higher risk for depression include: physical and sexual abuse; sexual harassment; sex discrimination; unwanted pregnancy; divorce; poverty and powerlessness. Epidemiological data link mental disorder with alienation, powerlessness, and poverty, conditions more commonly experienced by women (Russo, 1985).

Theories and Therapists

Significant changes have taken place in our beliefs and expectations about women's roles and identities in the contexts of work, family, and community over the last decades. During the same time period there has been an explosion of knowledge which signifies the attempt to understand and explain the female experience. This new scholarship has identified sex bias in psychological theories and methods.

Webster and Ipema (1986) illustrate how the "world view" taken by a therapist will affect what is defined as a problem, what is seen as appropriate intervention and what constitutes success when evaluating an outcome. A historical look at theories and philosophies illustrates how powerful they are in determining how problems are interpreted. During the middle ages, signs of dementia were treated by skull trepanation, to release the evil spirits. During the Renaissance it was believed that any woman who claimed to have power to heal was a witch who could be cured only by torture or death. In the last century recalcitrant or wilful women were treated by oophorectomy. Showalter (1987) described how Darwinian ideas led to the view that biology determined destiny "there is sex in mind as well as in body". Female physiology marked women "for very different offices in life from those of men". Theories of sex differences were elaborated into highly prescriptive traditional sex-roles and used to control female behaviour. Consequently women were viewed as domestic and maternal. Medical ideology fostered the view that a woman's biological system predisposed her to ill-health and failure. In short, women were viewed as inherently sick, predisposed by their constitutions. Hygiene manuals preached a cause-effect relationship between female sexual transgression and ill-health reinforcing the connection between women's social role and her health status. The two major feminist texts (Chesler's "Women and Madness", 1972, & Showalter's "Women, Madness and English Culture, 1830 - 1980", 1987) have highlighted the equivalence of "madness" and "femininity", and described fashions in the presentation of women's symptoms and in the (usually) male medical response. The concept of the "hysterical female" was born. Women were repeatedly diagnosed and treated for what feminist writers viewed as culturally determined behaviour patterns women used to deal with the situational anxieties created by their restricted social life.

Plath once remarked that as a woman you are damned anyway; if you are normal you are mad by implication and if you are abnormal you are mad by definition (Calvert, 1979).

The Freudian view of women as passive, inferior and receptive has profoundly influenced all successive theories. Some theories, such as behaviourism, seemed to ignore women altogether. Women and women's role is discussed by the learned helplessness theory of depression which links depression to low self-esteem and powerlessness.

Rigidity towards sex differences and gender-roles persisted into the late 1970s. Evidence for the persistence of sex-role stereotyping in health care is found in studies such as that of Broverman et al (1970). This study found that when considering men and women, clinicians maintained parallel distinctions in their concepts of what behaviourally is healthy or pathological. A double standard of mental health existed. A healthy woman was seen as having traits which differed from those of mentally healthy men or healthy human beings. This placed women in a double-bind as either rejecting feminine behaviour or being feminine at the cost of being a healthy human being. Others suggest that the amount of gender-related bias among experienced practitioners is comparatively small. Nevertheless the documented experience indicates a need for health care practitioners, particularly those in the area of mental health where subjective judgements are commonplace and there is the exercise of power over the lives of others, to be constantly aware of possible sex discrimination in providing service.

Therapy is criticized for attempting to fit women back into the situation in which they became mentally ill, and for failing to look at the necessity for social change. Sex-role stereotyping has limited the roles for women and necessitated greater role adjustments than for men. Criticisms of psychology documented by Webster (1988) include the potential for finding individual pathology and "treating it" in lieu of identifying the social causes of the problems and addressing them. Other criticisms pertain to the problems of subjectivity, and the narrowness of focus. Therapy may distort women's experiences and contribute to women's oppression. Of special concern is the problem of sexual abuse of clients by psychotherapists, perhaps the ultimate abuse of the power relationship inherent in the psychotherapy process. Women's differential rates of depression associated with marriage, with having children, and with work outside the home all put into question the wisdom of fostering women's traditional roles.

The need for new ways to understand women and to help them deal more effectively with problems unique to them, as well as problems which may affect women differently has led to new approaches to therapy for women, such as consciousness raising groups. Differentiation was made between therapy which is non-sexist (attempts to avoid sex-role stereotyping which discriminates against either sex) and therapy which is feminist (goes further and questions the power relationships inherent in any therapy process and calls for new ways to provide an egalitarian experience in therapy which might facilitate learning about women's experiences, rather than telling women what their experiences are or should be). Feminists have made a large impact on the mental health system in their campaign against violence against women and development of alternative models of service such as rape crisis centres and refuges for battered women. New attitudes and knowledge from feminist critiques have helped develop preventative programs and led to legislative change. Examples of the

contribution made by feminists include the feminist analysis of eating disorders which views these problems as occurring in societies which have limiting sex stereotypes and which promote a body image ideal that is impossible for most women to achieve. Thus more than 90% of those who suffer from eating disorders are women. Where women are a distinct minority and services cater largely for men, feminist energy has gone into the development of women-oriented services, such as special alcohol services. A major area requiring further attention is the position of women in psychiatric institutions which may include sexism, neglect and trauma as well as sexual abuse.

Today many developmental and psychological theories still present the male experience as normative and ignore or negatively evaluate women's differences in relation to these norms. Consideration of the female experience and its context is essential to developing better theories, and in providing relevant and empowering strategies (O'Rourke, 1984).

Current research together with social change will help in producing a new conception of women. Differences between men and women do not mean that one is weaker than the other, rather there is a need to seek explanations for differences in order to provide a higher standard of health for men and women (O'Rourke, 1984).

2. MEASUREMENT OF OUTCOMES

Most health measures focus on physical and psychological ill-health. Examples include mortality and morbidity measures. Well-being measures will become increasingly important as health services shift emphasis from the provision of curative services to the prevention of ill-health (Kilgour, 1991) and focus on health promotion and quality of life. Health behaviours are activities engaged in to promote or protect one's health, and include breast examination, cervical cytology, medication, diet change. Self-perceived health asks the individual to comparatively rate his or her health as worse, the same or better than others her age. Self-perception has been shown to be a significant indicant of health (Mossey & Shapiro, 1982).

Murchie (1984) in a New Zealand study compared Maori women who said their general health was good with those who said their health was "fair" or "poor". This study used measures of well-being, and ill-health and derived a profile of factors associated with good health among Maori women. A woman in good health was twice as likely to say she has no major worries; 1.5 times as likely to say she has no frustration over her work situation; 3 times as likely to be not at home with dependents; twice as likely to have no worries about her children; 1.5 times as likely to be not primarily in home care.

Symptom checklists provide estimates of distress and demoralisation, but do not permit classification of subjects into discrete disease categories and the relationship between impairment ratings and specific diagnoses is not strong. Depressive symptoms are the most common type of manifestation of

psychological distress and are common to many and varied types of psychiatric disorders.

A large survey was carried out in the Otago region in New Zealand and focused on women's mental health (Walton et al, 1990). The outcome measure was the General Health Questionnaire (GHQ) which measures psychiatric symptomatology. This study illustrates the way in which physical and social factors may act to initiate or perpetuate mental ill-health. Poor physical health and major marital problems were related to becoming mentally ill. Other factors which correlated with psychiatric morbidity were: quality of social networks; difficulties with alcohol; childhood sexual abuse; low socioeconomic status; and adult experiences of sexual and physical abuse (Romans-Clarkson et al, 1990). Of those who became ill, 2/3 had recovered within one year. All of the women who continued to be ill had suffered a major financial crisis (Walton et al, 1990).

A United Kingdom general practice survey of women aged between 20 and 59 years found similar results (Ballinger & Smith, 1985). Separated and divorced women had the highest risk of psychiatric morbidity and single women had the lowest risk. Women with three or more children had higher GHQ scores. High scores on the GHQ were associated with interpersonal relationship problems with parents or husband, marital status, numbers of children, social class, and gynaecological problems such as painful, heavy or irregular periods.

Gath and Iles (1990) highlight the need to distinguish between depressed mood (feelings of sadness familiar to everyone) and depressive disorder (a syndrome which is less common but far more serious). The features of depressive disorder include depressed mood, loss of interest, energy, and enjoyment, poor concentration, gloomy thoughts of guilt, worthlessness, hopelessness or suicide, disturbances of appetite, weight, sleep, and sex drive and slow speech or movement.

LaDue in an unpublished paper noted that all diagnostic criteria and assessment methods rest on theoretical constructs about human behaviour, normality and pathology. For example it is commonly assumed that auditory hallucinations and disordered thoughts coupled with social withdrawal are symptomatic of schizophrenia. Traditional practices of certain ethnic groups may mean that symptoms reflect religious practices and are part of a healing process rather than increasing pathology. The use of drugs, trance states, withdrawal from one's community and other "abnormal" behaviours need to be viewed within a cultural, religious context before being deemed to be deviant and/or detrimental. There appear to be few universals as regards pathological behaviours with many groups having syndromes specific to only that group. Thus standard assessment and diagnostic tests may not be appropriate for minority groups and other cultures.

3. GENDER DIFFERENCES IN MENTAL (ILL-) HEALTH

A range of studies indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with marital status, work and roles in society. The 1983 Australian Health Survey found that 357,000 females and 197,000 males reported mental health problems.

Russo (1990) reports that epidemiological community-based studies found that for the 15 diagnostic groups studied there were substantial gender differences in prevalence rates of lifetime diagnoses. Women predominate in major depression, agoraphobia, and simple phobia whereas men predominate in antisocial personality and alcohol abuse/dependency. Women were more likely than men to have received a diagnosis of dysthymia, obsessive-compulsive disorder, somatization disorder, and panic disorder. No gender differences in manic episode or cognitive impairment were apparent. It should be noted that there is controversy about the inclusion of alcohol disorders (as well as drug and personality disorders) in the definition of mental disorder as these disorders may not cause personal distress or mental disorganisation. There were also marked gender differences evident in the utilisation of mental health services in the USA. Gender differences varied by marital status and race/ethnicity and cannot be explained by biomedical models. Never married and separated/divorced men have higher overall admission rates to mental health facilities than women in the same marital status categories. In contrast, married women have higher admission rates than married men. However this does not hold for all diagnoses. These findings emphasize the importance of understanding complex relationships among gender, ethnicity, sex-roles, and mental health. Research has rarely considered such joint effects.

Social factors may aid women's adjustments to certain disorders. For example a different pattern but not prevalence level exists for schizophrenia, where women appear to have a later onset by 4 - 6 years, shorter and fewer hospitalisations, and better prognosis and greater support to remain at home. Social factors contributing may include lessened social role expectations, more social support and greater societal (and parental) tolerance of women's schizophrenic symptoms (Report of the Health Care Committee, 1991).

Gove and Tudor (1973) had earlier argued that because of the roles women occupy in Western society, women are more likely than men to have emotional problems. Major reasons proposed were that: 1) men have two sources of gratification - work and family, whereas women have only one - family; 2) raising children and keeping house is frustrating; 3) the role of housewife is relatively unstructured and invisible; 4) when a married woman works she is in a less satisfactory position than the married male; 5) expectations confronting women are unclear and diffuse. These authors noted that both community-based and treatment studies clearly showed that more women than men have mental ill-health problems. However this applies to married women and married men. Amongst the single, within each category men were more likely to be mentally ill. Prior to World War II more studies show a higher rate of mental illness for men than for women indicating that

social change has adversely affected women. Also in communities undergoing economic depression, there was a higher incidence of mental illness and the rates were higher in men than in women. In contrast in an integrated French Arcadian village - traditional, family orientated and culturally isolated, there were lower overall rates of mental illness and women had lower rates than men.

Ibrahim (1980) in an earlier review of the relationship between marital status and mental health found that married women experience higher rates of mental disorders than married men, although single women exhibit rates of mental disorders similar to or even lower than the rates shown for single men. Married individuals of both sexes experience better physical health than the unmarried. It would appear that being married as compared with being single is generally associated with better physical health for both men and women, but is not associated with better mental health for women unless they are gainfully employed. Such employment under certain circumstances may have detrimental consequences.

Ross et al (1983) tested the hypothesis that in societies which value the family and the woman's role in the home, psychological distress levels of married men and women will be more similar. These authors utilized a questionnaire to compare an Anglo-American community with a Mexican community. The gap in psychological distress levels of married men and women was less in Mexican culture than in Anglo culture. However, education and the wife's participation in the labour force affect marital satisfaction which in turn affects the level of psychological distress. Education increases marital satisfaction whereas paid employment decreases it. Wife's employment decreases her psychological distress directly in both cultures. Parry and Shapiro (1986) found that in the case of working class women, working outside the home was associated with less depression where there was good social support, but more depression where there was not good support.

Russo (1990) in her review noted that parenthood, particularly when children are young, increases the symptoms of psychological distress for women whether or not they work outside the home and these symptoms appear to increase with the number of children living in the home. Whether or not employment brings mental health costs or benefits to women depends substantially on husband's attitudes, and satisfaction with child care. For employed mothers, if child care was accessible and husbands shared in it, depression rates were low. In contrast, employed mothers without accessible child care and with sole responsibility for child care had extremely high depression levels. For non-employed wives, children increased depression levels. Rosenfield (1989) proposed that role overload causes greater symptoms for the same reasons as low power: through lowering an individual's sense of personal control. Thus employment may trade one source of low control for another. Personal control may also explain differences in symptomatology by social class.

Depression

Depression, the most prevalent psychiatric condition, is the most frequently encountered women's health problem in many Western countries.

Depression may vary imperceptibly through subclinical distress to a normal mood which is part of universal human experience. Defining threshold for disorder and separating this from normal experience have been important. Community prevalence studies indicate that about 5% of the population satisfy the criteria of the PSE (Present State Examination) or the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 3) for psychiatric depression in a six month period. Sex ratios in treated cases of depression in Western cultures show a 2:1 predominance of women to men (Weissman & Klerman, 1977). Jorm (1987) from a quantitative synthesis of published prevalence data shows that the sex differences in depression for females are age-specific, and also a function of social situations. In children and the very old there is little sex difference, but in the years 15 - 50 depression is more prevalent in women.

The following review of gender differences in depression is abstracted from Paykel (1991) who offers the following explanations and evidence:

1. Women may more often seek help for depression which both sexes suffer from equally.

Most studies show that women attend doctors more often than do men. Kessler et al (1981) analysed data for psychiatric symptoms from four large-scale community surveys. Women reported more psychiatric distress but also showed a greater readiness to consult at the same level of morbidity; this appeared to be due to a greater readiness to translate non-specific feelings of distress into a recognition that they had an emotional problem. However for specific depressive symptoms and anxiety the female predominance is present in community surveys to an equal or greater extent. Studies using questionnaires to measure depressive symptoms give point prevalence rates varying from 13%-20%. The mean sex ratio was 1.9, virtually the same as the treatment studies. Studies which employ psychiatric criteria give lower total rates (6 month prevalence 3.0%-7.4%), however the average sex ratio remains at 2.0. The female predominance of depression is therefore not an artifact of treatment seeking.

2. Given that there is a difference does it reflect biological factors such as chromosomal factors or female sex hormones?

There is clear evidence from twin studies of a genetic element in affective disorders. This is most marked for bipolar disorder, but also significant for unipolar psychotic depression. For unipolar neurotic depression twin studies are less conclusive. There is a familial element but it is not clear whether this is genetic or environmental. There is some evidence in some families of X-linkage in bipolar disorders. However the sex ratio for bipolar disorders is approximately equal. There is no good evidence for X-linkage in unipolar disorders.

Other biological explanations centre on the different hormonal background for men and women. Indirect evidence can be gleaned from hormone-related phenomena. Premenstrual tension includes depressive mood changes but has not been linked to specific hormone changes. Oral contraceptive studies are not conclusive and suggest that any clinical effect is small. Childbirth is associated

with an increase in onsets of psychoses and hospital admissions and is a time of massive hormonal change. Increased onset of bipolar disorder occurs at this time. Recent evidence is that postpartum psychoses are not related to recent life stress making biological (and hormonal) explanations more plausible. Milder postpartum depression at the sub-clinical or general practice level is common.

Gater et al (1989) studied first admission rates for psychosis in the North West region of England. Rates were higher for women. The excess was accounted for by women who had one or more children. The excess was related to parity rather than marital status. Bebbington et al (1991) using data for prevalence of minor affective illness obtained similar findings, although it was not clear whether having children or marital status was responsible. These findings of a peak in depression in young mothers in developed Western societies could reflect families that are nuclear and geographically mobile, lack of extended family support and the woman's dependence on the quality of her relationship with her partner.

Another phase in which women experience great hormonal change occurs at menopause. However there is no peak in major depressive disorder at the biological menopause.

3. Another explanation is based on the social effects of life stress, of social vulnerability factors and absence of support, and of women's role in society more widely. There is now a large and conclusive volume of research showing that clinical depressions are preceded by elevated rates of the more threatening classes of life events. Women do not experience more life events than men. Men and women rate the stressfulness of life events similarly. Nevertheless community studies suggest that women react with higher symptom intensities to the same stress. Thus there seems to be more vulnerability to the effects of life events. Social vulnerability studies have particularly emphasized social support, implicating most clearly the absence of a confidant and less consistently, the presence of young children in the home, lower social class, not working outside the home, and early loss of mother. For work outside the home there has been less replication and complex effects (see previous discussion).

Other hypotheses outlined earlier, centre on the disadvantage of women's roles in society with low social status accorded to homemakers, and social discrimination leading to low aspirations, dependency, low self-esteem.

4. A final explanation for differences in depression rates may reflect a difference in acknowledgment and direction of distress. Alcoholism is more common in men. Winokur (1979) described depressive spectrum disease in which women tend to have depression, while male family members have alcoholism and antisocial personality. Men may direct their distress in different directions. Men have a higher rate of suicide although more women attempt suicide. Briscoe (1982) found women more willing to acknowledge feelings, both positive and negative.

Studies of other cultures are informative. The Old Order Amish of Pennsylvania, a religious group with strong prohibitions on drink and antisocial behaviour have high rates of affective disorder. Unipolar and bipolar

depressions show an approximately equal sex incidence. Weissman & Klerman (1977) reviewed treatment studies from Guinea, India and Papua which show a reversal of the Western sex ratio to a male predominance. However women may not have had equal access to help seeking. Community-based studies which are culturally appropriate are needed.

Recent Western community based studies repeated 10 to 20 years apart show a trend for the sex ratios to equalize. This may reflect societal changes with less gender-role differentiation, which might change the acknowledgment and the social stress. Sex ratios for depression appear to be more equal in university students and no major sex differences were found in certain occupational groups. Klerman & Weissman (1989) suggest the narrowing in the gender differential may be due to a greater increase in risk among young men. These trends were evident in studies from the USA, Sweden, Germany, Canada, New Zealand but not in Korea, Puerto Rico and for Mexican Americans living in the USA. This may reflect changes in social factors such as changing family structures and social roles.

4. ETHICAL ISSUES IN WOMEN'S MENTAL HEALTH

Special ethical issues of concern to women were reviewed by Nadelson (1991). Some of these issues have reflected the historical development of the health care delivery system as paternalistic and hierarchically based, with the doctor dominating the system. The doctor was usually male, informed, authoritative and protective and this conformed with traditional social roles of men and women. Policies and priorities have often been based on this perspective particularly related to reproduction. An example of paternalism quoted by Nadelson was the USA decision to prohibit the use of RU486, an abortifacient with other potential uses. Those most affected were not involved in the decision-making process. Interestingly, there has been an increase in paternalism in the health care systems of the USA and other countries at the same time as there has been a decrease in paternalism in the individual doctor-patient relationship with decision-making shifting to the patient and the doctor becoming the adviser. Paternalism has shifted from the doctor to the bureaucracies. Documentation of gender bias in medical care and in research has led to the creation of an Office of Research on Women's Health by the US Government and to proposed legislative changes.

Ethical issues also relate to informed consent, the giving of which implies understanding and assent. Patients may not comprehend because of educational level, mental illness and other factors.

The special characteristics of women's reproductive roles lead to specific ethical considerations. Since decisions about childbearing, contraception, abortion, sterilisation and surgery involving reproductive organs have profound social consequences, the autonomy of women in deciding these questions is often challenged. In most cultures women have not been in a position to achieve their own goals if they are distinct from those of their own family and society. Decisions may reflect the personal, cultural or religious values of the

patient, doctor, the family or society. Examples of ethical dilemmas include those arising from genetic testing in pregnancy and use of this technique for sex selection, and the use of reproductive technologies such as in vitro-fertilisation, artificial insemination and surrogate motherhood. These techniques raise the question of the rights of biological versus social parents, the rights of children born from these procedures, and the nature of informed consent by all parties. Also these techniques may be reserved for specific types of individuals or situations (e.g. heterosexual couples). Substance abuse during pregnancy has also caused controversy, pitting the autonomy of the mother against the needs of the foetus.

A number of clinical studies have found that sexual relationships between carers and patients are harmful and may have acute as well as long term consequences. In addition to the shame, guilt and mistrust they experience, these patients have been reported to suffer from post-traumatic stress disorder, anxiety and depressive disorders, sexual symptoms, sleep disorders and are at higher risk for substance abuse. Most cases of reported incidents of sexual misconduct in the USA involve male doctors and female patients (88%).

For society the changing roles of women and the emergence of new reproductive and other technologies have raised questions with profound ethical implications. Culturally determined values and ethical values may clash (Nadelson, 1991).

5. PSYCHOSOCIAL DETERMINANTS OF WOMEN'S MENTAL HEALTH

A significant change of perspective regarding women's mental health was signalled by the priority areas outlined in both the National Institute of Mental Health's document (Eichler & Parron 1987) in the United States and the National Women's Health Policy (Commonwealth Department of Community Services and Health 1989) in Australia.

Both reports recognized the inadequacy of existing scientific knowledge relating to gender differences in mental disorder and its treatment. The five areas requiring research according to the US report were the diagnosis and treatment of mental disorder, mental health issues for older women, violence against women, multiple roles and poverty. Importantly, three of these five areas, namely violence, multiple roles and poverty, focus specifically on the way in which women's actual experience and their subordinate position in society contribute to their mental health. Further, the first two areas, diagnosis and treatment of mental disorder and mental health issues for older women can also be seen to be directly contingent on sociocultural factors.

Research undertaken in the 1970s underlined the way in which gender stereotypes and views on gender appropriate behaviour held by psychiatrists and psychologists could influence the diagnosis and treatment of women patients (Broverman et al, 1970; Kaplan, 1979; Billingsley, 1977). While this early work demonstrated that mental health professionals upheld gender stereotypes and attributed externally imposed societal limitations to intrapsychic

conflicts, research undertaken since 1985 suggests clinicians no longer hold significantly different mental health expectations for male and female patients (Phillips & Gilroy, 1985; Poole & Tapley, 1988; Kaplan et al, 1990).

The seven priority areas delineated by the Australian policy were reproductive health and sexuality; health of aging women; emotional and mental health; violence against women; occupational health and safety; health needs of women as carers and the health effects of sex role stereotyping on women. The Australian policy rests on two stated perspectives. First, that provided by the World Health Organization's 'Health for All by the Year 2000' initiative with its emphasis on primary health care and social justice and second, a 'social health' perspective which recognizes the interaction between social and economic factors and health.

However, this sociocultural perspective is relatively new in research on women's mental health. Until recently, much of the therapeutic and research endeavour in this area, sought to establish an intrinsic biological, hormonal or endogenous explanation for psychological distress, illness and disorder in women. A large research literature exists, for example, on the relationship between women's reproductive processes, from menarche to menopause, and their mental health and well-being. In reviewing this literature, Gitlin and Pasnau (1989) consider the evidence relating to four psychiatric syndromes which have been specifically linked to women's reproductive functions, namely postpartum depression, premenstrual syndrome, post-hysterectomy depression and involuntional melancholia. They conclude postpartum depression comprises three separate syndromes; the effective study of premenstrual syndrome is dependent on improved methodologies and there is no evidence for post-hysterectomy depression and involuntional melancholia. They argue our current level of understanding is poor as it rests on unwarranted assumptions and conclusions based on old, poorly conducted studies and a mixture of myths and culturally biased attitudes towards women. These attitudes have biased supposedly objective observations and implied aetiological links, with the result that observations more often and more accurately reflect the psychology of the observer, usually a man, than the observed. Acquiring knowledge, they conclude, will depend on designing better quality studies using data based research. Progress in this direction is still in its early stages.

While it is not disputed that the frequencies and patterns of mental disorder do differ for men and women, as found by the NIMH Epidemiological Catchment Area (ECA) Program (Eaton & Kessler 1985) for the fifteen diagnoses studied, the interpretation and explanation of these differences is open to discussion.

Women do predominate in diagnoses of depression, agoraphobia, simple phobia, dysthymia, obsessive compulsive disorder, schizophrenia, somatization disorder, panic disorder and histrionic personality disorder. The question is whether these differences in psychological morbidity are reducible to biologically based differences or whether they are better explained by reference to social role obligations, acquired risks and sociocultural factors in general (Kandrack et al, 1991). Certainly, the assumption that to be biologically female is to be intrinsically at higher risk for certain forms of psychopathology, such as

Histrionic Personality Disorder, previously known as Hysterical Personality Disorder, is being increasingly challenged by empirical research. Thus, a recent epidemiological study (Nestadt et al, 1990) of almost 3,500 subjects, carried out in conjunction with the ECA survey in Baltimore, on Histrionic Personality Disorder, found that males and females were equally affected. The population prevalence was 2.1%. The researchers concluded previous studies which reported the disorder was largely confined to women, focused on clinical populations and exhibited significant ascertainment biases relating to help seeking and sick role behaviours.

The historical dominance of an individual, pathologizing approach to women's mental health is in large degree derived from the clinical and theoretical influence of Sigmund Freud's work. The overwhelming emphasis Freud gave to biological over social factors, was influential in bringing about a preoccupation in much subsequent psychological and psychosomatic research, with a search for factors within a woman's own body and/or mind to account exclusively for her mental health. This search for 'within' woman factors was probably bolstered by the radical change in Freud's theorising on the question of childhood sexual abuse.

Initially, Freud hypothesized a clear connection between childhood sexual events and the development of hysteria in adult life. The events which occurred were referred to in such terms as 'rape', 'assault', 'trauma', 'aggression', 'abuse' and 'seduction'. All but the last of these explicitly acknowledge that violence by an adult has been perpetrated on a child. By his retraction of the early theory and subsequent reliance on the word 'seduction' with its ambiguity and blurring of who is responsible, Freud tended to remove an awareness of violence being perpetrated but involved the child in being a possibly willing and in a sense, an equal participant. In addition, when Freud decided that the reports of abuse he was hearing from his women patients were fantasies rather than facts, the distinction between the two fell away and became unnecessary for therapeutic purposes.

What actually happened to the woman as a child in a real world, which Masson (1988) calls 'external truth' or historical truth, with its marked asymmetries of power between children and adults, became ablated in this therapeutic revision. Only what went on within the woman herself, as determined by Freud's own theories of the unconscious, became a suitable object of therapeutic endeavour; nothing external to her could or should be changed, real trauma did not occur.

Masson, in discussing Freud's case history of Dora (Freud, 1905) which marks the change of his theories on the causes of hysteria, says:

'It is his declaration to his colleagues, (who had given his original theory on trauma an 'icy reception') as if he were telling them: "Look, Dora was suffering from internal fantasies, not external injuries. The source of her illness was internal, not external; fantasy, not reality; libido, not rape".'
(p105)

One of the givens of feminist critiques of knowledge in the social sciences (Harding 1987) is that previous theories have never been constructed by or based on the experiences or ideas of women. Yet the effect of psychoanalytic thinking with its emphasis on internal rather than external reality, suggests that the simple exclusion of women's voices from the theories of social science is not the sole difficulty. Alongside exclusion, there is a problem of distortion when women do not speak for themselves but rather are spoken for through a theoretical model they had no part in devising. In Freudian therapy, it would seem the woman patient and her therapist are in a remarkable relationship to one another. The therapist listens to what the patient is saying, but 'knows' psychoanalytically speaking, that what she says happened did not happen and that what she says she does not want, is, in fact, what she deeply desires. Thus a double crossover, has to be effected in the correct psychoanalytic translation of the patient's narrative; something which the patient can never properly understand for herself without the aid of her therapist. She is rendered incapable of being a 'knower' or even a reliable observer of her own life; not only does she want what she says she does not want, but what she says happened never occurred. Consequently the true state of her desire is the opposite of what she thinks: unconsciously, she is deeply desirous of something which did not take place and consciously, she is deeply distressed by something which did not occur.

Elaine Showalter (1987) argues that throughout the history of psychiatry men such as Pinel, Conolly, Charcot, Freud and Laing, have claimed they would free women from the 'chains of their confinement to obtuse and misogynistic medical practice'. However, until women speak for themselves Showalter argues, these 'dramas of liberation become only the opening scenes of the next drama of confinement'. (p250)

So effective was Freud's repudiation of the idea that actual childhood abuse had related to hysteria in adult women that Morrison (1989) in a review of the research literature, found that of the 75 papers published since the 1950s, only two provided any data at all on the patients' childhood sexual histories. One of these (Winokur & Leonard, 1963) did not even inquire about childhood experiences per se but rather reported the adolescent sexual experiences of the women with hysteria, did not differ from the general population as reported by Kinsey in 1953. The second paper (Coryell & Norten, 1981) reported an 18% incidence of childhood sexual abuse in patients with somatization disorder compared with no incidence in patients with primary affective disorders. However, this finding was discounted by the authors in a way which suggests the primacy of Freudian theory over patient perception. They disclaimed their own findings by explaining away the discrepancy between their data and the theory by saying 'questions concerning the validity of (early sexual molestation) are classic.'

Morrison's own research comprised an interview-based study which compared 60 women with somatization disorder and 31 with primary affective disorders, matched for race, age and level of education. He found 35% of women with somatization disorder had been sexually molested as children compared with 13% of the women with affective disorders. He concluded: 'The paucity of research into the sexual backgrounds of women with

somatization disorder may stem from the traditional belief that women with hysteria have only imagined early sexual molestation.'

The individual, biological, 'within' woman focus originally emanating from Freud, deflected clinical and therapeutic attention and research endeavour away from a consideration of the actual conditions of women's lives, their social and sex role obligations and position in society and their experiences of physical and sexual violence. All of these factors could be expected, from a social health perspective, to have a bearing on women's mental well-being.

Thus an important effect of the focus on biological, (hormonal/reproductive) within woman factors, was to localize pathology within the individual patient and decontextualize mental illness and its treatment. By implication, social realities were denied the possibility of making a contribution to mental illness. Alternatively, the individual focus might recognize social and economic contexts, but only as immutable 'givens' in a person's life, to which she must accommodate rather than attempt to change.

However, while individual approaches to treatment focus on bringing about change within the individual, Kleinman and Cohen (1991) have shown how very powerful messages about appropriate social roles are contained in psychiatric drug advertisements. In a content analysis of drug advertisements which appeared in the *American Journal of Psychiatry* between 1980 and 1988, they found advertisements aimed at women patients stressed the taking of medication would achieve 'maintainability' and 'manageability' of the traditional domestic division of labour. While reinforcing the view that women should perform all domestic work, the advertisements conspicuously failed to recognize how inadequate social support, a more equitable division of domestic labour, the absence of social recognition or alternative job opportunities, could cause psychiatric symptoms. Instead, they conveyed the implicit message that 'the problem lies within individual women themselves.' Kleinman and Cohen comment on the specious causal sequence implied in such advertisements which further obscures the impact of social roles and expectations on the development of distress:

'If there is a drug which will alleviate their problems, then they must be ill; this logic reveals the extent to which drug advertisements have influenced medical conceptions of health and illness'.

The denial of the social context of women's mental illness in these advertisements cannot be explained away on the grounds that there is no knowledge of the role social context and social support plays in the aetiology of mental illness.

As far back as 1855, there was evidence which suggested adverse social circumstances played an important role in mental illness, with the finding that rates of 'insanity' were proportionately 64 times as high in the 'pauper' as in the 'independent' class (Jarvis, 1971).

More recently, the classic study of Brown and Harris (1978), *Social Origins of Depression: A study of psychiatric disorder in women*, preceded the

time span of advertisements included in Kleinman and Cohen's study by two years. Brown and Harris underlined the importance of stressful life events in bringing about depression. Four vulnerability factors were found which increased the chances of a woman developing depression in the presence of a stressful life event or difficulty. The factors were: parental loss before 17 years of age - particularly the loss of one's mother before the age of 11, the presence at home of three or more children aged less than 14, a poor, nonconfiding marriage and the lack of full or part-time employment. The importance of these factors, especially the quality of a woman's relationship with her husband, have been confirmed in a number of other studies (Roy, 1978, 1981; Brown & Prudo, 1981; Paykel et al, 1980; Campbell et al, 1983 & Parry & Shapiro, 1986).

The sociocultural conditions of women's lives and their contribution to emotional and mental well-being are now receiving the attention of researchers.

Recent research differs in a number of ways from earlier research. Firstly, it often has an explicit concentration on gender differences which contrasts with the older research on sex differences wherein sex and gender were often confounded. The distinction between the two is crucial, because it acknowledges that gender is socially and culturally constructed while sex is a biological given. Thus while sex is immutable, (surgery apart) the construction of gender may change according to changes in culture and social attitudes.

Secondly, recent research on gender, is usually informed by feminist critiques of social science (Keller, 1985; Bleier, 1986; Harding, 1987) and the gendering of knowledge and as such is often powered by very different questions and hypotheses relating to women's social role and experience. It eschews biological reductionism, both as a starting point for research and as a ready source of interpretation of empirical results. This research typically seeks to convey the female experience from a 'woman centred' viewpoint (Lempert, 1986). It investigates rather than perpetuates gender bias in psychological theories and methods and it documents the deleterious effects of gender inequality and sex-role stereotyping in various aspects of women's lives. As such it has led to new areas of psychological research, an increased awareness of and questioning of gender-based assumptions in research and a reconceptualisation of women's psychology and men's psychology, previously equated with psychology in general (Carmen et al, 1981; Gilligan 1982). Before the development of a feminist perspective which provided the methodological tools for applying a gender analysis to psychology, it contained an androcentric bias. Many issues such as male violence against women were not defined as important topics for scientific attention (Walker, 1989).

Evidence bearing on the relationship between the conditions of women's lives and their mental health will now be discussed under two broad headings:

1. The conditions of women's lives.
2. The impact of physical and sexual violence.

5.1 Conditions of Women's Lives: Effects on Mental Health

Poverty, social position and mental health.

A strong, consistent, inverse relationship between socioeconomic status and a variety of mental disorders has been found in epidemiological investigations of the prevalence of psychiatric disorder in community populations since the turn of the century. Neugebauer, Dohrenwend & Dohrenwend, 1980, in a review of studies to that time, found that psychopathology was at least two and a half times more prevalent in the lowest social class than in the highest. This estimate parallels that found for many physical disorders, where the same relationship between social class and health obtains (Marmot et al, 1987).

Holzer et al, (1986) summed ECA data across all five research sites in the 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. Dohrenwend (1990) in a more recent review of the evidence provided by studies using the more rigorous and explicit diagnostic criteria of DSM-111, RDC or Feighner, found there was still compelling evidence of the relationship of SES and certain psychiatric disorders, namely schizophrenia, major depression, antisocial personality disorders and substance abuse.

Belle (1990) in a review of poverty and women's mental health notes that a great deal of research has been focused on depression because of the high prevalence of depressive symptoms among women compared with men. Two thirds of depressed patients are women and depression is the most commonly encountered women's health problem (Carmen et al, 1981; Benedek, 1981; Lempert 1986).

Amongst the correlates of depression identified in community studies since the 1970s high levels of depressive symptoms were common among women without confidants, child rearing assistance, employment, economic problems and chronic stressful conditions (Brown et al, 1975; Pearlin & Johnson, 1977; Radloff, 1975; Belle, 1982; Makosky, 1982). Kaplan et al, (1987) in a longitudinal study of depression found inadequate income was associated with an elevated risk of depressive symptoms over the nine year period of their study. Another study reported that nearly half low income mothers of young children had depressive symptoms and low income, unemployment and single parent status were all associated positively with the extent of depressive symptoms (Hall et al, 1985).

Perhaps the two groups of women most severely affected by poverty and its associated adverse effects on mental health are women heading single parent families and their children, amongst whom there has been a dramatic increase in numbers and also the numbers living below the poverty line (Belle 1988; Blaxter 1981; Trethewy 1989) and elderly women. Mowbray and Benedek (1988) using US figures have estimated that the numbers of women 65 years and older will double in the next 50 years, the majority of whom will be reliant on Government support. Currently more than a quarter of white

women, almost a half of hispanic women and 60% of black women live below the poverty level (Eichler & Parron, 1987). Further, the care of this increased population, if current trends continue will largely fall on their female relatives, with associated costs to their mental health (Eichler & Parron 1987). Leading mental health problems in the elderly are depression, organic brain syndromes and dementias. A quarter of those over 85 years have Alzheimer's disease or a related condition and most of them are women (Cohen, 1988). The use of psychotropic drugs, often in combination with a variety of other medications, is a particular concern for elderly women.

The relationship between low socioeconomic status and a high prevalence of psychiatric disorders has been subject to two quite different explanations. One, explains the relationship in terms of the greater environmental adversity which accompanies lower socioeconomic status which, in turn, produces high levels of social and personal stress. The other, a more biologically based explanation, is that rates of psychiatric disorders are higher in lower socioeconomic groups because persons with the disorders or with other personal characteristics predisposing towards the disorders are selected down into these groups or fail to rise out of them. Dohrenwend (1990) comments that the issue still remains unresolved. Despite this lack of resolution, publications investigating the relationship between SES and psychiatric disorders have decreased in the last decade, which cannot be attributed to compelling new evidence. Angermeyer and Klusmann (1987) in tracing the shift in social research from an emphasis of societal level analyses of SES to more micro-level, individual based analyses of stress experience, assert there is

'a possibility that social class issues may be simply ignored instead of elucidated by the new thrust toward stress research'. (p6)

Dohrenwend (1990) referring to his own, current, epidemiological study in Israel and the ECA collaborative study, (Holzer et al, 1986) the largest ever undertaken in psychiatric epidemiology, notes that for schizophrenia, major depression, and alcohol abuse or dependence there is still a highly significant inverse relationship with SES. He argues that far from the potential of the concept of social class being exhausted, a great deal remains to be done but what is needed is that more theoretically informed analyses of SES based on more sophisticated and relevant measures from disciplines including psychology, genetics and sociology have to be applied.

One suggestion he makes is that the relationship of SES to psychiatric disorder should be explored within the context of knowledge about how SES relates to various personality characteristics such as locus of control, values and attitudes and various stressful events and situations.

Clearly, there is a need to go beyond the 'facts' of the documented association of SES and mental health, where SES is crudely operationalized into measures of educational level, occupational level and income and ask what the conception of SES means, in terms of the conditions of women's lives, their exposure to stressors and the choices and opportunities, which may or may not be open to them as a result. It is only on the basis of this information that a fruitful enquiry could be made into why there is a higher prevalence of certain

mental health disorders such as depression among women and especially among poor women.

Belle, (1990) does, in fact, incorporate this approach into her investigation of the association between poverty and poor mental health in women. Belle asserts that poverty itself imposes a considerable stress on women as individuals and on their families while at the same time is responsible for attacking many potential sources of social support.

Positive correlates of depressive symptoms identified by Belle include low and uncertain income, inadequate housing, single parent status, unrelieved child care, lack of college education and unemployment. Paltiel (1987) confirms that there are obstacles, deficits and threats to health inherent in poverty such as the lack of the basic necessities and amenities of life, exposure to dangerous environments, isolation from information and support and an increased incidence of behaviours which pose a risk to health. These 'mal-adaptive' behaviours such as the use of alcohol, tobacco and licit and illicit drugs often represent counterproductive coping behaviours undertaken to provide relief from stressful lives over which the women may have little or no control. Alternate healthy coping behaviours might require the investment of time, energy, knowledge or money beyond the individuals perceived or actual capacity such as psychological counselling, exercise, nutritious food and the uptake of preventive health behaviours. It is also known that poor women use the medical services available less often than their better off counterparts and are less likely to participate in preventive programs (Australian Government Commission of Inquiry into Poverty, 1976).

Chronic life conditions can be even more potent stressors than acute crises Belle (1990) argues. In addition, poor women are disproportionately exposed to crime, violence and discrimination especially if they belong to minority groups. They experience more frequent, more threatening and more uncontrollable life events than does the general population, including the illness and death of children and the imprisonment of husbands (Brown et al, 1981; Belle 1982; Makosky 1982). While income levels have been shown to predict depressive symptom level, through their link to specific financial problems, parenting problems and child care problems, the linkages between various stressors and supports and depressive symptoms levels can vary with both marital and employment status. Thus role overload and marital difficulties can be more predictive with married women and the size of the social network may be more important with unemployed women (Hall et al, 1985).

Unemployment has also been shown to be a contributing factor in increased rates of suicide among women, as well as men, during the period 1974-1986, when major rises in both unemployment and suicide occurred in many Western nations (Pritchard 1990). Pregnant women and mothers of young children who are unemployed also have higher rates of anxiety and depression than employed women (Brown & Harris, 1978; Najman et al, 1983).

Further, as Belle (1990) points out social networks do not simply function as sources of social support, they can also serve as 'conduits of stress. Thus, women in difficult economic circumstances, whose relatives and friends are in the same position and also vulnerable to an increased number of stressful life events, may experience considerable stress 'contagion' (Wilkins, 1974).

Coping with the conditions imposed by poverty can be further constrained by having to be financially dependent on the state through its various bureaucratic institutions. Dealing with each of these for such basic necessities as housing, health, social justice and child welfare, can be time consuming, frustrating, frightening and the dependence created is likely to heighten feelings of powerlessness, lack of autonomy and a sense of worthlessness.

Depression may therefore become an almost unavoidable response to an environment that allows women little control over the most important things in life and little hope that life will improve (Belle, 1982). The use of drugs and alcohol as a means of dealing with life's seemingly intractable problems, briefly referred to here, will be discussed more fully in the section on the consequences of physical and sexual violence.

In addition, homelessness, which has emerged in the USA, United Kingdom and Australia as a major social problem in the last decade has been characterized by both an increasing incidence and decreasing age when first experiencing homelessness. Homelessness is known to be related to high rates of mental disorder, with up to a third of all homeless people suffering severe mental illness (Burdekin et al, 1989; Tessler & Dennis, 1989).

Increasing numbers of young women are being affected by homelessness according to The National Inquiry into Homeless Children in Australia (Burdekin et al, 1989). These young women experience every stress and adverse psychological outcome which has been documented for women, including poverty, violence, both physical and sexual, exploitation and abuse, disenfranchisement, inequality and substance abuse.

The Inquiry reported that in one city (Newcastle) there was a 50% increase in juveniles appearing before the Children's Court, in the first three months of 1988. The majority of these were first offenders with no fixed address.

Accommodation options for girls and young women were more problematic than those for boys and girls were at higher risk of exploitation and abuse. Rape, sexual violence and harassment not only occurred on the street, but also within 'refuges' when accommodation could be obtained there. Pornography, prostitution, theft and drug dealing were all resorted to as ways of obtaining money to survive. Eligibility requirements for obtaining government assistance such as possessing multiple documents proving identity, were so stringent that many destitute applicants were refused. Prostitution was often engaged in by girls in exchange for shelter, which was insecure. Sexually

transmitted diseases and unwanted pregnancy were common. A study commissioned by the Inquiry (O'Connor 1988) and reported in it, notes that over half the respondents reported having first experienced homelessness while 14 years of age or younger. Physical and/or sexual abuse was commonly given as the reason for leaving home. Three-quarters of the respondents reported experiencing severe depression, just under one-third had attempted suicide and many engaged in self-harm of other kinds. Alcohol and drugs were used to dull the pain of a daily experience marked by fear, loneliness and the constant threat of violent attack. Chronic physical ill-health was also reported but cost was an insuperable barrier to seeking medical attention.

Similarly, powerlessness, high rates of stress and psychological distress and the inability to afford adequate care during illness or take preventive health care measures affects poor, single mothers. Women head one seventh of all families in the USA and one half of all families living in poverty (Carmen et al, 1981). Between 1970 and 1980 there was a 97% increase in the number of single parent households headed by women in the USA (US Department of Commerce, 1982).

There are no reliable measures of the incidence of child and youth homelessness because as the US Institute of Medicine (1988) points out, conventional methods such as the Census are based on counting people where they live and the methodological problems of counting people without a fixed address are formidable. In Australia, it is estimated that there are some 50,000 to 70,000 homeless children and young people under 18 years of age.

Multiple roles - The double shift

Since 1950 there has been a highly significant increase in the numbers of women in paid employment in Western countries. In 1950, 30% of US women were in the labour force but by 1986 this had increased to 55%. During the same period the number of married women with children under six years of age increased from 23% to 54% (US Bureau of Labor Statistics, 1988). Similar figures pertain to Australia where 50% of married women were in the workforce by 1988 and there was a 23% rise between 1981 and 1986 in the proportion of two-parent families with children under five years of age where both parents worked (Australian Bureau of Statistics, 1988). Women typically have also assumed a large burden of care for elderly parents and in-laws, which can compromise their prospects of promotion at work and lead to emotional collapse, strained personal relationships, financial hardship and poor physical health (Horowitz 1985; Brody, 1985; Brody & Schoonover 1986).

At the same time, women as a group are concentrated in 'female' jobs and still only earn around 60% of the male wage in the USA (Carmen et al, 1981) and 65% in Australia (Probert, 1989). Hazards in traditional female employment, such as health care, clerical jobs and the textile industry may be overlooked (Lempert, 1986).

There has been no significant change in the domestic division of labour following increased workforce participation by women. Estimates of the time spent on housework and child care consistently reveal women do 90% of this unpaid work. Thus Szalai (1972) found working women averaged around three hours a day on housework, compared with the 17 minutes spent by men and about 50 minutes a day with their children compared with 12 minutes spent by men. On the other hand working fathers watched television an hour longer than their wives, slept half an hour longer (Szalai, 1972) and spent a longer time eating meals (Coverman, 1983).

Hochschild (1989) in a recent review of studies, estimated that women work an extra month of twenty-four hour days over a year. She argues there is a potent connection between lower wages in the workforce and less leisure for women at home, with inequality outside the home operating as a lever which reinforces and recreates inequality regarding the domestic division of labour within the home.

A number of studies have been carried out which investigate the psychological impact of roles, including marital status, paid and unpaid work and child care, on the emotional well-being of women.

Marital status

There is a striking relationship between marital status and mental illness (Guttentag et al, 1972; Gove & Tudor 1973; Gove, 1979). Women's higher overall rates of mental illness in the categories studied by Gove were largely accounted for by higher rates of illness among married women. Single, divorced and widowed women were found to have lower rates of mental illness than men. Data analysed by Gove and Geerken (1977) revealed the best mental health was experienced by employed married men and the worst mental health by unemployed married women. The presence of children in the household generally contributed to poor mental health as found by Brown and his associates (1975, 1978, 1981, 1986).

Subsequent research has yielded contradictory results. Some researchers have argued for the mental health benefits of multiple roles, saying that paid work for women has provided them with additional sources of self-esteem, financial autonomy, increased status within the home and increased social contacts (Nathanson, 1980; Verbrugge, 1983; Kendel et al, 1985; Haavio-Mannila, 1986). Others have argued that role accumulation has produced role strain, role conflict and role overload which together bring about negative health outcomes (Stellman 1977; Cleary & Mechanic, 1983). Still others have stressed the need for a more sophisticated theoretical approach to the relationship between multiple roles and mental well-being. Thus Kessler & McLeod (1984) found it was not simply the number of events in women's own lives that affected them but the events in the lives of those about whom they cared. Likewise Verbrugge (1986) highlighted the importance of ascertaining how women feel about their roles; whether they have been able to choose them and organize resources to meet the demands they impose, rather than

simply counting the number of burdensome events or tasks associated with a particular role. It has been found that spousal support for a woman's choices eases the stress of multiple roles (Elman & Gilbert 1984), while dissatisfaction with child care arrangements increases it (Van Meter & Agronow, 1982).

A recent large study of over 25,000 men and women from the 1985 and 1986 British General Household Survey (Arber 1991) found family roles were important to the health status of women, confirming the findings of Hirsch & Rapkin, (1986). Previously married housewives and unemployed women were nearly twice as likely to report long standing illness compared with employed women of equivalent marital status. Arber points out that studies to date have tended to study inequalities in men's health largely in terms of their occupational role and to conceive of and analyse differences in women's health using a theoretical framework of role analysis. Thus, in an ironical parallel to the inequalities in the domestic division of labour, research has paid little attention to men's marital and parental roles and women's employment has been conceptualized as an additional role rather than a structural variable, which it is for men. Arber notes that in the Black Report (1980), four explanations for inequalities in health were provided but none considered the way in which family roles might influence health. She argues for an integration of the findings from role analysis within a structural framework so that the relative contributions of and interactions between, family roles such as marital and parental status and structural variables including occupational class, housing tenure and participation in paid employment can be clarified.

McBride (1990) also suggests the need for more careful research and more refined theoretical concepts. Notions such as social support need to be distinguished from social involvement and the particular aspects of support need to be delineated, including emotional, informational and instrumental support. Coping is another concept in need of more precise operationalization according to McBride and coping strategies must be evaluated according to their contextual appropriateness (Aldwin & Revenson 1987). Similarly, while it is well documented that depression is identified with role conflicts (McBride 1989) work is required to elucidate how role strain leads to subsequent mental disorder and what part the cognitive or attributional style of the individual may play in this (Brewin 1985; Sweeney et al, 1986; Riskind et al, 1987). Care-giving obligations should be evaluated not just in terms of the number and ages of dependent children, but should also incorporate information on whether they have any health or behavioural difficulties.

Thus both Arber (1991) and McBride (1990) see the need for the development of a more thoughtful conceptualization of the problem of multiple roles and women's health.

What is needed is a move beyond the mere enumeration of events and roles to an inclusion of the subjective perceptions and understandings of the women who are directly involved with these events and roles.